SUBCOMM.

HEALTH

CARE

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11/8-9/01

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

October 26, 2001

To Whom It May Concern,

On November 8 and 9, the Senate Health, Education and Social Services Subcommittee on Health Care and Welfare will be meeting at the Mat-Su LIO to discuss the future of health care and welfare. We will be discussing Medicaid, welfare reform, rural health care, the certificate of need program, private health insurance access, and bio-terrorism preparedness and response.

Our focus during these meetings will be to gather information to prepare us for the upcoming session. We hope to determine if there are issues that need to be addressed in legislation.

As always, the legislature is concerned with the cost of providing Medicaid coverage. We will be exploring cost-containment measures to ensure that Medicaid coverage is provided in the most efficient way possible. However, we do not plan on having a line-item budget discussion. This meeting is intended to give us a general overall picture of the programs. We hope to include an overview of anticipated changes to the Federal programs, particularly in light of the events since September 11, 2001.

We are asking that public testimony be submitted in writing. All written testimony will be included in information given to committee members and considered in any concluding report.

Attached is a draft agenda for the meetings. If you have any suggestions, questions or requests, please feel free to contact my aide Aurora Hauke at (907)376-3370.

Thank you for your attention to these issues. I look forward to seeing you or hearing from you at the meetings.

Sincerely,

Lyda Green
Senate District N

Senate Health, Education and Social Services Committee

Subcommittee on Health Care and Welfare

November 8 – November 9, 2001

Senate Health, Education and Social Services Committee

Subcommittee on Health Care and Welfare

November 8-9, 2001

Agenda

November 8, 2001

9:00 a.m.-9:15 a.m.	Opening remarks (Senator Lyda Green)
9:15 a.m.-10:15 a.m.	Rural health care: role of the State of Alaska, the federal government and the native non-profit corporations (Division of Medical Assistance, Denali Commission, Alaska Native Health Board)
10:15 a.m.-10:30 a.m.	Overview of forecasted federal changes to formula programs
10:30 a.m.-12:00 p.m.	Overview of the current Medicaid program, budget trends, etc. (Legislative Finance Division, committee staff, Division of Medical Assistance)
12:00 p.m.-1:30 p.m.	Lunch
1:30 p.m.-3:00 p.m.	Medicaid fraud (Medicaid Fraud Unit)
3:00 p.m.-5:00 p.m.	Public testimony, committee discussion

November 9, 2001

9:00 a.m.-10:30 a.m.	Welfare reform status (American Institute for Full Employment, Division of Public Assistance)
10:30 a.m.-11:30 a.m.	State bio-terrorism response (Division of Public Health)
11:30 a.m.-12:30 p.m.	Certificate of need program (Department of Health and Social Services, Alaska State Nursing Home and Hospital Association, medical community)
12:30 p.m.-1:30 p.m.	Lunch
1:30 p.m.-2:30 p.m.	Access to private health insurance (Division of Insurance, Division of Medical Assistance, private insurance representatives, Chamber of Commerce)
2:30 p.m.-3:30 p.m.	Public testimony
3:30 p.m.-5:00 p.m.	Committee discussion: where to go from here? Cost containment strategies, access, coverage, and legislation needed.
	Possible request to non-legislative persons to meet in subgroups to bring further information and suggestions to the Legislature by February 1, 2002.

RURAL HEALTH CARE

Rural Health Update

The Division of Public Health's recent efforts in **rural health** have focused on increasing access to primary care, assuring the continuum of care for patients in rural areas, investigating reimbursement strategies for rural facilities and providers, supporting rural hospitals interest in becoming critical access hospitals, and strengthening emergency medical services.

Programs that have these targeted these activities include the Assistance for Community Health Facilities Program, the Primary Care/Frontier Health Program, the Denali Commission's Rural Primary Care Facilities Program, the Rural Hospital Flexibility Program, and the Emergency Medical Services Program.

The **Assistance for Community Health Facilities** program is authorized under 7 AAC 13.010 - 7 AAC 13.900 and is intended to partially subsidize operational deficits of rural clinics staffed by mid-level practitioners in order to increase the availability of health care in rural areas. In FY 02, the program awarded $351,000 in grants to seventeen community clinics. The program encourages grantees to network with other facilities to strengthen their viability.

The **Primary Care/Frontier Health Program** addresses access to primary health care and reduction of health disparities. The program supports activities and partnerships with other agencies and organizations to help communities in Alaska achieve access to primary, dental, and mental health care. Partnering with other organizations, to carry out activities to strengthen and expand preventive and primary care capacity is a major strategy of the program.

In the past year, activities of the program include, but are not limited to, community development efforts, workforce development, outreach efforts, designation of areas with need as underserved, improvement of health status by matching providers with communities in need, strengthening public and private reimbursement for community-based primary care services, and increasing federal funding for delivery of health care services in health centers.

A major focus of activity has been the **Frontier Health Initiative**, a major primary care effort that requested $6.5 million in federal funds from US DHHS, Health Resources and Services Administration. Of this request, $5.7 million was awarded in HRSA Section 330 Community Health Center grants to local communities and clinics to provide primary care services and strengthen health care delivery. The $500,000 of new funds awarded to DHSS, will be used to hire staff to provide t nical assistance to the new and existing health centers. The project will support health center operations to provide primary care in frontier communities.

Major activities for FY 2002 include: pulling together state, federal and local health agencies for joint strategy development on service delivery; investigating public and private reimbursement for community-based primary health care services; providing technical assistance for the development and operation of community health centers and rural clinics; further documenting state health unmet needs through designation of health professional shortage area applications and primary care access plans; providing advocacy at state and national levels for the underserved populations in Alaska; and providing site development and recruitment through the National Health Service Corps (NHSC)and other workforce development programs.

The **Denali Commission** Act of 1998 created the Denali Commission to promote job training, economic development, and rural infrastructure development. DPH has helped lead efforts to

support physical and operational improvements in facilities and clinics in rural Alaska. DPH has worked with the Denali Commission and other partners to commit over $22 million in funds for rural primary care clinic planning, design, and construction. In FY02, DPH will support the above objectives, including the review of proposals for primary care facility construction funds. DPH will be provide technical assistance to communities in the development of viable proposals.

The **Medicare Rural Hospital Flexiblity Program** seeks to strengthen and stabilize rural hospitals, develop and strengthen rural health networks, enhance and expand rural emergency medical services, and enhance and implement quality assurance for rural health services. The mission is accomplished in large part by providing technical assistance to communities in addition to providing direct funding to assist communities to examine all aspects of their local health care system in order to develop and implement a plan and strategies to strengthen that system.

Four hospitals, Valdez, Seward, Sitka, and Petersburg, have become CAHs. Cordova considered conversion and decided not to convert at this time. Funding has been made available to an additional five communities, Wrangell, Kodiak, Homer, Nome, and Kotzebue, to consider the CAH option. Discussions are underway with four other communities, Barrow, Unalaska, Metlakatla, and Dillingham; that may pursue program funding this year so that they can consider conversion. Program funds have been used to conduct community needs assessment and planning activities, rural EMS training, and development of EMS protocols for medical direction as well as regulations.

Major activities planned for FY02 include: a rural health care conference; revision of the rural health plan; rural health network development; support to hospitals to address staff training and hospital performance improvement; development of an on-line database of continuing medical education; assistance from specialized EMS teams to several communities; and completion of initial CAH designation activities with all interested rural hospitals.

Emergency Medical Services and Injury Prevention program within the DPH coordinates public and private agencies engaged in the planning and delivery of emergency medical services, including trauma care. The program assists public and private agencies to deliver emergency medical services through the award of grants in aid. EMS conducts and approves programs of education and training for health personnel involved in emergency medical services. The program maintains a process in which hospitals and clinics can represent themselves to be trauma centers.

Activities are conducted to ensure that qualified and properly equipped emergency medical services personnel are available to respond to the emergency medical needs of Alaska's citizens and visitors and, whenever possible, to prevent injuries from occurring in the first place. Some of the activities include: certifying emergency medical technicians, emergency medical services instructors, emergency medical dispatchers, and ground and air ambulance services; reviewing and approving Emergency Trauma Technician, Emergency Medical Technician, and Mobile Intensive Care Paramedic courses in Alaska; maintaining the population based Alaska Trauma Registry and using this dat ., and other data sources, to focus injury prevention efforts; and providing training and technical expertise to local EMS agencies.

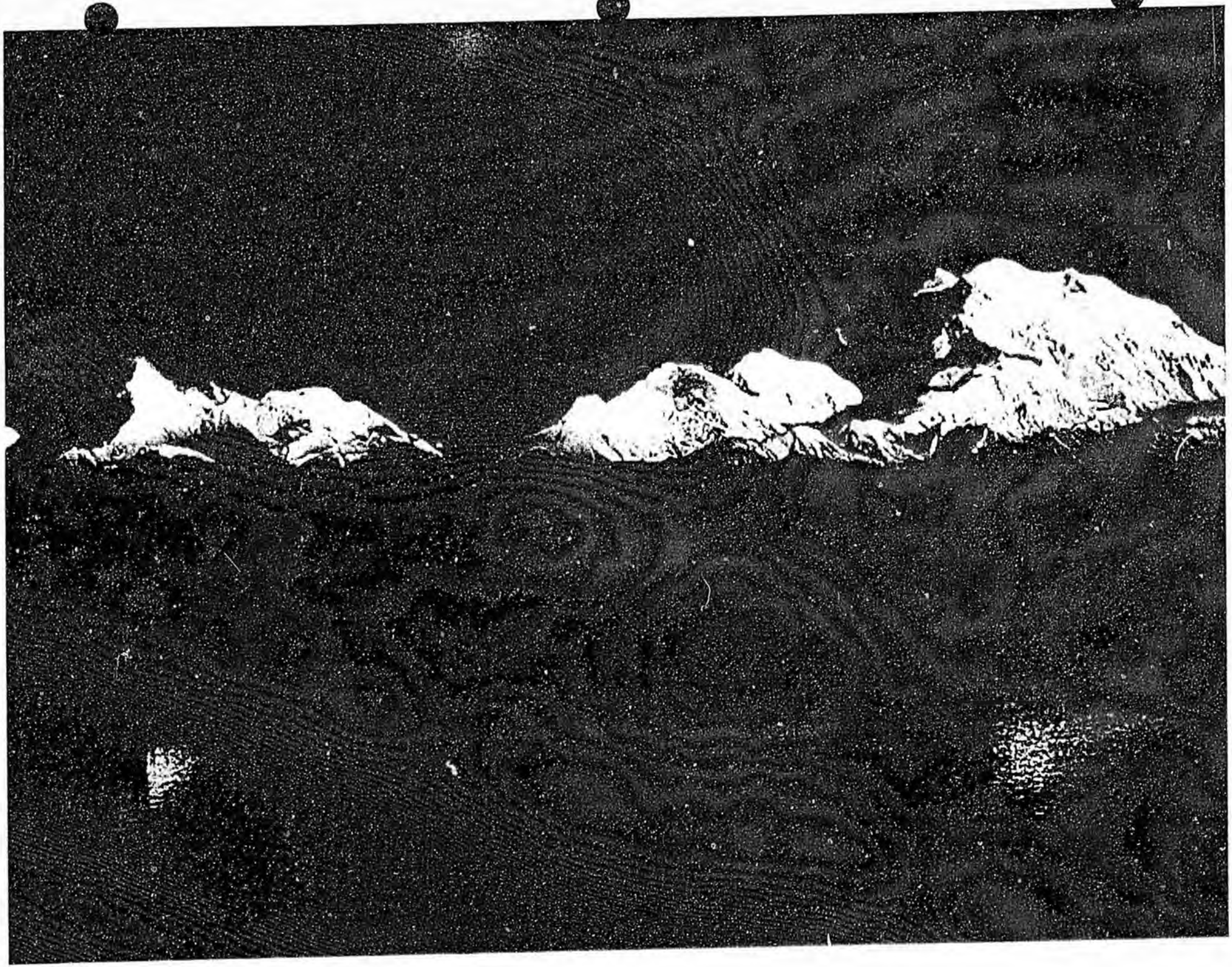
Other programs which reflect the breadth of activities in EMS and injury prevention include: Disaster Planning and Consequence Management; the Code Blue Project; Emergency Medical Services for Children Program; and the Alaska Comfort One Program; the Alaska Trauma Registry; and the Injury Surveillance and Prevention Program.

Comparison of Medicaid Allocation Methods

District	By Provider	By Eligible	Difference
1	16,839.0	16,904.5	-65.5
2	15,957.2	16,170.1	-213.0
3	24,875.8	19,680.6	5,195.2
4	6,836.3	12,173.4	-5,337.0
5	6,531.8	12,103.4	-5,571.7
6	11,376.9	12,928.0	-1,551.1
7	18,781.5	24,094.5	-5,312.9
8	25,461.5	23,993.8	1,467.7
9	14,955.8	20,081.8	-5,126.0
10	7,608.7	10,173.1	-2,564.4
11	31,192.9	23,906.8	7,286.1
12	8,050.0	15,223.3	-7,173.3
13	10,991.9	13,482.7	-2,490.8
14	6,186.8	15,939.2	-9,752.4
15	18,150.5	34,213.3	-16,062.8
16	20,749.2	34,164.3	-13,415.1
17	8,932.6	15,287.1	-6,354.5
18	6,824.2	8,412.8	-1,588.6
19	58,160.4	17,866.1	40,294.2
20	40,999.3	29,447.4	11,551.9
21	113,124.9	21,205.2	91,919.7
22	7,853.9	16,346.2	-8,492.3
23	6,382.9	12,629.6	-6,246.6
24	14,473.1	20,067.7	-5,594.5
25	9,226.8	12,413.8	-3,187.1
26	23,761.7	20,063.1	3,698.5
27	19,472.6	24,292.2	-4,819.5
28	10,653.4	25,358.8	-14,705.4
29	4,446.9	7,866.4	-3,419.5
30	9,663.6	12,941.1	-3,277.4
31	49,518.6	26,445.7	23,072.9
32	4,071.4	6,593.5	-2,522.1
33	4,481.7	8,078.1	-3,596.4
34	4,281.8	7,960.4	-3,678.6
35	8,457.9	11,543.2	-3,085.3
36	6,460.0	19,582.3	-13,122.3
37	6,929.9	13,115.0	-6,185.1
38	15,252.6	31,420.9	-16,168.3
39	30,002.1	30,858.4	-856.3
40	2,426.8	5,383.4	-2,956.6
Total	710,405.0	710,411.3	-6.3

Allocation of FY 2001 Authorized Operating Expenditures by District
(in $ thousands)

District	Entitlements	Grants	Program Services	Facilities	Administration	Total
1	16,904.5	4,383.1	3,812.8	95.6	0.0	25,196.1
2	16,170.1	3,996.3	1,994.4	0.0	0.0	22,160.8
3	19,680.6	4,470.2	19,631.1	1,247.8	2,906.4	47,936.1
4	12,173.4	4,481.3	19,631.1	1,247.8	2,906.4	40,440.0
5	12,103.4	2,479.5	684.4	0.0	0.0	15,267.3
6	12,928.0	2,304.6	1,212.3	0.0	0.0	16,444.8
7	24,094.5	3,386.7	2,072.6	0.0	0.0	29,553.8
8	23,993.8	2,812.4	2,072.6	0.0	0.0	28,878.8
9	20,081.8	2,074.7	2,072.6	0.0	0.0	24,229.1
10	10,173.1	2,649.3	6,194.6	1,752.4	217.3	20,986.7
11	23,906.8	2,649.3	6,194.6	1,752.4	217.3	34,720.4
12	15,223.3	2,649.3	6,194.6	1,752.4	217.3	26,036.9
13	13,482.7	2,649.3	6,194.6	1,752.4	217.3	24,296.3
14	15,939.2	2,649.3	6,194.6	1,752.4	217.3	26,752.8
15	34,213.3	2,649.3	6,194.6	1,752.4	217.3	45,026.9
16	34,164.3	2,649.3	6,194.6	1,752.4	217.3	44,977.9
17	15,287.1	2,649.3	6,194.6	1,752.4	217.3	26,100.7
18	8,412.8	2,649.3	6,194.6	1,752.4	217.3	19,226.4
19	17,866.1	2,649.3	6,194.6	1,752.4	217.3	28,679.7
20	29,447.4	2,649.3	6,194.6	1,752.4	217.3	40,261.0
21	21,205.2	2,649.3	6,194.6	1,752.4	217.3	32,018.8
22	16,346.2	2,649.3	6,194.6	1,752.4	217.3	27,159.8
23	12,629.6	2,649.3	6,194.6	1,752.4	217.3	23,443.2
24	20,067.7	2,649.3	6,194.6	1,752.4	217.3	30,881.3
25	12,413.8	2,649.3	6,194.6	1,752.4	217.3	23,227.4
26	20,063.1	3,524.0	2,248.6	408.9	0.0	26,244.6
27	24,292.2	3,392.6	2,248.6	408.9	0.0	30,342.3
28	25,358.8	3,489.7	2,248.6	408.9	0.0	31,506.0
29	7,866.4	3,227.1	3,431.5	477.5	0.0	15,002.5
30	12,941.1	3,231.8	3,431.5	477.5	0.0	20,081.9
31	26,445.7	3,193.6	3,431.5	477.5	0.0	33,548.4
32	6,593.5	3,219.1	3,431.5	477.5	0.0	13,721.7
33	8,078.1	3,247.8	3,431.5	477.5	0.0	15,234.9
34	7,960.4	3,184.1	3,431.5	477.5	0.0	15,053.5
35	11,543.2	1,089.5	1,036.3	0.0	0.0	13,669.0
36	19,582.3	3,401.4	1,290.5	0.0	0.0	24,274.2
37	13,115.0	7,924.6	1,212.3	0.0	0.0	22,251.9
38	31,420.9	5,201.3	2,424.6	687.7	0.0	39,734.4
39	30,858.4	11,640.9	9,600.5	2,081.7	0.0	54,181.5
40	5,383.4	1,712.5	352.0	0.0	0.0	7,447.8
Total	710,411.3	133,457.3	195,548.2	37,491.4	9,289.3	1,086,197.5

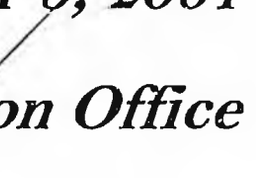


Rural Health Care Infrastructure

Presented to the Health Care and Welfare Subcommittee

November 8, 2001

@ Mat-Su Legislative Information Office



To Address:

"Rural Health Care and

The role of the State, the Federal government, the Denali Commission and native non-profit health corporations"



The Denali Commission- An Overview

- **Established in 1998 to provide critical utilities, infrastructure, economic development and training.**

  5% administrative cap – the Commission must therefore seek out program/project partners to carry out it's work.



Commission Health Facilities Programs

- 1999 amendments to P.L. 105-277 authorized demonstration projects between the Commission and the U.S. DHHS that include:
  - Hospitals
  - Mental health facilities
  - Elder care and child care
  - Primary care facilities



Health Facilities Focus

- Rural Primary Care Facilities
  - "Large" Clinics > $1 Million & pop. > 750
  - "Small" Clinics < $1 Million & less than 750 yr.-round pop.
  - "Repair/Renovation of Existing Clinics
- No facilities to date requiring a "Certificate of Need" from the State
- Future Health Facilities Infrastructure development to be guided by the Commission's Health Care Steering Committee



Health Care Steering Committee Representatives (All "State-wide Organizations")

- Alaska Native Tribal Health Consortium
- State of Alaska, Department of Health and Social Services
- Indian Health Service

- Alaska Primary Care Association
- Alaska Mental Health Trust
- University of Alaska
- Alaska Native Health Board



Evolution of the Steering Committee

- Formed (Feb. 2000) to complete Needs Assessment - $253 Million need identified
- Expanded membership and role (Sept. 2000)
- Still a "working group" – developed Small Clinic RFP (March 2001)
- Changes (October 2001): membership & SC/Workgroup process



New Role for the Steering Committee

- Addition of the University of Alaska – Vice President for Health and Social Services (Karen Perdue)
- Addition of the Alaska Native Health Board
- The Committee is to become more of a <u>policy advisory group</u> instead of a workgroup



Denali Commission Partners

Alaska DHSS (Pre-Award Manager)

- Manages the RFP processes for the Commission

ANTHC (Post-Award Project Manager)

- Partner and agent of the Denali Commission for the "small" clinics
- Develops a relationship with each community.
- Offers construction options based upon community's preferences and capabilities.

Successful "Large" Clinic Applicants



Denali Commission Clinic Funding- Construction Options

1. Community-managed force account
2. Community-managed competitive contract with strong local hire component
3. Regional Health Corporation – managed force account
4. Regional Health Corporation – managed contracts with strong local hire requirement

- ANTHC-managed competitive contract with strong local hire requirement
- ANTHC Department of Environmental Health and Engineering – managed force account

or combinations thereof



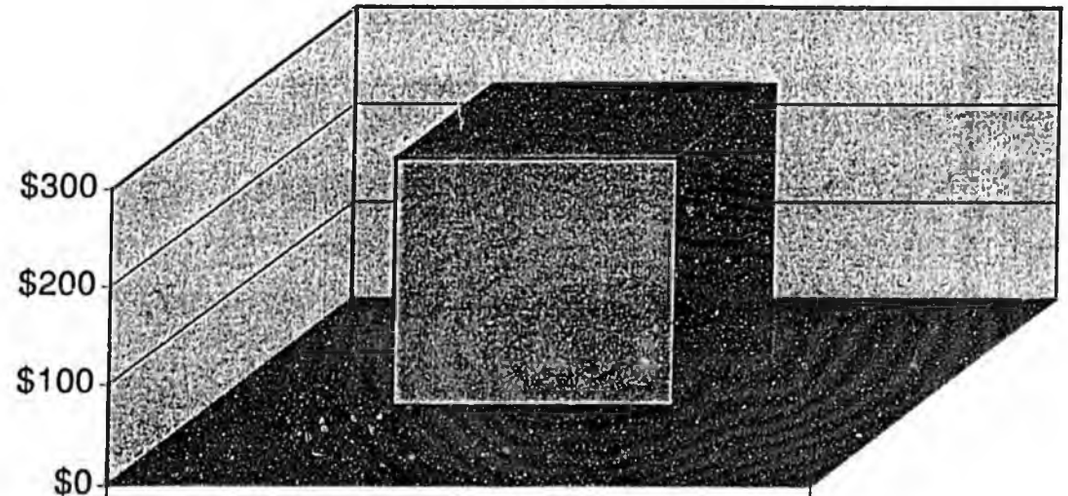
Denali Commission Clinic Funding

- FY 00 funds for clinics = $1 million
- FY01 funds = $20 Million ($10 M from HRSA, $10 M from the Commission)
- FY02 Funds = unknown – but planning is for $20 to $30 Million
- On 9-20-01 the Commission approved up to $12.5 Million for "Small" Clinics



Commission Clinic Efforts to Date

Primary Care (Clinics) Needs (millions of dollars)



	1
Total Need	$253
Total Funded (Commission $)	$22
Total Completed	$1

Features about Commission Funded Clinic Projects

The Commission wants projects that are "good to go," serve the greatest need, and will last for many years.

- Community Planning
- Cost Share
- Sustainability – both facility and program
- Project Readiness



Project Funding Approach

- No maximum project funding level (must be reasonable though)
- The goal is for a facility that can provide the appropriate **minimum level of primary care**:
- See Minimum Program Goals (Page 24)
- See Space Guidelines (Page 25)
- Area Adjustment Factor



Project Funding - Continued

- A community can develop a project larger than "Minimum" or that which is recommended in the C&C surveys, but will have to pay the difference

  Likewise, a community can develop a smaller project, but the 20 or 50% cost share requirement remains



Denali Commission Clinic Funding- Community Planning

- Seek to fund comprehensive community-based, regionally supported, sustainable projects
- Health services are responsive to the needs of the community
- Encourages communities to look at their needs in three primary care service areas: mental health, substance abuse, dental health
- Multi-use projects (e.g. Clinic and Washeteria or Headstart) are encouraged.



Cost Share Score

- Federal law requires a cost share match
- Required $ minimum – construction & equipment
- 20% (severely economically distressed)
- 50% (economically distressed)
- No minimum $ for planning/design (including multi-use facilities; excluding interior architectural design)



Cost Share Match-
In-Kind Contributions

- Only cash, land, and sand/gravel are allowable cost share matches
- All other matches – in-kind labor, equipment costs, construction material, etc. will not be considered.



Program and Facility Sustainability

- Service Delivery Plan: shows how the health services fit with the proposed facility
- Facility Sustainability Plan: shows how the organization will pay for O&M costs for the facility



Project Readiness: What are Measures of Readiness?

Funding in the bank or committed

- Site control secured
- Design completed, or a plan to complete design
- Community selection of 1 of 6 project management options through ANTHC
- Documented project management plan – schedule, budget, etc.
- Environmental and SHPO clearance



Proposal Scoring System

- **Local Support – 0**
- **Site Availability and Control – 0**
- **Utility Extension Plan – 0**
- **Match/Cost Share – 20**
- **Service Delivery Plan – 13**
- **Facility Sustainability Plan – 6**
- **Existing Facility Deficiency Score – 45**
- **Multi-Use Facility – 5**
- **Readiness Score – 11**



Denali Commission Clinic Funding- Selection Process

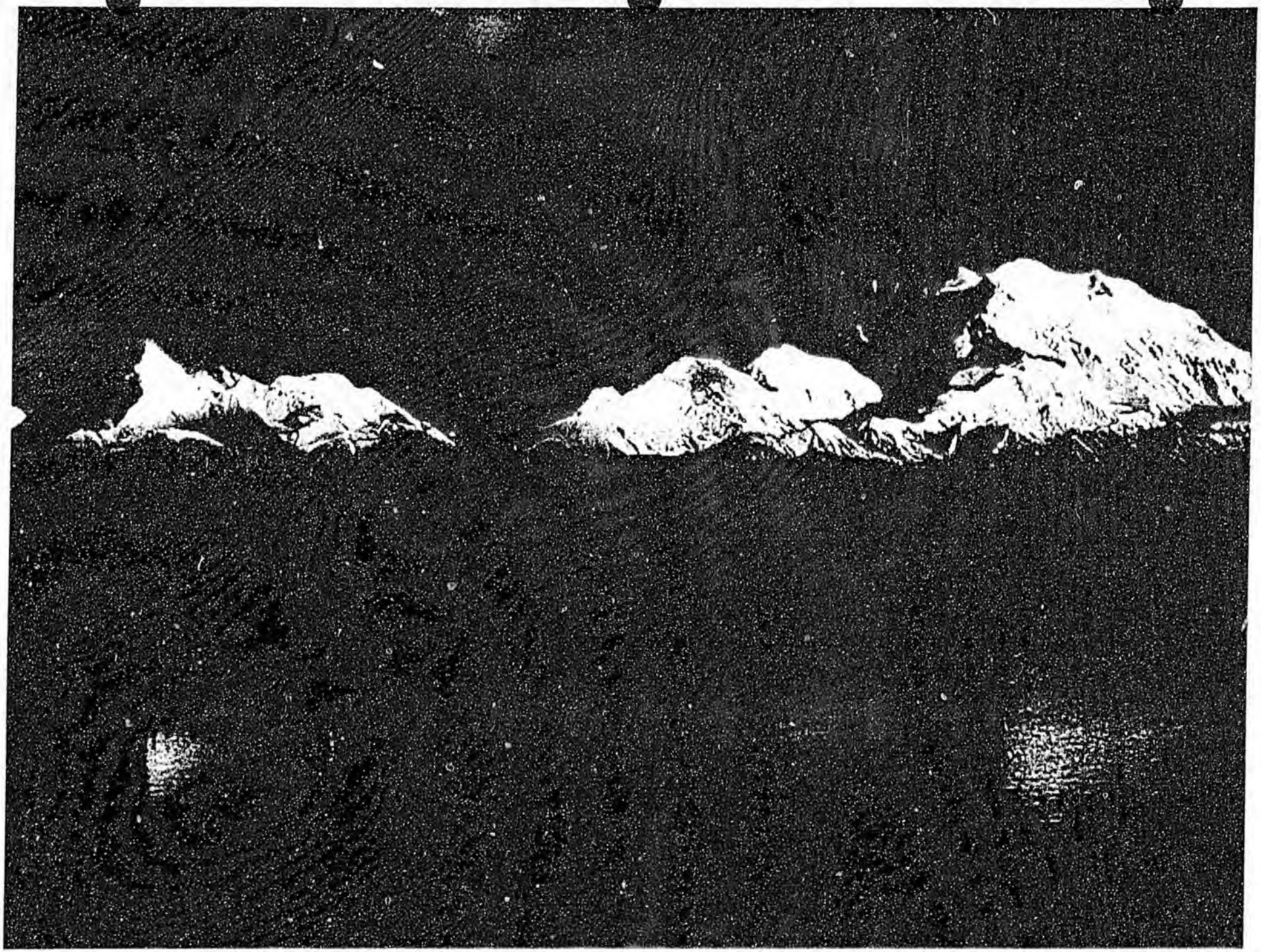
- **Multi-discipline Review Panel (MRP)**
- **Highest scoring proposals will be selected**
- **Projects will be funded based on availability of funds,**
- **The Commission is not bound to select lowest cost proposals**
- **The Commission may negotiate funding, performance level and assign award contingencies.**



Additional Commission Health Care Efforts

- **A-DOT&PF initiative on "Coordinated Transportation"**
- **FAA report to Congress on airport improvements to support health care**
- **Standardized clinic designs**
- **Code and Condition surveys of existing clinics**
- **Coordinated project funding with HUD and other funders**





Denali Commission Update
November 2001

Note to Legislators and Staff: Please contact Krag Johnsen, Alaska State Legislature's Staff Representative at the Denali Commission for further information. (907) 271-1413, Kjohnsen@denali.gov.

Energy

Energy projects comprise nearly $65 million of Denali Commission funding. This is leveraging an additional $22 million from other funding sources. The two primary agents used to complete projects are **Alaska Industrial Development and Export Authority/Alaska Energy Authority (AIDEA/AEA)** with **$43.8 million, and Alaska Village Electric Cooperative (AVEC)** with $21.3 million presently funded.

All Federal FY01 financial awards incorporated sustainability criteria for their projects. This requires that a business plan be developed demonstrating how the community will operate and maintain the utility in a business-like manner, attain the full expected economic life of the utility, and build some equity for future replacement. Construction funds are not authorized for these projects until the business plan has been approved, and a potential backup operator is named for the event that a community is unable to adhere to the business plan. Funding for business plan development is currently available for 54 communities. Most Denali Commission Energy projects need a two-year cycle to complete planning design and construction. As the cycle has developed, questions continue to arise on how to fund projects equitably, and how to plan for future work. In September, the Denali Commission issued three draft policies regarding capacity, fuel pipelines and dispensers, and energy project prioritization.

BULK FUEL UPGRADES

Bulk Fuel Upgrades are the largest part of the Energy program at $39.3 million. By the end of 2001, new bulk fuel projects will be substantially complete and operational in nine communities: **Kotlik, Chignik Lagoon, Old Harbor, Noorvik, Port Graham, Manokotak, Kiana, Allakaket, and Napaskiak.** Three projects were put into operation last year.

RURAL POWER SYSTEMS UPGRADES

Rural Power Systems Upgrades represent $16.9 million of the Energy program. Twelve other energy projects (including power plant upgrades, electrical distribution upgrades, and fuel-line replacements) should be complete in **Kasigluk, Kiana, Huslia, Kivalina, Ambler, Quinhagak, Pilot Station, Shishmaref, Savoonga, Toksook Bay, Tuntutuliak and Kotlik.**

ENERGY COST REDUCTION RFP

Energy Cost Reduction RFP, with $4 million in Denali Commission funds, was issued by AEA on May 18, 2001. Preference in evaluation will be given to economically distressed rural communities, or those with extremely high-energy costs. It is anticipated this money will be allocated to projects in the January 2002 Quarterly meeting.

Contact Information:
AIDEA/AEA Contact Mike Harper, (907) 269-3000
AVEC Contact Meera Kohler, (907)561-1818

Denali Commission Program Manager Kathy Prentki, (907) 271-1414

Health

To date the Commission has obligated $22 Million for health care facilities leveraging an additional $20 Million in contributor funding. A total of 24 clinic construction projects have been funded and an additional 28 planning/design projects have been funded.

There is no one State or Federal agency tasked with provision of health care facilities throughout all of Alaska. Many agencies and health care organizations have overlapping interests, but there is no one agency to turn to. Accordingly, the Commission established a Health Care Steering Committee of agencies and organizations with interests in health care. The Steering Committee is chaired by the **Director, State of Alaska Division of Public Health** and has members from the following organizations: **Indian Health Service, Alaska Native Tribal Health Consortium (ANTHC), University of Alaska, Alaska Primary Care Association, Alaska Native Health Board, and the Alaska Mental Health Trust Authority.**

For carrying out its Health Care Program for the "Small Clinic" program (typically a clinic that serves one community with a year-round population less than 750) and the "Clinic Repair/Renovation" program, the Commission has turned to the State of Alaska as our "pre-award" partner and ANTHC as our "post-award" partner. The State manages the Commission's request for proposals process in conjunction with the Commission. Once projects have been identified, then ANTHC will manage the projects on our behalf. Communities have a choice of 6 management options through ANTHC:

- Community-managed force account
- Community-managed competitive contract with strong local hire component
- Regional Health Corporation - managed force account
- Regional Health Corporation - managed contracts with strong local hire requirement
- ANTHC-managed competitive contract with strong local hire requirement
- ANTHC Department of Environmental Health and Engineering - managed force account

For our "Large Clinic" program (typically a clinic that serves multiple communities or a community with a year-round population greater than 750) the State of Alaska is our "pre-award" partner. To date, all project applicants are our "post-award" partners and provide project management. However, in time the Commission may have to revisit this approach as the volume of "Large" clinic grantees grows beyond Commission staffing ability to respond to our Large Clinic partners needs.

Contact Information:
Denali Commission
Joel Neimeyer, Health Care Program Manager: (907) 271-1459
Al Ewing, Chief of Staff: (907) 271-1426

ANTHC
Rick Boyce, Facilities Program Manager: (907) 729-3601
Seth Yerrington, Clinic Construction Program Manager: (907) 729-3747, (907) 729-3600

State of Alaska
Karen Pearson, Director, Division of Public Health & Chair of the Steering Committee: (907) 465-3090
Pat Carr, Program Manager, Primary Care and Health Promotions: (907) 465-8618

Training

DENALI TRAINING FUND

The Denali Training Fund was established by the Denali Commission specifically to ensure that local residents have the skills to become employed on the construction, operation, and maintenance of Denali Commission and other state and federally funded public infrastructure projects. To date over three hundred people from rural Alaska communities have been trained for numerous construction, operations, and maintenance careers.

The **Department of Labor and Workforce Development** operates, selects, oversees, and administers the Denali Training Fund. On a quarterly basis applications of up to $25,000 for training are solicited from non-profit and for-profit organizations and governments.
Contact Information: Gerry McDonagh, (907) 269-4551

ALASKA NATIVE COALITION ON EMPLOYMENT AND TRAINING (ANCET)

ANCET consists of the **twelve regional Native Nonprofit Corporations** and **Metlakatla** as a unified organization to further employment and training issues statewide and nationally. The focus of ANCET for the Denali Commission has been to implement a **Regional Coordination Initiative** that handles much of the recruitment for various training courses that are funded by the Denali Training Fund.
Contact Information: Bonnie Jo Savland, (907) 644-8312

ASSOCIATED GENERAL CONTRACTORS OF ALASKA

With Denali Commission funds the **Associated General Contractors** administer the **Construction Career Pathways Initiative**, placing construction curriculum in rural schools through **Build Up!** for elementary grades. To date **Build Up!** has been introduced to 27 different schools in 13 rural school districts. AGC is looking for more for more rural schools to offer the curriculum.
Contact Information: Vicki Schneibel, (907) 561-5334

ALASKA WORKS PARTNERSHIP

Alaska Works Partnership (AWP) and the Denali Commission have partnered to deliver apprenticeship outreach services in rural Alaska. **AWP** provides information to students and adults about jobs in the construction industry and opportunities to learn construction skills through registered apprenticeship. To date thirty rural residents successfully entered specific craft apprenticeship programs, and over sixty are registered as **Building Maintenance Repair (BMR)** apprentices with **Alaska Works**.
Contact Information: Tom Brice, (907) 457-2597

ALASKA VOCATIONAL TECHNICAL CENTER

AVTEC has implemented two programs that provide advanced skills certification. The first is the **Building Maintenance Repairer Apprenticeship (BMR)**, which includes comprehensive training in the basics of carpentry, plumbing, heating, and electric. The second initiative developed the curriculum for the **Bulk Fuel Tank Farm Operator course**, which trains the individual in the statutes, regulations, and requirements of the operation and maintenance of bulk fuel storage facilities in Alaska.
Contact: Dick Harrell, (907) 224-4162

Contact Information:
Denali Commission
Krag Johnsen, Program Manager, (907) 271-1414

Other Infrastructure

MINI-GRANT PROGRAM

The Division of Community and Business Development (DCBD) administers the program, under the **Alaska Department of Community and Economic Development.** The program has one grant cycle, which began August 8, and will conclude with final awards on January 15. The Denali Commission contributed $500,000 and the **USDA Forest Service** contributed $144,755, for a total Mini-grant program of $644,755. *Contact Information: Nelda Warkentin, (907) 269-4568*

COMMUNITY PRIORITIES PROGRAM

The Denali Commission invested $4,500,000 in this program, which is administered by the **Division of Community and Business Development (DCBD),** under the **Alaska Department of Community and Economic Development.** The program has quarterly grant cycles. The second grant cycle is under way. Pre-applications for the third and fourth grant cycles are due November 2, 2001, and February 18, 2002 respectively. *Contact Information: Nelda Warkentin, (907) 269-4568*

ALASKA GROWTH CAPITAL PROGRAM

The Denali Commission has invested $2,340,000 with **Alaska Growth Capital** to support viable businesses in rural Alaska, with emphasis on Alaska-owned businesses in economically distressed communities. The program does not have a funding cycle, but responds to requests for assistance on a year round basis. **Alaska Growth Capital** (AGC) has made $1,625,000 in loans this year to Alaska-owned businesses in economically distressed communities. An additional $600,000 in loans is in the closing process. The businesses that received loans have an annual payroll of $350,000. In addition, AGC has made 15 consulting engagements with clients or potential clients. *Contact Information: David Hoffman at (907) 349-4904*

Contact Information:
Denali Commission
Paul McIntosh, Program Manager, (907) 271-1640

First Alaskans Foundation

In late 2000, the Commission granted $1.2 million to the First Alaskans Foundation. The foundation, a non-profit organization affiliated with the Alaska Federation of Natives, is working to develop capacities of Alaska Native people and communities "to meet social, educational and economic challenges of the future." This capacity building program will be phased over a two-year period and will work on the development of local decision-making, and enhancement of management and governance skills necessary to plan and implement sustainable community development efforts. Funding has been made available through five separate RFP processes: community development, community economic development, statewide visioning, regional/sub-regional infrastructure planning, and community infrastructure construction.

Contact: Jason Metrokin, Director of Programs, (907) 263-9890

Denali Commission brings GrantStation.com to Rural Alaska

The Denali Commission, Alaska State Libraries, USDA Rural Development, and GrantStation.com Inc. recently announced a jointly funded project to bring state of the art grant seeking services to organizations and residents in rural Alaska.

GrantStation.com is an Alaskan owned and operated company provides an on-line comprehensive, fully interactive and searchable database of funding sources for organizations at www.grantstation.com. Members of GrantStation have access to worldwide funding sources (soon to include all state and federal sources) with the most up-to-date contact information, an accurate understanding of a funder's philosophies and rules, and valuable information on the most effective way to work with a particular funder.

Under the terms of the contract GrantStation.com membership will be provided to the following organizations for two years:

- All State Libraries (approximately 75 Rural Locations will have grantstation.com access for the public)
- All Tribal offices
- All City offices
- All Health Corporations
- All Regional Native Non-Profits
- All Rural School Districts
- All Rural Borough offices

Jeff Staser, Federal Co-Chair of the Denali Commission said, "The Denali Commission has already been successful in securing private foundation dollars with previous projects, we believe that GrantStation.com services will help expand on this success and bring more funding to rural Alaska and ultimately stretch the federal and state's investment into rural communities

MEDICAID PROGRAM

A Brief Overview of the Alaska Medicaid Program

Presented to members of the Senate
Health, Education and Social Services Subcommittee on Health Care and Welfare

November 8 and 9, 2001

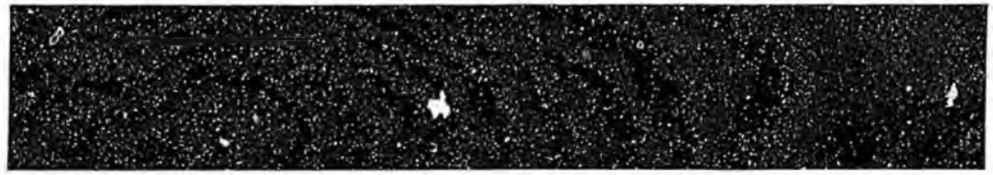
What's the difference between...

Medicare?

Medicare, the nation's largest health insurance program, covers 39 million Americans. It is a health insurance program for people 65 years of age and older who have worked 40 Social Security quarters, and for some disabled people under 65 years of age. Eligibility is not based on income. The Health Care Financing Administration (HCFA) administers Medicare.

Medicaid?

Medicaid is a "means-tested," jointly-funded, Federal-State health insurance program for certain low-income and needy people. It is an "entitlement" program which currently covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Medicaid is administered by the State.



- Established by the Social Security Act Amendments of 1965 to pay for medical assistance for certain individuals and families with low incomes and resources.
- Administered by each State under a host of Federal rules, with both sharing in the cost of the program.
- Eligible groups per Federal law
  - Mandatory: Family Medicaid; Newborns and Children in Lowest Poverty Levels; SSI recipients
  - Optional: APA recipients; Denali KidCare; Pregnant women
- Services allowed per Federal law
  - Mandatory
  - Optional
- Federal law requires each State to have a committee (MCAC) to advise the Medicaid agency in order to obtain Federal matching funds.

- Medicaid Program Enacted July 6, 1972
- AS 47.07 includes:
  - Sec. 47.07.020. Eligible persons.
  - Sec. 47.07.030. Medical services to be provided.
  - Sec. 47.07.035. Priority of medical assistance.

Eligible Persons

Federally mandated groups include:

- Family Medicaid
- Newborns and children at lowest poverty levels
- SSI recipients
- Children at lower poverty levels
- Pregnant women at lower poverty levels

Optional groups include:

- Some APA recipients
- Children at higher poverty levels
- Pregnant women of higher poverty levels

Eligibility: In Simpler Terms...

To be eligible for Medicaid, a person must be one of the following:

A Child	Aged
A Caretaker of a Child	Blind
A Pregnant Woman	Disabled

Who will not qualify?

Adults (ages 21-64) with no children -- regardless of their medical need or lack of financial resources. *

**Unless the adult meets disability requirements.*

Federally Mandated Services

Mandatory Services: Sec. 1905, Social Security Act

Inpatient hospital services
Outpatient hospital services
Prenatal care
Vaccines for children
Physician services
Nursing facility services
Family planning services and supplies
Rural health clinic services
Home health care for persons eligible for skilled-nursing services
Laboratory and x-ray services
Pediatric and family nurse practitioner services
Nurse-midwife services
Federally qualified health-center (FQHC) services
Early and periodic screening, diagnostic, and treatment (EPSDT)

Children's Services

- All medically necessary health care services must be covered for eligible children.
  - ***Within the scope of mandatory or optional services under Federal law.***
  - ***Even if those services are not included as part of the covered services in that State's plan.***

Optional Services

AS 47.07.030

(◗ Selected by the Alaska Legislature for coverage)

◗ Ambulatory surgery center services
◗ Case management services
Chiropractic
Christian Science sanatorium
Clinic services
Community supported living arrangements
◗ Dental *(adults limited to emergency treatment for pain and infection)*
Dentures
Diagnostic services
◗ Durable medical equipment
Emergency hospital services (for hospitals not enrolled)
◗ Home and community care
◗ Home health
◗ Hospice services
◗ Intermediate Care Facility for the Mentally Retarded (ICF/MR)
◗ Services in an inpatient psychiatric facility for age 65 and older
◗ Medical supplies
◗ Occupational therapy
Optometrist services
◗ Personal care services
◗ Physical therapy
Podiatry
◗ Prescription drugs
Preventive services
Private duty nursing
◗ Prosthetics and orthotics
◗ Rehabilitation services *(mental health and substance abuse)*
Respiratory therapy
Screening services
◗ Speech, language and hearing services
◗ Vision services

AS 47.07.035 Priority of medical assistance

Priority	Type of Service	FY01 Recipients	Cost
1	Clinical Social Workers Services	0	$0
2	Psychologists Services	0	$0
3	Chiropractic Services	0	$0
4	Advanced Nurse Practitioner Services	0	N/A
5	Adult Dental Services	4,798	$1,699,255
6	Emergency Hospital Services	0	$0
7	Midwife Services	0	N/A
8	Treatment of Speech, Hearing, and Language Disorders	1,686	$920,912
9	Optometrists Services and Eyeglasses	9,407	$1,135,807
10	Occupational Therapy	292	$404,894
11	Mammography Screening	928	$33,733
12	Prosthetic Devices	285	$248,949
13	Medical Supplies and Equipment	1,874	$2,564,022
14	Targeted Case Management Services	0	$0
15	Rehabilitative Services for Substance Abusers and Emotionally Disturbed or Chronically Mentally Ill Adults	735	$2,507,124
16	Clinic Services	4,005	$42,516,123
17	Physical Therapy	9,316	$918,404
18	Personal Care Services in a Recipient's Home	1,198	$6,251,068
19	Prescribed Drugs	26,664	$27,659,154
20	Hospice Care	5	$7,494
21	Long-Term Care Noninstitutional Services	2,246	$55,495,465
22	Inpatient Psychiatric Facility Services	490	$13,845,681
23	Intermediate Care Facility Services for the Mentally Retarded	0	$0
24	Intermediate Care Facility Services	0	$0

Source: MMIS MARS MR-O-12 Reports

15. Rehabilitative services includes day treatment facilities, rehabilitation centers & drug & alcohol abuse centers
16. Clinic services includes mental health clinics

Medical Care Advisory Committee

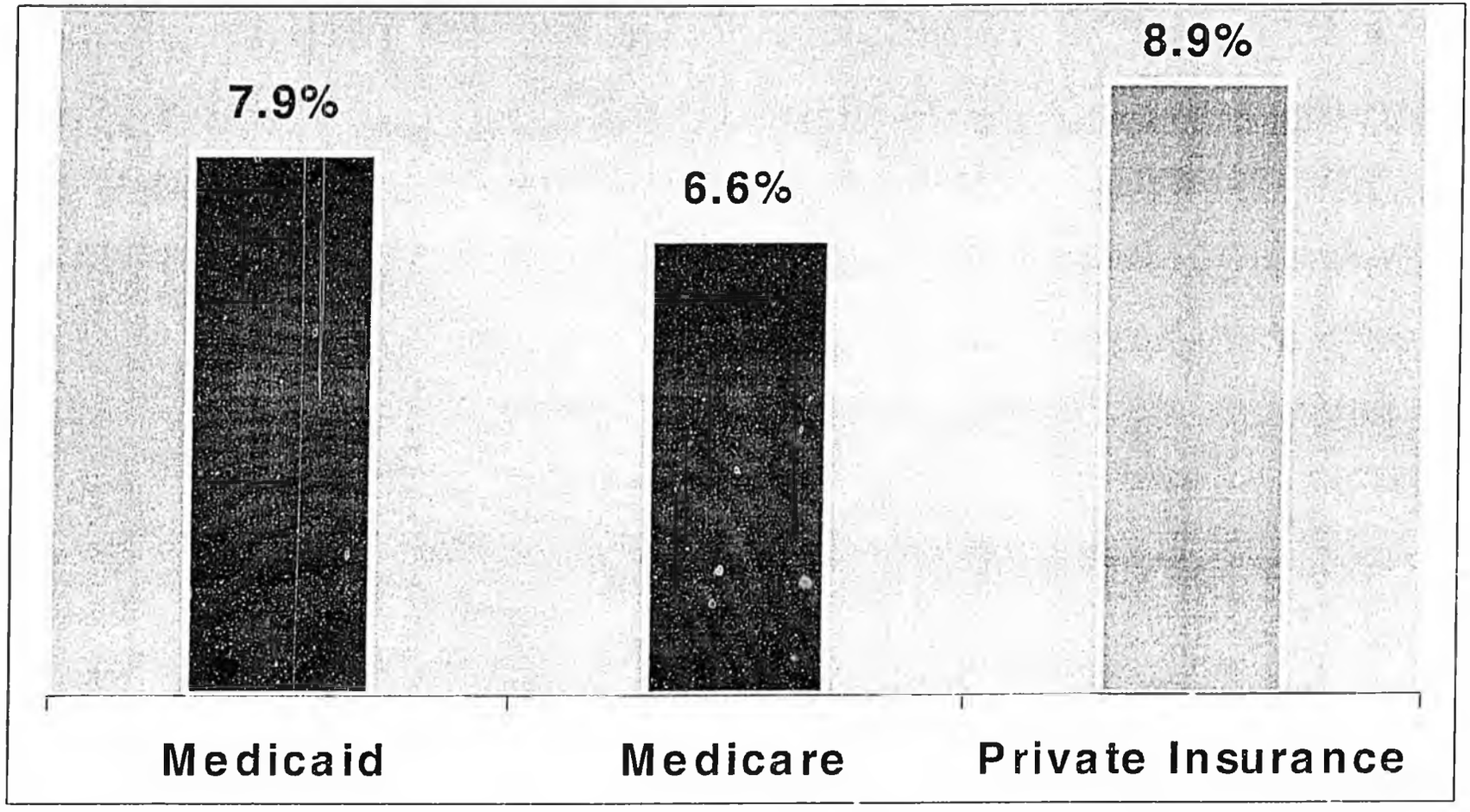
- Federal law requires each State to have a committee to advise the Medicaid agency in order to obtain Federal matching funds.
- Committee meets quarterly.
- Members appointed by Commissioner of Health and Social Services.
- Members must include:
  - Physician(s) and other representatives of health professions
  - Members of consumer groups, including beneficiaries, and consumer organizations

Nationwide Medicaid Expenditure Growth Converging Trends are Causing Medicaid Expenditure Growth

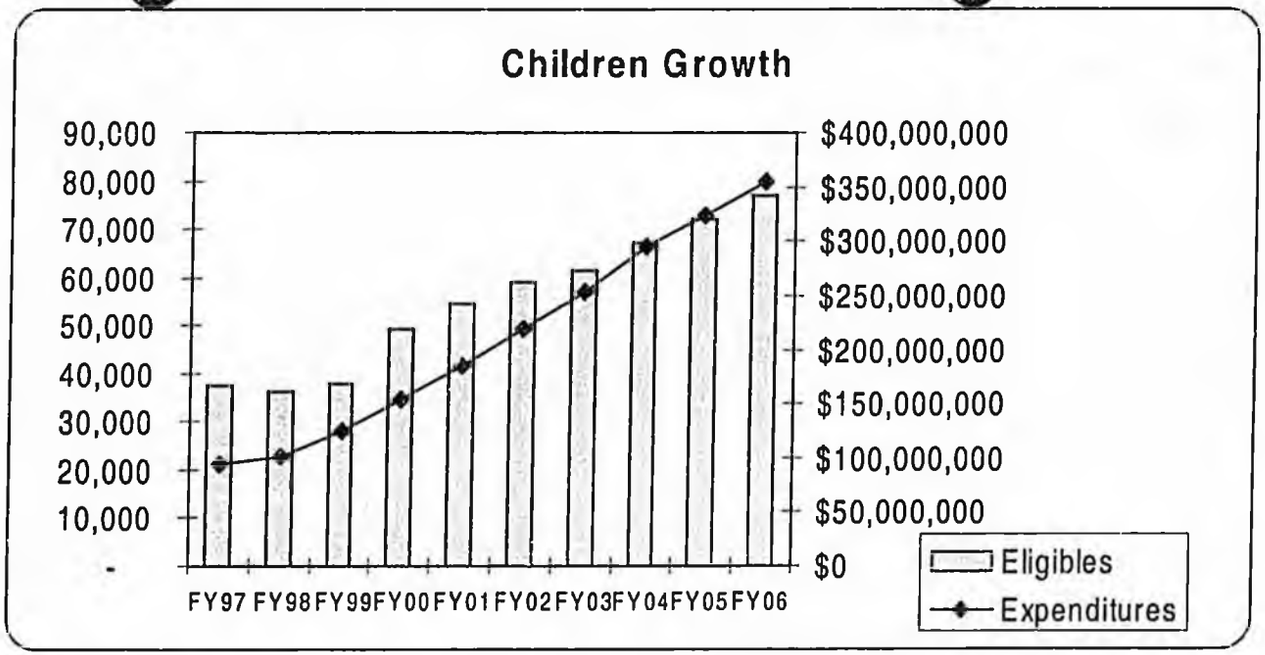
- Increasing Inflation in Health Care Market
  - Pressure to increase provider payments
  - Higher costs for brand and generic prescription drugs
- Changing Health Care Utilization
  - Reliance on home & community based services
  - Greater use of prescription drugs, new technology
- Expanding Enrollment
  - Eligibility expansions
  - Growth of the disabled population in Medicaid
  - Use of Upper Payment Limit (UPL) Arrangements

Source: Kaiser Commission on Medicaid & the Uninsured, 2001

National Projected Average Annual Growth Rate in Medicaid, Medicare, & Private Health Insurance, 2000-2005



Source: HCFA, National Health Expenditures Projections, 2001



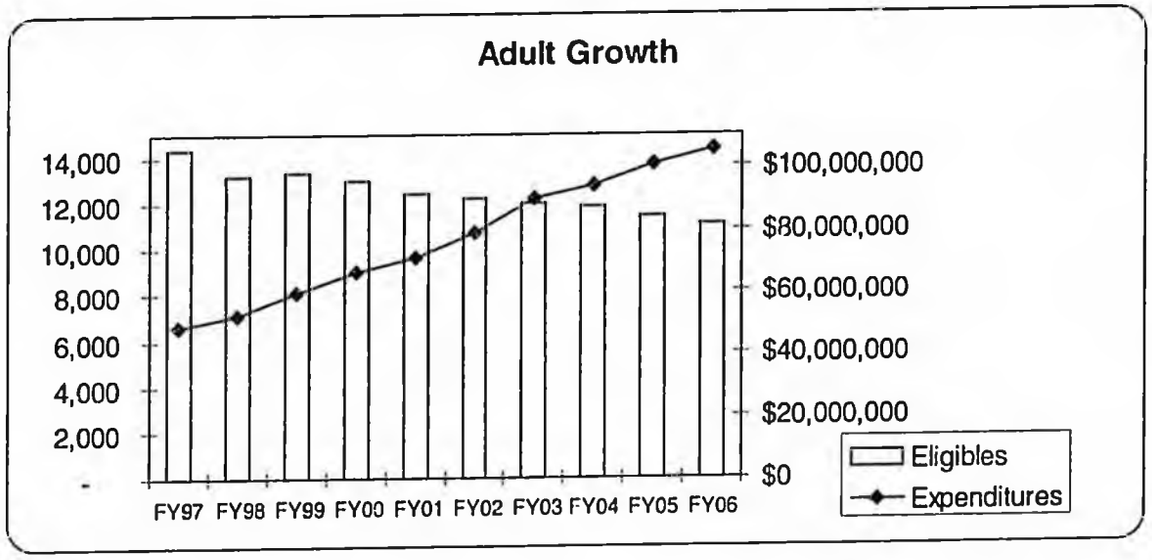
Alaska's Children

- **Children's eligible recipient numbers**
  - FY01 eligible numbers represent 24% of Alaska's total population ages 0 - 18
  - Average increase in eligible growth over last 4 years has been 10.4%
  - Children's eligible recipient rate of growth decreased by more than 50% in FY 01
  - FY01 average cost per month per eligible child was $280

- **Children's expenditures**:
  - 35% of total FY01 Medicaid expenditures are attributed to Alaska's children.
  - Over the past 4 years, Medicaid's total rate of expenditure growth has averaged 15%
  - Over the past 4 years, the average increase in expenditure growth for children has been 18.8%
  - 55% of FY 01 expenditure growth was attributable to increased eligibles

FY04 through FY06 total projections are based on a simple linear trend with a 7.1% health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.

Adult Medicaid

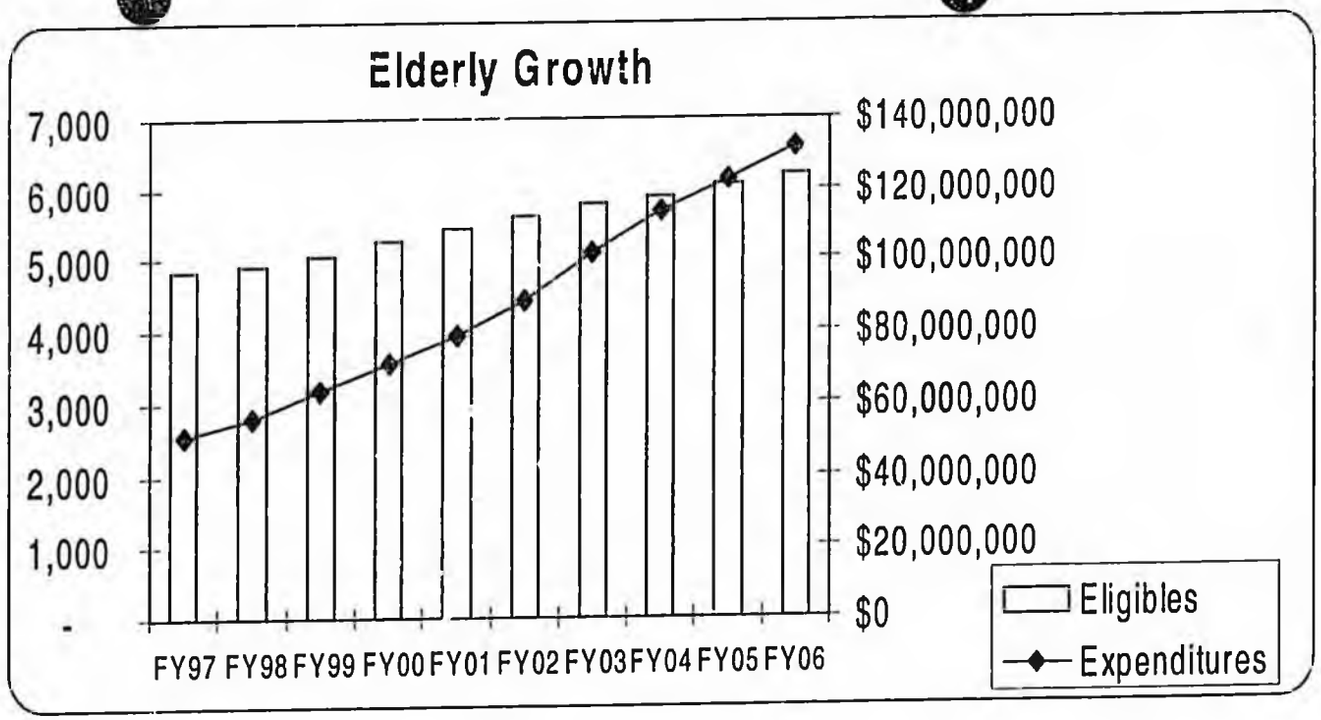


- **Adult Eligible Recipient Number:**
  - Average rate of growth for Adult eligibles has been -3% over past 4 years
  - FY01 average cost per month per eligible adult was $470

- **Adult Expenditures:**
  - Expenditure growth has averaged approximately 11% in the past 3 years
  - No assumptions applied in FY 02 - FY 03 - straight trend accepted

Note: Medicaid Adult eligible numbers and costs include pregnant women.

FY04 through FY06 total projections are based on a simple linear trend with a 7.1% health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.



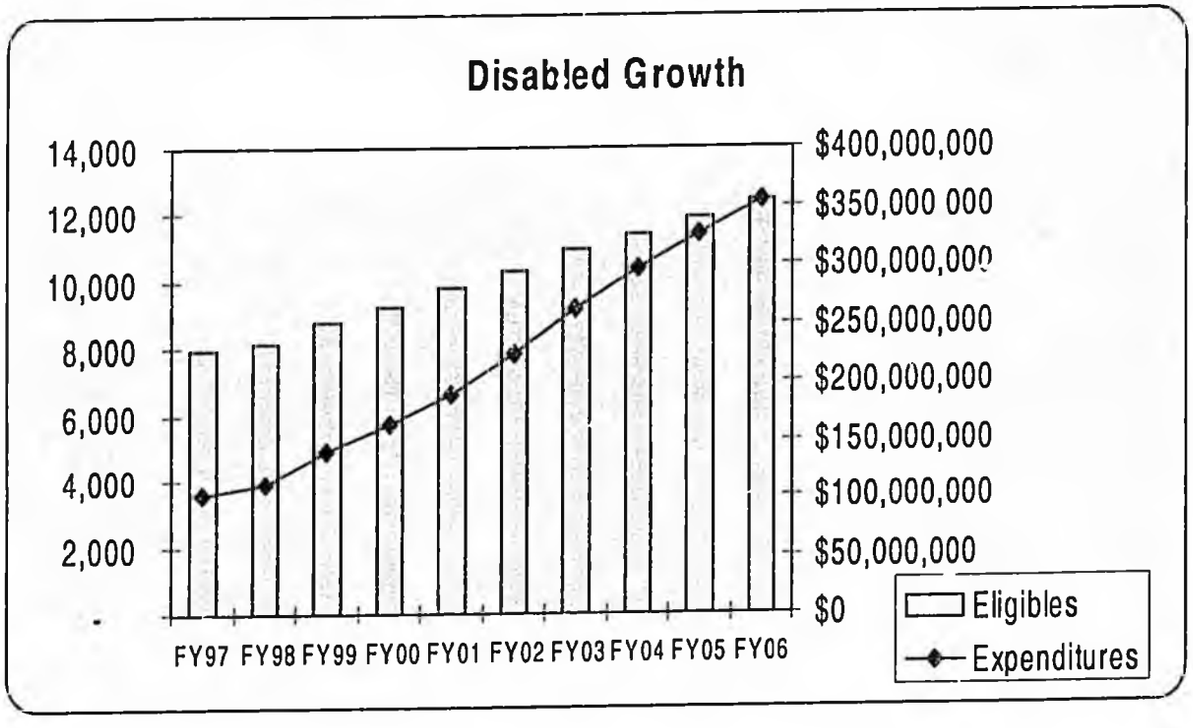
Alaska's Elderly

- **Elderly Eligible Recipient Number:**
  - Elderly eligible growth has averaged 3% for the past 4 years
  - Elderly Rate of growth is Medicaid's most consistent
  - FY01 average cost per month per eligible elderly person was $1,209

- **Elderly Expenditures**
  - Expenditure growth for the elderly has average 12% for 3 years
  - 29% of FY01 expenditure growth was attributable tc increased eligibles

FY04 through FY06 total projections are based on a simple linear trend with a 7.1% health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.

Alaska's Disabled



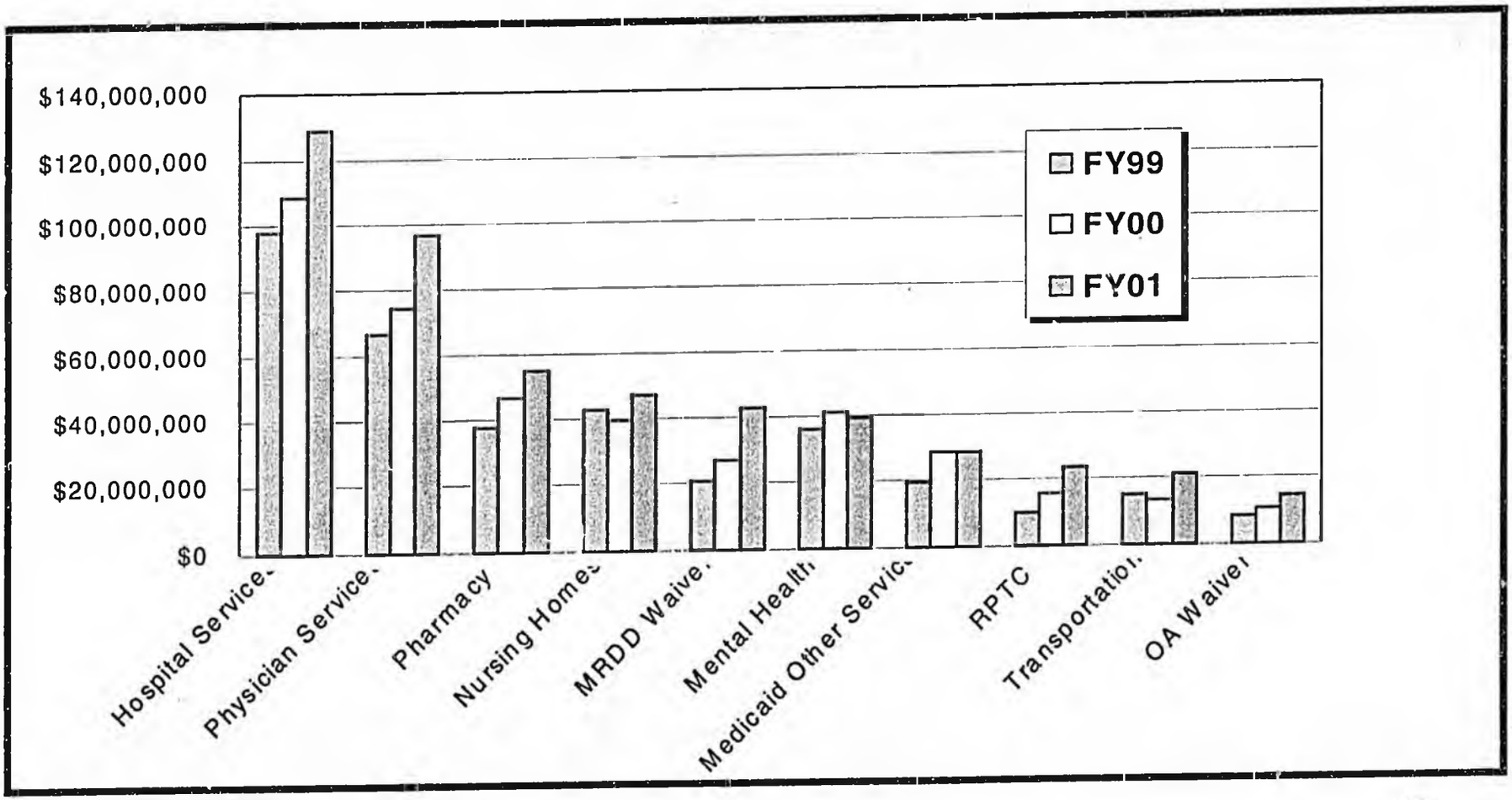
- **Disabled Eligible Recipient Number:**
  - Disabled eligible numbers have maintained a steady increase of about 5% for 4 years
  - FY01 average cost per month per disabled recipient was $1,624

- **Disabled Expenditures:**
  - Expenditure growth has averaged more than 17% for 4 years
  - 28% of FY01 expenditure growth was attributable to increased eligibles

FY04 through FY06 total projections are based on a simple linear trend with a 7.1% health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.

Cost Center Growth

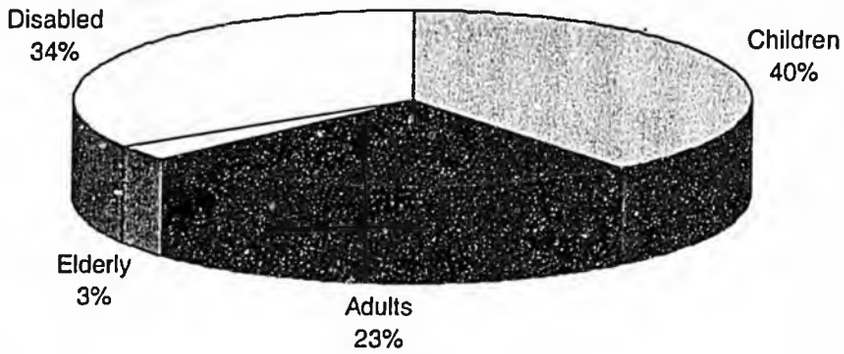
Top Ten Expenditure Categories



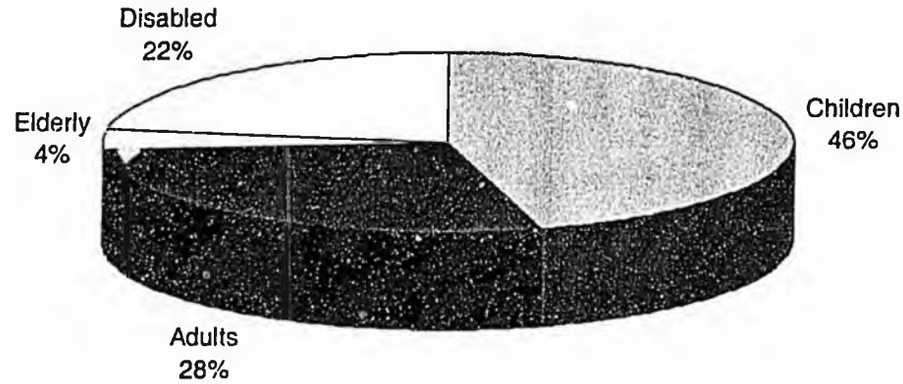
Categories include Indian Health Services.

Top Four Categories of Service by Expenditure by Eligible Group

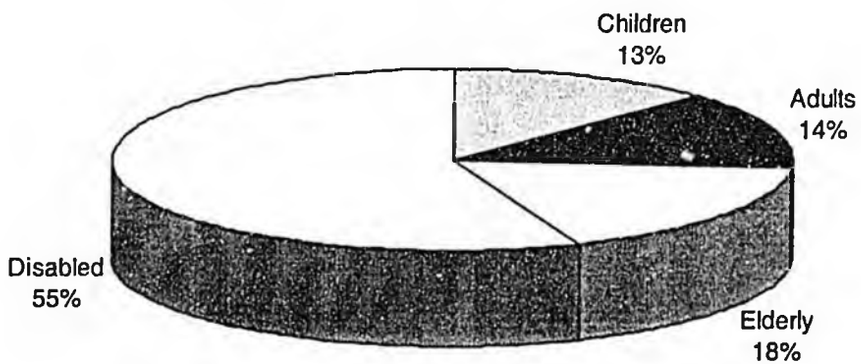
Hospital Services



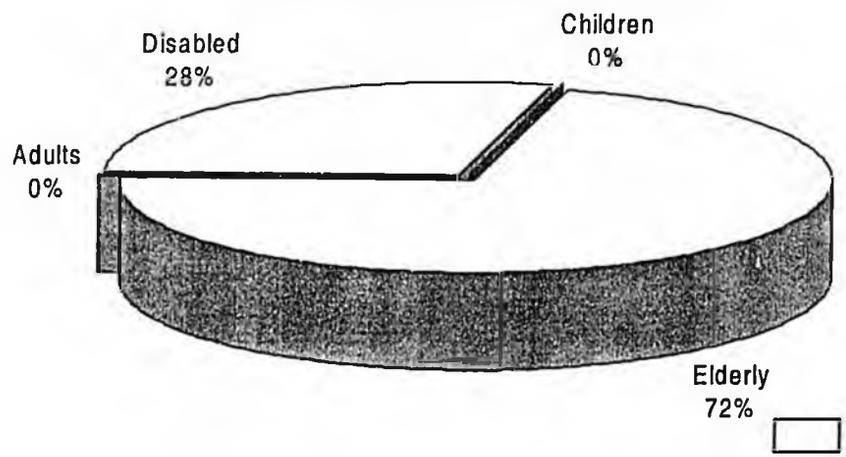
Physician Services



Pharmacy Services

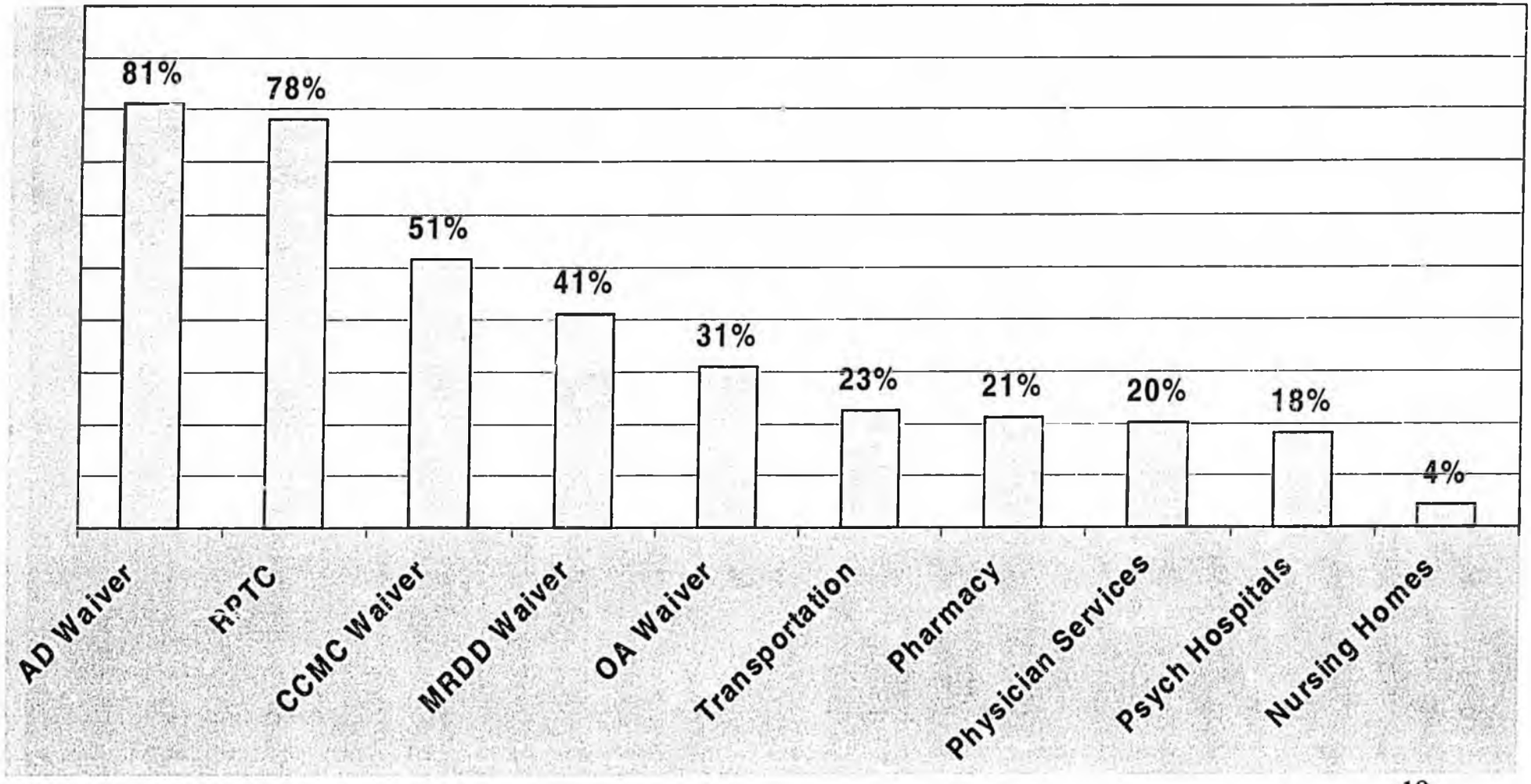


Nursing Home Services

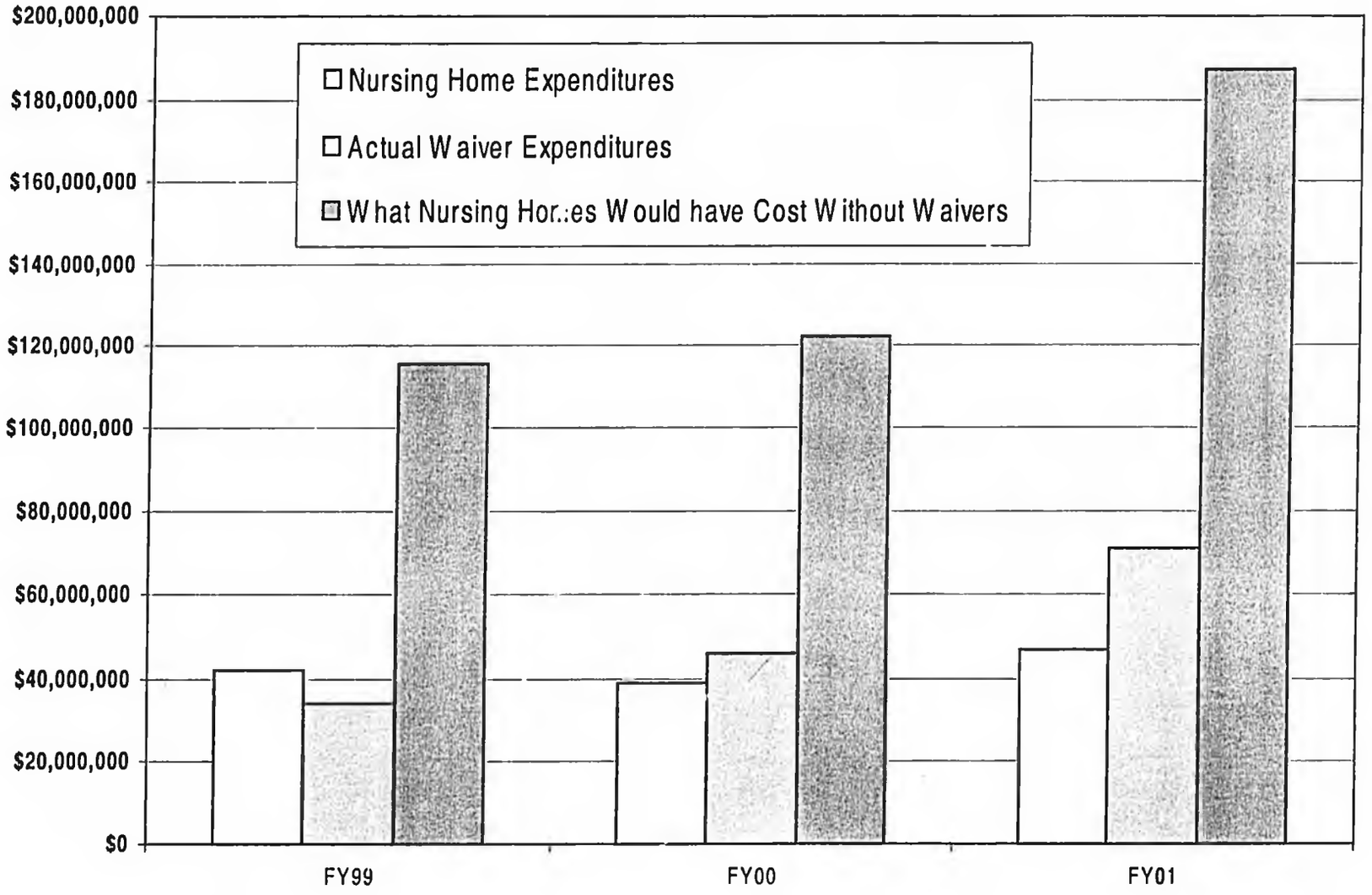


Ten Fastest Growing Categories of Service

(three year average rate of growth from FY99 – FY01)



Long Term Care: Comparing Waiver and Nursing Home Costs



Medicaid Expenditures as a Percent of State Budgets

- Nationally, Medicaid general fund spending as a percentage of state general fund expenditures is estimated at 14.7% for 2001 (National Association of State Budget Officers (NASBO) State Expenditure Report, various years.*

- Alaska's Medicaid General fund expenditure in FY01 was 10.8% of the total state general fund budget.

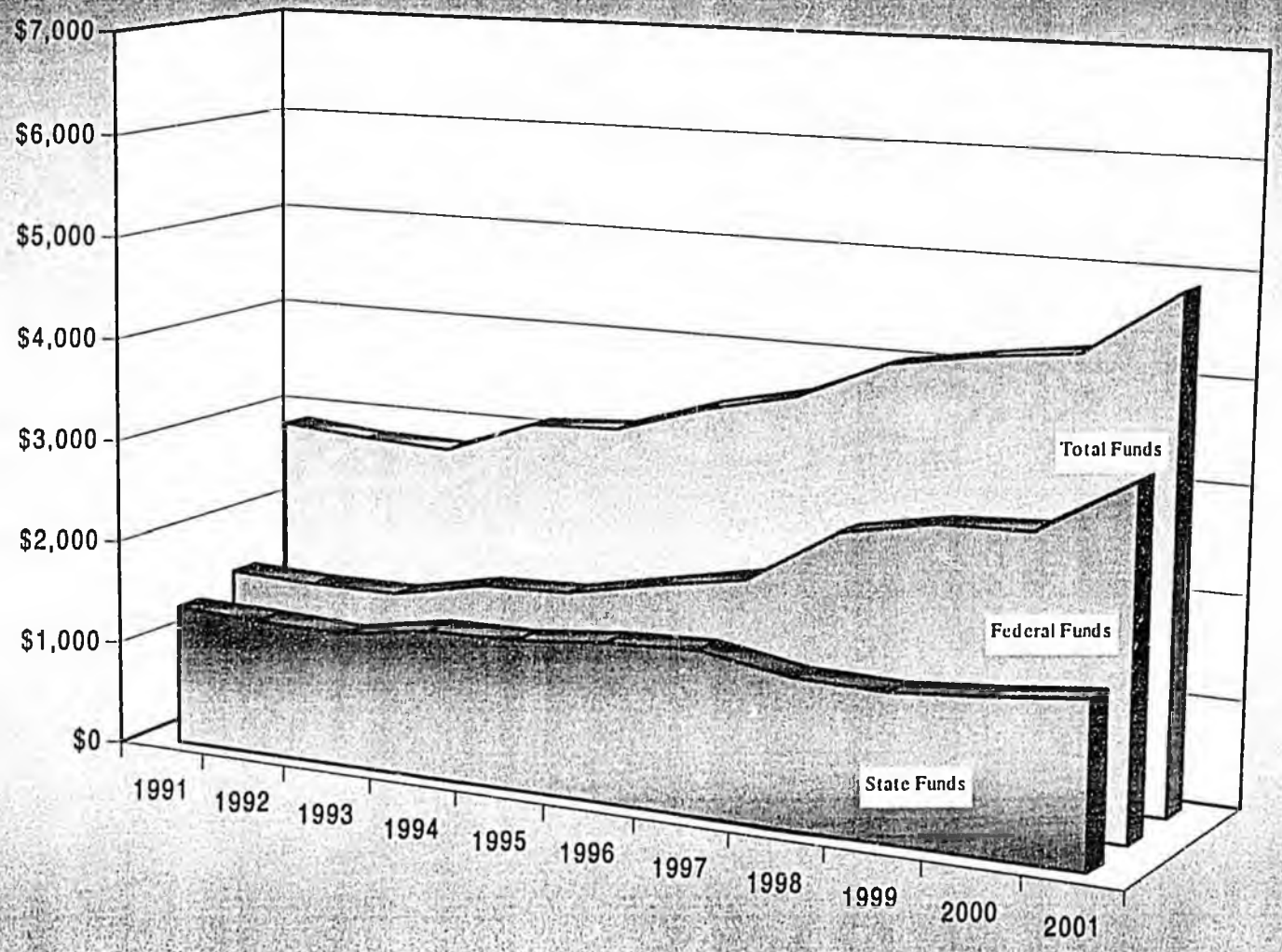
Compiled by the Kaiser Commission on Medicaid and the Uninsured, October, 2001.

- Alaska Medicaid Ranked:

  - ✔ 20th in Nation for spending per enrollee during FY98.
  - ✔ 46th in Nation for state fund spending during FY98

Source: Kaiser Family Foundation State Health Facts 1995 - 1998
Statistics are based on federal fiscal year data.

Average Annual Cost per Eligible Medicaid Beneficiary - Federal and State Shares (FY91 through FY01 Actuals)



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
State Funds	$1,341	$1,308	$1,279	$1,427	$1,443	$1,531	$1,574	$1,422	$1,403	$1,469	$1,577
Federal Funds	$1,508	$1,471	$1,481	$1,647	$1,690	$1,873	$2,029	$2,560	$2,728	$2,768	$3,294
Total Funds	$2,849	$2,779	$2,760	$3,074	$3,133	$3,403	$3,603	$3,982	$4,131	$4,237	$4,871

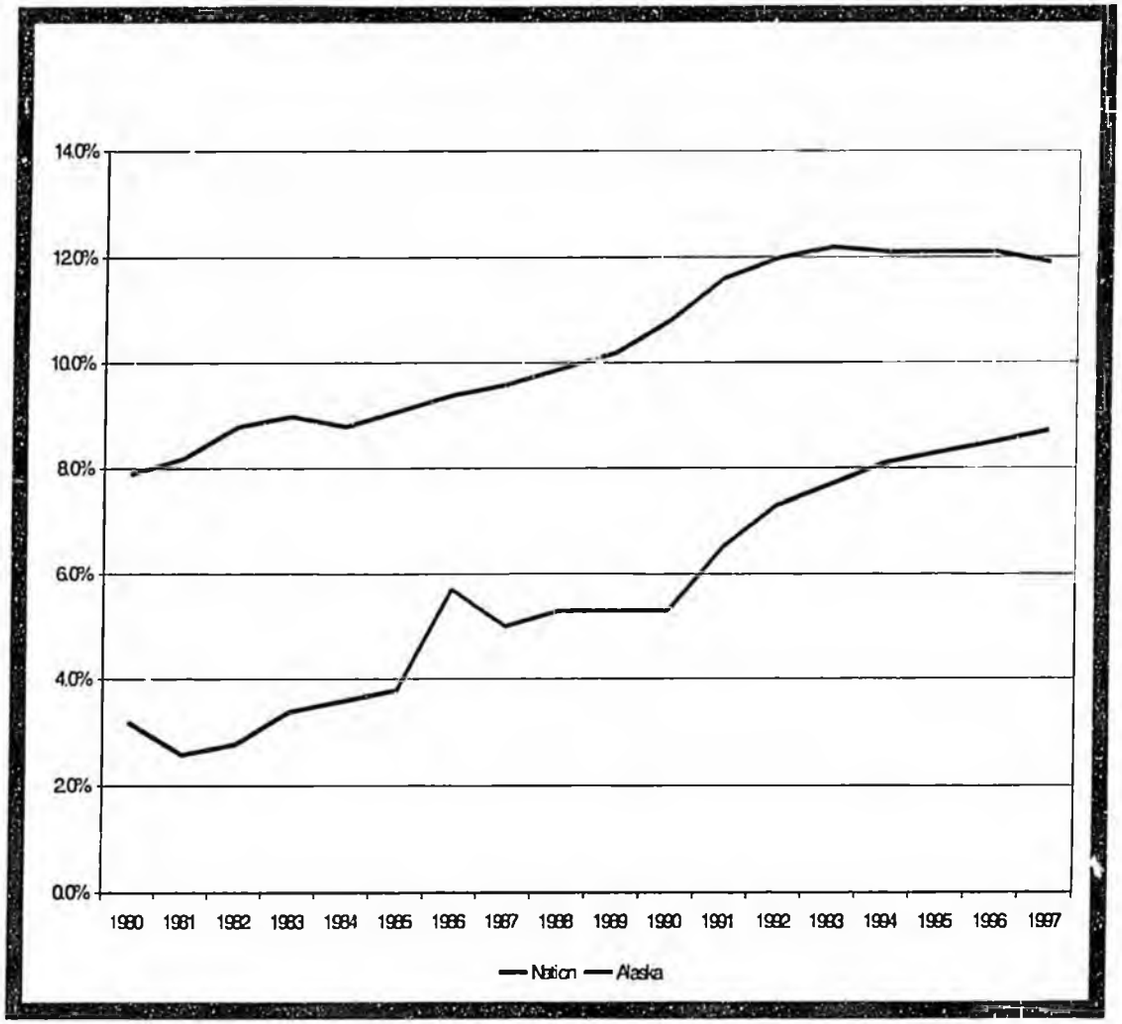
U.S. State FY2000 Spending

- The combined U.S. States total Medicaid expenditures as a percent of the combined U.S. states total spending was 19.5%
- Alaska's Medicaid expenditures as a percent of total state spending was 9.3%
- Alaska's ranked 47th in the nation when comparing Medicaid expenditures as a percent of total expenditures
- State spending for Medicaid as compared to total state spending outside of Alaska ranges from New York at 34.5% to Kansas at 7.2%
- As a percent of total state expenditures, Medicaid expenditures have increased from 10.8 % in 1988 to 19.5 % in 2000

- Source: National Association of State Budget Officers, 2000 Expenditure Report, Summer 2001.

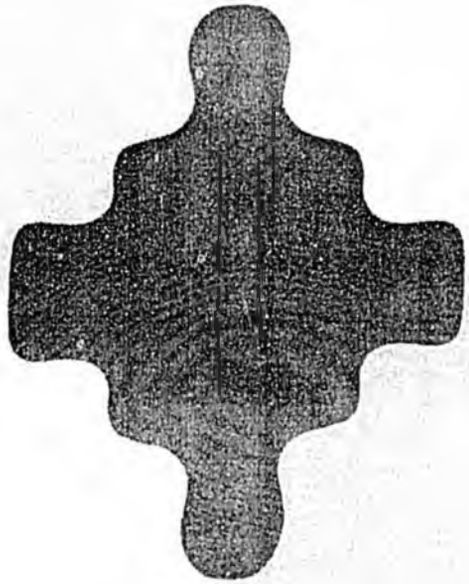
Personal Health Care Expenditures (PHCE) as a Percent of Gross State Product (GSP)

- ⇛ The rate at which PHCE as a percent of GSP has changed since 1980 in Alaska was only slightly faster than that of the Nation
  - ⇛ In 1980 Alaska's PHCE percentage of GSP was 4.7% less than the Nation's
  - ⇛ By 1997 the difference had decreased to 3.2%
- ⇛ Factors contributing to the reduced difference in Alaska's PHCE/GSP
  - ⇛ Alaska's younger median age
  - ⇛ Growing rate of our 65+ population
  - ⇛ Health care delivery infrastructure improvements mean more & better health care services are provided



Current Issues

- Indian Health Service (IHS) Deferrals
- Olmstead
- ProShare
- SCHIP
- FMAP



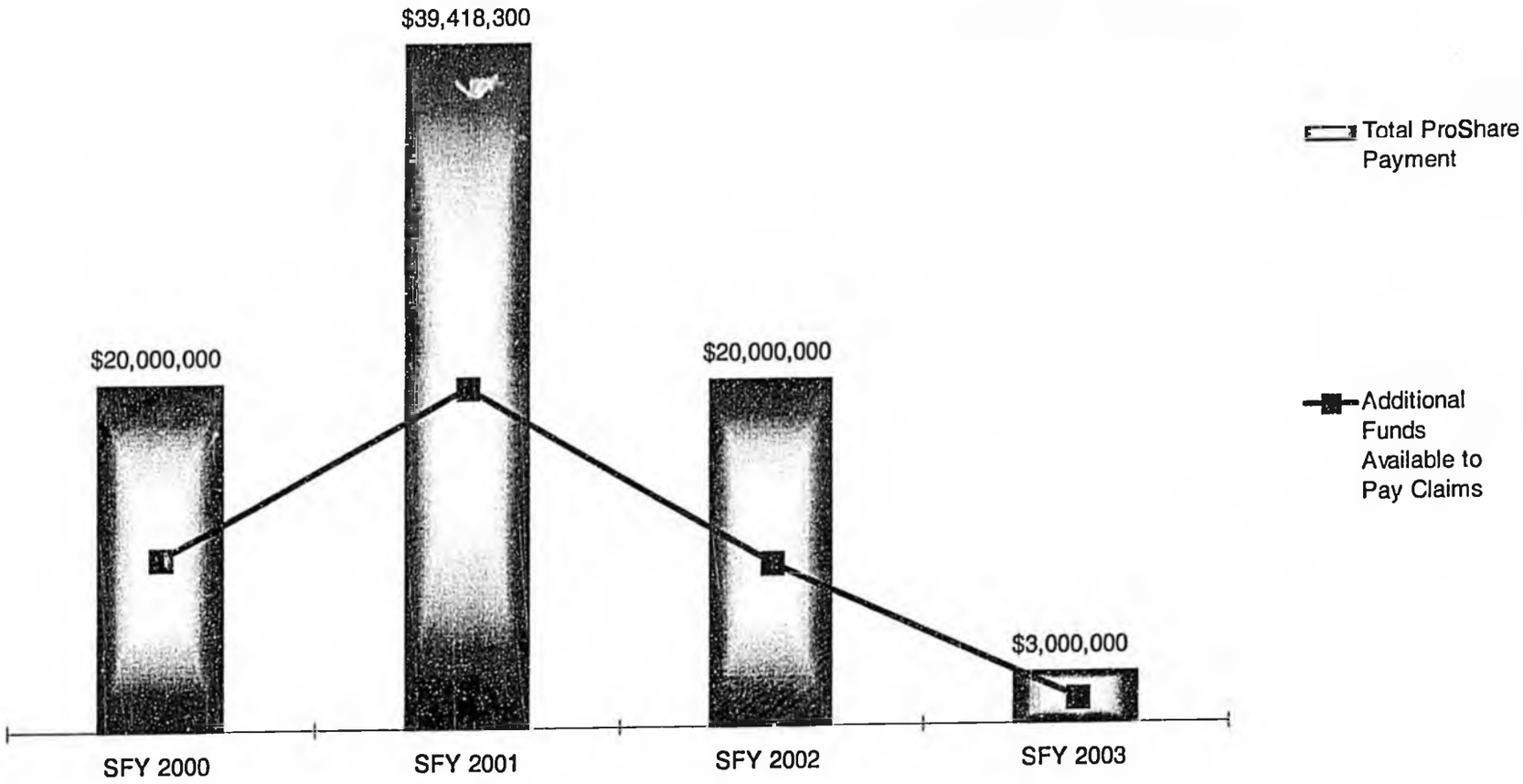
Indian Health Services Deferrals

- Cost Containment Directive in 1998
- Referral Services $5.1 Million
- IHS Transportation $1.8 Million

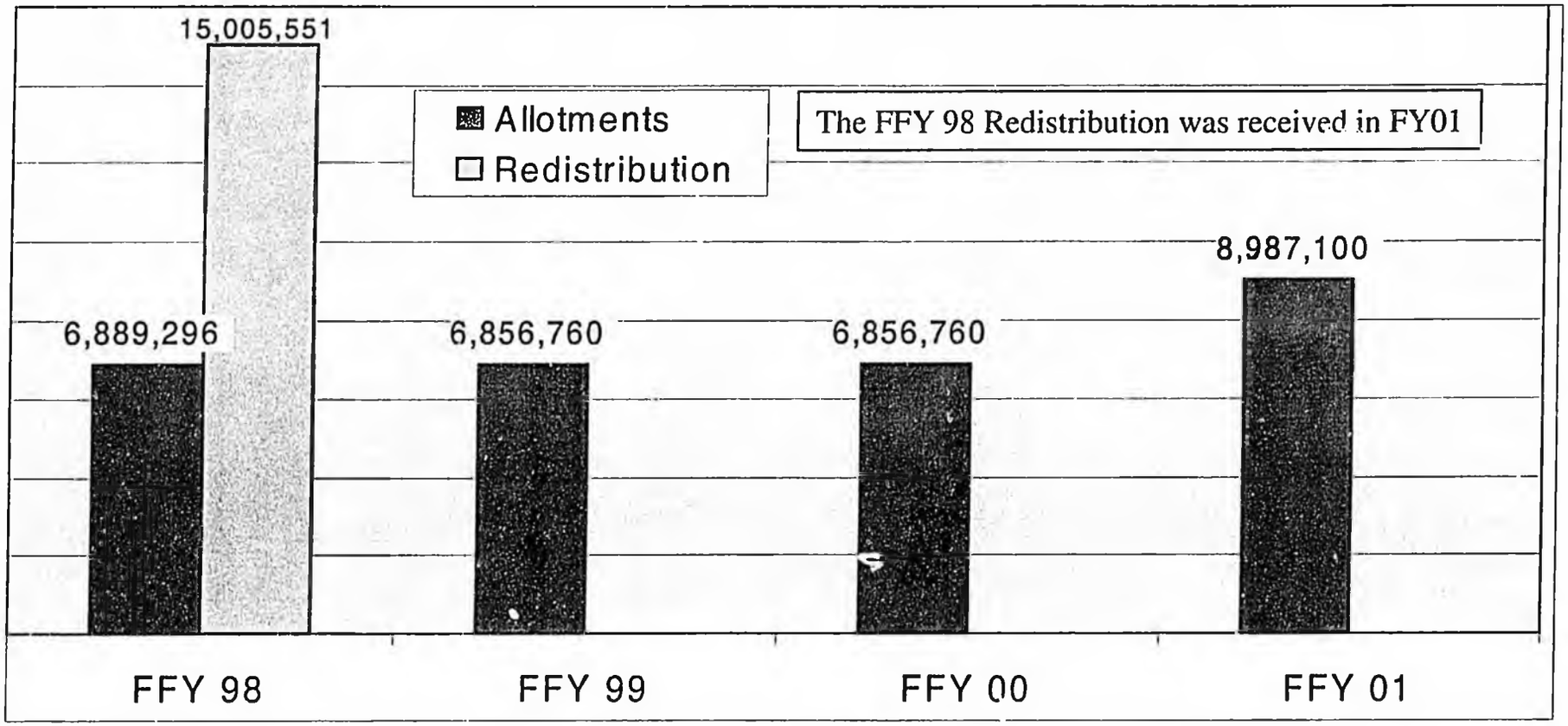
Olmstead

- Americans with Disabilities (ADA) Act Decision
  - ➢States are obligated to provide services the appropriate, most integrated setting to persons with disabilities
  - ➢Waivers are Alaska's primary tool in addressing Olmstead

Alaska's ProShare

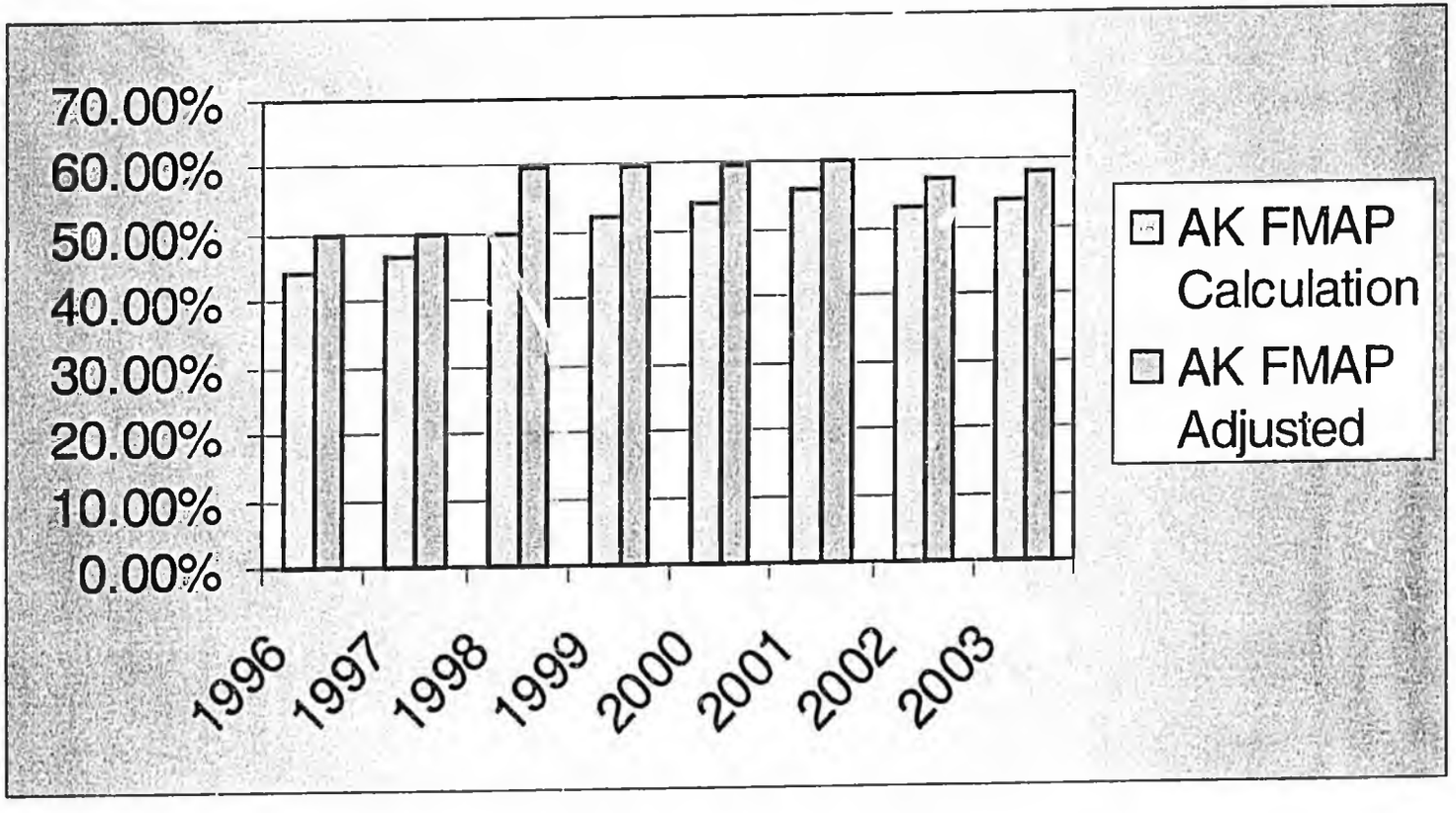


Title XXI Allotment History



- Allotted amount is reimbursed at a higher federal match
- Alaska has not received it's fair per capita share of federal funds
- It is expected that redistribution will make Alaska whole

Alaska's FMAP History



	1996	1997	1998	1999	2000	2001	2002	Est. 2003
AK FMAP Calculation	44.35%	46.86%	49.90%	52.26%	54.13%	56.04%	53.01%	54.00%
AK FMAP Adjusted	50.00%	50.00%	59.80%	59.80%	59.80%	60.13%	57.38%	58.27%

Status and Impact of the FMAP Rate Reduction

- Problem
  - Federal statistical change increased Alaska per capita income above National average -- result is lower FMAP
  - FFY01 FMAP rate adjustment to 60.13% mitigates decrease
  - FFY02 Rate set at 57.38%
  - FFY03 Rate calculation at 58.27%
  - Each 1% drop in FMAP can mean as much as $8 million in general fund dollars
- Potential for Solution
  - Work toward possible reduction cap of 1%
  - Congressional economic stimulus package

kaiser commission on

medicaid and the uninsured

MEDICAID BUDGETS UNDER STRESS: SURVEY FINDINGS FOR STATE FISCAL YEAR 2000, 2001 AND 2002

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Prepared for
The Kaiser Commission on
Medicaid and the Uninsured

October 2001

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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Executive Director

Medicaid, a joint federal-state program, provides health and long-term care coverage for over 40 million Americans. Medicaid is often the only source of health coverage available for low-income children, a critical support for people with disabilities in the community and the sole source of financial assistance for nursing home care. Federal Medicaid payments are projected to be $130 billion in fiscal year 2001, while state spending is estimated to be about $94 billion. Medicaid is the largest source of federal funds to the states accounting for 44 percent of all federal grants-in-aid in 1999.

Attention has focused on recent Medicaid spending growth. Although the growth in Medicaid spending has been substantially below the levels experienced a decade ago, it has stood out because it comes on the heels of historically low spending increases and revenues are beginning to decline is some states. The purpose of this study is to provide current information on Medicaid spending, identify the factors that states report are contributing to spending increases and describe the actions states are taking to limit spending growth. A survey of state Medicaid directors was conducted during May and June 2001 to examine details of each states' budget for the years 2000, 2001, and 2002.

This study finds that Medicaid expenditures are growing due to a number of factors, including medical inflation facing the health system generally, increased costs due to prescription drugs, "catch up" increases in provider payment rates, expansion of community-based long-term care, increased enrollment, and state efforts to refinance current state spending with more federal dollars. To meet Medicaid spending obligations in state FY 2001, 37 states provided supplemental funding beyond original legislative appropriations, typically drawing from a Medicaid trust or reserve fund or transfer of funds from other programs. The picture for FY 2002 looks bleaker because state revenues are declining and many states have been dipping into their year-end balances to address budget shortfalls. Twenty states are starting off FY 2002 anticipating that they have underfunded Medicaid. As of Summer 2001, states were not planning to cut back on eligibility or services, but were particularly concerned about the growth in pharmacy costs for elderly and disabled beneficiaries. However, the economic picture in many states is rapidly deteriorating and state Medicaid programs are headed toward a difficult period that could be exacerbated by an economic downturn.

Medicaid's Role in the States

Medicaid is a joint federal and state program that is administered by the states within federal guidelines. Each Medicaid program is different reflecting state priorities in coverage and benefits. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients.

State Medicaid programs currently provide health coverage to over 40 million Americans annually, or more than 12% of the U.S. population.[1] Medicaid provides health coverage for over 20% of all children in the U.S. Medicaid pays for the births of over one-third of all U.S. children. Almost three-fourths of all Medicaid beneficiaries are low-income children and their parents. Among the remaining one-fourth, about 10% are elderly, and about 15% are persons with disabilities. Medicaid is the single largest payer for long-term care, accounting for half of all nursing home spending and nearly 40% of home and community-based spending. While children and their parents comprise the majority of Medicaid beneficiaries, elderly and disabled beneficiaries account for 70% of Medicaid spending on benefits reflecting their greater health and long-term care needs.

Medicaid Provides Substantial Federal Funds to the States

The federal and state governments share in the financing of Medicaid expenditures. In fiscal year 2000, Medicaid spending totaled about $207 billion. This amount includes all State, local and Federal funds. Altogether, Medicaid helped to finance 73% of all State health spending. The federal share is determined annually based on a formula (known as the Federal Medical Assistance Percentage or FMAP) that adjusts for per capita personal income. The federal share currently ranges from 50 to 77% and averages 57%. Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. At a 50% matching rate, a state draws down one federal dollar for each state dollar it spends. At a 70% matching rate, a state draws down $2.33 in federal funds for every $1 it spends. Medicaid's matching formula provides an important vehicle for states to leverage federal dollars to increase funding for health and long-term care services.

From a State fiscal perspective, Medicaid is a large program relative to the overall State budget. Federal Medicaid spending represents, on average, 15% of state general fund expenditures in FY 2000 and about 20% of all State spending, including general fund, and Federal funds (Figure 1).[2] Medicaid is the largest share of total federal grants to

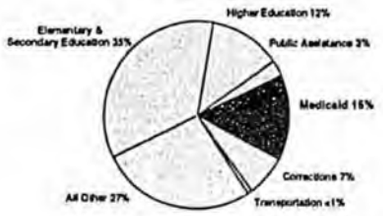
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[1] Data are for the most recent year for which HCFA data are available, Federal fiscal year 1998, and reflect the number of persons enrolled for one or more months during the fiscal year. Cited in: Christie Provost and Paul Hughes, "Medicaid: 35 Years of Service," Health *Care Financing Review,* Fall 2000 / Volume 22, Number 1. 141-174.

[2] National Association of State Budget Officers / Reforming States Group, *1998-1999 State Health Care Expenditure Report,* Milbank Memorial Fund, 2001.

states, comprising 44% of $222 billion in total federal grants in 1999 up from 26% in 1987 (Figure 2).[3]

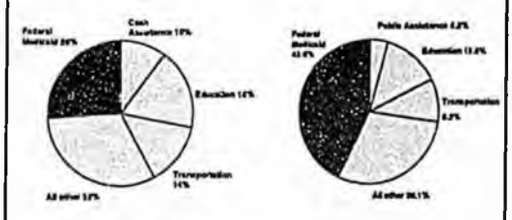
Figure 1: Medicaid Spending as a Percentage of State General Fund Expenditures, FY 2000



Total = $467 Billion

SOURCE: National Association of State Budget Officers, Fiscal Survey of States, June 2001

Figure 2: Medicaid as a Share of Total Federal Grants to States, 1987 and 1999



SOURCE: National Association of State Budget Officers, 1999 State Expenditure Report, June 2000

Medicaid expenditure growth can have an important impact on the overall fiscal condition of a State. If the growth in Medicaid general fund expenditures exceeds the growth in State revenues, less money may be available for other State programs. As shown in Table 1, the share of State budgets allocated to Medicaid increased during the early 1990s, but has actually remained fairly stable since 1995. However, as state revenue growth declines and Medicaid expenditures increase, this picture could change.

Table 1
Medicaid as a Share of State General Fund and Total
1987-2001

State Fiscal Year	Medicaid General Fund Spending as % of State General Fund Expenditures	Medicaid Total Spending as % of Total State Expenditures, all Fund Sources
1987	8.1%	10.2%
1989	9.0%	11.3%
1991	10.5%	14.2%
1993	13.3%	18.8%
1995	14.4%	19.8%
1997	14.6%	20.0%
1999	14.4%	19.5%
2001	14.7%	19.6%

Source: NASBO, *State Expenditure Report*, various years.

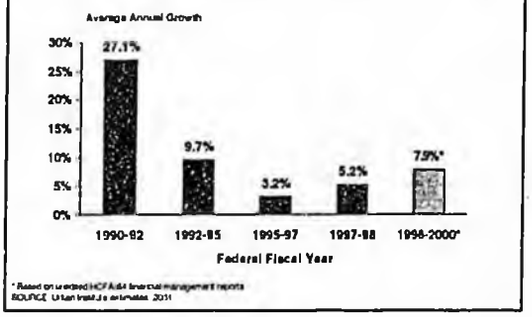
Recent Medicaid Spending Growth Reflects Program Priorities, Health Care Inflation, and State Financing Strategies

The current rise in Medicaid expenditures follows a period of unprecedented low growth in the Medicaid program due primarily to enrollment declines and restrictions on disproportionate share hospital payments. The period from 1995 to 1998 was characterized by a robust economy, rapidly dropping welfare rolls and a decline in the number of people enrolled in Medicaid. In addition, low health care inflation, state limits

[3] National Association of State Budget Officers, *1999 State Expenditure Report*, 2000.

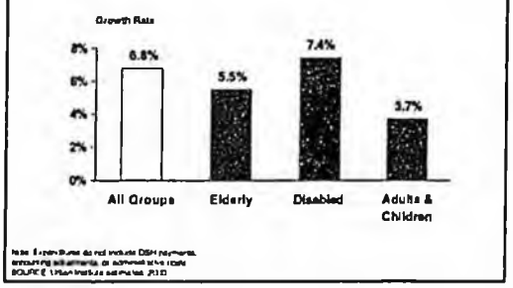
on provider payments, and increased use of managed care resulted contributed to the slow growth in spending.[4] Between 1995 and 1997, the average annual growth rate in Medicaid expenditures averaged 3.2%, the lowest rates in the history of the program (Figure 3). [5]

Figure 3: Average Annual Growth Rates of Total Medicaid Expenditures, 1990-2000



However, beginning in 1997, Medicaid expenditures began to grow again, averaging 5.2% from 1997 to 1998 and 5.5% from 1998 to 1999, with signs that spending was likely headed upward. [6] [7] Expenditures per enrollee increased by 6.8% between 1997 and 1998, with the growth greatest for the disabled (7.4%) and elderly (5.5%) and lowest for the adults and children (3.7%) (Figure 4).

Figure 4: Growth of Expenditures per Enrollee by Eligibility Group, 1997-1998



Since 1998, a number of factors have come together to generate higher rates of growth in Medicaid spending (Figure 5). Among the significant factors are:

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[4] Bruen and Holahan, 2001. Also see: U.S. General Accounting Office, "Medicaid: Sustainability of Low Spending Growth is Uncertain," GAO Report No. HEHS-97-128 (Washington, DC: GAO, June 27, 1997).
[5] Brian Bruen and John Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*, Kaiser Commission on Medicaid and the Uninsured, February 2001.
[6] Brian Bruen and John Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*, Kaiser Commission on Medicaid and the Uninsured, February 2001. Publication 2230.
[7] National Association of State Budget Officers / The Reforming States Group, *1998-1999 State Health Expenditure Report*, Milbank Memorial Fund, 2001.

Figure 5: Converging Trends Are Causing Medicaid Expenditure Growth

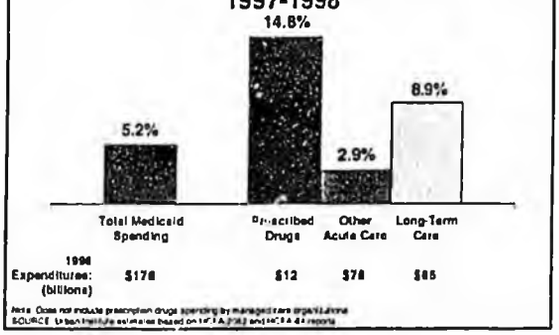
- **Increasing inflation in health care market**
  - Pressure to increase provider payments
  - Higher costs for brand and generic prescription drugs
- **Changing health care utilization**
  - Reliance on home- and community-based services
  - Greater use of prescription drugs, new technology
- **Expanding enrollment**
  - Eligibility expansions
  - Growth of the disabled population in Medicaid
- **Use of upper payment limit (UPL) arrangements**

SOURCE: The Kaiser Commission on Medicaid and the Uninsured, 2001

- Health care price inflation in the general health care market place began to increase in 1999. At the same time annual increases in private health insurance premiums increased substantially. Medicaid must operate in the same health care market place as other health care purchasers. The forces that placed pressure on the private health insurance rates also placed pressure on Medicaid to increase provider payment rates, particularly in States that had not increased rates in several years.[8]

- An additional factor, however, was the substantial increase in spending for prescription drugs. Medicaid programs spent $11.7 billion for prescription drugs in 1998, a 14.8% increase over 1997 spending levels (Figure 6). Again, rising drug costs are not limited to the Medicaid program. However, because Medicaid covers a population in poorer health than the population in general, the program is particularly vulnerable to rising drug costs.

Figure 6: Average Annual Growth of Medicaid Spending for Selected Services, 1997-1998



Note: Does not include prescription drugs spending by managed care organizations
SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 reports

- There was a net decrease in the number of managed care organizations serving the Medicaid market. Those that exited the Medicaid market often cited lowMedicaid payment rates. Managed care organizations continuing to participate in Medicaid were able to secure significant increases in payment rates.[9]

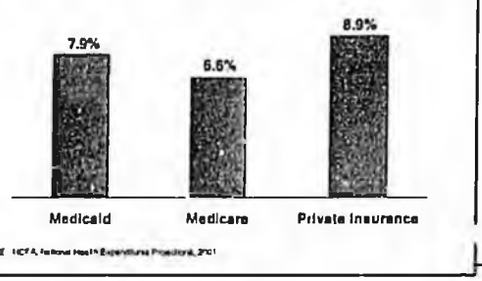
[8] Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs: Inflation Returns," *Health Affairs*, Vol. 19, Number 6 (November/December 2000).

- Medicaid enrollment began to increase in 1999, reversing a three-year downward trend. U.S. Medicaid enrollment decreased in 1996, 1997 and 1998, for a total three-year decrease of 3.1%.[10] Over the twelve months from December 1998 to December 1999 Medicaid enrollment increased by 3.9%.[11] The State Children's Health Insurance Program (SCHIP) was enacted in 1997 and implemented by the States beginning in 1998. For the first time ever, States organized efforts to find and enroll low-income uninsured children in their SCHIP programs. These outreach efforts for SCHIP had a case-finding effect for Medicaid.[12] In many states, increasing the enrollment of low-income children became a policy priority. In addition, enrollment of the disabled who have considerably higher per capita costs also grew.

- An additional factor leading to greater Medicaid expenditure growth is the increase in "upper payment level" or UPL financing programs. In these programs, states pay rates that are higher than regular Medicaid reimbursements to publicly-owned facilities who return some of the extra payments to the state. The states get federal matching funds based on the higher payments, so they collect additional federal money without a net contribution of state funds. The result is an "expenditure illusion" in the sense that expenditures for Medicaid services appear to be higher than they really are. The number of states using UPL arrangements grew rapidly in 2000, although the federal government has now limited the amount of federal money that states can obtain through this mechanism.

The expected increase in Medicaid expenditures has materialized. States have reported Medicaid expenditure growth rates of 8.9% for state FY 2000 and 9.8% for state FY 2001. Rising health care costs are an important factor behind expenditure growth rates in Medicaid. As a large third party payer, Medicaid is very much affected by changes in the health care market in general. Health care costs and premiums are increasing for private and public payers, although Medicaid growth rates are lower than those in the private sector (Figure 7).

Figure 7: Projected Average Annual Growth Rate in Medicaid, Medicare, and Private Health Insurance, 2000-2005



SOURCE: HCFA, National Health Expenditures Projections, 2001

For example, in Michigan, Medicaid rates for HMOs were reduced through a bid process in 1997. In FY2001 HMO rates increased over 11%. See the Michigan text box later in this document. Also see: Susan Felt-Lisk. 2000.

[10] Bruen and Holahan, 2001.

[11] Eileen Ellis, Vernon Smith and David Rousseau, "Medicaid Enrollment in 50 States: June 1997 to December 1999, Kaiser Commission on Medicaid and the Uninsured, October 2000. Publication 2210.

[12] *CHIP Program Enrollment: December 1998 to December 1999*, The Kaiser Commission on Medicaid and the Uninsured, July 2000. Publication #2195

In many States, the higher growth rates for Medicaid expenditures occurred at a time when the original Medicaid appropriations were based on lower rates of growth. At the time they were made, the lower rates of growth were easily justified on the experience over the 1995-1999 period, and a confidence that managed care would now control Medicaid expenditures. In September 2000, Medicaid budget shortfalls were reported in seven States.[13] In December 2000, the National Conference of State Legislatures polled all the States and found that Medicaid expenditures were occurring at a pace that would exceed appropriations for State fiscal year 2001 in 23 States.[14] As State legislatures convened early in 2001, a number of States reported slower revenue growth and higher expenditure levels than had been anticipated when their 2001 budgets were adopted. In some cases, the increasing rate of expenditure in Medicaid budgets was seen as a contributing factor to overall State budget problems because of the size of the Medicaid budget shortfalls,[15] although budget shortfalls were occurring in other programs as well, including corrections and K-12 education.[16]

State Medicaid Appropriations and Budgeting Procedures

By law, the Medicaid program, like any other state program, can only spend funds that are appropriated. Legislative appropriations at the start of the state fiscal year do not always match realized expenditure levels. Budget forecasting is subject to uncertainty and the actual budget need can fall within a wide range. In determining the state budget, policymakers weigh the consequences of over-budgeting versus under-budgeting Medicaid. An over-allocation of funds for Medicaid could mean fewer funds available for other programs. On the other hand, an under-allocation of funds toward Medicaid that becomes apparent later in the fiscal year could result in the need for additional appropriations, particularly if it is too late in the year to make policy changes that would reduce expenditure levels for that year. Because Medicaid is an entitlement program, the state is required to pay for covered services that are provide to persons who are enrolled.

In some cases, policymakers recognize the possibility that the initial appropriation for Medicaid may not be the final appropriation because of the difficulty of forecasting the exact amount needed for the budget year. The legislature and the executive branch will track Medicaid expenditures through the year, update their forecasts as data become available for actual monthly expenditures, and then near the end of the year when the actual need is more certain determine if a supplemental appropriation is necessary. In other cases, the legislature makes an appropriation based on the best forecast of need, expects that amount to be sufficient for the year, but actual expenditures exceed expectations. This creates an unexpected need to align expenditures with the authorized funding level.

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[13] Charles Ornstein, "New Cost Problems Plague Medicaid--Rising enrollment, drug costs among causes as Texas, other States face budget overruns." *Dallas Morning News*, September 23, 2000. 1A.

[14] National Conference of State Legislatures, *State Fiscal Outlook for 2001*, December 2000. The 23 States included: AZ, CO, CT, DE, FL, GA, ID, IL, IN, KY, ME, MD, MA, MO, MT, NM, NC, OH, OK, TX, VT, VA, WA.

[15] Pamela Belluck, "Free Spending in Flush Times Coming Back to Haunt States," New York Times, March 19, 2001, A14.

[16] As of February 2001, 31 States expected to make supplemental appropriations for fiscal year 2001 for various State programs, such as corrections or K-12 education. National Conference of State Legislatures, State Fiscal Outlook for 2001, February Update, as updated March 8, 2001.

A Medicaid budget shortfall is said to occur when Medicaid spending for the State's fiscal year exceeds the amount the legislature authorized in the Medicaid appropriation for that year. The entitlement nature of Medicaid makes it more difficult to interpret a budget shortfall. Policy makers know that ultimately the full obligations of Medicaid will be paid, even if they were not fully authorized in the original appropriation. In a given budget situation, a legislature might even intentionally underfund Medicaid, expecting to return later in the fiscal year to resolve an anticipated budget shortfall when the actual budget requirements for the year are more certain.

A more difficult situation occurs when a budget shortfall is entirely unanticipated. This would occur when actual expenditures exceed expectations even when policy makers were confident that the amount would be sufficient for the year because the legislature made its original appropriation for Medicaid based on what were regarded as reasonable assumptions about the future. This creates an unexpected need to adjust expenditures or the authorized funding level, or both. When the budget shortfall is identified well into the fiscal year, as often occurs, there is insufficient time to adjust the pace of spending. The only alternative may be to find a source of funds to cover the Medicaid obligations.

When expenditures exceed appropriations, policymakers can reduce expenditures, increase the budget, or (in some states) shift the costs to a future year. Reducing expenditures typically involves reductions to covered benefits, provider payment levels, or eligibility levels for beneficiaries. Implementation of any of these strategies takes time and may be politically infeasible during the course of a fiscal year. Similarly, shifting costs to a future year may not be an option. Most states use an accrual accounting method for Medicaid where the financial obligation is booked in the year in which the service was rendered, not year in which the payment occurs. However, in states that use a cash accounting method for Medicaid, provider payments may be deferred to the next fiscal year, when additional funds would be available. In states with a biennial budget, it may be possible to spend funds in the first year of the biennium that were otherwise intended for the second year.

If sufficient expenditure reductions or payment deferrals are not accomplished, it is necessary to secure additional funding. Usually this is accomplished by a legislative appropriation of supplemental funds (sometimes referred to as a "deficiency appropriation"), drawing from a special Medicaid reserve or trust fund or transferring funds to Medicaid from other programs. In some states, it is common practice for Medicaid officials to return to the legislature part way through the fiscal year to report on current expenditure trends and to request a supplemental appropriation of necessary (Exhibit 1). In a few states, the legislature and the executive branch have created a formal process to fund Medicaid. On prescribed dates, a special consensus meeting is held to reach agreement among budget forecasters on the amount needed to fully fund the program as it has been defined by law. The legislature then assures that the necessary funding is available.

Exhibit 1

Budgeting Procedures: Comments of State Medicaid Officials

"In our State, shortfalls are a standard procedure. (Legislature appropriated $38 million less than agency projected in 2000.)"

"Medicaid is the balancing act for the State budget. The legislature funds us to the extent they are able."

"We did not start off 2001 as a fully funded program."

"In our State, the legislature appropriates on the basis of available funds. Almost all the cuts have to be borne by education and Medicaid, because the rest of State government is statutorily protected."

"Most of our shortfall comes from deliberate underfunding. If you look at the growth rate, Medicaid is budgeted to grow 5% to 6% per year, but it has been growing every year 10% to 11%."

"Yes, [we expect a shortfall], it is the general way things are done. We just expect it every year. We budget Medicaid very tightly."

"The budget practice is to use a revenue and caseload estimating conference."

"Technically, we cannot have a shortfall because we use a "consensus process for estimating Medicaid and TANF. However, actual expenditures are coming in above the original consensus estimates."

According to the National Conference of State Legislatures, the original legislative appropriations for Medicaid for State fiscal year 1999 reflected average annual increases of 3.7%. However, the actual rate of growth in total Medicaid spending for 1999 turned out to be 5.5%[17], after the necessary mid-year supplemental appropriations. For State fiscal year 2000, the average Medicaid budgeted increase was 4.2%.[18] State budget officers reported actual Medicaid spending growth in State fiscal year 2000 of 8.9%.[19] These percentage differences between the original legislative appropriation and realized expenditure levels can be very large dollar amounts that are of major significance to State budgets.

Methodology

This study is based on a survey of all Medicaid programs to examine current state Medicaid expenditure trends, factors contributing to higher Medicaid spending, and steps states are taking to deal with them for three specific years: last year (state FY 2000); the current year (State FY 2001, that was closing as this study was conducted); and next year (state FY 2002, for which budgets were being developed as this study was conducted). [20]

[17] NASBO / Reforming States Group, 2001.
[18] "Medicaid Spending on the Rise Again," *State Budget & Tax News*, National Conference of State Legislatures, Volume 19, Number 24, December 15, 2000.
[19] National Association of State Budget Officers, The Fiscal Survey of the States, June 2001. Table 9.
[20] State fiscal years run from July 1 to June 30 for all States except four: Fiscal years begin on April 1 in NY, September 1 in TX and October 1 in AL and MI.

A five-page survey was designed and sent to all Medicaid directors in late April 2001. The survey instrument is attached in Appendix A. Each Medicaid director was then contacted to schedule a structured telephone discussion, using the survey instrument as a discussion guide. The telephone interviews were conducted during the months of May and June 2001. Medicaid agencies completed the surveys during May and June 2001. In about two-thirds of the states, the survey was completed in the course of the scheduled interview with the Medicaid director. In other states, the interview was conducted with a person designated by the Medicaid director, usually the person responsible for the Medicaid budget. In ten states, the Medicaid agency submitted the completed survey and did not participate in a telephone interview to discuss the responses. Fifty states completed the survey. Results were compiled in June and July 2001.

Conducting this survey provided insight into the variations among States in how Medicaid is defined, budgeted and appropriated at the State level. The term "Medicaid budget" was found to vary in its meaning among States. Some Medicaid officials were able to provide information about all services financed with Medicaid funds. Others would have found that very difficult or impossible, but they were able to provide information about the portion for which they were responsible. Some had budget data for vendor payments for medical services, while others included payments for services provided through the public health or mental health systems. Because States budget Medicaid differently the same definition could not be applied to all States. For this study, the focus was on annual rates of change so it was sufficient to ensure that same definition was used for all three survey years. Because the definitions varied from State to State, no attempt was made to add the budget totals for all States. The definition used by Medicaid officials for this survey may also not be the same definition used by the State budget agency or legislative fiscal offices.

Survey Results

State Budget Appropriations for State Fiscal Year 2000 and 2001

When forecasting expenditure trends and developing budgets, state policymakers tend to give greater weight to recent experience. The low spending growth rates of the late 1990's may have resulted in initial appropriations that were below actual spending in state FY 2000 and 2001. A number of states reported that they did not start off state FY 2000 or 2001 with Medicaid as a fully funded program and, therefore, the need to appropriate additional money for Medicaid later in the year was not unexpected. In both state FY 2000 and FY 2001, the original legislative appropriations for Medicaid were below the actual rate of growth in total Medicaid appropriations and supplemental appropriations were made (Table 2).

Table 2

States Reporting Medicaid Shortfalls: FY 2000 and FY 2001			
State	Was there a Medicaid budget shortfall in SFY 2000?	SFY 2001 Medicaid Shortfall in State General Fund (in millions of dollars)	SFY 2001 Medicaid State Shortfall as % of State General Fund Medicaid Budget
Alabama	No	66.0	15.6%
Alaska	Yes	9.3	6.5%
Arizona	No	20.1	4.1%
Arkansas	No	No	—
California	Yes	No	—
Colorado	Yes	17.0	1.8%
Connecticut	No	71.6	6.3%
Delaware	Yes	17.8	8.3%
Florida	Yes	260.0	7.0%
Georgia	Yes	71.3	5.8%
Hawaii	No	No	—
Idaho	Yes	33.4	19.7%
Illinois	Yes	200.0	NA
Indiana	Yes	73.3	7.2%
Iowa	Yes	19.9	4.5%
Kansas	Yes	13.6	5.5%
Kentucky	No	No	—
Louisiana	Yes	21.6	2.5%
Maine	Yes	9.0	2.7%
Maryland	Yes	196.8	18.2%
Massachusetts	Yes	118.5	5.3%
Michigan	No	No	—
Minnesota	No	12.0	0.7%
Mississippi	No	No	—
Missouri	No	No	—
Montana	Yes	6.8	6.2%
Nebraska	Yes	3.2	0.9%
Nevada	No	No	—
New Hampshire	No	NA	NA
New Jersey	No	No	—
New Mexico	Yes	38.8	16.2%
New York	No	No	—
North Carolina	Yes	113.0	6.8%
North Dakota	No	1.8	2.4%
Ohio	Yes	237.0	9.7%
Oklahoma	Yes	9.7	2.0%
Oregon*	NA	12.0	1.9%
Pennsylvania	Yes	30.2	0.9%
Rhode Island	Yes	20.0	5.3%
South Carolina	Yes	2.0	0.5%
South Dakota	Yes	2.4	2.5%
Tennessee	No	2.4	0.1%
Texas	Yes	400.0	10.0%
Utah	No	No	—
Vermont	No	1.1	0.8%
Virginia	Yes	46.2	3.3%
Washington	Yes	170.0	15.9%
West Virginia	No	No	—
Wisconsin	Yes	17.7	1.7%
Wyoming	Yes	9.2	11.8%

Notes to Table 2: For SFY 2000 NA indicates State response was that specific information was not available because this was the second year of biennium and. For SFY 2001 NA indicates no response to this question; States reported original appropriations and final expenditures in both general funds and total amounts. These values were used to calculate shortfall amounts.

Legislative Appropriations and Medicaid Expenditures

For state FY 2000, 20 out of 50 states reported that actual expenditures were in line with original legislative appropriations. In the remaining 30 states, however, expenditures exceeded original legislative allocations. Oftentimes, these shortfalls were anticipated (Exhibit 2). In every case, states covered the additional expenditures through a supplemental appropriation or by drawing from a special Medicaid reserve fund. In at least two states (Kansas and Rhode Island), a formal consensus process assured adequate funding for Medicaid. The amount established through this consensus process is automatically authorized for Medicaid.

Exhibit 2

FY 2000: Comments of Medicaid and Budget Officials.

"In State FY 2000, pharmacy costs again increased far faster than any other service type and was the single most significant factor influencing Medicaid costs."

"In FY 2000, we made budget adjustments, transfers from other programs, used $60 million from the Medicaid Trust Fund and delayed the last check in 2000 into 2001."

"The budget shortfall was partly expected. Enrollments increased, and the appropriation was not what was requested. Certain cuts were not implemented. A drug manufacturer lawsuit prevented some pharmacy cost containment initiatives."

"From 1992 to 2000 the budget was flat due to State revenue issues. In 2000 Medicaid had to borrow from other health programs for increased nursing home rates, the costs of pharmacy, and to improve community services."

For state FY 2001, 13 out of 50 states reported that original legislative appropriations were in line with actual expenditures. In the remaining 37 states, actual expenditures exceeded original legislative appropriations. On average, expenditures that exceeded original appropriations comprised 6.1% of the Medicaid general fund budget and ranged from .1% to 19.7%.

State Medicaid officials reported the rates of growth in Medicaid general fund spending and general fund spending for the entire state (Table 3). Based on information provided by state Medicaid officials, Medicaid program expenditures, on average, increased faster than overall state expenditures in state FY 2000 and 2001. In state FY 2000, Medicaid general fund expenditures growth was 7.7%, compared to 5.6% for all state general fund expenditures. In state FY 2001, Medicaid general fund expenditure growth was 9.9% compared to 7.1% for overall general fund expenditures.

Table 3: Average Increases in Total Spending vs. Medicaid Spending, FY2000-2002

State Fiscal Year	Number of States Reporting	Average Increase in Medicaid Spending (General Fund Dollars)	Average Increase in Total State Spending (General Fund Dollars)
2000	32	7.7%	5.6%
2001	34	9.9%	7.1%
2002 Proposed	29	11.1%	7.4%

Source: Health Management Associates State Survey May/June 2001

Medicaid grew faster than the overall State general fund budget in about two-thirds of the States in State FY 2000 (67%) and in FY 2001 (68%). Medicaid general fund spending was projected to grow faster than the overall State general fund budget in three-fourths of the States in State FY 2002 (76%). Exhibits 3 and 4 describe the budget experience in Illinois and Michigan.

Exhibit 3

Illinois Case Study: Budget Expansions and Cost Containment

"In State FY 2000, Illinois was forced to contend with a Medicaid program that was expanding eligibility to aged and disabled populations, enrolling more children through SCHIP, and yet still ensuring adequate reimbursement rates to hospitals, long term care facilities, and physician providers. The FY 2001 Budget Agreement reached by the Governor and legislature provided additional reimbursements to hospitals for tertiary care, cost-of-living adjustments for long term care and non-institutional providers while staying committed to AABD [Aged, Blind and Disabled] and children's health enrollment growth. Yet, while addressing new budget initiatives, Illinois had to deal with ever-escalating pharmacy costs that in FY 2000 had grown by more than 22%. The combination of increased caseloads, especially AABD caseloads, relatively modest provider reimbursement increases, and large annual drug liability increases, drove the FY 2001 budget beyond manageable levels."

"In December 2000, Illinois enacted a number of cost containment measures necessary to bring the Medicaid program back to more manageable levels. These measures included reductions in prescription drug dispensing fees, changes in prescription drug pricing, expanded drug prior approval and utilization review, delayed implementation of the hospital tertiary care reimbursement initiative, and limitations of hospital reimbursements to the lesser of charges or allowable payments. Combined with other control measures, the estimated savings to the Medicaid program were projected to total $100 million in FY 2001." --Excerpted from written survey response.

Exhibit 4

Every Budget Year Is Different– A Michigan Example:

Medicaid budget situations change so quickly that a very different picture can emerge from one year to the next. Michigan provides a good example, looking at the three fiscal years 2000, 2001 and 2002.

In fiscal year 2000, Michigan increased payments to HMOs, physicians and hospitals by an average of 4%. For physicians, this was the first rate increase since 1991. For HMOs the increase was a significant change from the 1997-1999 period, because Michigan had decreased HMO rates through competitively bid prices and curtailment of rate increases.

In fiscal year 2001, physician payments were increased by an average of 7% and most hospital rates increased by 4%. HMO rate increases averaged more than 11% as a result of a "re-bid" of managed care rates. These were some of the largest provider rate increases ever granted by Michigan Medicaid. They were justified by the fact that most Michigan HMOs were losing money, higher pharmacy costs and their need to cover higher rates paid to providers. While not every HMO bid was accepted, the average accepted bid reflected an increase of 11.8%.

In fiscal year 2002 the Executive budget originally included 2% rate increases for providers. During the legislative session, State revenue estimates declined and this recommendation was revised to freeze provider rates at 2001 levels. The legislature adopted the provider rate freeze.

Each of these years -- the reductions in the 1997 – 1999 period, the 4% increase in fiscal year 2000, the 11.8% HMO rate increase in fiscal year 2001 and the 0% increase in fiscal year 2002 – reflects the continuous change that occurs in the State budget and Medicaid situations.

Factors contributing to the growth in Medicaid expenditures in 2001

Medicaid officials were asked to identify the key factors contributing to the growth of Medicaid expenditures in SFY 2001. State officials listed many factors that were contributing to increasing Medicaid expenditures (Table 4). The following four were listed most frequently by State officials when asked specifically to list the top two or three factors causing the increases in Medicaid costs in their State:

- Prescription drug cost increases
- Provider rate increases
- Enrollment increases
- Long-term care cost increases

Table 4: Factors Contributing to Increases in Medicaid Expenditures for FY 2001

Alabama	Pharmacy (19.9% increase), managed care enrollment (3.7% increase), some physician rate increases. Other increases are due to better claims processing (claims up 55%).
Alaska	Home & community-based services (HCBS) waiver and other non-institutional LTC programs (43% cost increase), pharmacy (19% cost increase), and hospital payments (14% cost increase).
Arizona	Pharmacy (18% increase), inpatient hospitalization (3.4% increase), enrollment increases (enrolling state-only members in Medicaid and an increase in 1931 enrollment), home and community-based services waiver (8.8% -12% inflation), transportation (3.2% inflation).
Arkansas	Pharmacy (17% growth), nursing homes, upper payment limits for state teaching hospitals.
California	Pharmacy (18% increase per unit), outpatient hospital (14% increase), nursing homes, physician rates (6% increase), enrollment (3.5% increase).
Colorado	Pharmacy (18% increase) increased home health utilization.
Connecticut	Pharmacy (20% increase), nursing home and home health care (labor shortage and subsequent wage inflation), increased utilization of services (both Fee-for-service and managed care), increase in hospital rates.
Delaware	Pharmacy (21.9% increase), nursing homes (16.4% increase), enrollment increases (mainly due to SCHIP outreach and expanded coverage for pregnant women).
Florida	Inpatient and outpatient hospital (32-34% increase), pharmacy (12.9% increase), nursing homes (8.9% increase).
Georgia	Pharmacy (increased use of single source brands), increased enrollment (TANF add-backs, more disabled), LTC/institutional care (increased rates).
Hawaii	Pharmacy (25% increase).
Idaho	Enrollment (28.3% increase), surge in CHIP and children's programs, increased outreach for CHIP.
Illinois	Pharmacy (large annual drug liability increases), increase in caseloads (due to expanding eligibility (especially for Aid to the Aged, Blind, or Disabled (AABD) and children), increase in provider rates.
Indiana	Pharmacy (21% increase), nursing homes (6% increase), enrollee increase (10.8%).
Iowa	Pharmacy, outreach (40% of applicants to SCHIP are referred to Medical Assistance Division).
Kansas	Pharmacy, home health transportation, increased enrollment (about 50% of cost increase).
Kentucky	Pharmacy, inpatient hospitals (policy change for 0-stay days), increase in enrollment due to aging population, and increased outreach of TANF cases and children.
Louisiana	Pharmacy (16% increase), enrollment (11.7%).
Maine	Pharmacy, enrollment expansion for kids, non-institutional care (social services residential care, mental health services for kids, adults, ICF-MR, and private non-medical institutions).
Maryland	Pharmacy, enrollment.
Massachusetts	Pharmacy (14%), managed care rates (22%), long term care and nursing home rates (22%).
Michigan	Pharmacy, provider rate increases.
Minnesota	Home & community-based waiver and other non-institutional LTC programs (41.7% increase), pharmacy (11.2%), nursing homes (13.3%).
Mississippi	Pharmacy (31% increase), Poverty-level aged and disabled (PLAD) expansion (17% increase).
Missouri	Increases in pharmacy costs, enrollment, disabled caseloads.
Montana	Pharmacy (18.5% increase), mental health, enrollment increases (up 5,000 children and 500 disabled).
Nebraska	Pharmacy (16% increase), nursing homes (8.4% increase), sharp increases in enrollment.
Nevada	Pharmacy (14% increase), inpatient hospitalization (13% increase), outpatient hospitalization (12% increase).
New Hampshire	Pharmacy (increases in utilization and cost of product), outpatient hospital cost settlements, poverty level and CHIP increases.
New Jersey	Pharmacy (16% increase), managed care (30% increase), dental costs, home health costs.

New Mexico	Pharmacy (23.9% increase), enrollment changes including doubling of SCHIP participants, physicians' fee increases, home & community-based waiver (personal care costs increase of $45 million).
New York	Pharmacy, nursing homes and community-based services, rate increases (e.g. dental), and eligibility increases (Family Care Plus waiver will add eligibility for persons aged 19-64).
North Carolina	Increases in number of services (units) per eligible, increase in cost per unit especially for drugs, physicians, and hospital inpatient services.
North Dakota	Pharmacy (13% increase), nursing homes (9% increase), outreach for CHIP has increased enrollment.
Ohio	Pharmacy (22.5% increase), nursing homes (9% increase), enrollment (13% increase).
Oklahoma	Provider rate increases (12% payment increases for pharmacy and hospitalization, 36% increase for nursing homes) and caseload increases.
Oregon	Pharmacy (17-20% increase), enrollment increases, changes in composition of Medicaid enrollees including increases in higher cost groups.
Pennsylvania	Managed care (7.3% increase), pharmacy (16.1% increase), enrollment increases (due to welfare reform).
Rhode Island	Pharmacy (16% increase), behavioral health, enrollment increases for kids and disabled.
South Carolina	Pharmacy, hospital rate increases, higher utilization of services.
South Dakota	Pharmacy, inpatient hospitalization, increases in number of enrollees.
Tennessee	Changes in number of people enrolled (temporary restraining order on disenrollment of waiver population), and pharmacy (double-digit growth).
Texas	Pharmacy (increase in number and average cost of prescriptions), slight shift in caseload toward aged and disabled and medically needy.
Utah	Pharmacy (18-20% increase), inpatient hospitalization (utilization increase), managed care.
Vermont	Pharmacy (20% increase), nursing home ($5 million increase), enrollment (5% increase).
Virginia	Rate increases for providers.
Washington	Pharmacy (21.6% increase), caseload growth (6.2% increase in total eligibles), efforts to expand DSH and UPL programs.
West Virginia	Pharmacy (increase in utilization and 6% cost increase), increase in dental provider rates.
Wisconsin	Family-related caseload growth (majority of 4.6% Medicaid enrollment increase), pharmacy (9.7% increase), hospital payments (8.4% increase for inpatient and 5% increase for outpatient).
Wyoming	Pharmacy (15% increase), and mental health (almost 300% increase for inpatient psychiatric services and mental health under 21).

Note: This table is based on responses to the question: What are the two or three most significant contributors to the increase in Medicaid expenditures in State Fiscal Year 2001?

Prescription Drugs: The number one factor driving Medicaid budgets today is pharmacy costs. Pharmacy costs were mentioned as one of the top two or three key Medicaid cost drivers by 48 States, and 36 listed it first (Figure 8). Many Medicaid officials reported dramatic increases in prescription drug costs (Exhibit 5). States attributed pharmacy cost growth to increases in the number of prescriptions per enrollee and to inflation in the average cost of each prescription. States often mentioned annual rates of increase in their pharmacy costs of 15% to 20%, with thirteen States reporting annual increases between 20% and 31%. Several States mentioned that their Medicaid budget now spends more for prescription drugs than for inpatient hospital care.

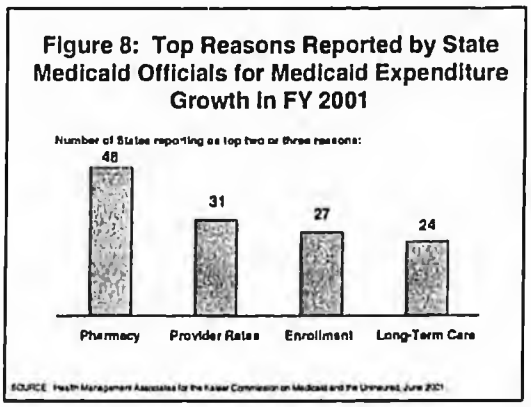


Exhibit 5

State Medicaid Officials Report Substantial Increases in Pharmacy Costs

"Over half of our supplemental is due to pharmacy."

"Pharmacy – An increase in the number and average cost of prescriptions."

"Pharmacy was half of the increase the past two years, and still came in $25 million in general funds over budget."

"The largest impact has been pharmacy. It has been up 18% to 20% for each of the past three years. It has been about 10% price inflation and 8% to 9% in utilization per person, over the whole Medicaid program."

Provider payments: Almost two-thirds of the States (31) indicated that increases for inpatient or outpatient hospital services contributed to Medicaid expenditure growth in their States. 22 States mentioned managed care payment increases. In some States, physician and dental provider payment rates were increased for the first time in several years.

Long-term care: Nursing home rate increases and cost increases for home and community based services were mentioned as one of the top two or three factors in Medicaid cost growth in about half (24) of the States. Long-term care was listed a factor overall in about two-thirds of all States, particularly in States in the Northeast and upper Midwest. A number of States mentioned labor shortages as a contributing factor to cost pressures.

Number of persons enrolled: Over half of all States (27) listed increasing Medicaid enrollment as one of the top two or three top reasons for current Medicaid cost growth. Certainly, increasing enrollment is one of the most visible factors. Over eighty-five percent of States (43 out of 50) indicated that recent increases in Medicaid enrollment were contributing to current Medicaid cost increases. Most often States mentioned increasing enrollment of children associated with recent outreach initiatives for the State

Children's Health Insurance Program. States usually mentioned that children are relatively less costly than other groups, so the budget impact was proportionately less than the increase in their numbers. However some States also mentioned steady increases in the number of disabled adults as a cost driver. Increasing enrollment has been a goal of many state Medicaid programs reflecting the continuing on reaching low-income uninsured children, expanded coverage of the disabled, and reinstatement of low-income families who mistakenly lost coverage under welfare reform efforts (Exhibit 6).

Exhibit 6

State Medicaid Officials Report Gains in Medicaid Enrollment:

"Outreach is being done under the April 7 letter. We are paying their back bills and enrolling them."

"The average number of monthly eligibles exceeded the number budgeted by over 7,000."

"We think the percent of eligibles enrolled has increased from about 50% in the mid-1990s to about 80% now. We are getting people into these programs that were never in the program before. At the same time, the economy has taken many people off."

"We had expected a reduction in the number of TANF individuals, but we saw an increase. The disabled caseload is increasing, and they tend to be heavy users of prescribed drugs."

"We had steep increases in the number of enrollees. SCHIP brought in Medicaid enrollees also."

"Our Family Care Program is expanding rapidly. It just began in October 2000. In six months we have 101,000 enrollees now."

"We had a mandate from our legislature to be aggressive in getting eligibles enrolled. In 2001 we saw large increases in the number of enrollees. SCHIP participation doubled. In Medicaid we went from 305,000 to 325,000."

"It is not the entire cause of the Medicaid increase, but we have a whole lot more recipients than we thought we would."

Different Expenditure Growth by Caseload Component: About half of the States indicated that costs were increasing faster for some components of the Medicaid caseload than for others in fiscal year 2001.

Some states responded based on the fact that aggregate expenditures for a particular component of the caseload had increased faster than for other groups. Sometimes this was a group that includes heavier users of prescribed drugs, such as the disabled. The number of enrollees might not have increased substantially, but total costs were growing faster than for other groups. In other states large increases in the number of enrolled children resulted in a higher increase in aggregate costs for children than for other Medicaid groups, even though children are relatively less expensive on a per enrollee basis.

Other states responded based on the component of Medicaid with the greatest increase in per capita costs. These States indicated that per capita costs for the disabled were increasing at a faster rate than other groups of Medicaid enrollees (Exhibits 7 and 8).

Exhibit 7

State Medicaid Officials Report that Expenditures are Growing Fastest for Elderly and Disabled Beneficiaries

"For what eligibility group are expenditures growing fastest? Any group that uses prescription drugs, so that would be the disabled and the aged."

"The three most significant factors [in our State] in the increase in Medicaid spending in 2001: Prescription drugs, higher utilization and a slight shift in the caseload toward aged and disabled and medically needy."

Exhibit 8

Case Study: Ohio Medicaid Budget

"We were on target for the first nine months of the biennium. It just skyrocketed beginning in April 2000 and got progressively worse each month."

"Because Medicaid is such a large portion of the State's budget, OBM has traditionally asked [Medicaid] to update Medicaid projections during the budget deliberation process, so we can provide the most timely advice to the budget Conference Committee. As we review our Medicaid projections, we remain concerned that Medicaid caseload growth is strong and healthcare inflation continues to increase. For example, pharmacy costs are rising at a rate higher than assumed in the Executive Budget. Last week OBM Director Tom Johnson expressed to you his nervousness about our Medicaid figures. I want to echo his cautionary words to you once again today."

"The Medicaid caseload is exceeding budget projections for the biennium [ending June 30, 2001] at an estimated cost of $279.4 million.... The overall growth in Covered Families and Children reflects a previous reaction to welfare reform, when many families dropped their health coverage as they left cash assistance, even though their health coverage could have continued. This turnaround in enrollment has occurred in response to retraining county eligibility workers, to outreach efforts at the State and local levels to inform uninsured families about coverage options, and to legislatively – directed simplification of the eligibility process."

"Growth in nursing home costs is increasing at twice the rate of the original estimate from four percent to 8.5%. This translates into a budget shortfall of $105 million. Other ABD services are also experiencing higher cost and utilization. This increase includes hospitals, prescription drugs and community based services, including home care, durable medical equipment, private duty nursing and transportation"

--Excerpted from testimony of Barbara Coulter Edwards, Ohio Medicaid

Covered Services: Seventeen States indicated new or expanded coverage of services, including home and community-based services such as home health care and personal care. Coverage expansions generally were not regarded as a major driver of cost increases.

State Actions to Control Medicaid Cost Increases in 2001

States were asked to identify the policy actions they had undertaken in State FY 2001 to address the increases in Medicaid expenditures. State Medicaid programs are continuously seeking to obtain better value as purchasers in the health care market place. This involves a constant effort to adjust policies to contain and control costs, regardless of the State fiscal position.

However, State FY 2001 was not a year for aggressive cost containment actions by most State Medicaid programs, except for the focus on controlling pharmacy costs (Exhibit 9). Indeed, States seemed intent on protecting recent eligibility expansions for children, pregnant women and the working disabled. During FY 2001, 17 States indicated that they added or expanded coverage, including initiating the option for breast and cervical cancer. Several States indicated that they expanded eligibility of simplified the eligibility process. It is noteworthy that for FY 2001 no States mentioned reductions of covered benefits or eligibility levels to control costs.

Exhibit 9

State Medicaid Officials Maintained Coverage and Eligibility Expansions in FY 2001

"We are not interested in any service cuts at all."

"We will reduce the outreach for the SCHIP program to keep down the increases in enrollment, because we've been bringing in more Medicaid kids than we expected."

"There was no cost containment. We used tobacco dollars to increase dental rates and physician fees, to increase access."

"We saw an uptick at the end of 2000. That led us to a supplemental for 2001. With the supplemental that leaves us with enough to finish the year."

"Medicaid expenditures for 2001 slightly exceeded the appropriation, but this is not regarded as a shortfall because Medicaid had some funds left over from the first year of the biennium."

The common theme among States with a budget shortfall in FY2001 was that the Medicaid spending authorization was increased to reflect the increasing fiscal requirements of the program. The increased authorization was accomplished through a supplemental appropriation, drawing from a Medicaid trust or reserve fund or transfer of funds from other programs. Although not universally true, most States were in the fortunate position to have reserves and general fund balances that did not force Medicaid program reductions in 2001.

The following summarizes actions undertaken by States to control Medicaid costs in SFY 2001.

- Restrictions on prescription drug utilization and costs
- Limitations on provider rate increases (in some States)
- Increased use of managed care and other actions to contain costs or increase Federal revenues

Restrictions on prescription drug utilization and costs: Reflecting the priority on controlling prescription drug costs, the primary cost control measures were in this area. States moved to increase the number of brand name prescription drug products that would be subject to prior authorization, introduced new drug utilization edits, reduced pharmacy dispensing fees, limited the number of covered prescriptions per recipient per month, mandated use of generic products, instituted aggressive "Maximum Allowable Cost" (MAC) pricing, increased the discount from "average wholesale price" (AWP) and contracted with a Pharmacy Benefit Managers (PBM) to manage costs.

Limitations on provider rates: Provider fees were frozen in at least three States. Rates were cut 7% in one State. However, in most States provider reimbursement was increased during this period, including increases for hospitals, nursing homes, physicians and dentists.

Increased use of managed care: Most States are already using managed care extensively. At least one State mentioned expanded use of managed care as part of its approach to controlling Medicaid costs. Several States mentioned increases in managed care capitation payments as a factor in their increasing expenditure rate.

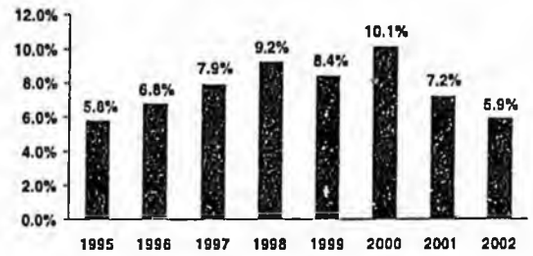
Other cost containment actions: Three States mentioned specific initiatives designed to improve program integrity and reduce fraud and abuse.

State actions to increase Federal revenue: In the past few years, a number of States have used Upper Payment Limit strategies to the State's financial advantage. The use of a UPL approach has an "expenditure illusion" effect as nominal Medicaid expenditures increase without an associated increase in State general fund expenditures or services provided. Congress and the Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) have placed limits on States' use of UPL approaches. Nevertheless, about a half dozen States specifically mentioned that they used a UPL approach as one way to help finance the increasing costs of Medicaid in 2001.

The Outlook for 2002

As States begin FY 2002, Medicaid is in a period of significant cost growth. This cost growth comes just at a time when State revenue growth is leveling or decreasing, State general fund balances are decreasing and other State programs are targeted to grow at rates much slower than is Medicaid (Figure 9 & Exhibit 10)

Figure 9: Average State Year-End Balances as a Percentage of Expenditures, FY 1995-2002



SOURCE: NASBO, June 2001

Legislative action was not complete on all Medicaid and State budgets for SFY 2002 at the time of this survey. However, an examination of the Governors' executive budget recommendations for SFY 2002 shows that many States are recognizing the upward trend in Medicaid spending, at least in part. According to the National Association of State Budget Officers, executive recommendations for SFY 2002 for Medicaid budgets reflected general fund increases that averaged 7.8%. The corresponding executive recommendations for the total State general fund budget averaged only 3.6%.[21] In other words, Governors' executive budget recommendations proposed that Medicaid expenditures grow at over twice the rate of other State expenditures in SFY 2002.

For State FY 2002, Medicaid officials were asked to indicate the expected percentage increase in Medicaid expenditures and also the expected percentage increase in the overall State budget. Officials in 29 States responded with estimated expenditure growth for both Medicaid and the entire State general fund budget. Among these 29 States, about three-fourths (22 of 29) indicated that the Medicaid growth rate would exceed that of the overall budget. The average expected increase in total State general fund spending for FY 2002 was 7.4%, and the expected increase for Medicaid general fund spending was 11.1%.

Medicaid officials were also asked if they expected actual Medicaid expenditures would exceed the amount that was authorized or was being proposed for authorization for FY 2002 at the time of the survey. A total 47 States responded. Officials in 20 of these 47 States indicated that they expected a Medicaid budget shortfall and a likely need for supplemental funding for SFY 2002 (Table 5 and Exhibit 11).

[21] National Association of State Budget Officers, *Fiscal Survey of the States*, June 2001.

Exhibit 10

State Medicaid Officials Report a Tightening Budget Outlook for FY 2002:

"We will have some real financial problems here in Medicaid in the year ahead of us."

"State revenues have been good so far. They are a little softer now, but it has not affected the Medicaid budget yet."

"We are having a hard time just sustaining the program. If we do not get new revenue it will not be enough to maintain the program. We are not looking forward to 2003 and 2004. We do not know what we are going to do."

"We are caught in the [statutory] limit in the growth of the overall State budget."

"Do we anticipate a budget shortfall in 2002? I wouldn't be surprised."

"We're suffering as the economy is slowing. We already declared a pro-ration on the school fund, so aid to schools is already being cut."

"The legislature appropriated $20 million less than the Executive Recommendation for 2002."

"We believe the Medicaid budget for 2002 is about 10% underfunded, but the legislature is still looking at this."

"The legislature is beginning to look at options, considering rate cuts or eliminating optional services."

"Everything we have done [in Medicaid] has been in the context of cuts, downsizing and shortage of funds."

"The economy is always a factor. But we are not budgeting for any kind of a downturn. [Actual budgeted increase was 5%.]"

"We are now in the middle of the budget process. There is a lot of pressure to increase rates. At the moment. there is no pressure to cut programs. But, we may be coming to a problem. Last year, the projections were too low, so the actual was a surprise."

"We expect it to be tight. We are expecting a slowdown in caseload and in pharmacy costs. If they continue at the recent pace, we will have a problem. If we are not thrown a curveball, I think we can get through the next two years."

'This will be tight. A limited reserve leaves us very little room for error. So it will force us to request a supplemental if expenditures increase."

"The Legislature appropriated less than the original executive recommendation and the re-projection is higher than the executive recommendation. Plus, the new FMAP for the last nine months of the biennium will add to the shortfall."

Table 5: States Anticipating Fiscal Year 2002 Medicaid Shortfalls as of May and June 2001

State	Without further action, do you anticipate a Medicaid shortfall in SFY 2002?	SFY 2002 Medicaid Shortfall in State General Fund (in millions of dollars)	SFY 2002 Medicaid State Shortfall as % of State General Fund Medicaid Budget
Alabama	No	—	—
Alaska	Yes	14.7	8.6%
Arizona	No	—	—
Arkansas	NA	NA	NA
California	No	—	—
Colorado	No	—	—
Connecticut	No	—	—
Delaware	Yes	6.2	2.3%
Florida	No	—	—
Georgia	Yes	141.0	9.7%
Hawaii	No	—	—
Idaho	Yes	5.6	2.4%
Illinois	No	—	—
Indiana	Yes	4.2	0.4%
Iowa	Yes	3.7	0.8%
Kansas	No	—	—
Kentucky	Yes	85.0	8.2%
Louisiana	Yes	104.0	11.1%
Maine	No	—	—
Maryland	Yes	96.2	6.6%
Massachusetts	No	—	—
Michigan	No	—	—
Minnesota	No	—	—
Mississippi	Yes	100.0	31.6%
Missouri	NA	NA	NA
Montana	NA	NA	NA
Nebraska	No	—	—
Nevada	No	—	—
New Hampshire	Yes	10.0	NA
New Jersey	No	—	—
New Mexico	Yes	5.0	1.6%
New York	No	—	—
North Carolina	Yes	389.0	15.9%
North Dakota	Yes	9.0	10.1%
Ohio	Yes	180.0	5.9%
Oklahoma	Yes	69.0	11.3%
Oregon	No	—	—
Pennsylvania	Yes	NA	NA
Rhode Island	No	—	—
South Carolina	No	—	—
South Dakota	No	—	—
Tennessee	No	—	—
Texas	No	—	—
Utah	No	—	—
Vermont	Yes	NA	NA
Virginia	No	—	—
Washington	No	—	—
West Virginia	No	—	—
Wisconsin	Yes	NA	NA
Wyoming	Yes	5.3	5.7%

* NA indicates no response to this question.

Exhibit 11

One State Budget Example for FY 2002: Ohio

The Biennial State budget for Ohio was adopted in June 2001. It reflected an annual increase of 2.4% for FY 2002 over FY 2001. Included in the 2.4% increase is an increase of 13.4% for Medicaid.

Factors Contributing to the Increase in the 2002 Medicaid Expenditures

For FY 2002 States identified the same cost drivers for Medicaid as they did for FY 2001 (Table 6).

- Prescription drug costs
- Provider rate increases
- Long term care
- Enrollment increases

Table 6: Factors Contributing to Increases in Medicaid Expenditures for FY 2002

Alabama	Pharmacy (increase is expected to continue so an 11% increase is budgeted).
Alaska	Pharmacy (21.5% cost increase), home & community-based services (HCBS) waiver and other non-institutional LTC programs (19.3% cost increase), enrollment (10% increase), continuing rise in disabled population, and potential reduction in FMAP due to CPI formula changes.
Arizona	Pharmacy (18% increase), enrollment (increase in 1931 population and expansion to 100% FPL which will result in more adults and SSI), home and community-based waiver and other non-institutional LTC programs (14.8% increase), nursing homes (5.6% increase).
Arkansas	Pharmacy, nursing homes, upper payment limits, and mental health. Other factors will be the increase of the federal poverty level, expansion of medical assistance for adults as well as children with limited benefits, implementing senior prescription program and an assisted living waiver.
California	No response.
Colorado	Pharmacy (18% increase), rate increases for home and community-based waiver and other non-institutional care programs (11.6-12.5% increase), welfare outreach may increase enrollment, and an HMO lawsuit.
Connecticut	Pharmacy (20% increase), nursing home and home health care (labor shortage and subsequent wage inflation), increased utilization of services (both FFS and managed care), increase in hospital rates.
Delaware	Pharmacy (18.8% increase), inpatient hospitalization (17 % increase), nursing homes (20.1% increase), MR waiver.
Florida	Pharmacy (27.6% increase), nursing homes (5.8% increase), enrollment and caseload (6% increase).
Georgia	Pharmacy (increase use of single source brands), enrollment increases (TANF add-backs, more disabled), federal poverty level increase.
Hawaii	Pharmacy (22.5% increase).
Idaho	Enrollment (16.2% increase), surge in CHIP and Medicaid kids.
Illinois	Increases expected for pharmacy, home and community-based waiver programs, and enrollment (ABD expansion).
Indiana	Pharmacy (22% increase), outpatient hospital (18% increase), managed care (8%), nursing homes (6% increase), increased enrollment due to change in disability definition, outreach programs (disease management & care management for aged, blind and disabled).
Iowa	No response.

Kansas	Pharmacy (17% increase) home health/transportation, increased enrollment including number of children and Transitional Medicaid for Temporary Assistance for Families (TAF) adults.
Kentucky	Pharmacy, inpatient hospitals (policy change for 0-stay days), increase in enrollment due to aging population, and increase in outreach of TANF cases and children.
Louisiana	Pharmacy (16%-18 % increase), inpatient hospital increases (due to outlier payments), significant impact due to Olmstead decision (currently in a negotiated settlement of a lawsuit), and enrollment increases (12,000 new Title XXI kids, large Title XIX increases, may cover adults of kids covered, and legislation to increase coverage for pregnant woman and kids).
Maine	Pharmacy, home and community-based services waiver and other non-institutional LTC programs as well as provider payments for mental health services.
Maryland	Pharmacy (15%-18% increase), managed care rates, and increase in enrollment (28,000 people).
Massachusetts	Pharmacy (14% increase), community long-term care (significant increases), managed care rates including behavioral health, and increase in enrollment (4% increase).
Michigan	Increase cost and utilization for: pharmacy, hospitalization, managed care, nursing homes, and home and community-based waiver and other non-institutional LTC programs.
Minnesota	Managed care (59% share of total budget increase), home and community-based waiver and other non-institutional LTC programs (16% share of total budget increase), nursing homes (10% share of total budget increase).
Mississippi	Pharmacy cost and utilization (27% increase), nursing homes (10% increase in allocated beds), home and community-based waiver programs (35% increase).
Missouri	Pharmacy (18-21% increase), managed care increases, enrollment (5.4% increase for TANF and 6% increase in disabled enrollees.)
Montana	Increases in provider payments for pharmacy and mental health.
Nebraska	Pharmacy, nursing homes (due to labor situation for professional and non-professional), sharp increases in enrollment (growth in number of kids and will enroll breast and cervical cancer patients to 225% FPL).
Nevada	Provider payment rates increase to make up for past rate freezes (totaling $40 million with majority going to LTC), caseload growth—especially TANF and children (7.6% increase projected).
New Hampshire	Provider payment increases for pharmacy and outpatient hospital services.
New Jersey	Managed care (17%-18% increase), practitioner fees, pharmacy costs, and personal care services.
New Mexico	Pharmacy (26.7% increase), inpatient hospitalization (25.6% increase), home and community-based waiver services, personal care program (10.8% increase).
New York	Pharmacy, nursing homes and community-based services, rate increases (e.g. dental), and eligibility increases (Family Care Plus waiver will add eligibility for persons aged 19-64).
North Carolina	Pharmacy (24% increase), hospital inpatient (17% increase), hospital ER (20% increase), physician services (15% increase), mental health clinics (18%).
North Dakota	Pharmacy (10% increase), nursing homes (legislature's budget shows 15.5% increase).
Ohio	Pharmacy, nursing homes, enrollment.
Oklahoma	Pharmacy (15% increase), managed care (5% increase), graduate medical education (GME) increasing $62 million (doubling in size and financed through IGT).
Oregon	Pharmacy (15-16% increase), managed care (20% increase), enrollment (6.4% increase), changes in composition of Medicaid enrollees including poverty level children, foster care, ABD.
Pennsylvania	Managed care (7.24% increase), pharmacy (16.1% increase), enrollment increases (due to welfare reform).
Rhode Island	Pharmacy (16.5% increase), nursing homes (4.8%), behavioral health, and enrollment increases (particularly disabled adults).
South Carolina	Pharmacy, physician rate increases, utilization trends.
South Dakota	Pharmacy, inpatient hospitalization, increase in number of enrollees.
Tennessee	Pharmacy (double digit increase in costs), managed care (4% overall increase in MCO capitation payments), changes in number of people enrolled.
Texas	Pharmacy (increase in number and average cost of prescriptions), higher utilization, slight shift in caseload toward aged and disabled and medically needy.
Utah	Pharmacy (18% increase), inpatient hospitalization (utilization increase), managed care. Inflation and utilization are higher than in previous years.

Vermont	Pharmacy (36.5% of increase in total expenditures), nursing home (30% of increase of total expenditures).
Virginia	No response.
Washington	Pharmacy (15% increase due to increased cost and higher utilization), hospital payments (8.7% increase for inpatient and 9.9% increase for outpatient), enrollment (3% total increase), efforts to expand nursing home, DSH and UPL programs.
West Virginia	Pharmacy, inflation, utilization.
Wisconsin	Pharmacy (15.3% increase), hospital payments (4.6% increase for inpatient and 4.2% increase for outpatient), nursing.
Wyoming	Pharmacy (15% increase), three new waivers (for elderly, acquired brain injury, assisted living), potential rate increases for inpatient and outpatient hospital payments due to previous underfunding.

Source: State Medicaid officials response to survey by Health Management Associates, May and June 2001.

Prescription drug costs: Pharmacy cost increases was listed as the number one cost driver (Exhibit 12). Many State officials were quick to describe how the pharmacy line in their budget was increasing at rates of 10% to 28% per year. Of the 26 States that indicated a specific expected increase in pharmacy costs for SFY 2002, the average was 18%. In addition to these rates, States mentioned increasing pharmacy costs as a cost driver in other areas of the Medicaid budget, especially in mental health services and managed care rates.

Exhibit 12

State Medicaid Officials Note Pharmacy and Nursing Home Costs in FY 2002:

"I wish we could do something about prescribed drugs. I don't know what can be done."

"Again, pharmacy costs are expected to be the largest single item influencing the FY 2002 Medicaid budget."

"The pharmacy prior authorization is the only reason we've been able to control costs."

"The biggest issue in the upper Midwest is how to control nursing home costs. We need to move people to home and community-based settings."

"The 2002 budget depends on the economy staying good and caseload growth occurring at the budgeted rate.... Caseload is budgeted at 6%. It quite likely will be higher and cause a budget problem."

"The managed care rate increase doesn't begin to account for the 20% increase in pharmacy costs."

Nursing home costs account for one-quarter of the Medicaid budget, and nursing homes will receive a 4.8% increase for inflation."

"The executive recommendation was for an increase of 4% for [nursing homes], but the Legislature granted 15.5%."

Provider rate increases: Inpatient and outpatient hospital costs are expected to be significant cost drivers. About half the responding States indicated that hospitals would receive rate increases in SFY 2002.

Managed care rate increases are significant in States with large numbers of enrollees in health plans. Reported rate increases ranged from 3.4% to 8%, although States with increasing managed care enrollment indicated their overall managed care expenditures might increase by 17% to 18%.

Long term care: Half of respondents indicated that nursing home rate increases would be significant (Exhibit 13). Eighteen States indicated home and community-based programs were a factor in Medicaid cost growth, due both to rate increases for personal care and other home-based services and due to expansions in coverage. The Olmstead decision is a factor in these expansions. One State specifically indicated that their policy changes were related to a lawsuit settlement process. Another States' response summarized a prevalent view regarding the impact of the Olmstead decision: "We expect a significant impact but it has yet to be reflected in actual expenditures."

Enrollment increases: States expect continued increases in the number of persons enrolled in Medicaid. Half of respondents listed enrollment increases as a key factor in expected Medicaid cost growth in FY 2002. States indicated expectations for increases in the 2% to 6% range, with a few States indicating increases in the range of 6% to 10% and one State indicating an expected increase of 16%. Reasons for the increases include expected increases in TANF caseloads, TANF-related Medicaid outreach[22], new efforts to enroll children in State Children's Health Insurance Programs, recent eligibility expansions for children and families. As in FY 2001, increasing enrollment of low-income uninsured families remained a policy priority for many states.

Notably, States also expect increases in enrollment in the aged and disabled categories, due to the aging population, a new definition of disability and coverage for the working disabled. States indicated this would likely change the composition of the caseload and impact program costs.

Other factors: Benefit coverage expansions are a minor factor for FY 2002. States mentioned limited benefit expansions targeted for family planning waivers and added coverage for persons with breast and cervical cancer.

State strategies to control expected Medicaid expenditure growth in SFY 2002
Recent Medicaid cost increases have forced Medicaid officials to focus on strategies for controlling expenditure growth. Many states have already begun to implement approaches as directed by their legislature. Other States are forming special task forces to identify possible options.

For SFY 2002, the dominant Medicaid cost containment strategies are those that target cost increases for prescription drugs. However, states are not limiting their attention just

[22] During 2002, many States plan to contact individuals whose Medicaid cases were closed at the time that their TANF cash assistance cases were closed. The outreach will seek to find individuals and families that still qualify for Medicaid coverage.

to drugs. Medicaid officials described the following Medicaid cost control strategies being considered in FY 2002:

- Controls on prescription drug costs and utilization
- Freezes or reductions in provider payments
- Increased use of managed care, care coordination, disease management and other utilization management approaches
- Using home and community-based services in place of nursing home care
- Competitively bidding for medical equipment, supplies or other services
- Increased efforts on control of fraud and abuse

Controls on prescription drug costs and utilization: States indicated multiple strategies to control the escalating costs of prescription drugs. The three most prevalent strategies mentioned include:

(a) prior authorization of selected brand name products to encourage use of generics,
(b) reduced payment for pharmacy products by applying a greater discount from average wholesale price (e.g., going from AWP less 10% to AWP less 15%), and
(c) contracting for a pharmacy benefit manager (PBM).

Other pharmacy strategies are also proposed. At least three States have proposed reducing the pharmacy dispensing fee. At least two States have proposed increasing copayments for prescription drugs. Other strategies include "brand necessary" or "dispense as written" policies for brand name products where a generic is available, a mail order pharmacy option, supplemental rebates for selected therapeutic categories of drugs, use of a drug formulary and initiation of disease management programs.

Freezes or reductions in provider payments: About one-third of the States adopted or proposed freezes or actual reductions in provider payments. Several of these reductions were to result from rebasing inpatient or outpatient hospital rates, or through the replacement of a cost-based reimbursement methodology. Nine States specifically mentioned rate freezes for hospitals or other providers. For example, in one State the legislature froze all discretionary provider rates at FY 2001 levels. Another State expected savings from selective contracting for inpatient hospital services.

Increased use of managed care, care coordination, disease management and other utilization management approaches: Most States have some form of managed care. For FY 2002 many States expect to expand their use of managed care, or to adopt case management strategies for populations that may not be in managed care. A number of States have experienced a decrease in the number of managed care organizations willing to serve Medicaid. Several of these States are considering the adoption of a Primary Care Case Management (PCCM) system. Another primary focus is on care coordination for the disabled populations. States describe their strategies in various ways, such as "case management for high utilizers" or "disease management for the disabled and aged" or "care coordination for complex cases." In each case the objective is to ensure that appropriate care is provided, with the expectation that the result will be higher quality care and lower costs.

Using home and community-based services in place of nursing home care: In some States, efforts to control long-term care costs are as significant as the pharmacy cost issue is in other States. States are looking at ways to control payment rate increases. However, labor shortages have created great pressure to increase rates for nursing homes and for home and community-based services. Several states are increasing the number of individuals authorized to receive home and community-based services. Some of these States also are adopting prior authorization policies to prevent overuse of home and community-based services such as personal care and home health.

Competitively bidding for medical equipment, supplies or other services: A few States indicated they are planning to competitively bid for durable medical equipment and medical supplies and other services such as vision care.

Increased efforts on fraud and abuse control and coordination of benefits: A number of States are dedicating more staff for audits and anti-fraud activities, more data matches with other State agencies including Treasury, high-cost claim analysis and additional efforts to recover third party liability payments.

Other Strategies: A number of other strategies were listed, including new information technology to enable better program management and premium subsidies to continue employer sponsored health coverage.

Eligibility and Coverage Strategies: Significantly, no State mentioned a proposed reduction in eligibility. Indeed, several States indicated they were considering or planning to adopt eligibility expansions, such as a Section 1931 expansion for uninsured adults. Similarly, few States indicated they were considering benefit reductions. Two States did indicate they were considering a proposal to eliminate coverage for adult dental or denture services, but these had not been adopted. Many states, however, were adding coverage such as limited benefits under a waiver for family planning or for breast and cervical cancer.

Revenue Strategies: Several States indicated that they continue to look for opportunities to use UPL or other strategies that might advantage the financing of the Medicaid budget. Even before SFY 2002 had begun, State Medicaid officials were looking at the possible need for supplemental appropriations in the future. Even before the year began, twenty States indicated a likely need for a supplemental appropriation for Medicaid in SFY 2002.

Summary and Conclusion

States are emerging from a period during which State revenues increased at near record rates at the same time that cost pressure from Medicaid, one of the largest programs in the budget, was at historic lows.

That favorable situation has changed rapidly. In early 2001, growth rates in State revenues declined, dramatically in some States, forcing some States to adjust their budgets for SFY 2002 downward even before they were adopted. State year-end fund balances were above 10%, the highest levels in twenty years in FY 2000, but dropped by half in FY 2001. In many States, Medicaid Upper Payment Limit and Inter-Governmental Transfer strategies that have assisted States in financing Medicaid are now limited and are being phased out.

At the same time that revenue is becoming more limited, Medicaid expenditure growth has accelerated to a pace that exceeds the growth in State revenues in most States. The reasons for the recent Medicaid cost growth increases are several. Among the key reasons are dramatic increases in Medicaid costs for prescribed drugs, "catch-up" increases in provider payment rates after several years of low or no increases, increases in rates paid to managed care organizations and for long-term care, increasing numbers of persons enrolled, and increased use of state financing strategies (i.e., UPL arrangements) to bring in more federal dollars.

As these trends converge, the immediate prospect is for a difficult and contentious period for Medicaid budgets. Medicaid cost pressures are already conflicting with a diminishing ability of States to finance the program. Without doubt, these forces will intensify and provide a difficult challenge for State health policy and budget decision-makers in the immediate future. Notwithstanding the state budget issues, the Medicaid program is an important factor in the local economy, bringing in at least $2 in federal dollars for each state dollar spent.

Facing these challenges, several major questions arise for public officials and policy makers.

- Will States be able to find ways to contain Medicaid cost growth within what is affordable?
- Will the new fiscal realities cause States to re-think the recent expansions of Medicaid and SCHIP coverage for children, families, the working disabled, persons qualifying for family planning coverage and women's treatment breast and cervical cancer; or will there be a slow down or reversal of this policy direction?
- Will states continue to use Medicaid as a vehicle to finance health coverage for low-income uninsured workers, and to assure coverage for the low-income families and children, the elderly and disabled populations served by the program?
- How will the safety net be affected, and will budget constraints at the State and Federal levels force communities to face additional challenges?
- Will states take action to shore up state revenues in order to preserve Medicaid and other state programs?

- As states seek to balance their budgets, will they try to preserve the federal dollars flowing to states through the Medicaid program?
- Does Medicaid's matching formula adequately protect states in times of fiscal crisis?

Fiscal realities are a powerful driver of public policy at all times, and this period of budget pressure will force the States to deal with difficult fiscal questions and tradeoffs for the first time in nearly a decade. Following years of program stability and expansion, potential program constraints and significant budget reductions will be especially challenging for policy makers and public officials, and will make this an especially significant time for the Medicaid program.

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Department of Health & Social Services
Summary of Operating Budget
ATAP, Child Care, AWP/Work Services
Adult Public Assistance

A nearly 50% caseload reduction has resulted since Welfare Reform was implemented during the FY97 budget. This caseload reduction has provided the department reinvestment opportunities to provide child care, work services and other related activities for recipients and working families as they leave welfare for work.

The federal welfare reform law authorized Alaska's twelve regional non-profit Native organizations and the Metlakatla Indian Community to administer TANF programs within their regions and in FY00, the Legislature passed a bill authorizing four Native Organizations in Alaska to run their own programs. These include Tanana Chiefs Conference, Tlingit & Haida Indian Tribes, Tlingit & Haida in Southeast, and Association of Village Council Presidents. Funding Native TANF program operations comes from federal TANF block grant and supplemented by state fund transfers from ATAP. The Native TANF program during FY00 was $2,405.2 (in thousands) and has risen to $7,691.7 in FY02.

AS 47.07.035 Priority of medical assistance. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) clinical social workers' services;
(2) psychologists' services;
(3) chiropractic services;
(4) advanced nurse practitioner services;
(5) adult dental services;
(6) emergency hospital services;
(7) midwife services;
(8) treatment of speech, hearing, and language disorders;
(9) optometrists' services and eyeglasses;
(10) occupational therapy;
(11) mammography screening;
(12) prosthetic devices;
(13) medical supplies and equipment;
(14) targeted case management services;
(15) rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults;
(16) clinic services;
(17) physical therapy;
(18) personal care services in a recipient's home;
(19) prescribed drugs;
(20) hospice care;
(21) long-term care noninstitutional services;
(22) inpatient psychiatric facility services[1];
(23) intermediate care facility services for the mentally retarded;
(24) intermediate care facility services;
(25) individuals described in AS 47.07.020(b)(11);
(26) individuals under age 21 not eligible for AFDC;
(27) skilled nursing facility services for persons under age 21;
(28) aged, blind, and disabled individuals;
(29) individuals in a hospital, skilled nursing facility, or intermediate care facility;
(30) individuals under age 21 under supervision of the department;
(31) subsidized adoptions
(32) working disabled

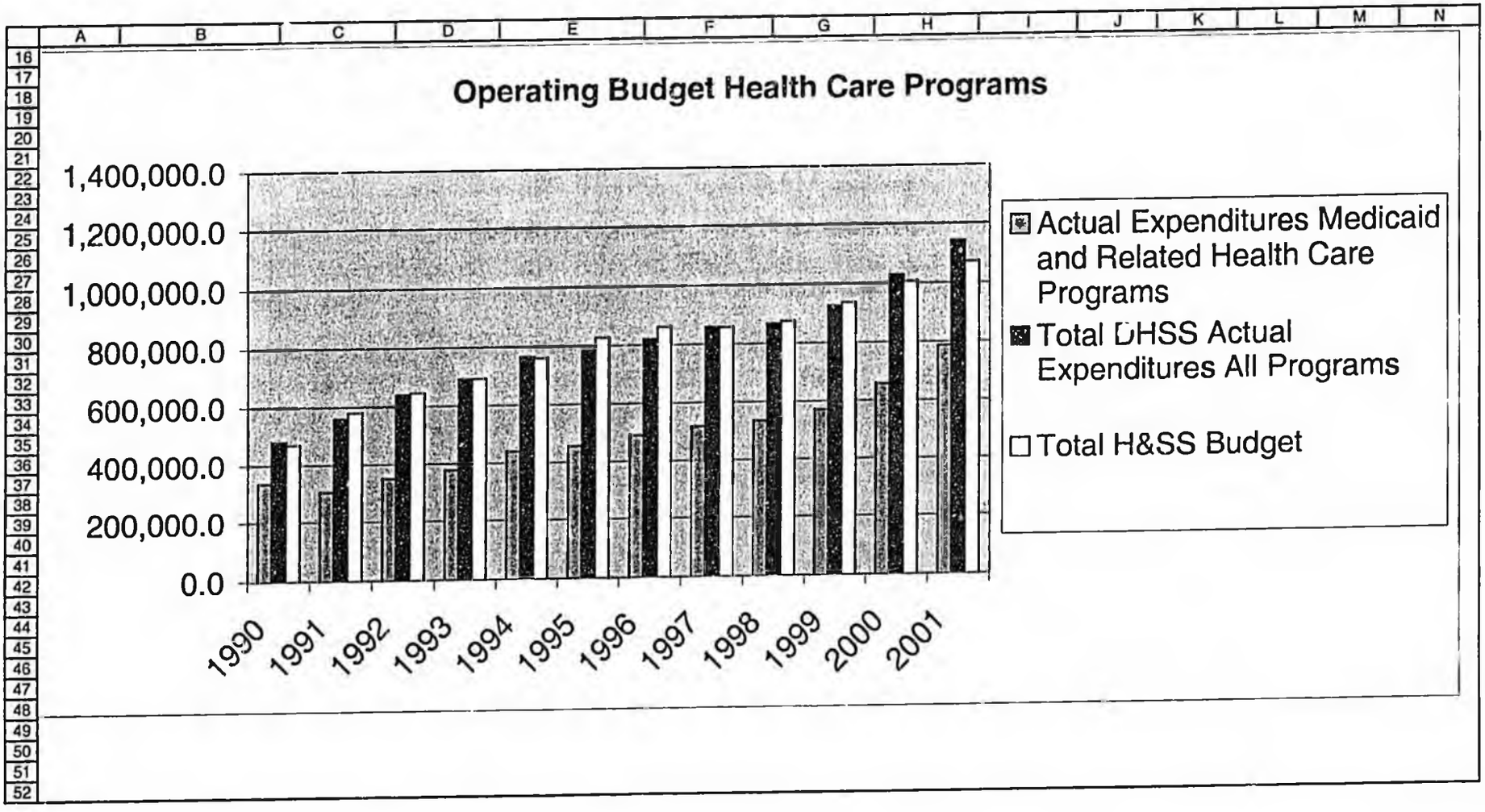
[1] Includes Alaska Psychiatric Institute.

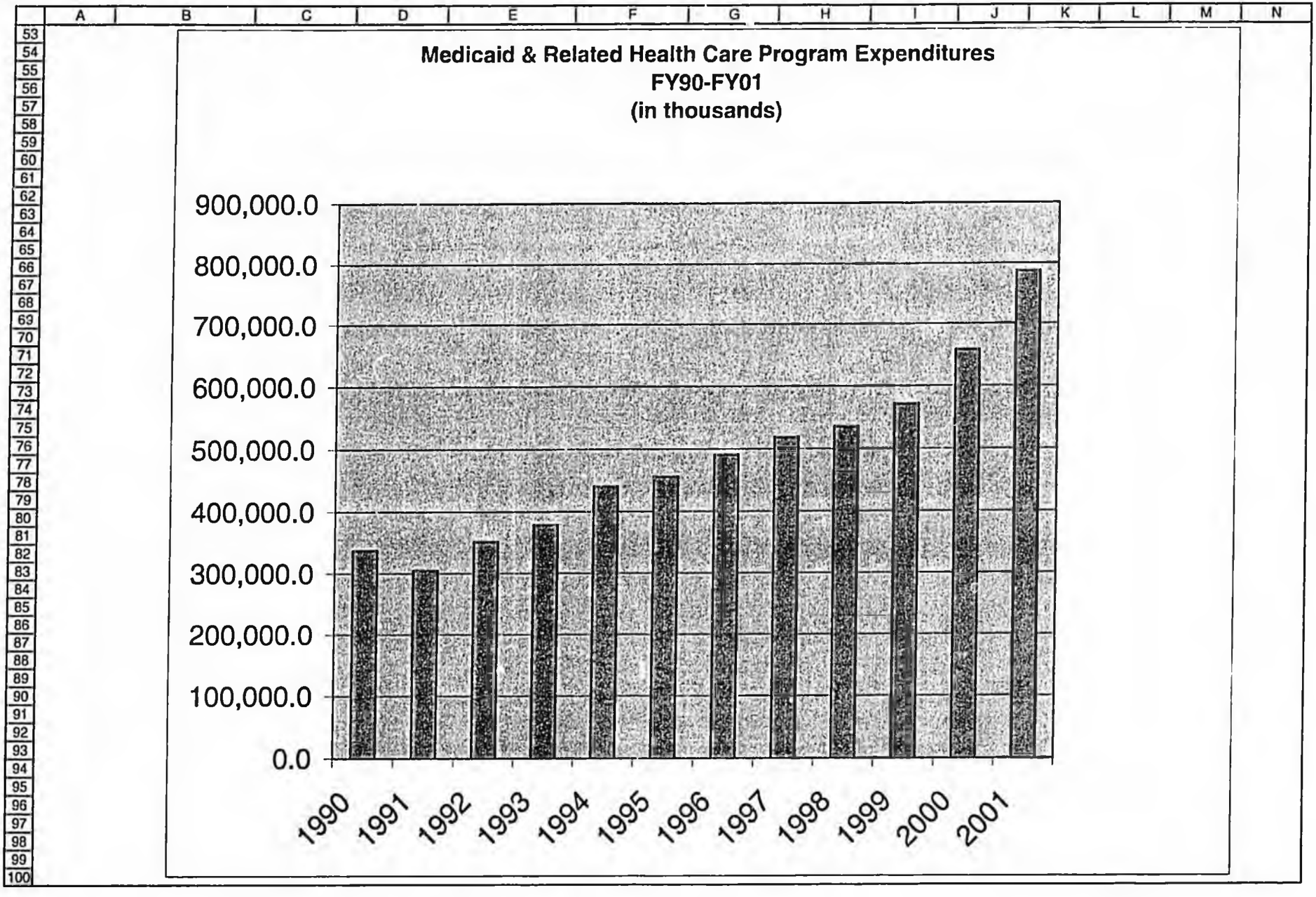
Operating Budget Health Care Programs
(in thousands)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Year	Actual Expenditures Medicaid and Related Health Care Programs	Total DHSS Actual Expenditures All Programs	Total H&SS Budget	Enacted Operating Total State Budget	% Healthcare Expenditures v DHSS Expenditures All Programs	% Healthcare Expenditures v State Budget	% DHSS Expenditures v State Budget	% Total DHSS Budget v State Budget					
2	1990	337,256.0	481,758.30	471,026.8	2,656,267.6	70.0%	12.7%	18.1%	17.7%					
3	1991	304,776.3	560,718.40	580,524.8	2,923,866.6	54.4%	10.4%	19.2%	19.9%					
4	1992	351,245.7	640,784.50	646,439.5	3,263,533.6	54.8%	10.8%	19.6%	19.8%					
5	1993	378,475.4	692,803.80	693,940.6	3,399,852.0	54.6%	11.1%	20.4%	20.4%					
6	1994	441,044.0	765,877.80	760,984.4	3,512,971.7	57.6%	12.6%	21.8%	21.7%					
7	1995	456,324.8	783,367.10	827,289.9	3,655,681.0	58.3%	12.5%	21.4%	22.6%					
8	1996	490,968.2	819,210.10	861,245.3	3,810,417.0	59.9%	12.9%	21.5%	22.6%					
9	1997	519,027.2	859,680.80	857,258.1	3,837,615.3	60.4%	13.5%	22.4%	22.3%					
10	1998	535,805.6	868,887.10	875,378.5	3,975,736.3	61.7%	13.5%	21.9%	22.0%					
11	1999	571,797.2	926,289.80	937,103.9	3,661,600.0	61.7%	15.6%	25.3%	25.6%					
12	2000	658,256.3	1,028,905.60	1,006,512.3	3,689,200.0	64.0%	17.8%	27.9%	27.3%					
13	2001	787,604.2	1,143,129.00	1,070,903.3	3,994,500.0	68.9%	19.7%	28.6%	26.8%					
14	Total:	5,044,976.68	9,571,412.30	9,588,607.40	42,381,241.1	60.5%	13.6%	22.3%	22.4%	Averages				
15														

Health Care Actual Expenditure History Total All Funding Sources	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01	Total
Medicaid Services	207,788.0	179,493.0	206,076.0	229,948.4	275,140.7	282,995.5	311,757.7	334,852.6	365,536.5	395,689.5	470,709.0	583,861.0	3,843,847.9
Catastrophic & Chronic Illness	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3,045.0	3,653.5	4,304.0	11,002.5
CHIP	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	1,128.1	2,363.4	2,632.8	6,124.3
Medical Asst Admin:	15,399.4	13,440.4	14,049.2	16,404.2	30,402.3	34,646.6	34,811.4	38,060.8	31,936.2	29,899.0	32,736.0	35,969.0	327,754.5
Medical Assistance Admin.													
Medicaid State Programs													
Health Purchasing Group													
Certificaiton/Licensing													
Hearings & Appeals													
State Health Services:	37,561.8	35,032.5	39,876.1	42,030.7	45,053.6	53,811.5	60,642.4	68,370.5	64,896.5	70,911.3	74,819.4	81,862.0	674,868.3
Nursing													
MCFH													
Public Health Admin Svcs													
Epidemiology													
Bureau of Vital Statistics													
Com. Health/Emerg Medical Svcs													
Community Health Grants													
Emergency Medical Svcs Grants													
State Medical Examiner													
Infant Learning Program													
Public Health Labs													
Tobacco Prevention & Control													
Radiological Health													
Community Mental Health Grants:	31,138.2	30,462.9	37,840.2	38,147.2	36,271.0	31,748.7	31,707.8	26,290.2	25,928.6	26,676.1	27,617.0	30,104.0	373,931.9
Gen. Comm MH Grants													
Psychiatric Emergency Services													
Svcs to Chronically Mentall Ill													
Designated Evaluation & Treatment													
Svcs for Seriously Emotionally Dist Yth													
Community Developmental Disabilities	13,318.1	13,255.6	18,569.9	19,916.8	20,606.0	20,225.3	20,619.1	21,644.9	20,033.0	19,500.0	20,293.0	19,954.0	227,935.7
Institutions & Administration:	28,201.8	29,405.5	31,529.9	28,620.6	30,204.2	29,450.3	27,982.6	26,394.9	24,061.5	21,410.3	22,526.7	24,527.0	324,315.3
Mental Health/DD Admin													
Alaska Psychiatric Institute													
Designated BRUs Public Health Svcs:													
Maniilaq Public Health Svcs	924.1	770.5	779.3	926.8	921.6	910.4	910.4	901.3	901.3	900.9	901.3	901.2	
Norton Sound Public Health Svcs	1,213.3	1,213.3	1,173.6	1,153.9	1,148.9	1,257.2	1,257.2	1,245.2	1,245.2	1,370.2	1,370.2	2,223.0	
SEARHC Public Health Svcs	276.8	276.8	129.1	126.7	122.8	121.3	121.3	120.1	120.1	120.1	120.1	119.5	
Tanana Chiefs Conference Public Health	280.5	271.8	257.1	252.4	244.7	241.7	241.7	239.3	239.3	239.3	239.3	239.3	
Yukon_Kuskokwim Public Health Svcs	1,154.0	1,154.0	965.3	947.7	928.2	916.3	916.6	907.4	907.4	907.4	907.4	907.4	
Total Designated BRUs:	3,848.7	3,686.4	3,304.4	3,407.5	3,366.2	3,446.9	3,447.2	3,413.3	3,413.3	3,537.9	3,538.3	4,390.4	42,800.5

Operating Budget Health Care Programs
(in thousands)




Medicaid & Related Health Care Program Expenditures
FY90-FY01
(in thousands)
900,000.0
800,000.0
700,000.0
600,000.0
500,000.0
400,000.0
300,000.0
200,000.0
100,000.0
0.0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001

Actual Expenditure Totals	337,256.0	304,776.3	351,245.7	378,475.4	441,044.0	456,324.8	490,968.2	519,027.2	535,805.6	571,797.2	658,256.3	787,604.2	5,832,580.9

Welfare Programs

Actual Expenditure History, All Funding Sources

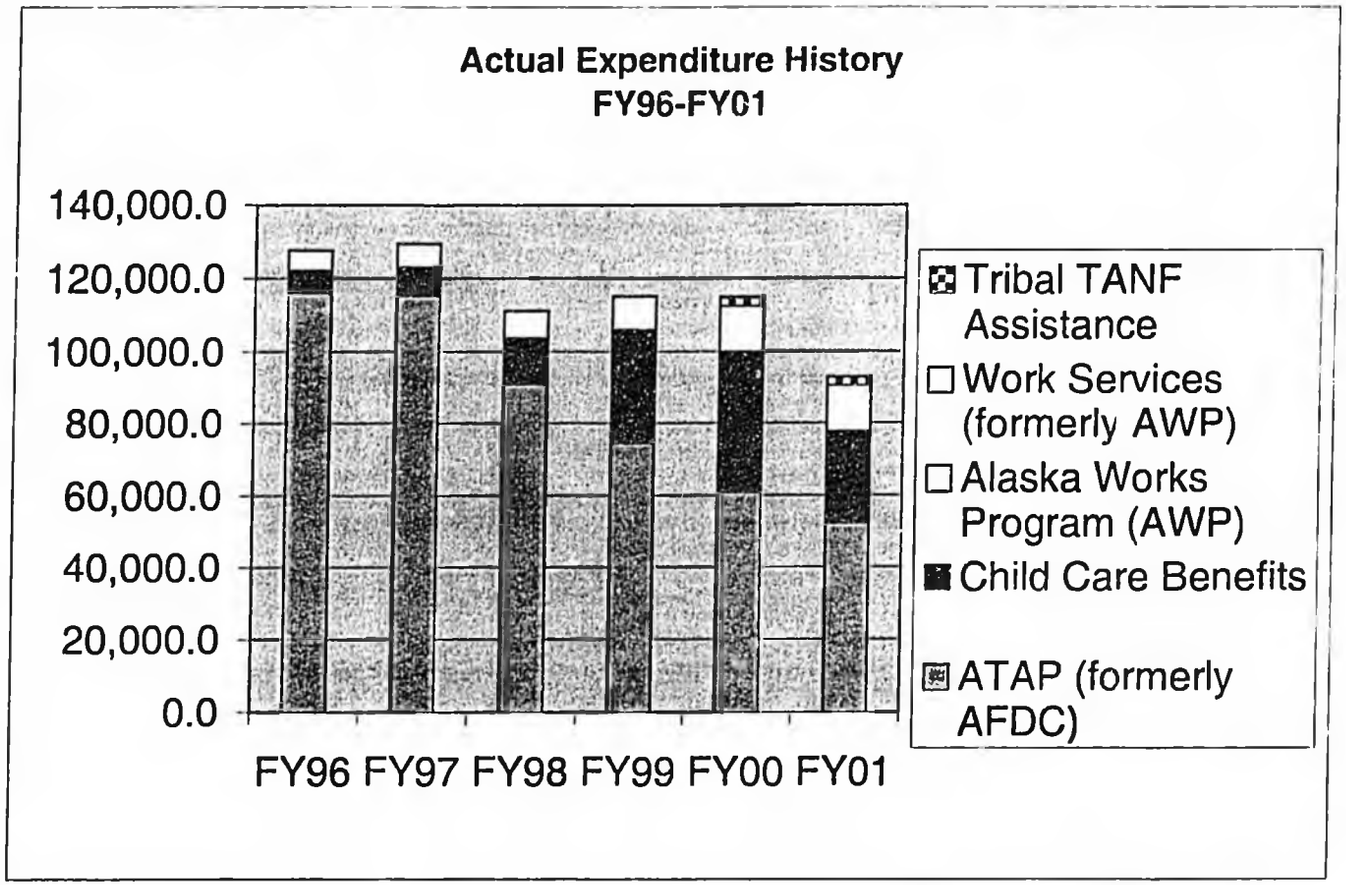
	FY96 Actual	FY97 Actual	FY98 Actual	FY99 Actual	FY00 Actual	FY01 Actual	Total
ATAP (formerly AFDC)	115,826.1	115,194.7	90,903.2	74,326.7	60,814.3	52,225.2	509,290.2
Child Care Benefits	6,390.3	7,884.8	12,848.1	31,714.4	39,154.0	25,371.2	123,362.8
Alaska Works Program (AWP)	5,374.5	6,385.9	7,398.2	9,120.1	0.0	0.0	28,278.7
Work Services (formerly AWP)	0.0	0.0	0.0	0.0	12,599.9	12,923.1	25,523.0
Tribal TANF Assistance	0.0	0.0	0.0	0.0	2,405.2	2,405.2	4,810.4
Total:	127,590.9	129,465.4	111,149.5	115,161.2	114,973.4	92,924.7	691,265.1

	FY96 Budget	FY97 Budget	FY98 Budget	FY99 Budget	FY00 Budget	FY01 Budget	Total
ATAP (formerly AFDC)	130,039.7	122,709.8	112,458.0	92,470.9	77,853.4	66,112.8	601,644.6
Child Care Benefits	5,838.8	6,788.6	12,042.7	23,712.8	40,853.7	31,852.0	121,088.6
Alaska Works Program (AWP)	5,644.2	5,828.5	7,424.1	10,424.1	0.0	0.0	29,320.9
Work Services (formerly AWP)	0.0	0.0	0.0	0.0	13,715.2	14,290.1	28,005.3
Tribal TANF Assistance	0.0	0.0	0.0	0.0	2,405.2	2,405.2	4,810.4
Total:	141,522.7	135,326.9	131,924.8	126,607.8	134,827.5	114,660.1	784,869.8

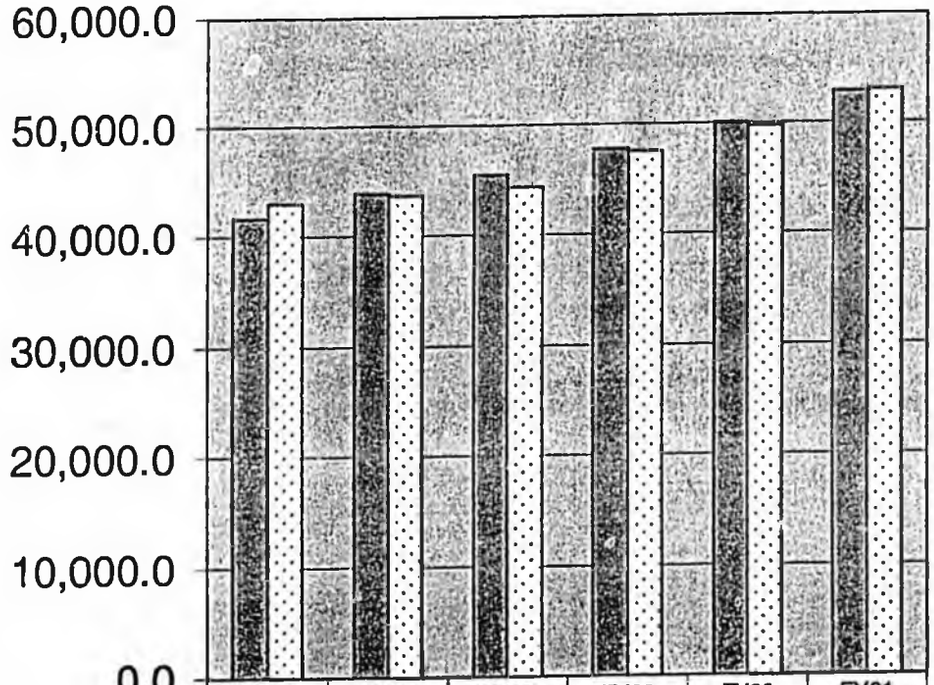
Budget v. Actuals:	FY96 Bud v Act	FY97 Bud v Act	FY98 Bud v Act	FY99 Bud v Act	FY00 Bud v Act	FY01 Bud v Act	Total
ATAP (formerly AFDC)	14,213.6	7,515.1	21,554.8	18,144.2	17,039.1	13,887.6	92,354.4
Child Care Benefits	-551.5	-1,096.2	-805.4	-8,001.6	1,699.7	6,480.8	-2,274.2
Alaska Works Program (AWP)	269.7	-557.4	25.9	1,304.0	0.0	0.0	1,042.2
Work Services (formerly AWP)	0.0	0.0	0.0	0.0	1,115.3	1,367.0	2,482.3
Tribal TANF Assistance	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Savings:	13,931.8	5,861.5	20,775.3	11,446.6	19,854.1	21,735.4	93,604.7
Reinvestment of ATAP Savings							
Child Care	0.0	4,159.8	2,541.1	4,639.2	7,024.7	0.0	18,564.8
Work Services	0.0	2,684.0	3,449.0	960.0	3,500.0	0.0	10,593.0
Native TANF Programs	0.0	0.0	0.0	0.0	2,405.2	0.0	2,405.2
Reinvestments related to Welfare Reform	0.0	5,539.6	662.2	2,984.0		0.0	9,185.8
Reinvestment Total:	0.0	12,383.4	6,652.3	8,783.2	12,929.9	0.0	40,748.8
Savings v. Reinvestment Difference	13,931.8	-6,521.9	14,123.0	2,663.4	6,924.2	21,735.4	52,855.9

Note: Savings was also allocated to other programs within DHSS.

Adult Public Assistance	FY96	FY97	FY98	FY99	FY00	FY01	Total
Adult Public Assistance Actual	41,675.5	43,886.3	45,528.8	47,766.3	50,058.2	52,848.7	281,763.8
Adult Public Assistance Budget	42,990.6	43,658.2	44,359.0	47,524.0	49,740.4	52,970.9	281,243.1
Budget v. Actual	1,315.1	-228.1	-1,169.8	-242.3	-317.8	122.2	-520.7


Actual Expenditure History
FY96-FY01
140,000.0
120,000.0
100,000.0
80,000.0
60,000.0
40,000.0
20,000.0
0.0
FY96 FY97 FY98 FY99 FY00 FY01
Tribal TANF Assistance
Work Services (formerly AWP)
Alaska Works Program (AWP)
Child Care Benefits
ATAP (formerly AFDC)

Adult Public Assistance
Actual versus Budgeted Expenditures
FY96-FY01
(in thousands)



	FY96	FY97	FY98	FY99	FY00	FY01
Adult Public Assistance Actual	41,675.5	43,886.3	45,528.8	47,766.3	50,058.2	52,848.7
Adult Public Assistance Budget	42,990.6	43,658.2	44,359.0	47,524.0	49,740.4	52,970.9

Supplementals FY90- FY01 Related to Health & Assistance

FY	BRU	Component	$ in thous	Description
Health Related:				
99	CCIA	CCIA	1,145.0	Underfunded Anticipated Caseload Catastrophic Chronic Ill
00	CCIA	CCIA	608.6	Catastrophic/Chronic Illness Assistance
92	Comm DD Grants	Com DD Grants	-349.9	SUP
94	Comm DD Grants	Comm DD Grants	1,248.9	Transfer from Waivers
92	Comm MH Grants	Gen Comm MH Grants	-150.0	SUP
99	Comm MH Grants	Psychiatric Emerg Svcs	-55.0	Reduce Operating MH Appropriation
99	Comm MH Grants	Svs for Ser Emot Dist Yth	-69.6	Reduce Operating MH Appropriation
99	Comm MH Grants	Svs to Chronically Ment Ill	-100.0	Reduce Operating MH Appropriation
01	Comm MH Grants	Designated Eval Treatment	974.1	Caseload Growth
90	Institutions & Admin	API	266.8	SUP
91	Institutions & Admin	API	560.0	SUP
92	Institutions & Admin	API	400.0	SUP
94	Institutions & Admin	API	424.6	API
95	Institutions & Admin	API	0.0	Uncollect Receipts -GF/PR +GF/MH
92	Institutions & Admin	Harbor View Dev Center	313.6	SUP
94	Institutions & Admin	Harbor View Dev Center	254.2	Cert. Deficiency
91	Medical Assistance	General Relief Medical	-2,514.6	SUP
94	Medical Assistance	General Relief Medical	400.0	Program Growth
90	Medical Assistance	Indian Health Service	3,446.2	SUP
91	Medical Assistance	Indian Health Service	-1,584.1	SUP
94	Medical Assistance	Indian Health Service	3,567.4	Increased HIS Billings
95	Medical Assistance	Indian Health Service	4,000.0	Indian Health Svs Medicaid
97	Medical Assistance	Indian Health Service	10,000.0	Increased HIS Medicaid Reimbursement Rates
90	Medical Assistance	Medicaid Facilities	8,524.9	SUP
91	Medical Assistance	Medicaid Facilities	-16,995.2	SUP

Supplementals FY90- FY01 Related to Health & Assistance

FY	BRU	Component	$ in thous	Description
93	Medical Assistance	Medicaid Facilities	884.8	Reduced Growth/Sec 137 Disprop Share
94	Medical Assistance	Medicaid Facilities	7,674.5	ASHNHA judgments
94	Medical Assistance	Medicaid Facilities	3,300.0	Increased Participants
94	Medical Assistance	Medicaid Facilities	1,802.5	Disproportionate Share
90	Medical Assistance	Medicaid Non-Facility	3,619.1	SUP
91	Medical Assistance	Medicaid Non-Facility	1,276.4	SUP
91	Medical Assistance	Medicaid PFD Hold Harml	792.2	SUP
96	Medical Assistance	Medicaid Services	-3,500.0	Med. Facilities Lapse transfer to Welfare Reform
98	Medical Assistance	Medicaid Services	1,306.6	School based services for school districts
98	Medical Assistance	Medicaid Services	10,018.4	Indian Health Svcs Entitlement Program
98	Medical Assistance	Medicaid Services	866.7	School based Services Related to Adoption
98	Medical Assistance	Medicaid Services	0.0	Funding Change 7,770.1 Due to Lower Fed. Match Rate
00	Medicaid Services	Medicaid Services	122.0	FY00 Operating Costs
00	Medicaid Services	Medicaid Svcs Lang	29,960.0	Medicaid ProShare Retroactive Program Appropriation
01	Medical Assistance	Medicaid Services	15,000.1	Replace FY01 Medicaid Claims Payments
01	Medical Assistance	Medicaid Services	80,890.8	Medicaid Caseload Growth and Higher Costs
01	Medical Assistance	Medicaid Services	57.8	Facility Rate-Setting Settlements w/Medicaid Providers
90	Medical Assistance	Medicaid State Programs	882.0	SUP
91	Medical Assistance	Medicaid State Programs	-488.9	SUP
94	Medical Assistance	Medicaid State Programs	6,000.0	API Disprop Share
94	Medical Assistance	Waiver Services	-2,497.8	Transfer to Comm Dev Disabilities
95	Medical Assistance	Waiver Services	-111.0	Lapse Appropriation
99	Medical Asst Admin	Medical Asst Admin	-30.0	Reduce Cap Emergency Medical Services Equipment
93	Medical Asst Admin	Claims Processing	750.0	Increased Costs
90	Medical Asst. Admin	Claims Processing	472.0	SUP
90	Medical Asst. Admin	Medical Asst Central Admin	100.0	SUP
98	Public Labs&Radiological	Chief of Lab & Rad Svcs	180.0	Planning and Designing for Public Health Labs
01	State Health Services	Bureau of Vital Stats	225.0	Increase Operating Costs Heirloom Certificates
99	State Health Services	Bureau of Vital Stats	0.0	Reduce Cap Archive Imaging System

Supplementals FY90- FY01 Related to Health & Assistance

FY	BRU	Component	$ in thous	Description
99	State Health Services	Comm Health Grants	-0.9	Reduction Uncommitted Grant Funds
95	State Health Services	Epidemiology	342.0	Control TB
99	State Health Services	Healthy Families	0.0	Reduction Unspent Grant to Bethel
00	State Health Services	Healthy Families	1,000.0	Add I/A Receipts for TANF from Public Asst Admin
94	State Health Services	Laboratory Services	-111.3	Loss of GF/PR
97	State Health Services	Laboratory Services	99.3	Indoor Random Monitoring Grant
98	State Health Services	MCFH	100.0	Maternal Child Care Health Specialty Clinics
90	State Health Services	Nursing	354.4	SUP
99	State Health Services	Nursing	-10.0	Reduction of Unspent Grant Reserves
93	State Health Services	Post Mortem Examinations	0.0	Autopsies
98	State Health Services	WIC	1,241.5	Sup
99	Y2K Supplemental	Y2K Supplemental	2,400.0	Medicaid Management Info System Upgrade
99	Y2K Supplemental	Y2K Supplemental	10.0	Public Health Lab Server Replacement
99	Y2K Supplemental	Y2K Supplemental	0.0	Emergency Medical Svs Certification Database
99	Y2K Supplemental	Y2K Supplemental	100.0	API Hospital Information System
Assistance Related:				
91	Assistance Payments	AFDC	9074.6	SUP
92	Assistance Payments	AFDC	16,366.2	SUP
93	Assistance Payments	AFDC	8,007.0	COLA/Caseload Increase
94	Assistance Payments	AFDC	-2,000.0	Program Reduction
95	Assistance Payments	AFDC	-4,100.0	Lapse Appropriation
91	Assistance Payments	APA	948.3	SUP
92	Assistance Payments	APA	1,662.3	SUP
93	Assistance Payments	APA	1,671.1	COLA/Caseload Increase
91	Assistance Payments	General Relief Assistance	550.0	SUP
91	Assistance Payments	Post Mortem Examinations	286.6	SUP
00	Front Line Social Workers	FLSW	261.8	Operating Costs
00	Public Assistance	APA	440.5	APA Assistance Payments

Supplementals FY90- FY01 Related to Health & Assistance

FY	BRU	Component	$ in thous	Description
96	Public Asst Admin	AFDC	-4,500.0	Transfer to Welfare Reform
90	Public Asst Admin	Alaska Work Programs	340.9	SUP
93	Public Asst Admin	Alaska Work Programs	390.0	Child Care Cost
97	Public Asst Admin	APA	800.0	Funding for Estimated FY97 Costs
97	Public Asst Admin	ATAP	-800.0	AFDC
98	Public Asst Admin	ATAP	-3,500.0	Caseload Reduction Savings
96	Public Asst Admin	Child Care Benefits	1,000.0	Increase for Welfare Reform
99	Public Asst Admin	Child Care Benefits	1,801.9	Add Federal Receipts for Child Care Benefits
99	Public Asst Admin	Child Care Benefits	3,600.0	Operating Costs for FY99
00	Public Asst Admin	Child Care Benefits	1,500.0	FY00 Child Care Benefits
92	Public Asst Admin	Eligibility Determination	304.9	SUP
93	Public Asst Admin	Eligibility Determination	265.3	Caseload Increase
96	Public Asst Admin	Public Asst Admin	3,500.0	EIS Upgrades for Welfare Reform
99	Public Asst Admin	Public Asst Admin	0.0	Reduce Cap Welfare Reform Info System
99	Public Asst Admin	Public Asst Admin	-30.0	Reduction Uncommitted Grant Funds
00	Public Asst Admin	Public Asst Admin	3,000.0	Increase Federal Receipts for TANF
Miscellaneous:				
91	Anchorage SSBG	Social Services Blk Grt	984.0	SUP
91	Fairbanks SSBG	Social Services Blk Grt	16.0	SUP
91	PFD Hold Harmless	PFD Hold Harmless	1,092.2	SUP
92	PFD Hold Harmless	PFD Hold Harmless	1,497.7	SUP
94	PFD Hold Harmless	PFD Hold Harmless	244.4	Increased Recipients
00	Public Assistance	Energy Asst Program	2,361.1	Emergency Heating Assistance
01	Public Assistance	Energy Asst Program	3,351.3	Addt'l Federal Funds for LIHEAP Grants

Comparison of Medicaid Allocation Methods

District	By Provider	By Eligible	Difference
1	16,839.0	16,904.5	-65.5
2	15,957.2	16,170.1	-213.0
3	24,875.8	19,680.6	5,195.2
4	6,836.3	12,173.4	-5,337.0
5	6,531.8	12,103.4	-5,571.7
6	11,376.9	12,928.0	-1,551.1
7	18,781.5	24,094.5	-5,312.9
8	25,461.5	23,993.8	1,467.7
9	14,955.8	20,081.8	-5,126.0
10	7,608.7	10,173.1	-2,564.4
11	31,192.9	23,906.8	7,286.1
12	8,050.0	15,223 3	-7,173.3
13	10,991.9	13,482.7	-2,490.8
14	6,186.8	15,939.2	-9,752.4
15	18,150.5	34,213.3	16,062.8
16	20,749.2	34,164.3	-13,415.1
17	8,932.6	15,287.1	-6,354.5
18	6,824.2	8,412.8	-1,588.6
19	58,160.4	17,866.1	40,294.2
20	40,999.3	29,447.4	11,551.9
21	113,124.9	21,205.2	91,919.7
22	7,853.9	16,346.2	-8,492.3
23	6,382.9	12,629.6	-6,246.6
24	14,473.1	20,067.7	-5,594.5
25	9,226.8	12,413.8	-3,187.1
26	23,761.7	20,063.1	3,698.5
27	19,472.6	24,292.2	-4,819.5
28	10,653.4	25,358.8	-14,705.4
29	4,446.9	7,866.4	-3,419.5
30	9,663.6	12,941.1	-3,277.4
31	49,518.6	26,445.7	23,072.9
32	4,071.4	6,593.5	-2,522.1
33	4,481.7	8,078.1	-3,596.4
34	4,281.8	7,960.4	-3,678.6
35	8,457.9	11,543.2	-3,085.3
36	6,460.0	19,582.3	-13,122.3
37	6,929.9	13,115.0	-6,185.1
38	15,252.6	31,420.9	-16,168.3
39	30,002.1	30,858.4	-856.3
40	2,426.8	5,383.4	-2,956.6
Total	710,405.0	710,411.3	-6.3

Allocation of FY 2001 Authorized Operating Expenditures by District
(in $ thousands)

District	Entitlements	Grants	Program Services	Facilities	Administration	Total
1	16,904.5	4,383.1	3,812.8	95.6	0.0	25,196.1
2	16,170.1	3,996.3	1,994.4	0.0	0.0	22,160.8
3	19,680.6	4,470.2	19,631.1	1,247.8	2,906.4	47,936.1
4	12,173.4	4,481.3	19,631.1	1,247.8	2,906.4	40,440.0
5	12,103.4	2,479.5	684.4	0.0	0.0	15,267.3
6	12,928.0	2,304.6	1,212.3	0.0	0.0	16,444.8
7	24,094.5	3,386.7	2,072.6	0.0	0.0	29,553.8
8	23,993.8	2,812.4	2,072.6	0.0	0.0	28,878.8
9	20,081.8	2,074.7	2,072.6	0.0	0.0	24,229.1
10	10,173.1	2,649.3	6,194.6	1,752.4	217.3	20,986.7
11	23,906.8	2,649.3	6,194.6	1,752.4	217.3	34,720.4
12	15,223.3	2,649.3	6,194.6	1,752.4	217.3	26,036.9
13	13,482.7	2,649.3	6,194.6	1,752.4	217.3	24,296.3
14	15,939.2	2,649.3	6,194.6	1,752.4	217.3	26,752.8
15	34,213.3	2,649.3	6,194.6	1,752.4	217 3	45,026.9
16	34,164.3	2,649.3	6,194.6	1,752.4	217.3	44,977.9
17	15,287.1	2,649.3	6,194.6	1,752.4	217.3	26,100.7
18	8,412.8	2,649.3	6,194.6	1,752.4	217.3	19,226.4
19	17,866.1	2,649.3	6,194.6	1,752.4	217.3	28,679.7
20	29,447.4	2,649.3	6,194.6	1,752.4	217.3	40,261.0
21	21,205.2	2,649.3	6,194.6	1,752.4	217.3	32,018.8
22	16,346.2	2,649.3	6,194.6	1,752.4	217.3	27,159.8
23	12,629.6	2,649.3	6,194.6	1,752.4	217.3	23,443.2
24	20,067.7	2,649.3	6,194.6	1,752.4	217.3	30,881.3
25	12,413.8	2,649.3	6,194.6	1,752.4	217.3	23,227.4
26	20,063.1	3,524.0	2,248.6	408.9	0.0	26,244.6
27	24,292.2	3,392.6	2,248.6	408.9	0.0	30,342.3
28	25,358.8	3,489.7	2,248.6	408.9	0.0	31,506.0
29	7,866.4	3,227.1	3,431.5	477.5	0.0	15,002.5
30	12,941.1	3,231.8	3,431.5	477.5	0.0	20,081.9
31	26,445.7	3,193.6	3,431.5	477.5	0.0	33,548.4
32	6,593.5	3,219.1	3,431.5	477.5	0.0	13,721.7
33	8,078.1	3,247.8	3,431.5	477.5	0.0	15,234.9
34	7,960.4	3,184.1	3,431.5	477.5	0.0	15,053.5
35	11,543.2	1,089.5	1,036.3	0.0	0.0	13,669.0
36	19,582.3	3,401.4	1,290.5	0.0	0.0	24,274.2
37	13,115.0	7,924.6	1,212.3	0.0	0.0	22,251.9
38	31,420.9	5,201.3	2,424 6	687.7	0.0	39,734.4
39	30,858.4	11,640.9	9,600.5	2,081.7	0.0	54,181.5
40	5,383.4	1,712.5	352.0	0.0	0.0	7,447.8
Total	710,411.3	133,457.3	195,548.2	37,491.4	9,289.3	1,086,197.5

(1) Retiree Medical Insurance

The following table summarizes the monthly premium per benefit recipient since retiree medical benefits have been provided under PERS and TRS.

Time Period	Monthly Premium Per Retiree For Health Coverage	Annual Percentage Increase	Average Compound Annual Increase Since FY78
2/1/76-1/31/77	$ 34.75	--	--
2/1/77-1/31/78	57.64	66%	--
2/1/78-1/31/79	69.10	20%	20%
2/1/79-1/31/80	64.70	- 6%	6%
2/1/80-1/31/81	96.34	49%	19%
2/1/81-1/31/82	96.34	0%	14%
2/1/82-1/31/83	115.61	20%	15%
2/1/83-1/31/84	156.07	35%	18%
2/1/84-1/31/85	191.85	23%	19%
2/1/85-1/31/86	168.25	-12%	14%
2/1/86-1/31/87	165.00	- 2%	12%
2/1/87-1/31/88	140.25	-15%	9%
2/1/88-/31/89	211.22	51%	13%
2/1/89-1/31/90	252.83	20%	13%
2/1/90-1/31/91	243.98	- 4%	12%
2/1/91-1/31/92	243.98	0%	11%
2/1/92-1/31/93	226.90	- 7%	10%
2/1/93-1/31/94	309.72	37%	11%
2/1/94-1/31/95	336.05	9%	11%
2/1/95-1/31/96	350.50	4%	11%
2/1/96-1/31/97	350.50	0%	10%
2/1/97-1/31/98	368.00	5%	10%
2/1/98-12/31/98	368.00	0%	9%
1/1/99-12/31/99	442.00	20%	10%
1/1/00-12/31/00	530.00	20%	10%
1/1/ 12/31/01	610.00	15%	10%

As you can see from the above table, the monthly retiree medical premium for the January 1, 2001 to December 31, 2001 time period has increased to $610.00. Since the 86/87 time period, annual premium rate changes have ranged from 51% up to 15% down, but the average compound annual increase has been about 9%.

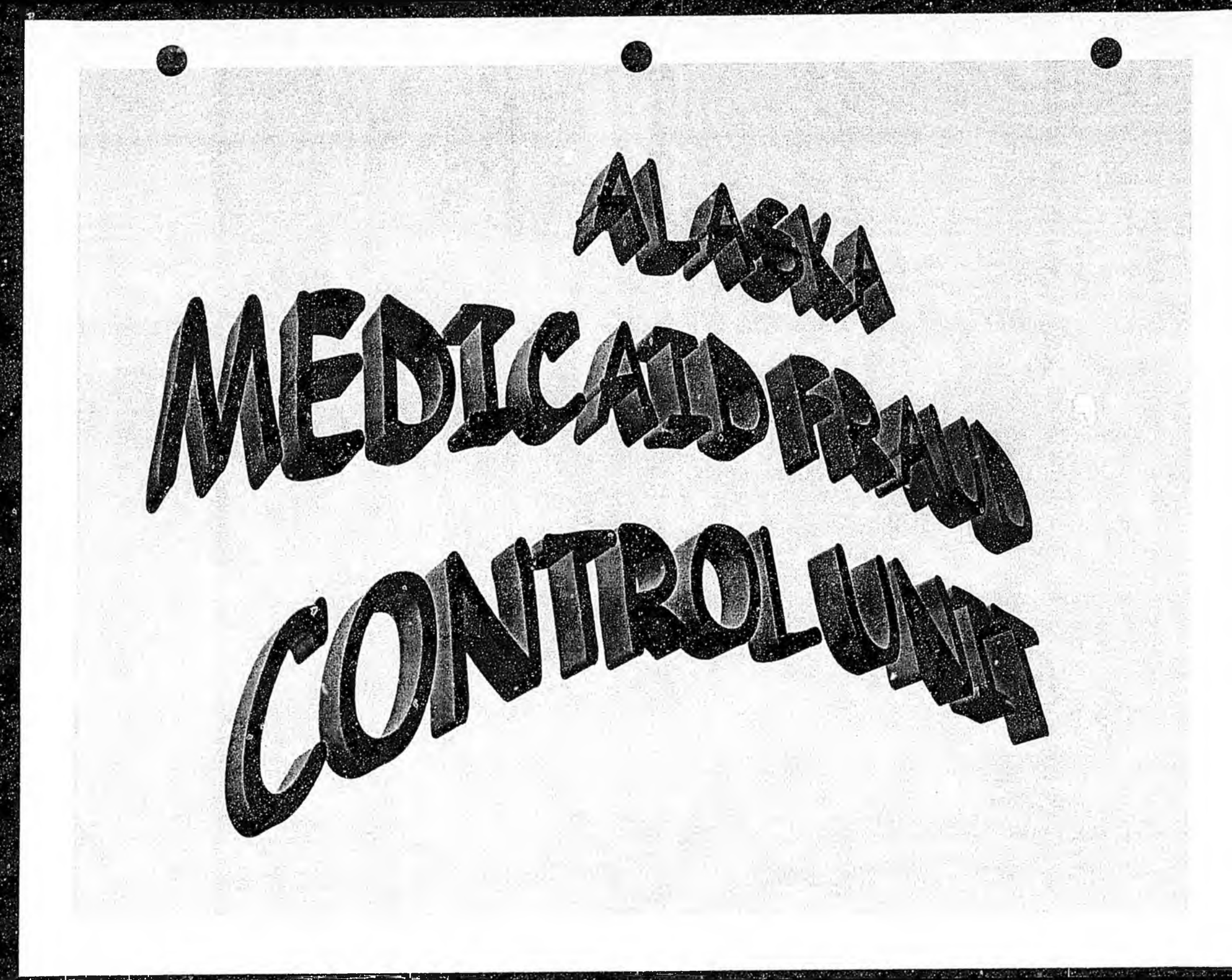
MEDICAID FRAUD

DIVISION OF MEDICAL ASSISTANCE
MEDICAL CARE ADVISORY COMMITTEE

OVERVIEW OF ALASKA's MEDICAID FRAUD CONTROL UNIT

STEPHEN E. BRANCHFLOWER
ASSISTANT ATTORNEY GENERAL
DIRECTOR
ALASKA MEDICAID FRAUD CONTROL UNIT

REGAL ALASKAN HOTEL MAY 12, 2000


ALASKA
MEDICAID FRAUD
CONTROL UNIT

• MEDICARE

- 100 % Federally Funded
- Related to Social Security Benefits
- Provides Medical Care for RETIRED People

• MEDICAID

- Jointly funded by State and Federal Governments
- Provides Medical Care for LOW INCOME AND DISABLED PEOPLE

EACH STATE IS FREE TO PARTICIPATE IN THE MEDICAID PROGRAM OR NOT TO PARTICIPATE.

IF THE LEGISLATURE VOTES TO PARTICIPATE, IT WILL HAVE TO……

STATES WILL HAVE TO...

- PROVIDE CERTAIN MINIMUM HEALTH CARE SERVICES
- PROMULGATE NECESSARY STATUTES AND REGULATIONS TO IMPLEMENT THE STATE'S MEDICAID PROGRAM-AS 47.07.01
- ESTABLISH PAYMENT STRUCTURES FOR AND OVERSIGHT OF PROVIDERS.

SPLIT IN ALASKA IS

60% FEDERAL MONEY

+

40% STATE MATCHING

FUNDS =

FULL ANNUAL FUNDING

AND ONE MORE THING.....

EACH PARTICIPATING
STATE IS
REQUIRED TO HAVE A

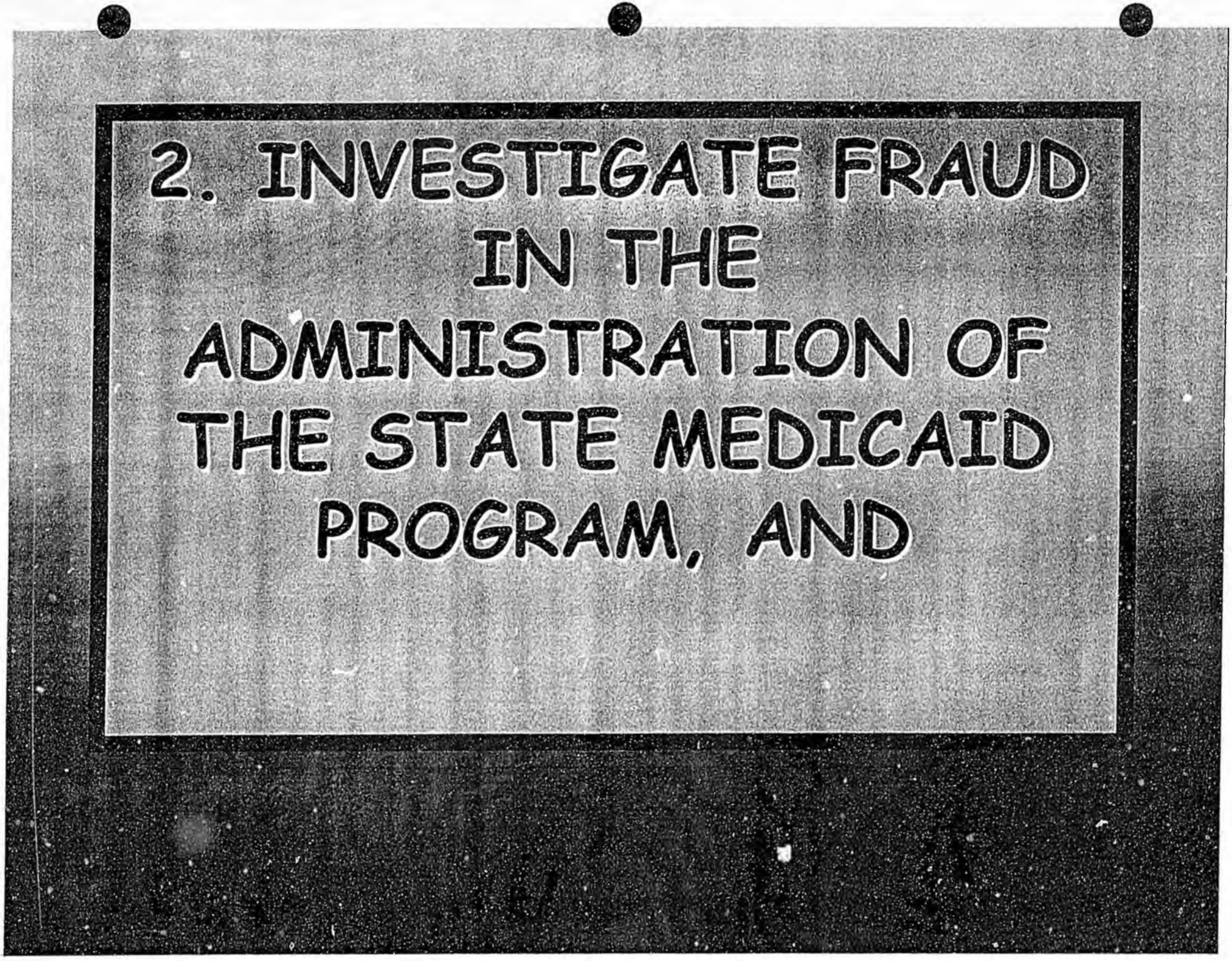
MEDICAID FRAUD CONTROL UNIT

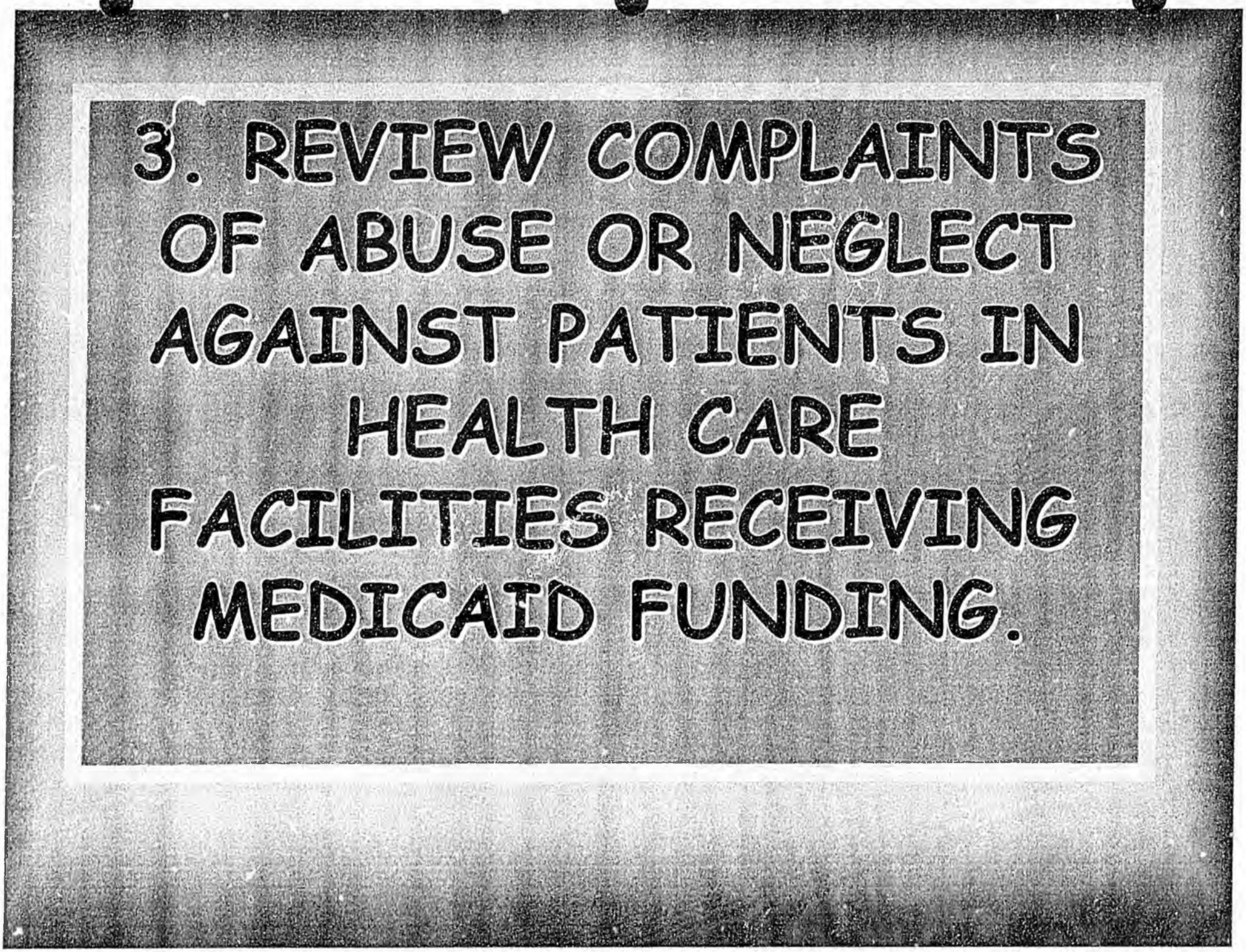
TO INVESTIGATE AND PROSECUTE
CRIMES AGAINST
THE MEDICAID FUND

THERE ARE 48 MFCU's NATIONALLY

EACH HAVE 3 MAIN OBJECTIVES:

1. CONDUCT A STATEWIDE PROGRAM FOR THE INVESTIGATION AND CRIMINAL PROSECUTION OF PROVIDERS WHO STEAL MONEY FROM THE STATE MEDICAID FUND.

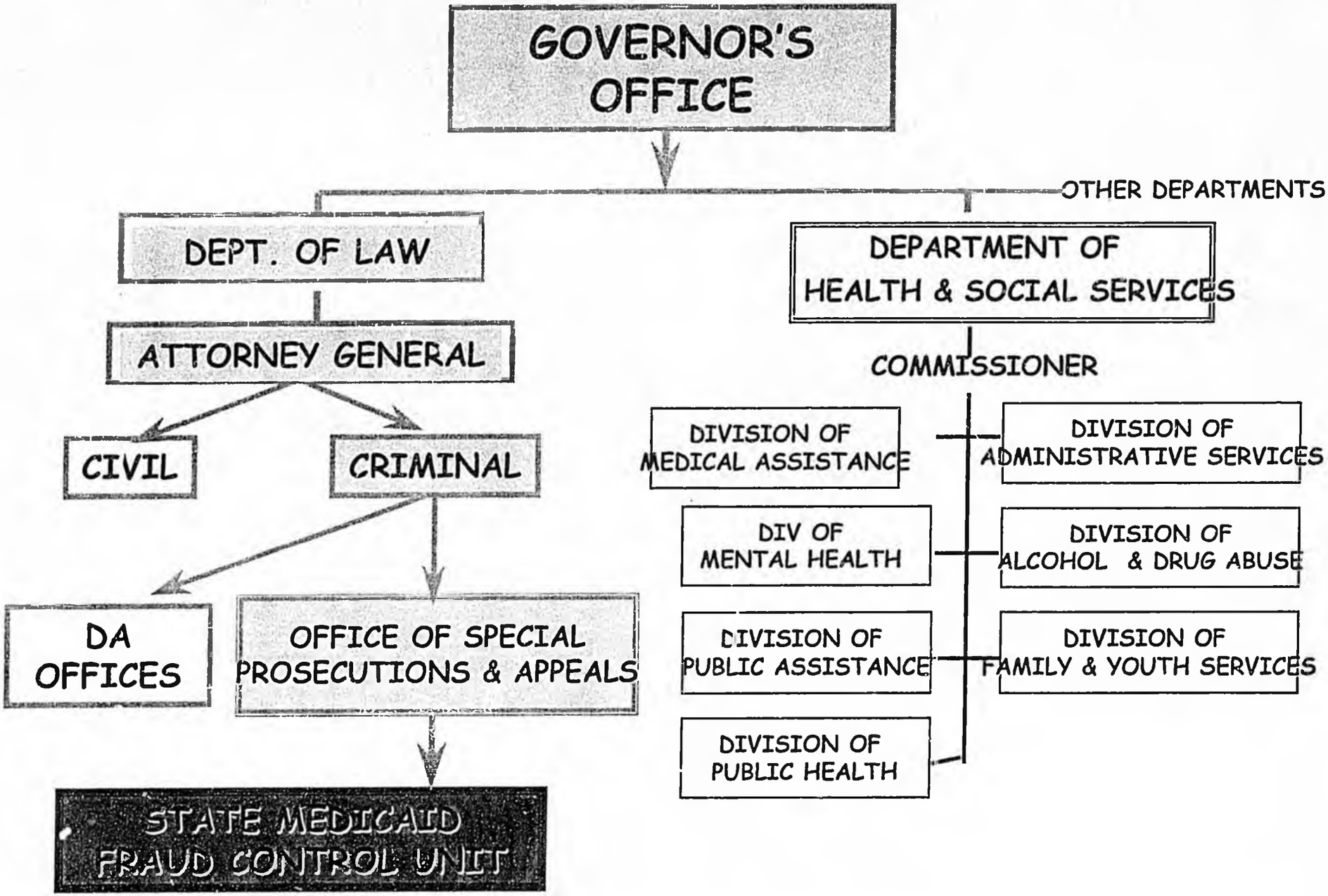

2. INVESTIGATE FRAUD
IN THE
ADMINISTRATION OF
THE STATE MEDICAID
PROGRAM, AND


3. REVIEW COMPLAINTS OF ABUSE OR NEGLECT AGAINST PATIENTS IN HEALTH CARE FACILITIES RECEIVING MEDICAID FUNDING.

ALASKA's MFCU CREATED IN 1992

~75/25% FEDERALLY FUNDED
~TWO INVESTIGATORS
~ONE INTERNAL AUDITOR-CPA
~ONE PROSECUTOR
(CROSS DESIGNATED STATE/FED)
~STATEWIDE JURISDICTION

THE STATE MEDICAID FRAUD CONTROL UNIT IS WITHIN THE OFFICE OF SPECIAL PROSECUTIONS AND APPEALS



ALASKA MEDICAID PROGRAM

FY 1999 STATISTICS

- Total Number of Participating Providers= 3,787

- **Total Number of Recipients= 79,777 (94,504 eligible)**

- **Claims Lines Processed- 3,091,484**

TOTAL REIMBURSEMENTS PAID= $378,451,845 MILLION

EQUALS=$4,743.87 PER RECIPIENT

ALASKA MEDICAID PROGRAM

FY 2000 STATISTICS

- Total Number of Participating Providers=

  -10,345 enrolled- - 4,414 participating

- **Total Number of Recipients= 92,103 (111,083 eligible)**

- **Claims Lines Processed= 4,683,421**

TOTAL REIMBURSEMENTS PAID= $467 MILLION
EQUALS=$5070.41 PER RECIPIENT

Medicaid Statistics: FY95 - FY99

	FY 95	% Change (FY95 to FY96)	FY 96	% Change FY96 - FY97	FY 97	% Change FY97 - FY98	FY 98	% Change FY98 - FY99	FY 99
Eligibles	86,445	0.8%	87,159	0.9%	87,977	6.3%	88,210	7.1%	94,509
Recipients	69,739	-0.2%	69,608	2.3%	71,179	3.8%	73,859	8.0%	79,777
Pct. of Eligibles Participating	80.7%	-1.0%	79.9%	1.3%	80.9%	3.5%	83.7%	0.8%	84.4%
Cost Per Recipient	3686.20	9.0%	4,016.19	1.5%	4,077.75	6.7%	4,349.43	9.1%	4,743.87
Cost per Eligible	2,973.82	7.9%	3,207.46	2.9%	3,299.16	10.4%	3,641.81	10.0%	4,004.40
Providers Participating	2,887	8.0%	3,119	7.0%	3,337	6.3%	3,547	6.8%	3,787
Payment Per Participating Provider	$89,045	0.7%	$89,631	-3.0%	$86,979	4.1%	$90,568	10.3%	$99,934
Total Reimb. for Claims Paid**	257,071,900	8.7%	279,559,000	3.8%	290,250,300	10.7%	321,244,383	17.8%	378,451,845
Claim Lines Processed*	2,067,963					0.5%	2,714,757	13.9%	3,091,484
Paid Claim Lines	1,807,[illegible]						2,255,370	10.5%	2,492,840
Processed Claim Lines Paid								-2.9%	80.6%
Payment Per [illegible]									$151.82
Paid [illegible]									31.2

Total reimbursements:

FY 95	FY 96	FY 97	FY 98	FY99
257,071,900	279,559,000	290,250,300	321,244,383	378,451,845
	+ 8.7%	+3.8%	+10.7	+17.8

FY 00= 467 MILLION= +18.96%

Nationally it is estimated that 10 to 20 percent

of health care dollars spent go to

FRAUD, WASTE and ABUSE.

For ALASKA this equates to

Approx. 39 MILLION TO 76 MILLION DOLLARS of our FY 99 Medicaid Budget.

THE FLOW OF MONEY.....

THE ALASKA MEDICAID PLAN IS ADMINISTERED BY THE STATE HSS-DIVISION OF MEDICAL ASSISTANCE.

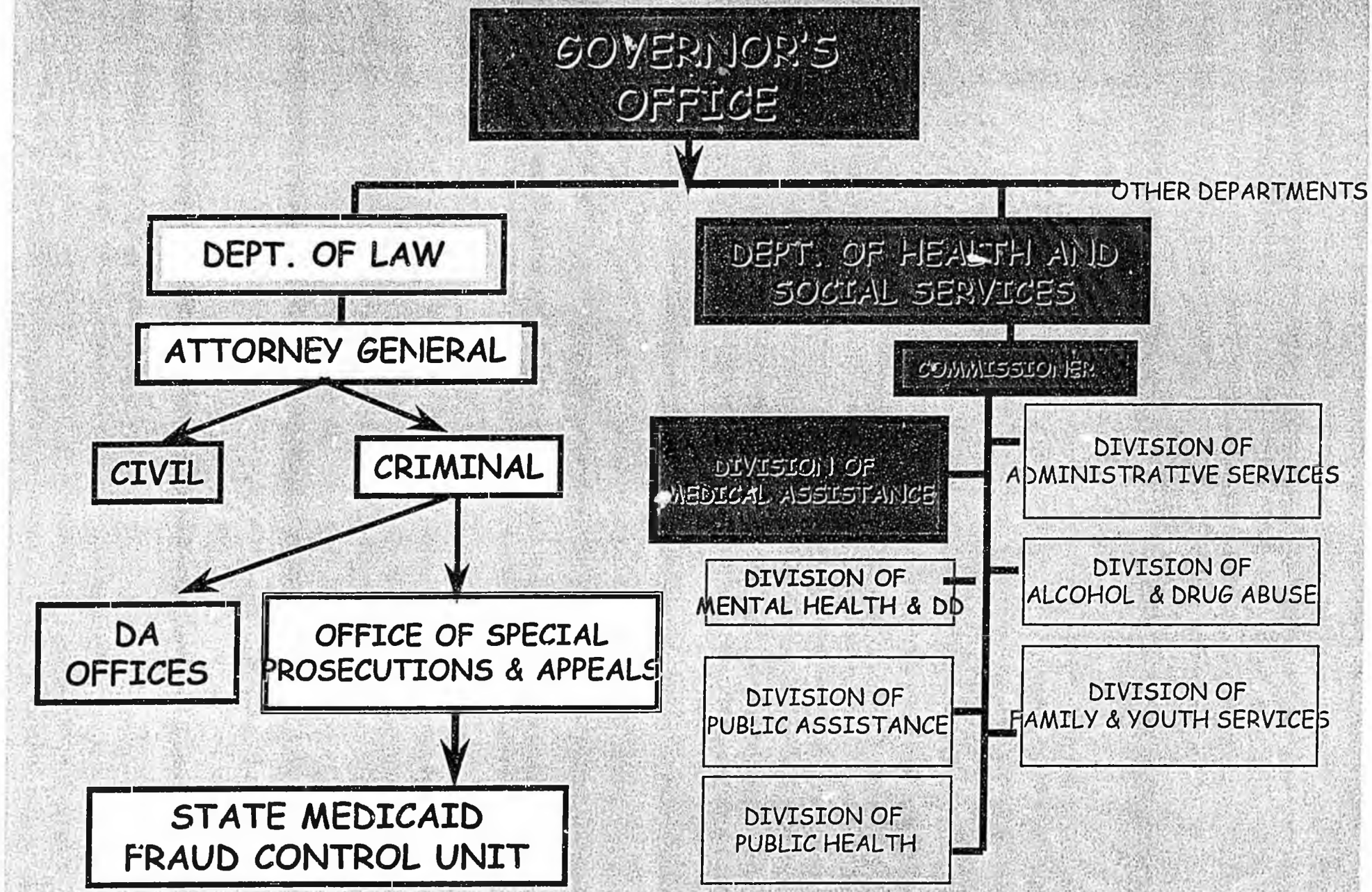
FEDERAL FUNDS =$ 60%

ALASKA STATE FUNDS=40%

ALASKA DIVISION OF MEDICAL ASSISTANCE =

Alaska Medicaid For FY 99 $378.4 MILLION

THE DIVISION OF MEDICAL ASSISTANCE OF DHSS ADMINISTERS THE ALASKA MEDICAID PROGRAM



DMA CONTRACTS WITH A FISCAL AGENT TO PROCESS MEDICAL CLAIMS

DMA

- Division of State Government
- Receives State and Federal Funds for Alaska Medicaid Program
- Administers AK Medicaid Program
- Sets Medicaid policies and procedures
- Determines Reimbursement Rates
- Contracts with First Health Services Corp.

First Health Services Corp
FISCAL AGENT

- Private Corporation
- Enrolls Medicaid Providers
- Processes Medicaid claims
- Make payments to Providers

HOW PROVIDERS GET PAID



FEDERAL FUNDS
60%

STATE OF ALASKA
TREASURY
40%

DIVISION OF
MEDICAL ASSISTANCE

FIRST HEALTH CORP.

"CLAIM"
SUBMITTED

CHECK SENT

PROVIDER'S
BANK

PROVIDER

MAJOR COMPONENTS OF A MEDICAID PROVIDER'S CLAIM

- RECIPIENT NUMBER ("MEDICAID NUMBER")- ASSIGNED BY DIVISION OF PUBLIC ASSISTANCE TO MEDICAID RECIPIENTS
- PROVIDER NUMBER -ASSIGNED BY FIRST HEALTH TO A PROVIDER OF HEALTH CARE SERVICES
- DATE OF SERVICE-THE DATE A MEDICAID RECIPIENT RECEIVES HEALTH CARE SERVICES FROM AN ENROLLED PROVIDER
- DIAGNOSIS (WHAT WAS WRONG?)-DETERMINED BY THE PROVIDER IN ACCORDANCE WITH AMA CODE BOOKS
- PROCEDURE CODE-(WHAT TREATMENT WAS PROVIDED?) DETERMINED BY THE PROVIDER IN ACCORDANCE WITH AMA CODE BOOKS
- REIMBURSEMENT-BILLED BY PROVIDER-PAYMENTS MADE ACCORDING TO A DMA SCHEDULE AND WITHIN PRE-ESTABLISHED LIMITS

MEDICAID IN ALASKA IS BASED ON A "FEE FOR SERVICE" BASIS NOT A MANAGED CARE SYSTEM

PRESCRIPTIONS ARE REIMBURSED ON A POS SYSTEM

REGARDLESS OF THE AMOUNT BILLED
BY THE PROVIDER
DMA WILL ONLY PAY THE
REIMBURSEMENT AMOUNT
FOR THE CPT CODE SELECTED BY THE
PROVIDER
IN HIS BILLING.

IF THE PROVIDER BILLS LESS THAN
THE ALLOWED
AMOUNT, DMA WILL PAY THAT LESSER
AMOUNT.

EVALUATION AND MANAGEMENT CPT CATEGORY	CPT CODE	SERVICE CATEGORY	DESCRIPTION OF HISTORY, EXAMINATION & DECISION MAKING	MEDICAID RATE EFFECTIVE 2/1/97
OFFICE OR OTHER OUTPATIENT SERVICES				
NEW PATIENT	99201	BRIEF	Problem focused H & E, Straightforward decision making	$44.73
	99202	LIMITED	Expanded problem focused H & E, Straightforward decision making	$69.79
	99203	INTERMEDIATE	Detailed H & E, Decision making of Low Complexity	$95.34
	99204	EXTENDED	Comprehensive H & E, Decision making of Moderate Complexity	$142.20
	99205	COMPREHENSIVE	Comprehensive H & E, Decision making of High Complexity	$177.30
ESTABLISHED PATIENT	99211	MINIMAL	Presenting Problems are Minimal	$21.59
	99212	BRIEF	Problem focused H & E, Straightforward decision making	$37.93
	99213	LIMITED	Expanded problem focused H & E, Decision making of Low Complexity	$53.52
	99214	INTERMEDIATE	Detailed H & E, Decision making of Moderate Complexity	$81.95
	99215	COMPREHENSIVE	Comprehensive H & E, Decision making of High Complexity	$129.62
CONSULTATIONS (NEW OR ESTABLISHED PATIENT)				
OFFICE CONSULTATIONS (Requires documentation of the request from referring physician, services performed or ordered by the consultant & communication to the requesting physician)	99241	BRIEF	Problem focused H & E, Straightforward decision making	$72.01
	99242	LIMITED	Expandod problem focused H & E, Straightforward decision making	$110.57
	99243	INTERMEDIATE	Detailed H & E, Decision making of Low Complexity	$142.02
	99244	EXTENDED	Comprehensive H & E, Decision making of Moderate Complexity	$198.16
	99245	COMPREHENSIVE	Comprehensive H & E, Decision making of High Complexity	$267.47
CONFIRMATORY CONSULTATIONS (Requires documentation of the request from referring physician, services performed by the consultant and communication to the requesting physician)	99271	BRIEF	Problem focused H & E, Straightforward decision making	$72.67
	99272	LIMITED	Expanded problem focused H & E, Straightforward decision making	$92.79
	99273	INTERMEDIATE	Detailed H & E, Decision making of Low Complexity	$130.84
	99274	EXTENDED	Comprehensive H & E, Decision making of Moderate Complexity	$171.04
	99275	COMPREHENSIVE	Comprehensive H & E, Decision making of High Complexity	$236.65
HOME SERVICES				
NEW PATIENT	99341	BRIEF	Problem focused H & E, Straightforward decision making	$94.05
	99342	LIMITED	Expanded problem focused H & E, Decision making of Low Complexity	$122.50
	99343	INTERMEDIATE	Detailed H & E, Decision making of Moderate Complexity	$160.19
	99344	EXTENDED	Comprehensive H & E, Decision making of Moderate Complexity	No Fee Listed
	99345	COMPREHENSIVE	Comprehensive H & E, Decision making of High Complexity	No Fee Listed
ESTABLISHED PATIENT	99347/99351	BRIEF	Problem focused H & E, Straightforward decision making	$73.23
	99348/99352	LIMITED	Detailed H & E, Decision making of Low Complexity	$93.24
	99349/99353	INTERMEDIATE	Detailed H & E, Decision making of Moderate Complexity	$117.77
	99350	COMPREHENSIVE	Comprehensive H & E, Decision making of Moderate to High Complexity	No Fee Listed
PREVENTIVE MEDICINE SERVICES				
NEW PATIENT	99381	Routine E & M	Infant - Under 1 year of age	$119.51
	99382	Routine E & M	Early Childhood - Age 1 through 4 years	$120.09
	99383	Routine E & M	Late Childhood - Age 5 through 11 years	$118.98
	99384	Routine E & M	Adolescent - Age 12 through 17	$115.13
	99385	Routine E & M	Age 18 - 39 years	$169.18
	99386	Routine E & M	Age 40 - 64 years	Not Covered
	99387	Routine E & M	65 years and over	Not Covered
ESTABLISHED PATIENT	99391	Routine E & M	Infant - Under 1 year of age	$97.67
	99392	Routine E & M	Early Childhood - Age 1 through 4 years	$107.33
	99393	Routine E & M	Late Childhood - Age 5 through 11 years	$105.12
	99394	Routine E & M	Adolescent - Age 12 through 17	$108.44
	99395	Routine E & M	Age 18 - 39 years	$150.71
	99396	Routine E & M	Age 40 - 64 years	Not Covered
	99397	Routine E & M	65 years and over	Not Covered

A MAJOR GLITCH IN THE SYSTEM: NO EOB's

ALL RECIPIENTS ARE NOT ROUTINELY SENT EXPLANATION OF BENEFIT (EOB) FORMS

- A RANDOM SAMPLE OF 400 EOB'S (OUT OF THOUSANDS OF RECIPIENTS) ARE SENT OUT MONTHLY BY DMA
- NO REQUIREMENT THAT THEY FILL OUT AND RETURN THE FORMS
- HISTORICALLY VERY FEW RESPONSES
- THE SYSTEM RELIES HEAVILY ON THE GOOD FAITH OF THE PROVIDER

EXCLUSIONS:

MEDICAID WILL NOT PAY FOR EXPENSES WHICH ARE

- NOT REASONABLY NECC. TO THE DIAGNOSIS/TREATMENT
- ITEMS/SERVICES NOT PROPERLY Rx'ed
- SCHOOL CHECK-UP's
- COSMETIC THERAPY/SURGERY
- TELEPHONE CONSULTATIONS
- SEX CHANGE OPERATIONS
- INMATES WHO ARE IN CUSTODY
- WEIGHT LOSS THERAPHY

FEDERAL CRIMES

- ***FALSE CLAIMS ACT:*** -18 USC sec. 287
- MAKING OR PRESENTING A CLAIM THAT IS FALSE, FICTICIOUS OR FRAUDULENT
- TO A DEPARTMENT OR AGENCY OF THE UNITED STATES
- KNOWING THAT IT IS FALSE, FICTICIOUS OR FRAUDULENT
- 5 YRS/$250 K PER COUNT

FEDERAL CRIMES

- *FALSE STATEMENTS*:-18 USC sec. 1001
- FALSE REPRESENTATION OF A MATERIAL FACT,
- CONCEALMENT OF A MATERIAL FACT,
- USE OF A WRITING OR DOCUMENT
- 5 YRS/$250 K PER COUNT

FEDERAL CRIMES

- ***MAIL FRAUD:*** -18 USC sec.1341
- DEVISING A SCHEME /ARTIFICE TO DEFRAUD OR FOR OBTAINING MONEY OR PROPERTY VIA A FALSE OR FRAUDULENT PRETENSE,
- USE OF THE MAIL
- 5 YEARS/$1000 PER COUNT (IF VIOLATION AFFECTS FINANCIAL INSTITUTION= 1 M OR 30 YRS OR BOTH)

FEDERAL CRIMES

- ***WIRE FRAUD:*** 18 USC sec.1343
- DEVISING A SCHEME OR ARTIFICE TO DEFRAUD OR FOR OBTAINING MONEY OR PROPERTY BY MEANS OF FALSE OR FRAUDULENT PRETENSES,
- INTERSTATE USE OF WIRE, RADIO OR TELEVISION COMMUNICATION
  - 5 YEARS/$1000 PER COUNT

FEDERAL CRIMES

- *MEDICARE AND MEDICAID FRAUD:* 42 USC sec. 1320(a)-7b(a)(1)
- KNOWINGLY AND WILLFULLY,
- MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT,
- IN A CLAIM FOR PAYMENT UNDER A FEDERAL HEALTH CARE PROGRAM
- 5 YEARS/$25K OR BOTH

FEDERAL CRIMES

- ***MONEY LAUNDERING:*** 18 USC sec.1956
- ENGAGING IN A FINANCIAL TRANSACTION
- KNOWING THE PROCEEDS COME FROM SOME FORM OF "UNLAWFUL ACTIVITY"
- CONDUCT INTENDED TO PROMOTE THE "UNLAWFUL ACTIVITY" or ENGAGE IN TAX FRAUD/EVASION or CONCEAL CONDUCT or AVOID A REPORTING REQ. 5 YRS/$250K PER CT.

- RICO :(RACKETEER INFLUENCED & CORRUPT ORGANIZATIONS) 18 USC sec. 1961 *et seq*
  - DEFENDANT INVESTED IN "ENTERPRISE" MONEY FROM RACKETEERING ACTIVITY, or
  - DEF. OBTAINED CONTROL OF "ENTERPRISE" THROUGH PATTERN OF RACKETEERING ACTIVITY, or
  - DEF. WHO WAS EMPLOYED BY OR ASSOCIATED WITH "ENTERPRISE" CONDUCTED BUS. AFFAIRS THROUGH PATTERN OF RACKETEERING ACTIVITY, or
  - CONSPIRED TO DO ANY OF THE ABOVE

RICO PENALTIES

- DEF. CONVICTED SUBJECT TO JAIL UP TO 20 YRS. AND "SHALL"
- FORFEIT INTERESTS/PROPERTY OBTAINED IN VIOL. OF RICO,
- ANY PROPERTY DERIVED
- COURTS MAY RESTRAIN FUTURE VIOL. BY ORDERING DIVESTITURE OF PROPERTY OR IMPOSING RESTRICTIONS ON ACTIVITIES.

IN AREA OF HEALTH CARE FRAUD RICO HAS BEEN USED TO PROSECUTE:

- PHYSICIANS WHO CONSPIRE WITH ATTORNEYS AND PATIENTS TO SUBMIT FALSE CLAIMS TO INSURERS FROM FICTICIOUS AUTO ACCIDENTS,
- DR's WHO DISPENSED UNNECC. RX's
- DR's WHO CONSPIRED TO SUBMIT FALSE CLAIMS FOR MEDICAL SERVICES NOT RENDERED.

RECENTLY ENACTED (1996) CRIMES UNDER HIPPA (Health Insurance Portability and Accountability Act)

- HEALTH CARE FRAUD- 18 USC sec1347
- THEFT/EMBEZZLEMENT IN CONNECTION WITH HEALTH CARE-18 USC sec. 669
- FALSE STATEMENTS RELATING TO HEALTH CARE MATTERS 18 USC sec. 1035

OTHER FEDERAL CRIMES

- CONSPIRACY
- THEFT OF GOVERNMENT PROPERTY
- OBSTRUCTION OF JUSTICE
- DISPOSING OF ASSETS TO OBTAIN MEDICAID COVERAGE
- ANTI-KICKBACK STATUTES

STATE OF ALASKA STATUTES

THEFT - AS 11.46.100 through AS 11.46.180

-FIRST DEGREE	B FELONY	$25,000 OR MORE
- SECOND DEGREE	C FELONY	$500 TO $25,000
- THIRD DEGREE	A MISDEMEANOR	$50 TO $500
- FOURTH DEGREE	B MISDEMEANOR	OVER $50

FORGERY-SECOND DEGREE- AS 11.46.500 through AS 11.46.510 - C FELONY

SCHEME TO DEFRAUD -AS 11.46.600-B FELONY INTENT TO DEFRAUD $10,000 OR 5 PERSONS

FALSIFYING BUSINESS RECORDS - AS 11.46.630 - INTENT TO DEFRAUD C FELONY

MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE- AS 11.71 PENALTIES RANGE FROM UNCLASSIFIED FELONIES, A,B,C,MISDEMEANORS

SOME COMMON RIP-OFFS

- BILLING FOR GOODS/SERVICES NOT PROVIDED
- BILLING FOR PHANTOM PATIENT VISITS
- UPCODING
- UNBUNDLING
- DOUBLE BILLING
- BILLING FOR MED. UNECC. SERVICES OR TESTS
- BILLING FOR NON-COVERED SERVICES
- BILLING MEDICAID HIGHER THAN OTHER PAYERS
- KICKBACKS

CRIMES AGAINST PERSONS-PATIENT ABUSE or NEGLECT

ASSAULT 1 through RECKLESS ENDANGERMENT
AS 11.41.200 through 250
Class A Felony through A Misdemeanor

SEXUAL ASSAULT AND SAM -
AS 11.41.410 through 460
Unclassified Through C Felony

MURDER THROUGH CRIM. NEGLIGENT HOMICIDE
AS 11.41.100-130
Unclassified felony through class C felony

ENDANGERING THE WELFARE OF A VULNERABLE ADULT
AS 11.51.200 through 210
First Degree C FELONY
Second Degree -A Misdemeanor
HARASSMENT -AS 11.61.120 B Misdemeanor

EXCLUSION OF INDIVIDUALS AND ENTITIES FROM HEALTH CARE PROGRAMS

- MANDATORY- GENERALLY 5 YEARS UPON CONVICTION FOR PROGRAM RELATED FELONY CRIMES-STATE OR FEDERAL.
- PERMISSIVE-GENERALLY UPON CONVICTION FOR MISDEMEANOR PROGRAM RELATED CRIMES
- CORP. INTEGRITY AGREEMENTS

INVESTIGATIVE TOOLS

MMIS - Medicaid Management Information System - Provider Billing History Database

MOTZNIK - Public Records Database

APSIN - Alaska Public Safety Information Network - Crim. Hist/Outstanding BW's

SEARCH WARRANT - Issued by Court upon showing of probable cause

AUDITS - of Provider Billing, Medical, and Other Records

EXPERT WITNESSES - Reports and Testimony

SURVEILLANCE - of Provider and /or Recipient Activity

UNDERCOVER - Visits to Provider- WIRES

INTERVIEWS-of Provider,Recipients,Employees or other Witnesses or Informants

REVIEW- of Other Tangible Medical Evidence such as X-rays, Rx's, Lab Reports by Expert or Staff

COOPERATION- and Information Sharing Between Program and Other Law Enforcement Agencies-FBI-DEA-AST-APD-IRS-POSTAL INSP.

42 CFR 455.2 of the CODE OF FEDERAL REGULATIONS DEFINITIONS

FRAUD -means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

ABUSE means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

FEDERAL LAW REQUIRES MOU BETWEEN DHSS & DOL

NEW ONE SIGNED IN OCTOBER 1999 BETWEEN DOL AND HSS.

~ Commissioner Karen Perdue

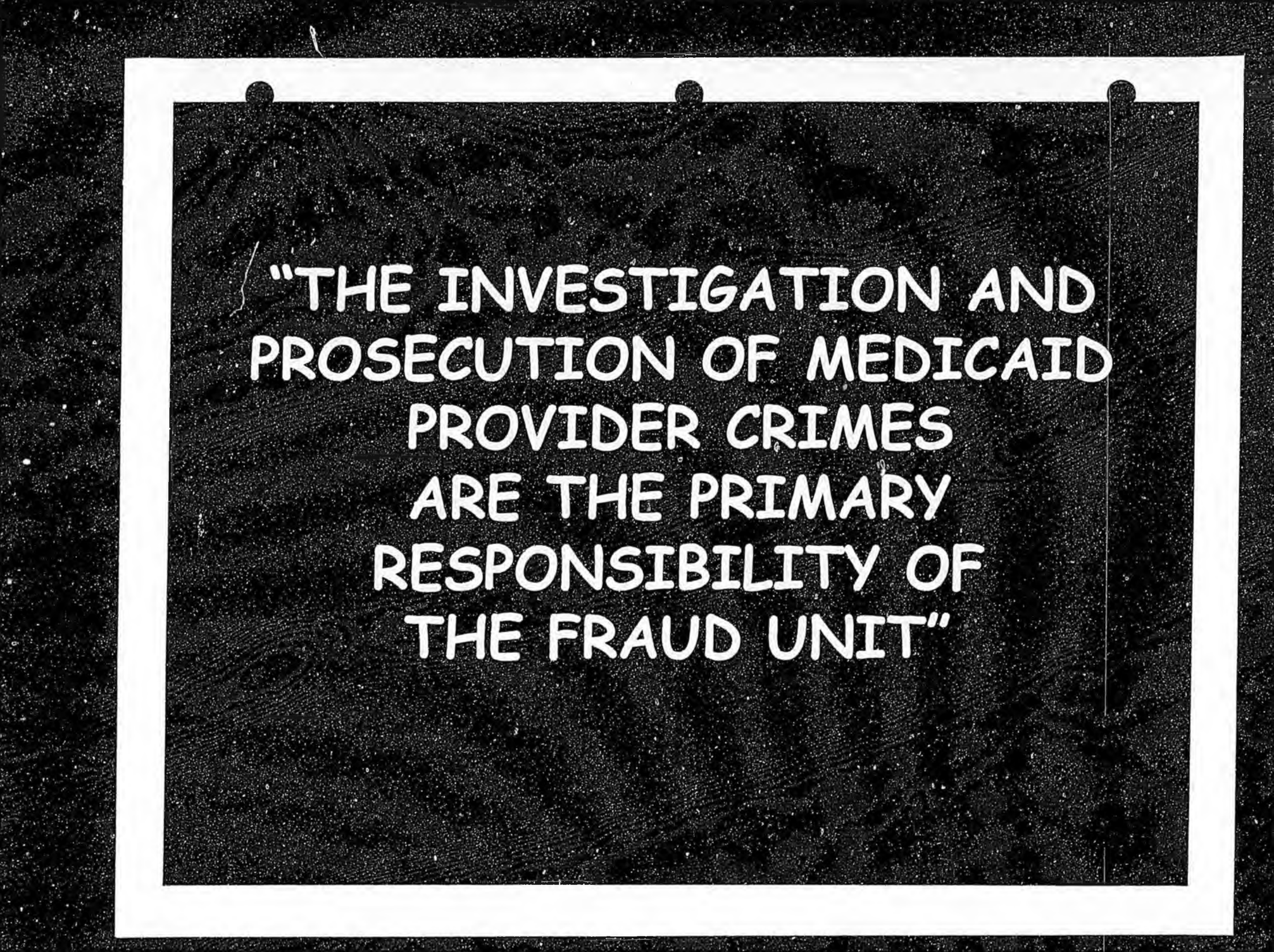
~ Atty Gen. Bruce Bothelo

~ DMA Director Bob Labbe

~ Stephen Branchflower Ak. MFCU

·OLD ONE DATED BACK TO 1992

"THE PREVENTION, DETECTION, AND ELIMINATION OF ALL MEDICAID CRIMES AND ALL ABUSIVE AND IMPROPER PRACTICES IN THE MEDICAID PROGRAM, ARE PRIMARILY THE RESPONSIBILITY OF DHSS"


"THE INVESTIGATION AND
PROSECUTION OF MEDICAID
PROVIDER CRIMES
ARE THE PRIMARY
RESPONSIBILITY OF
THE FRAUD UNIT"

UNDER FEDERAL LAW:

MFCU... 33 INVESTIGATIONS

~INVESTIGATES ALL REFERRAL'S FROM DHSS

~HAS EQUAL ACCESS TO ALL MEDICAID RECORDS AS DOES DHSS

~MFCU CAN PRE-EMPT THE RESOLUTION OF A CASE UNDER INVESTIGATION BY DHSS

~NEITHER AGENCY HAS AUTHORITY OVER EACH OTHER'S EMPLOYEES

INVESTIGATING AND PROSECUTING HEALTH CARE FRAUD REFERRALS

- Private Citizen
  - Providers
  - Website
  - Hotline 269-6279
  - National TV Ads

STATE or FEDERAL AGENCIES
DMA-SURS-DURS-NAMFCU





INVESTIGATED BY MFCU VIA:

- SEARCH WARRNTS
- INTERVIEWS-EMPLOYEES-RECIPIENTS
- AUDIT OF PROVIDER RECORDS
- LAB WORK
- INTERACTION WITH OTHER AGENCIES APD.AST.DEA

STANDARD=PROOF BEYOND REASONABLE DOUBT

ACCEPTED

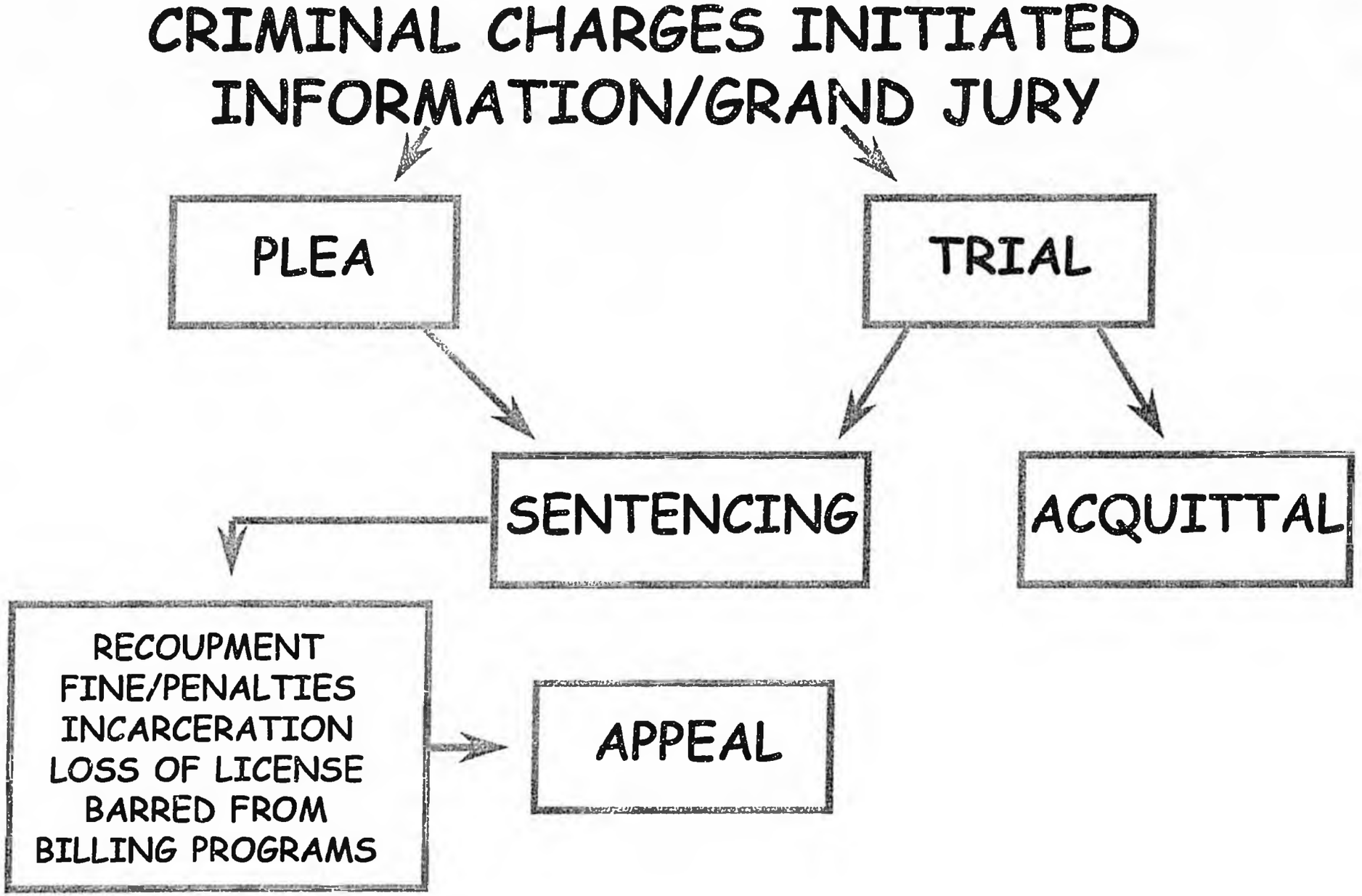
CHARGES FILED BY MFCU

REJECTED

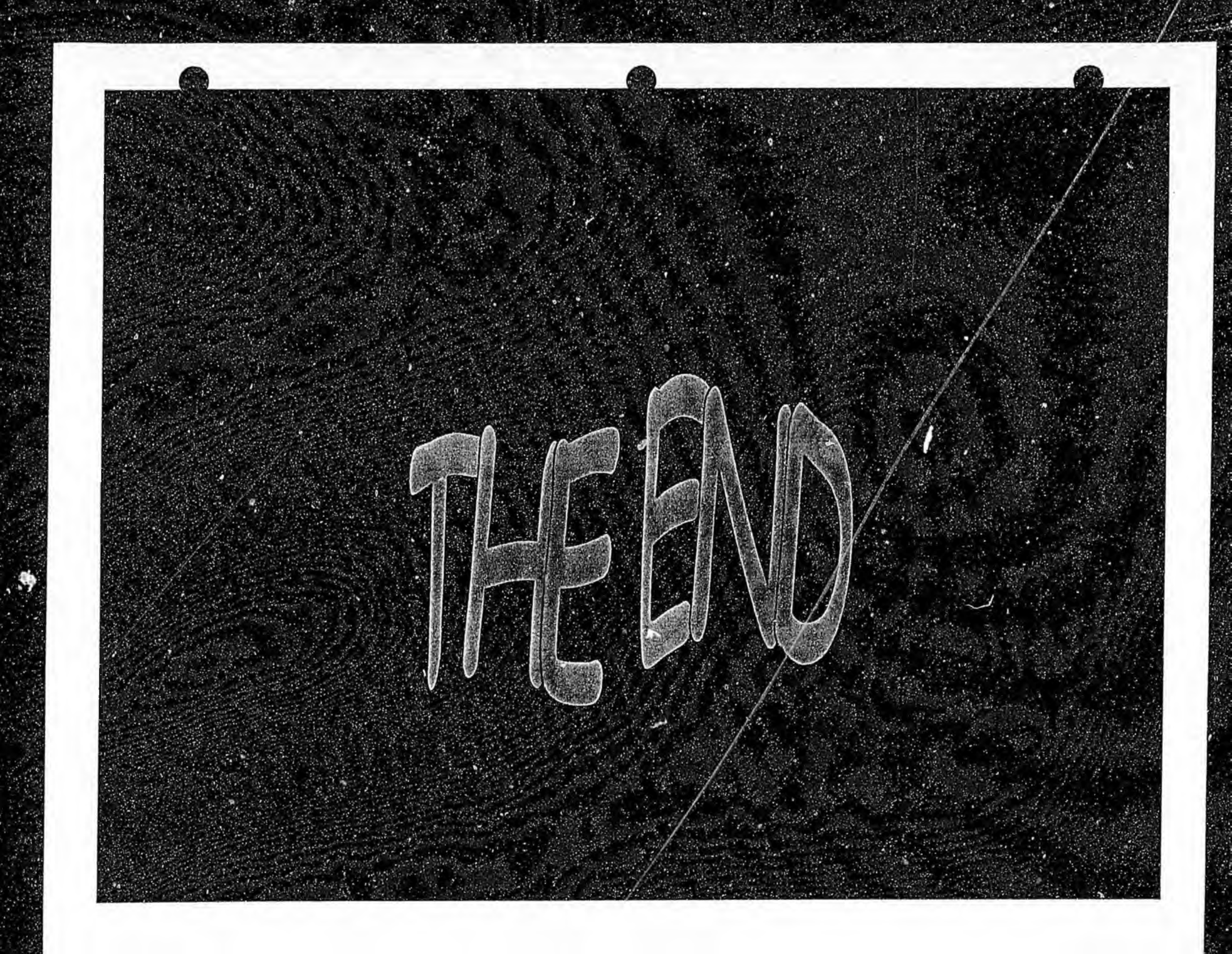
CASE REFERRED TO OTHER AGENCY

CASE DECLINED

THE PROSECUTION




QUESTIONS?


THE END

WELFARE REFORM

October 2001

2001 Welfare Reform Status Report

Year Four

Fiscal Years 1998-2001
(July 1, 1997 – June 30, 2001)

INSIDE THIS REPORT

Introduction	1
Four Year Statistics	2
Partnerships	3
Evaluation	3
The Future	4

INTRODUCTION

With four years of welfare reform behind it, Alaska has remained successful at moving Alaskans off welfare and into work. The caseload has dropped, millions of benefit dollars have been saved and most families are better off than they were on welfare. This success is not without challenge, however, as families will soon reach their 60-month lifetime limit on welfare benefits.

Federal and state laws implemented in 1997 made fundamental changes to welfare programs that had been in place for decades. The new Temporary Assistance program has a strong emphasis on work. At the same time it remains an essential safety net program for poor Alaskan families.

In Alaska, several families will hit the time limit in July of 2002. An estimated 180 families may be removed from the program during the year after that date. About 7,000 families now receive benefits in Alaska through state and Native run programs.

Alaska has many tools to help families on welfare find independence before their 60-month limit runs out. Each year, the State reinvests millions of welfare savings to assist families toward self-sufficiency. Strong partnerships between state and community agencies provide case management, childcare, workforce development and other supportive services.

Native organizations play an increasing role in delivering welfare services in Alaska. Tanana Chiefs Conference, Tlingit & Haida, and the Association of Village Council Presidents have taken over welfare services for Native families in their regions.

Currently, the State is partnering with the University of Alaska to study long-term recipients



with the greatest barriers to employment. The results of this study will help the State better understand what steps to take to help low-skilled welfare recipients into employment before their clock runs out.

This year's *Welfare Reform Status Report* is an abbreviated version a similar report that has been published for the past three years. Copies of earlier reports are available from the Division of Public Assistance.

WELFARE REFORM IN ALASKA

Welfare reform laws have changed welfare by:

- Imposing a 5-year lifetime limit on benefits
- Requiring most recipients to be in a work activity within two years
- Diverting families from welfare by addressing immediate needs
- Reducing benefits to two-parent families in the summer and to families with low housing costs
- Requiring recipients to develop a family self-sufficiency plan
- Allowing families more earned income so that it pays to work
- Penalizing recipients for quitting or refusing a job
- Enabling communities to play a greater role in the delivery of welfare-to-work services
- Requiring minor parents to live with their parents or safe home, and finish high school

FOUR YEAR STATISTICS

Welfare Caseload Down

39%

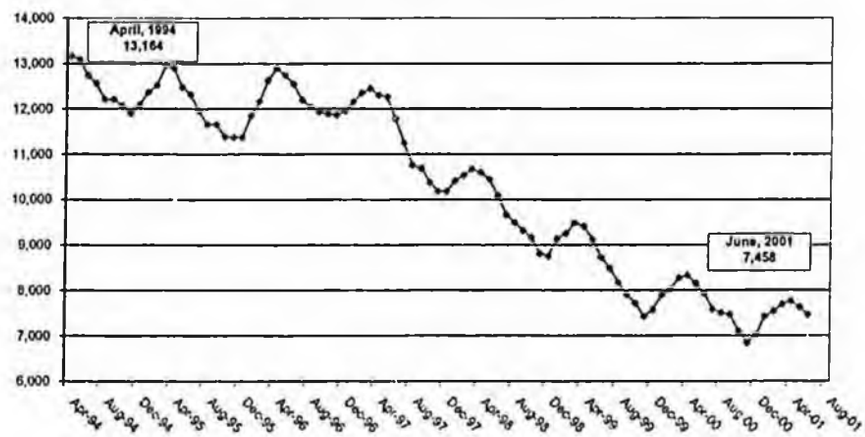
(FY97-FY01)

HIGHLIGHTS

- The average caseload for FY01 was 39% below FY97, the year before welfare reform was implemented.
- In November of 2000, the caseload dropped 48% below the historic high in April of 1994.
- In FY01, the percent of Alaska's population on welfare declined to approximately 3.5%, down from 6.2% in FY94.
- Annual savings in welfare cash benefits reached $55 million in FY01. The FY02 budget shows a $48 million state general fund savings due to welfare reform.
- In June of 2001, 35% of the adult Temporary Assistance caseload was working with an additional 30% assigned to other activities leading to work. The average wage of working recipients was $8.88/hr.
- Over $27 million is invested in FY02 to help recipients find work, receive childcare, eliminate barriers, and stay on the job. Twenty-nine community organizations are helping the welfare-to-work effort.
- Childcare assistance has increased from $19 to $30 million in four years.
- Denali KidCare provides over 18,000 children from low-income working families with health insurance.
- Child support collections have increased from $50 million in FY93 to $91 million in FY01.

CASELOAD AND SPENDING STILL DECLINING

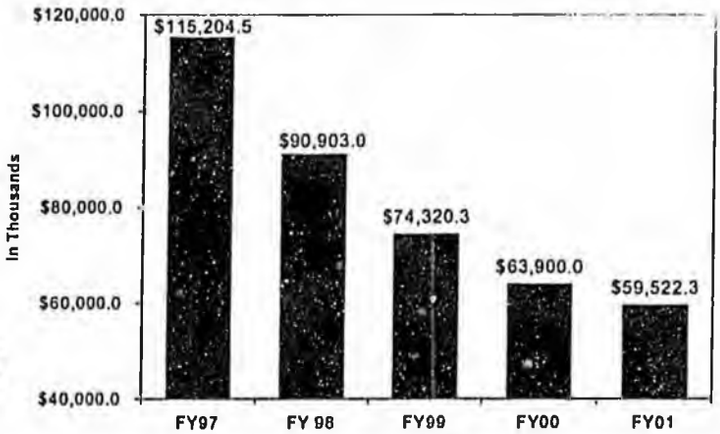
AFDC/TANF Caseload FY94-FY01



The state's TANF caseload was down 39% in FY01 compared to FY97, the year before welfare reform took effect. In November of 2001, the caseload for TANF programs in Alaska declined to 6,847 families, a 48% reduction from the historic high of 13,164 in April of 1994. These figures include the state's Temporary Assistance program and three Native TANF programs.

The percentage of Alaskans receiving cash welfare benefits has declined, from 6.4% in FY94 to 3.5% in FY01.

Temporary Assistance Cash Benefit Expenditures



Spending on welfare payments continues to decline. In FY01, cash benefit expenditures dropped to $59.5 million, down 48% from the $115.2 million spent in FY97. This is attributed to recipients leaving welfare for work, fewer applicants, more recipients working, and seasonal benefit cuts to two-parent families.

Welfare reform has saved the state millions of general fund dollars. The general fund savings for FY02 alone is $48 million when compared to FY97.

PARTNERSHIPS

Welfare reform in Alaska has been successful because of strong partnerships:

COMMUNITY PROVIDERS are critical to providing case management and supportive services to welfare recipients. Over 50% of welfare families receive services from 29 separate organizations through grants or contracts with the Division of Public Assistance (DPA). These providers are knowledgeable about the local economy, jobs, social services, and needs of their communities. Native organizations are key partners in service delivery.

CHILD CARE is essential to the success of welfare reform. The Department of Education and Early Development in partnership with DPA and local administrators assist hundreds of families in their move from welfare to work. Continued efforts are underway to increase the availability of safe, nurturing and developmentally appropriate childcare.

WORK SERVICES is a partnership between DPA and the Division of Employment Security, which provides services designed to move Alaskans from welfare to work. This includes work search, transportation, ESL, vocational training programs, and job retention, development, and advancement. Effective case management is the core of work services.

ONE-STOP JOB CENTERS provide welfare recipients with professional and convenient resources to find work. Job Centers combine under one roof various state and community services geared to assist job seekers with workforce development and social services. Key partners include DPA, Employment Security and Vocational Rehabilitation, the Workforce Investment Act agencies and local non-profit organizations.

WORKSTAR is a business-led initiative created by Governor Tony Knowles to connect welfare reform and employers. It is operated by the Alaska Human Resource Investment Council with funding from DPA. Exemplary employers who have hired welfare recipients are recognized at an annual event. WorkStar also hosts job fairs statewide and provides an avenue for the state to receive advice from employers in the design of welfare-to-work programs.

DENALI KIDCARE provides health care for over 18,000 children of low-income working parents and is administered jointly by the Divisions of Medical Assistance, Public Assistance, and Public Health. Parents are more comfortable leaving welfare for work when they know their children will have health coverage.

CHILD SUPPORT collections are essential to the long-term success of welfare reform. The Division of Child Support Enforcement helps to ensure that both parents live up to the responsibility, within their means, of providing financial support for their children. A portion of child support collections are used to reimburse the state for welfare payments provided to poor families.

Community Service Providers
- Adult Learning Programs of Alaska
- AK Vocational/Training Center
- Aleutian Pribilof Island Assoc.
- Assoc. of Village Council Presidents
- Bristol Bay Native Assoc.
- CARTS, Inc.
- Catholic Social Services
- Catholic Comm. Services – Juneau
- Center for Community
- The Child Care Connection
- Cook Inlet Tribal Council
- Delta Mine Training Center
- Fairbanks Borough School District
- HRC, Inc.
- Job Ready Inc.
- Kenai Alternative HS
- Kodiak Area Native Association
- Kodiak Island Borough
- Love INC
- Maniilaq Manpower
- MASCOT
- Metlakatla Indian Community
- Nine Star Enterprises
- SE Regional Resource Center
- Tanana Chiefs Conference
- Tanana Valley Community College
- Tlingit and Haida
- U of A – Adult Learning Center
- Valley Women's Resource Center

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EVALUATION

WELFARE "LEAVER" STUDY: A comprehensive study of 694 former welfare recipients has found that most who leave the welfare rolls stay off and find employment. The "leaver" study assessed those who left after welfare reform began in 1997. Highlights:

- The average wage for people who had worked was $10.52/hour in 1999;
- Health problems, disabilities, and child care problems were frequent challenges to working;
- Thirty percent of respondents reported at least one family member with no medical coverage;
- Over 80% agreed people on welfare should be required to work;
- Only 18% reported their household received child support payments.
- Seventy-five percent of the "leavers" have worked since leaving welfare;
- Over half of respondents said their lives were better after leaving welfare;
- Almost 90% of recipients who left welfare were female and the typical family included two children.

The study was conducted by UAA's Institute for Circumpolar Health Studies with support from DPA.



THE FUTURE

WELFARE REFORM: WHAT'S NEXT



While welfare reform in Alaska has met with significant success, serious challenges lay ahead.

THE 60-MONTH LIMIT: Welfare recipients with employment barriers such as mental illness, drug and alcohol abuse, learning disabilities and family violence represent a higher proportion of the caseload.

The 60-month time limit for many families will run out in July 2002. In the past year a number of efforts have been underway to plan for families reaching the 60-month time limit:

- Community meetings were held to solicit input on welfare reform policy and possible solutions to challenges in the future.
- The Division of Public Assistance developed enhanced partnerships with other agencies and organizations to collaborate on providing services.
- Criteria were developed for allowing extensions based on the language in state law.
- The state has developed processes to ensure families are fully assessed and referred for services they need, and to determine if they should receive extended time on assistance if they meet the criteria provided in law.

The state will insure that a safety net remains for families who reach 60-months, but face circumstances that would make them eligible for an exemption to the limit.

STUDY OF LONG-TERM RECIPIENTS: The Division of Public Assistance and the UAA Institute for Circumpolar Health Studies are continuing efforts to learn more about why some families have a difficult time leaving public assistance. A new phase of research will focus on families who have received Temporary Assistance benefits for 40 months or longer.

The purpose of this study is to discover the factors associated with long-term reliance on Temporary Assistance and the degree to which they are being addressed so that the State can continue to develop effective policy and service responses. Some of the factors to be studied include work history, employment barriers, screening and assessment activities and client perceptions.

REAUTHORIZATION: At the same time Alaska is preparing for the imposition of the 60-month limit, Congress will be debating reauthorization of the federal welfare reform law.

The entire law may be reconsidered including the purpose, funding levels, work requirements and time limits.

States will undoubtedly want to retain their current federal funding and the flexibility that has allowed them to be so successful. Reauthorization of Native TANF will be an important issue in Alaska.

While four years of welfare reform have yielded positive results, only if families escape poverty and reach self-sufficiency can Alaska's welfare reform efforts truly be considered a success.

This report was produced by the:
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View this report online at:
http://www.hss.state.ak.us/dpa/

American Institute *for*
Full Employment

ASSESSMENT OF ALASKA'S WELFARE REFORM PROGRAM

Prepared by:

The American Institute for Full Employment

For:

Senator Lyda Green

Chair, Senate Health, Education & Social Services Committee

and

Representative Fred Dyson

Chair, House Health, Education & Social Services Committee

September 2001

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Introduction

Responding to a Welfare Reform Progress Report prepared by the American Institute for Full Employment (AIFE), and a subsequent presentation, Senator Lida Green and Representative Fred Dyson requested that the AIFE assess Alaska's welfare reform efforts. This report contains our assessment of Alaska's welfare reform program, and includes recommendations for improvements.

It is important to point out that although the purpose of this report is to recommend changes, we were for the most part very impressed both with the design of Alaska's welfare reform program and with Alaska's attempts to implement a program based on work-first principles. We met with dedicated, knowledgeable staff at all levels; reviewed policies that are in general conducive to a program that will be successful in assisting families toward self sufficiency; and found service delivery methods that clearly constitute best practices. In particular, we found that staff at all levels are committed to a work-first approach and believe that the great majority of welfare recipients are capable of self-support. Thus, although much of the report discusses problems and recommends solutions, we believe that the main programmatic elements of Alaska's program are valid, and that sound management practices have been used to implement the program. At the same time, we saw significant variations in the levels and kinds of services provided, and found gaps in the provision of services.

The recommendations in this report result from a very quick review of Alaska's program. We interviewed DPA central office management officials, and both management officials and line staff in each Regional office. Both urban and rural program operators and line staff were interviewed, and review staff traveled to remote locations to view program operations. In addition, administrators of two native TANF programs were interviewed. We also reviewed Alaska's statute, regulations, program manual, TANF State Plan, organization charts, data reports,

Welfare Reform Status Reports, Implementation Memoranda, proposals from potential contractors, Tribal Grant Awards, budgetary material, and Alaska's study of welfare leavers.

In addition, we attempted to review descriptions and evaluations of welfare reform program aspects for other states and the nation produced by researchers and technical experts. However, the limited time for the onsite review did not permit us to actually attend and assess the eligibility interview process, case management sessions, or Work Search classes; and interviews with line staff members were limited in both time and number. In addition, we were not able to talk to work program participants to gain their perceptions of the services they were receiving. Despite these limitations, we hope that our understanding of Alaska's TANF program and of the delivery of Alaska Temporary Assistance Program (ATAP) services is correct, and apologize if we misinterpreted any facet of program rules or delivery mechanisms.

We also want to thank DPA officials and line staff for their cooperation in fitting our visit into their already busy schedules and for the openness with which they conversed with us. We hope that these recommendations will assist Alaska to deliver an even better welfare reform program.

1. Work-First

1.1 Background/Findings: Using Work-First Principles

The "work-first" philosophy is consistently espoused by managers, workers, and contractors, and this is an important accomplishment. We were also impressed with workers' understanding of work-first principles. In the one-stops we visited, we found the Department of Labor and Workforce Development (DOL) staff as well as Alaska Temporary Assistance Program (ATAP) staff working together, and this, combined with the clients' ability to access employment related-resources immediately, certainly promotes the work-first message. However, in practice, we found considerable variation in the actual application of work-first principles, and we believe that there are additional steps that Alaska can take to ensure that work-first is more consistently employed.

One of the key principles of work first is that the labor market is the best test of employability. A strong diversion program utilizing structured work search is necessary to achieve this principle. There is an existing policy for diversion in Alaska, which allows a lump sum payment of up to two months benefit to enable a potential applicant to avoid opening a grant. However, it is rarely used. We provide recommendations for enhancing the use of diversion elsewhere in this report.

1.1.1 The Up-Front Process and Assignment of Case Managers

Despite the philosophy of work first, Alaska's up-front process continues to have eligibility for the cash ATAP benefit as the primary focus instead of employment and self-sufficiency. To some extent this is unavoidable when: (1) separate workers handle eligibility and case management; (2) eligibility is the first activity; and (3) case managers are not always assigned immediately. Time frames range anywhere from a few days to six weeks from first day of contact until a client is engaged in the contracted Work Search class.

Both the assignment of a case manager as well as the assessment process used to determine if clients should be referred to the Work Search class vary greatly from area to area and from worker to worker. In Ketchikan, clients are assigned a case manager at the same time they have their eligibility interview. In this office, clients meet with their case manager on the same day as their eligibility interview, a Family Self Sufficiency Plan (FSSP) is developed, and they are referred immediately

to the Work Search class. Often clients will be attending Work Search class even prior to the actual opening of the ATAP grant.

However, in other areas, the assignment of a case manager and the length of time before a client meets with the case manager is much more haphazard. While the Division of Public Assistance's (DPA) goal is to have 100% of non-exempt clients case managed, we visited areas where not all clients were working with a case manager. For example, we found clients on a waiting list for case management in Juneau. In addition, clients in only five of the Nome area villages have case managers; in the Kotzebue villages, most clients are not being regularly served by a case manager.

While the policy is that virtually all clients should be referred to the Work Search class as the first activity, some areas report that a number of applicants are actually not being referred to Work Search class as a first activity because of perceived barriers.

In summary, the determination of who to refer and when by case managers varies greatly, not just from office to office, but within the same office, and there does not appear to be any uniform guidance or assessment form to assist case managers in this determination.

1.1.2 Work Activities Versus "Barrier Removal"

Another principle of the work-first philosophy is that assessments should focus on an individual's and family's strengths and build upon those rather than presume that there are numerous barriers which must be overcome before the family can make any movement forward. While DPA administration clearly endorses a strength-based assessment approach, some of the case management and Work Search class staff and managers with whom we met appear to be moving away from this approach. For example, Work Search class staff in Ketchikan and a case manager in Sitka informed us that most clients now have so many barriers that a great deal of assessment must be done first, followed by barrier removal rather than employment activity, or at least a combination of barrier removal and employment. As a result, we were told that fewer clients are being referred to the Work Search class.

In Fairbanks, we were advised that orientations are now being done only every other week and that only one individual is in the newest Work Search class. In addition, once in the class, fewer clients are actually

looking for work or engaging in actual work activities versus "barrier removal" activities. "Barrier removal" activities include obtaining a driver's license, mental health counseling, and working on family issues. While some of these activities may be necessary to move the individual to employment, they do not need to be done to the exclusion of work activities for most people. Because of this "barrier-based" view of clients, some of the Work Search classes have moved away from a standardized curriculum to a more individualized approach.

While there are no data to quantify the exact number of referrals to vocational rehabilitation services, anecdotal information from case managers creates the impression that referrals are high relative to other states' experience. This may be another sign that there is too great a concentration on barriers to employment. Traditionally, vocational rehabilitation services tend to be much longer term and more expensive than other welfare-to-work services.

1.1.3 On-the-Job Training/Community Service

A third principle of the "work first" philosophy is that on-the-job training is often the most productive method of training. To this end, DPA is implementing several new on-the-job training approaches. Since these are just being implemented, it is too early to assess their effectiveness. However, some areas believe that the wage reimbursement level, i.e. one-half the wage for OJT, and the requirement that employers make a good faith agreement to hire the participant, will not attract many employers. This is especially the case in the rural areas.

In the extremely rural areas, where there is very little employment, a greater use of community service, e.g. helping at the local school, should be possible. Often because of lack of resources, these communities have significant infrastructure issues which clients could help meet. However, some staff raised concerns that in small communities clients assigned to perform such unpaid community services will be stigmatized.

1.1.4 Exemptions from Work Participation

State policies providing exemptions to work participation requirements also prevent full implementation of work-first principles. Alaska's statute was recently changed to require adults exempt because of physical or mental limitations to complete a self-sufficiency plan. However, Alaska's

regulation still provides that individuals automatically qualify for an incapacity exemption even if the individual is able to work part-time (7AAC45.235(a)(2)).

Even individuals who are physically or mentally incapacitated can take steps toward self-sufficiency and should be obligated to agree to appropriate activities. Although the inability to perform full-time work may prevent an individual from participating to the level where his/her activities are countable in calculating participation, such individuals should not be totally exempted from work participation. A similar issue concerns individuals with mental health and substance abuse problems. Currently Alaska cannot require that such clients include treatment as a FSSP activity. In addition, even where a client agrees to treatment, there are waiting lists for substance abuse treatment in some areas. We understand that DPA is already addressing these problems.

Although parents with children under 12 months of age are required to complete FSSPs, such individuals are permitted to be exempt from work participation requirements for this total period (Section 47.27.035). This exemption is only allowed one time per parent(s). Most workers with whom we met believe that the 12-month exemption period is too long; several related their own experiences in this area, advising that they had been required to and had successfully returned to work 16 weeks after the birth of a child.

Experience in other states varies widely in this area. Thirty states provide at least a 12-month exemption after childbirth, 11 states provide a three-month exemption, one state exempts parents for six months, one for four months, one for 13 weeks, while six states provide no exemption in such cases (Urban Institute, Welfare Rules Data Book: State TANF Policies as of July 1999). Although work-first principles support a reduction in the exemption period, there are other considerations in determining appropriate policy. Elsewhere in this report we advise that some areas in Alaska report there is already a shortage in infant care and this would be exacerbated were the exemption period to be reduced. In addition, Alaska has just added funding to child care to eliminate a large child care waiting list. Both these issues need to be considered in revising exemption policies.

1.1.5 ATAP Clients Filing for Disability Benefits

Although only peripherally related to this section on work-first, we note that Alaska does not require individuals receiving ATAP but claiming a disability to file for federal disability benefits (Title II and SSI). Although disabled individuals are not subject to Alaska's 60-month time limit, federal policy does not exempt such individuals from the 60-month federal time limit for receipt of cash benefits provided using TANF funding. DPA did point out that even without the requirement, it has moved approximately 500 individuals from ATAP to SSI. However, Alaska's failure to require disabled individuals to file for federal disability benefits may increase the state's risk of being subject to a federal penalty because more than 20% of recipients have received benefits more than 60 months.

1.2 Work-First Recommendations: Take Further Steps To Incorporate the Work-First Philosophy Into ATAP Operations

We recommend a number of enhancements/changes to ensure that the work-first philosophy is carried out in practice. First, the "up front" process should be strengthened. On a consistent basis, clients should be interacting with a case manager on or as close to the first day of contact as possible. This will send a clearer message that public assistance is as much about obtaining employment as it is about providing cash benefits. The Ketchikan office is potentially a good model to follow in this area.

Second, DPA should provide stronger, more consistent guidance with regard to assessment. As a start, a statewide assessment form should be developed to assist case managers and work search staff, and case managers should be trained to utilize a strength-based approach in completing assessments. The emphasis should be on utilizing the labor market as the best test of employability and the key presumption should be that all individuals are capable of moving themselves and their families forward. Only one week of basic training is routinely provided to case managers although some additional topic-specific trainings are also provided, e.g. domestic violence. The materials presented in this training should be reviewed to ensure that a family strength-based approach is utilized versus an over-emphasis on predetermining family barriers. Additionally, the curriculum of the Work Search classes should be reviewed to assure there is a consistent strength-based, work-first approach.

Our third recommendation deals with participation activities for individuals who do not obtain unsubsidized jobs through their participation in a Work Search class. Where appropriate, actual work activities such as subsidized employment, work experience and community service should be more uniformly utilized from the outset. In this regard, Alaska should consider piloting a more complete subsidized employment program than is now being implemented through OJT or Trial by Hire. Oregon has demonstrated that a subsidized work program can be effective in promoting economic development. In Sitka, staff believed that if employers could be reimbursed for somewhat more than 50% of the wage, they could be motivated to hire clients during the slower winter months. In addition, where neither unsubsidized nor subsidized jobs exist, particularly where infrastructure needs are great, such as in rural Alaska, the utilization of community service should be increased. Alaska should look at how successful mass work experience/community service programs in other states (e.g. West Virginia) overcame or mitigated the issue of stigma where it existed.

Finally, Alaska should revise its policies and practices for treating individuals limited by incapacity from full participation in work activities. Such individuals should be required to complete FSSPs that include activities appropriate to the individual's condition; actual work activities should be required for individuals able to participate on a part-time basis; and Alaska should require fully disabled persons to file for and pursue applications for federal disability benefits. Entitlement to ATAP should be on a contingency basis for such individuals, with federal benefits when approved used to reimburse the state for ATAP funds provided in the interim. Clients should be required to access substance abuse and/or mental health treatment where needed. We understand that DPA is already taking steps to resolve most of these issues. We also recommend that Alaska obtain and analyze data on referrals to vocational rehabilitation to determine the appropriateness of referrals and the achievement of clients served. In addition, if additional child care dollars and resources can be found, Alaska should consider reducing the 12-month exemption period for parents of infants.

2. Diversion Program

2.1 Background/Findings Related to the Current Diversion Program

Statutory Section 47.27.026 is explicit in providing that a lump-sum diversion payment may only be offered to an ATAP applicant if the family appears to be eligible for benefits, the adult applicant is job ready, and the family is determined to need only short-term financial assistance. The amount of diversion assistance that can be provided cannot exceed two months of ATAP benefits and must be sufficient to meet the family's immediate needs. Alaska Regulations (7AAC 45.266) provide that three factors shall be considered in deciding whether to offer a lump-sum diversion payment to an applicant for ATAP: "(1) the job readiness of the applicant; (2) the family's critical financial needs...; (3) other resources available to the family...". Job ready is defined as "currently working or having prospects for employment within 30 days."

Diversion is rarely used in Alaska because of the extremely limited circumstances under which diversion can be offered and the limited cash diversion benefits that are available. Yet workers report that a more open diversion program could assist a significant number of families while avoiding dependency on cash ATAP benefits. Workers advised that, even when diversion is appropriate, it is often not offered because of the long waiting period to obtain an appointment to apply for PASS III child care. Processing the application for ATAP provides the family with immediate PASS 1 child care.

2.1.1 Broader Diversion Options Are Available

A broader and more responsive diversion program could be effectively used to assist families to avoid dependency on cash benefits while providing them with the resources they need to obtain and/or retain employment and support their families. Because the amount of cash benefits provided would be very limited, a greater use of diversion would also save TANF program dollars. Successful diversion programs in other states provide several months of benefits that may be used for a number of purposes that would prevent dependency. Some states even provide vouchers to enable an individual to purchase an automobile. Other states use PRWORA options including Social Security Act Section 1931 to ensure that diverted families are eligible for Medicaid and transitional Medicaid; and provide other "transitional" benefits, such as child care and transportation, to diverted families.

2.2 Diversion Program Recommendation: Revise Diversion Program to Offer More Useful Diversion Benefits/Services and Provide Diversion Option as an Up-Front Activity

We recommend that diversion be an up-front option that is presented to applicants at or near the beginning of the eligibility process, as soon as the worker can determine that the family appears to be eligible for ATAP. Although Alaska's monthly ATAP benefits are the highest in the nation, the cost of living is also quite high. We, therefore, believe that DPA should request statutory authority to increase the maximum amount of cash benefits that can be provided as a diversion payment to the equivalent of three months of cash ATAP benefits. In addition to a cash payment, workers should be able to provide the same transitional benefits, such as child care and six months of transportation assistance, to diverted families as are available to families leaving ATAP for employment. The delay in access to PASS II and PASS III child care must be eliminated to make child care available immediately. In addition, Alaska should use available PRWORA options to provide Medicaid or transitional Medicaid to diverted families.

3. Performance Goals and Performance Monitoring

3.1 Background/Findings Related To Performance Goals and Performance Monitoring

The Division of Public Assistance (DPA) has developed and utilizes performance measures to assess the state's welfare reform progress, and this use of an ongoing system of performance measures as a management tool puts Alaska ahead of many other states. DPA also collects and analyzes additional caseload data. However, to mirror TANF's legislative expectations, additional performance measures need to be added. In addition, we suggest that performance measures should be turned into performance expectations, with performance standards established for DPA and contractor staff.

Although the PRWORA legislation doesn't list performance goals per se, they can be readily ascertained through program requirements, penalties that can be assessed, and bonus opportunities. Clearly participation in work activities is a TANF goal, since minimum participation requirements are provided and states that do not meet the requirements are financially penalized. Two separate factors can be used to conclude that caseload reduction is also an important goal. First, work participation rate requirements are reduced by a state's caseload reduction percentage, making it easier for states with larger reductions to meet work participation requirements. In addition, the 60-month TANF time limit for cash benefits confirms that states are supposed to assist recipients to exit cash assistance.

The TANF bonus categories can also be used to determine important goals. Bonuses are provided to the top performing states in job entry and job success, as well as to the states with the biggest improvements in these measures. Job entries can be claimed for adult recipients who enter employment for the first time in the performance year. Job success consists of two measures that are equally weighted in determining whether a state qualifies: job retention, for the first and second quarters following employment; and earning gains, also measured for the two quarters following employment. Additional bonus categories that have been announced for future years are: rates of family formation, enrollment in Medicaid and state Children's Health Insurance Programs, Food Stamp enrollment, and providing child care to working families.

Twenty eight states received a bonus in fiscal year 2000 based on their 1999 performance in one or more of the four current categories: job entry, job success, improvements in job entry, or improvements in job success. Alaska was not one of the states awarded a bonus in any of these categories, and Alaska's performance ranked in the middle third of states in each category.[1]

3.1.1 Current Performance Data Collected and Reported by DPA

The Division's Monthly Caseload and Benefit Summary Reports provide a wide range of statewide data, including:

- Monthly caseload comparisons with percentage changes since the implementation of welfare reform in April, 1997;
- Expenditure comparisons;
- Families served by child care and child care wait list;
- Initial application comparisons;
- All-family and two-parent family work participation rate;
- Months remaining on the TANF time limit for non-exempt families.

Performance measurement data compiled by DPA and published by region and offices within each region, include the following data reports:

- Average and Median Hourly Wage of Employed Temporary Assistance Adults;
- Families that Left Temporary Assistance with Income and Child Support;
- Temporary Assistance Families with Income and Child Support;
- Average and Median Months on AFDC and/or Temporary Assistance;
- Federal Work Participation Rates;

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[1] Table 1, *High Performance Bonus: FY2000 Awards by Category Amount*, 12/14/2000, http://www.acf.dhhs.gov/programs/opre/hpb/table 1.htm.

- Food Stamp Payment Accuracy Rates;
- Customer Service Survey - Benefit Timeliness (1999); and
- Percent of Temporary Assistance Clients Working >30 Hours Per Week.

3.1.2 Current Use of Data Reports

DPA administrators with whom we met in Juneau are very aware of Alaska's current performance in each area for which data is collected and compiled, and advise that they do use the data to identify problem areas.

The reports that DPA field managers reported they frequently used were monthly data providing:

- Overall Participation Rate by JAS Office;
- Two-Parent Participation Rate by JAS Office; and
- Adults with Earned Income.

However, based on the information provided to us, even though field managers are required to submit weekly reports, they are not required to address their performance specifically related to the data measured in these reports. The regional reports we were given discussed regional activities and issues, but these reports varied in content and did not appear to be designed to be responsive to any of the performance data cited above. Reports are organized into four to six sections, but none of the reports we reviewed for the week ending June 8 directly addressed performance goals. In addition, since data in the reports were not uniformly reported and information was not necessarily organized in similar format, they could not be meaningfully compiled to ascertain whether there were systemic successes or problems.

All interviewees reported that unsubsidized employment is a major ATAP priority and that the percentage of participants employed 30 hours or more per week is closely monitored. However, a Fairbanks Supervisor who did report using performance measures as a management tool, expressed concern because the two-parent participation rate in her section (a measure that includes employment), had declined ten percent from the prior to current month because so many cases were closed because of high wage employment. Although closure is a good outcome,

she noted that the office performance record doesn't look positive if they have too many closures because of the resulting decline in participation. While we understand that case closure due to employment is measured at the state level, it is not utilized to set performance expectations at the local level. It was suggested that a performance requirement for case closure be added to feature the trade-off between TANF recipient participation in work activities and exit from welfare because of work activity, and to emphasize that welfare exit due to work is a positive outcome.

3.1.3 What Performance Measures Should Be Included in DPA's Performance Measurement System?

What gets measured gets done. For this reason, the performance measures selected need to include all the important factors that signal success. In addition to participation and employment/job placement, which DPA already measures, we believe that Alaska should develop performance measurement reports for caseload reduction and job retention. If Alaska intends to compete for performance bonuses based on success in employment, it will also need to compile data that will enable it to determine wage increases.

In another section of this report, we advise that there is no systematic process required by DPA for the six months of post-temporary assistance case management. Case managers advise that they primarily provide services to their active caseload, and they only work with employed clients who contact them for assistance. Further, DPA advises that it does not have a good way to track job retention using existing automation programs, and job advancement is also not tracked. We believe that it is important to gain the ability to track these factors.

How Can Performance Measures Be Used to Improve Performance?

Developing additional factors to include in the performance measurement system is only the first step. For a performance measurement program to succeed in improving performance, staff and contractors must be assigned performance targets for each measure adopted, their performance must be monitored against these targets, and corrective action plans must be developed and implemented where minimum performance standards are not being met. DPA top administrators should work with regional staff to develop program enhancements, and should review corrective action plans to ensure that changes proposed

are likely to produce improvements. Furthermore, performance measurement must be a continuous effort, including review of performance, development and implementation of corrective actions, and evaluation of their effectiveness. Using a feedback model, DPA should be able to utilize current findings to ascertain what initiatives were successful and for what areas different strategies need to be developed.

In addition, both staff and contractors should be rewarded where their performance exceeds expectations. We discuss in another section the use of pay-for-performance arrangements to reward providers with whom DPA contracts. Although staff salaries cannot be strictly geared to performance standards, pay raises, bonuses, and non-monetary awards can be used to encourage high-level staff performance.

DPA is mindful of the need to create expectations for staff, but sees the difficulty of setting realistic performance standards, because each region in Alaska has such different demographic, geographic, cultural, and labor market issues; and region-to-region performance varies so much at the current time. One way to handle this is to establish initial improvement targets as a percentage from the current baseline performance.

3.2 Performance Goals and Monitoring Recommendation: DPA'S Performance Goals Should Be Expanded and Performance Requirements Should be Established for DPA Staff and Contractors

Clear outcome-based performance standards should be developed for both DPA and contractor staff. At a minimum, measures for job retention and caseload reduction should be added to the current job placement and participation rate measures, and performance targets should be established for each measure. A measure and target for job enhancement will also be needed to ensure that Alaska is a viable candidate for a job success performance bonus. To overcome initial objections about different regional environments, improvement targets should be established as a percentage from current baseline performance.

4. Case Management

4.1 Background/Findings Related to Case Management

It is important to invest in services for clients because self-sufficiency is such an important family goal and TANF time limits provide family heads with such a short period to achieve independence from cash benefits. To ensure that individuals are making good use of their 60 months of time limited eligibility for ATAP, Alaska aims to provide case management to assist every adult required to participate in work services. We found that most clients were being served by case managers and that case managers were working diligently to ensure that individuals received the services they needed to become self-sufficient. However, a number of problems with the way case management is organized and provided limits the ability of case management to be optimally and consistently effective. Below we identify issues we found with the current case management system. We then provide recommendations for improving the effectiveness of case management services.

4.1.1 Organization of Case Management Staff

The Division of Public Assistance does not appear to have a consistent model for providing case management services. Some case managers are generic, providing both case management and eligibility functions (the integrated case management model), while other staff members serve as specialist case managers. Some case managers are DPA staff, while others are contracted staff. In some offices, there is a mix, with both generic case management/eligibility and specialist case management staff, and both DPA and contracted case managers.

Some offices have developed a well-functioning division of labor with good communication between the exclusively eligibility staff and various case managers. For example, in Ketchikan, eligibility workers and case managers are teamed together. Both staff and the local manager believe this allows for building closer working relationships, better communication, and a common service philosophy within the team. It also appears to create a mutual sense of accountability toward the team's caseload. In other offices, the way in which cases are assigned to case managers and subsequent communication between case managers and eligibility workers is inconsistent. For example, in the Gambell office in Anchorage, eligibility workers and case managers are not teamed, meaning an eligibility worker works with numerous case managers, and

vice versa. From our interviews, there did not appear to be a consistent procedure for determining how cases were assigned to case management and to whom. This could be particularly problematic given the large number of contractor organizations providing case management. Interviewees also reported that there is no consistent system for communication between the various workers. Each individual case manager apparently determines how and when to communicate with the eligibility worker, as well as "appropriate" services to be provided to the client. Where assignment and communication is inconsistent, philosophies between the various workers with regard to such things as appropriate referral to activities, job readiness, and criteria for disqualifications appear to vary greatly.

Where case management and eligibility functions are separated and there is not close communication, joint decisions can become problematic. For example, some case managers requested that they be able to implement sanctions, because imposition of a penalty immediately associates the penalty closely with the non-compliance, and sanctions were not always implemented timely by eligibility workers.

4.1.2 Case Management Training

Although the administrators, managers and line case managers with whom we spoke were very positive about the case management training they received, only one week of training is provided. As noted elsewhere, standard assessment and other case management instruments are not prescribed, so that even though all case managers receive the same training, there is no assurance that all case managers will apply the same importance to various client strengths and barriers, or that they will deal comparably with the same situation presented by similar individuals.

For example, we were told by case managers in Anchorage that penalties for non-compliance are applied differently by different workers and that, in particular, whether or not to grant "good cause" is a gray area. Several case managers advised that more training in this area and others, such as cross-cultural differences and how to better utilize supportive services, would be useful. Completion of FSSPs and making proper entries in the JOBS Automated System (JAS) system were other areas in which additional training was provided by local staff. In the absence of additional formal training for all case managers, it is up to individual managers and team leaders to provide these services. While

we were impressed with the diligence with which interviewees pursued these tasks, it is also true that leaving so many basic training tasks to team leaders and/or managers will mean much less uniformity in the level of additional training provided and in the actual handling of similar case management tasks.

4.1.3 Developing Standard Case Management Tools and Forms

Although we recognize that case management services must be specific to the individual client, we believe that the basic tools used by case managers should be uniform, so that the decisions made by all case managers utilize at least the same minimum information about each individual's situation. Currently, ATAP does not utilize a statewide assessment form nor is there an assessment checklist to ensure that this basic information is available. In the absence of statewide forms some individual offices have developed forms and procedures for their own use. However, there is no systematic way to ensure that all offices have access to these locally-developed forms and processes, that the forms and process used by an office are adequate, or that all offices have developed needed forms and processes. The same issues exist regarding local PC-based notices that individual offices have developed to handle what they believe are gaps in the automated notice system (e.g. post-employment notice; scheduled appointment letter to follow up on a FSSP; home visit appointment letter).

In another section of this report we discuss DPA's plans to ensure that extensions are granted to those families reaching the 60-month time limit who need more time to become self-sufficient.

Case managers will be at the forefront of this process and it will be very important that case files contain the information needed to support extension decisions and to indicate what additional services are needed to assist the family to become self-supporting.

DPA management advised us that they are in the process of developing more standard case management forms and processes and we support these actions.

4.1.4 Developing Services and Processes to Insure that Individuals Retain Jobs and Enhance their Ability to Secure Better Jobs

Our experience indicates that post-employment case management is critical for success. Studies indicate that case management involvement is particularly valuable in the first weeks after an individual begins employment, and is learning to adjust to child care, transportation, and other issues. In addition, case management at this time can assist in resolving potential employer-employee conflicts. Because issues continue to arise that might result in job loss, many states require contacts with both the client and the employer to be made for at least six months. Some employment programs (e.g. Welfare-to-Work) require continuing contacts for at least six months. DPA advises that it does not have a way to track job retention using existing automation programs, and that data on recidivism is also not collected. Although we are unable to establish the degree to which job retention problems exist, data from other states confirm that job retention is a significant issue.

In addition, an important tenet of the "work first" philosophy–that any first job is a good start on the road to self-sufficiency–presupposes that an initial job may not always be the perfect job, but it will almost always lead to a better job. To ensure career development, post-employment services should also assist individuals to obtain better jobs, including helping them gain the necessary skills to improve their chances of job enhancement.

Although Alaska continues case management services for six months after employment, there is no systematic contact process required. Workers report that they are primarily engaged in providing services to their currently active caseload and will only work with employed individuals who contact them for assistance. To rectify this deficiency, DPA intends to use a call center modeled after the successful Washington state model, whereby individuals are randomly called to see if additional assistance is needed. Although we certainly support the addition of a call center, we believe that Alaska must also have a systematic approach to stay connected with all working clients and former clients, for at least three months after jobs begin. If possible, data should also be collected, at least on a sample basis, to ascertain whether job retention and job advancement goals are being met.

4.1.5 Turn-Over and Other Issues Contribute to Case Manager Shortages

Several interviewees indicated that there were problems maintaining a sufficient number of case managers to serve all ATAP clients adequately. For example, Juneau staff indicated that some clients were on a waiting list for case management because there were not enough case managers to serve all individuals. Long-distance case management is provided by Fairbanks in the Delta Junction and will be provided to Barrow, because of the inability to obtain a contractor in Barrow. Case management (under contract to the Department of Labor and Workforce Development) is only provided to Nome and four other villages; in the other Nome area villages. DPA eligibility staff assists clients to develop FSSPs and does only limited monitoring. This may account for the fact that the participation rate for Nome DOL is 27.1% while it is only 6.5% in the remaining Nome area. We understand that DPA has plans underway to provide case management services to all the villages.

4.2 Case Management Recommendation: Develop a Statewide, Consistent Case Management Model That Maximizes the Ability of Staff to Meet Performance Expectations

Our recommendations for improving case management follow from the above sections. First, both the integrated case management model, which uses a single worker to provide both case management and eligibility services, and the use of separate workers for each function, can achieve good results if roles and performance expectations are clear. Where separate workers are used, an approach such as work teams, which promote communication and contribute to providing a consistent message, is essential. Where the models are mixed in the same office and both DPA and contractor staff are used, it is essential that procedural requirements be clear and enforced so that comprehensive case management services are provided no matter which case manager is assigned.

Second, to assure that case managers are doing the best job possible to assist recipients achieve self-sufficiency, DPA should: (1) develop standard assessment and other case management instruments; and (2) require their use.

Third, case managers should be provided with additional formal training, including training on using the standard assessment and other case management instruments identified in the findings above.

Fourth, DPA should develop a systematic contact process for at least the first three of the six months of post-employment case management. In addition, data should be collected to determine whether job retention and job advancement goals are being met. Finally, if DPA management believes that case management promotes self-sufficiency (and we believe it does), the Division must provide regular case management to all recipients.

5. Contractor Performance

5.1 Background/Findings Related to Contactor Performance

Many states including Alaska contract out for the provision of some TANF services. Privatization of government functions makes good sense where contractors are able to provide services more efficiently and effectively than in-house workers. Using such criteria, usually contractors are used for functions for which in-house workers have no particular expertise, such as the provision of job search workshops and other employment activities.

The most successful contracts are outcome based, with contractors required to provide a continuum of services if necessary to produce the required outcome. For example, in the state of Delaware, Job Connection contractors are required to place referred clients into unsubsidized work within 30 days. If the client is unable to find an unsubsidized job, Job Connection places them in work experience until a job becomes available. Contracts are "pay for performance" and payment is strictly based on employment outcomes, with contractors receiving 20% of their payment for initial enrollment (they are not paid this fee until a referred client is actually brought in for services), 40% for job placement for at least 30 days, and another 40% upon job retention for 90 days. No payment is made unless the appropriate payment milestone is achieved.

5.1.1 Current DPA Contracting Practices

Although DPA contracts contain performance expectations, payment is provided whether or not outcomes are achieved. Contracts are awarded for a particular service, such as case management or work-search rather than a continuum of services, so that it is difficult to hold the contractor responsible for meeting client outcomes. We were informed that the performance expectations in case management contracts include the size of the caseload and expected participation rates, while work search contracts have an employment placement goal.

Based on provider proposals we reviewed, performance goals tend to be somewhat general: for example a provider proposal for comprehensive case management for rural southeast Alaska ensures that "at least 60% of all families and 85% of the two-parent families [will] participate in the defined work activities with a primary goal of unsubsidized employment."

Another proposal, to provide post-employment case management services to 257 families, 232 of which still receive ATAP benefits, advises that "the success of the Project will be evaluated based on 70% of the individuals who receive post employment case management services maintaining and/or obtaining unsubsidized employment. Additionally, at least 80% of the families receiving ATAP and 85% of the two parent families will be participating in countable work activities. Post employment case management services are to be provided at a minimum of six weeks to a maximum of six months dependent on the needs of the individual clients." Missing from the proposal is an expectation of the length of time that work retention is expected.

Furthermore, contractors in many areas are not able to provide the expert services that they contract to provide. Several DPA regional directors advised that DPA has had to train contractor case management staff on basic case management functions, developing sufficiently detailed Family Self Sufficiency Plans, and on proper case file documentation. This lack of contractor expertise was echoed by supervisory and line staff.

In Alaska, multiple contracts are deliberately awarded for the same function in many areas. According to interviewees this is done so that there will be some continuity when not all contractors receive renewals during the annual renewal cycle. For example, in the Central Region, there are four case management contractors and three contractors providing work search, and there are also contractors providing specific work services, such as community work experience. This means that DPA staff in each office must work with several contractors for each discrete function, with each having different strengths and weaknesses; and that the contractors are constantly changing. Regional directors advised that the huge number of contractors makes coordination complex. For example it is difficult to assure that a case manager is assigned within ten days. The DPA administrator indicates that involving a large number of community organizations was done consciously to leverage additional resources as well as raise the level of community commitment to serve DPA's clientele. This is a worthy goal, but it needs to be balanced with sound performance.

The achievements of contracted services appear to reflect the lack of specificity in performance requirements. Although administrators advise that whether case management is performed better internally or by

contractors depends on the area, they also advise that performance (measured by work participation rates) for contractors and DPA case managers are comparable, even though DPA staff are generally given the more challenging cases.

DPA administrators indicate that about 40% of case management is provided by DPA staff, most of this in offices with significant caseloads such as Anchorage, Fairbanks, Ketchikan, and Juneau. Contracts for case management exist with community agencies, DOL, and Alaska Native organizations.

5.1.2 Contractor Services to the Villages

In regards to services to the villages, DPA staff questioned the achievements of contractors and admitted that, although contracts/grants exist, DPA lacks the assurance that every client in these areas is currently being served by a case manager. We can verify that clients in the Kotzebue Regional Center and its villages have not been receiving ongoing case management services through the contract with Maniilaq Manpower.

The recently hired case manager working for the contractor advises that she receives no support from Maniilaq and indeed that they try to block proposed case management activities. She has not visited the 14 villages, and advised that, because of high turnover, no one has been in regular contact with clients, and that no case files exist documenting prior case management services for recipients. Because she is not co-located with eligibility staff and does not have access to EIS or JAS (although case managers are supposed to have read-only access), she depends on contacts with eligibility staff to learn about changes in the status of cases. Further, she suggested that the villages don't want to deal with the regional Maniilaq organization (although evidently they also do not want to deal with state staff). Although a plan exists to hire part-time case managers in the villages to supplement the services of the Kotzebue case manager, no steps had been taken to effectuate this plan as of the time of this program review.

Partly because of the lack of case management, we were told that compliance with work participation requirements in the village of Selwick, within the Kotzebue area, was only 10%; no participation rate data are shown for Kotzebue itself on the May 2001 report while the participation rate for Maniilaq Manpower is shown as 27.9%. According

to DPA, Maniilaq Manpower is an unusually low performer, and one of the reasons they sent us out to this area was to show us the particular challenges facing remote rural Alaska. DPA further pointed out that many of the Native Organizations provide exemplary services whether in cities or villages.

5.1.3 Contract Monitoring

Contract monitoring appears to be administered at the regional level. Local DPA managers do not play a formal role in holding contractors accountable and some local DPA managers with whom we met do not even know what are the contract requirements for the contracts serving their offices. For example, we found this to be true in Kenai. In addition, because of regional assignment, the local DPA managers interviewed felt that addressing contractor performance was not part of their role. Furthermore, contractor performance deficiencies where found are not used as a rating factor in deciding whether to award a subsequent contract to the same provider organization.

Contractors are co-located with DPA in many areas, but even where they are co-located, they cannot directly access all necessary information from DPA's automated systems. Without access, communication is more cumbersome and providing case file information to contractors creates an additional work burden for DPA staff.

5.2 Contractor Performance Recommendation: DPA Should Ensure That Case Management and Work Search Contractors Are Accountable for Performance

We agree that services that are not within the normal functions of a TANF agency should be contracted out by DPA, particularly where value-added contractors can be found. Although some state TANF agencies contract out case management, at least as many states perform this function in house; either using generic eligibility technician/case management staff or with the case management functions provided by separate staff. Thus, case management can be considered a legitimate TANF agency function, and if DPA finds that in-house staff achieve higher performance levels, the Division should be able to transfer more case management duties to DPA staff. If DPA continues to contract out some case management services, we recommend that this function be bundled with the additional contracted services, as described below.

In many states, actual work services, such as life skills, work search training, job development, job search, and management of work experience and community service programs, are seen as a less integral part of the TANF agency function and are contracted out. We fully support DPA's decision to contract out these services. However, we believe that four fundamental changes should be considered to ensure that contracts that are awarded for these services (as well as for case management if Alaska decides to continue to contract out case management) are value added.

First, to the extent possible, contracts for work services should be multi-functional. A prime contractor (who can have sub-contractors performing some of the needed services), should bid to provide services that will result in unsubsidized employment for the clients referred to the contractor. The contractor would be responsible to provide case management, if contracted out; work search; remedial basic training like life skills where needed; job search; job development; work experience where needed; and community service functions. It would be up to the contractor to provide all the services needed so that the end product would be an employed individual who was able to retain her/his job. Alaska could satisfy its desire for multiple contractors by awarding these multiple service contracts to several providers.

Second, true performance based contracting should be initiated, with contractors paid for their staged achievements, as is done with the Delaware contracts described above. Payment points could be for achievements such as the initial enrollment, completion of work search, placement in an unsubsidized job, and retention for 30, 90, and 120 days. Since the work participation rate is an important DPA performance goal, work participation achievements could also be rewarded. Contractors could be required to successfully serve a minimum percentage of the clients referred, or, instead, bonuses could be provided to contractors who were successful with a higher percentage of referrals, to prevent "creaming" (where services are only provided to those needing little assistance).

Third, although we agree that DPA should award multi-year contracts, only the first year should be guaranteed. The contracts should provide DPA with the authority to renew the contracts each year, so that high-performing contractors are rewarded and needed continuity would be achieved, while contractors who fail to meet basic performance goals

could be discontinued. Obviously, this means that contractor performance in one year would be used to determine whether to renew the contract for the succeeding year. In other states this has produced competition among the selected providers at the same time as it has caused contractors to reach out to other agencies in the community, to secure needed supplementary services and work experience and community service slots.

Fourth, the local DPA manager should have much greater involvement in overseeing performance. While the more formal monitoring and corrective action processes can be handled effectively at a regional level, day-to-day problem solving would be more effectively handled at the local level. This is particularly critical to creating the interdependency necessary for the recommended performance-based system.

We believe that such a system would, where the service area has a large enough population to capture the interest of provider organizations, achieve a number of Alaska goals. Entered employments would increase, participation rates would at least be comparable, and caseloads would continue to decline. DPA could provide work to as many community organizations as they do currently, but the community agencies would have to coordinate services to provide the multiple functions required.

6. Child Care Services

6.1 Background/Findings Related to the Delivery of Child Care Services

Although Alaska has funded child care generously, to assist low-income workers to obtain and retain employment, the system for providing child care creates delays and funding gaps, and forces individuals to make extraordinary efforts to access child care assistance. In addition, the reimbursement schedule for non-ATAP child care is poorly designed, creating disincentives for individuals to achieve workplace promotions. Our specific findings are contained in the following sub-sections.

6.1.1 Child Care System in Alaska

Three child care programs exist in Alaska. PASS I provides child care without a co-payment requirement to families receiving ATAP who are participating in employment and training services and/or in subsidized or unsubsidized employment. Upon termination from ATAP, families needing child care so they can work become eligible for transitional child care, called PASS II. In addition, low-income working families can access assistance with child care through the PASS III child care program. PASS II and PASS III child care are provided on a co-pay basis, using a schedule that increases the level of co-pay as income increases. TANF funds are utilized to provide PASS I child care, while funds transferred from TANF to the Child Care Development Fund (CCDF) are utilized to provide PASS II and PASS III child care.

Because of difficulties transitioning from PASS I to PASS II child care, TANF funds are also used to pay the first month of PASS II child care, so that working individuals transitioning off ATAP are able to have continuous child care. DPA's JOBS Automated System (JAS) is used to authorize and pay child care providers for PASS I child care, while information about the Department of Education and Early Development (EED)-provided PASS II and PASS III child care, paid to the client, is entered on separate PC-based systems.

DPA authorizes PASS I child care, while EED, through local contractors (known as local administrators), authorizes PASS II and III child care. The local administrators operating PASS II and PASS III child care are not co-located with DPA in regional and local offices.

Workers report that individuals face considerable barriers obtaining child care, using this multi-tier system. First, individuals receiving ATAP must obtain information from the local administrator, which requires making an appointment and traveling to a different location. There is often a wait to obtain a list of child care providers, and the individual's receipt of self-sufficiency services are delayed while they are awaiting the information. For example, we were told that it takes about a week to obtain this information in Anchorage. DPA officials indicate this has been resolved through an internet application.

Workers transitioning from ATAP to self-sufficiency must take time off from their new jobs to arrange to continue receiving child care because they must move from PASS I to PASS II child care. Working individuals using PASS II or III child care must also take time off from work to meet with separate local administrators. Because local providers require frequent renewal of authorizations and renewal authorizations be done in person, workers must frequently miss work to continue receiving assistance with child care.

In addition, appointments with local administrators are not immediately available. Workers report that it can take a month to obtain an appointment with the local provider and two months before child care is authorized. We have been told that these delays cause "entry effects", in that ATAP-eligible individuals who do not want welfare but just assistance with child care must, nevertheless, apply for ATAP so they can obtain immediate assistance with their child care expenses.

Another problem has been the delay caused by processing backlogs. Although the waiting list for PASS III child care has been eliminated by DPA's transfer of additional TANF dollars to EED, the field reports that child care waiting lists have not yet been completely worked. In Anchorage, for example, the waiting list of 600 families was still being cleared at the time we interviewed staff.

6.2 Child Care System Recommendations: Improve the Delivery of Child Care

We recommend that child care be provided through a more user-friendly child care structure that eliminates delays and gaps; that child care assistance be "seamless", so that an individual moves automatically

between child care levels; and that the child care co-pay schedule be revised to eliminate payment cliffs. To accomplish this we recommend the following program changes:

6.2.1 Client-Friendly Child Care

To create a seamless child care system that promotes employment and discourages needless welfare usage, the child care authorization existing as of the termination of ATAP should be used to continue child care funding, so that the movement between PASS I and PASS II does not require an individual to make additional appointments or complete additional forms. In addition, in-person appointments should not be required to continue authorized child care assistance; telephone contacts should be used except in extraordinary circumstances.

We also recommend that local administrator contracts should require that all child care services be provided in DPA one-stops. And finally, these child care contracts should require that applications for child care are taken and processed quickly, so that individuals are provided needed assistance without delays. Based on their success in providing timely PASS I child care, we believe that seamless child care that is immediately available can be most easily accomplished if authorization of PASS II and PASS III child care is also shifted to DPA. If administration of CCDF funds remains with EED, DPA should become the PASS II/PASS III child care provider under contract to EED.

6.2.2 Enhance Recruitment of Infant and Extended Hours Child Care Providers

Workers report that infant and extended hours (evening/weekend) child care is in short supply or unavailable, particularly in rural areas. Fairbanks is attempting to reduce this problem: they have a new Resource and Referral (R&R) grant to recruit providers and to provide incentives for current providers to expand to these special categories. The need for more infant care slots will become even more apparent if Alaska reduces the period of exemption from work participation from 12 months after birth to 16 weeks as is recommended.

The Department of Education and Early Development should step up contractor efforts to recruit, train, and license child care providers who are willing to provide infant and/or extended hour child care. As a condition of their contracts, contractors must recruit and register new

child care providers. Although the provider in Nome now understands its obligations in this area, we were told that it took a concerted effort by DPA workers before the contractor agreed to register new child care providers.

6.2.3 Change the Child Care Co-pay Schedule to Eliminate Perverse Incentives that Result in Clients Forgoing Pay Raises/Employment Promotions

The child care co-pay levels create funding "cliffs". For example, in Anchorage a three-person family with monthly income up to $1,423 would be required to pay only 3% of child care costs. Were the same family to have only one dollar more of income, their co-pay obligations would rise to 15%. Income between $1,779 and $2,134 obligates them to provide 25% of the cost, and income of $2,135 and $2,489 requires a 50% co-pay. Only 25% is reimbursed if earnings are $2,490 to $3,694, and no co-pay is available if income exceeds $3,694. Because of these funding cliffs, individuals with small increases in income face huge increases in child care costs, and the increases are especially steep if there is more than one child needing care. Clearly these cliffs create incentives to forgo pay raises and employment promotions.

There is also a problem in that the daily reimbursement rates in the rate schedule now being implemented provides a much higher reimbursement (an example was provided where the daily rates would yield $223 more for the month), for a whole month than the monthly rate, creating an incentive for individuals to create irregular work schedules so that they are paid based on a daily (attendance) rather than a monthly (enrollment) authorization. DPA is currently working with EED to modify the schedules.

We recommend that child care funding schedules be redesigned to create narrow changes in payment obligations that match narrow changes in income. If percentage changes are used to determine co-pay amounts, many more percentage levels should be used. We recognize that this will be a delicate operation, since the schedules must ensure that payments provided do not exceed available funding for child care. In designing its new schedule, Alaska may want to obtain payment schedules used by other states.

7. TANF Time Limits

7.1 Background/Findings Related to TANF Statutory Time Limits and Alaska's ATAP Program

Although TANF is a block grant, there are several specific statutory prohibitions that restrict state flexibility. A major restriction is the provision that a state can not use any part of its federal TANF grant to provide assistance to a family that includes an adult who has received assistance under any state program using federal TANF dollars for 60 months (Section 408(a)(7)). States are permitted to exempt families from the 60-month limit for hardship or because of domestic violence, but no more than 20% of the average monthly number of families provided benefits using federal TANF funds can be families headed by an adult who has received benefits more than 60 months. States violating this restriction are subject to a substantial penalty, a reduction of five percent of their TANF grant for the succeeding year (Section 409(a)(9)). Any month of assistance received while an adult was living in certain Alaskan Native villages with at least 50% of adults not employed are excluded in determining whether an individual has received assistance for 60 months.

Section 47.27.015(a)(1) of Alaska statutes repeats this federal requirement by providing that a family is not eligible for ATAP if the family includes an adult who has received benefits under ATAP or an applicable program of another state for 60 months, unless the adult has been a victim of domestic violence, is physically or mentally unable to perform gainful activity, is a parent providing care for a disabled child, or the family is determined to be exempt by reason of hardship. Alaska's statute further limits the number of long-term recipient families by providing that the number exempted "may not exceed 10 percent or the maximum percentage of families allowed an exemption under federal law, whichever is greater."

7.1.1 DPA's Proposed Sixty-Month Policy

Long-term TANF recipients in some states are already beginning to reach their 60-month time limit. In Alaska a number of families currently receiving ATAP will hit the time limit in July 2002, five years after the effective date of TANF in Alaska. DPA has developed draft criteria to use to qualify clients for extensions beyond 60 months. The criteria provide for extensions for certain situations of domestic violence, incapacity of

the adult, caring for a disabled relative, and hardship. To receive a hardship extension, the caretaker must be complying with their FSSP and participating in work activities, but cannot earn enough to leave ATAP because of medical, mental health or functional limitations; or the family is impacted by a catastrophe; or the children are at risk of placement outside the home if assistance is ended. The draft procedures establish a process whereby there is screening and assessment of long-term recipients, collaboration with other agencies involved with the family, a Local Office Review Committee making extension decisions, development and monitoring of plans during the extension period, and periodic review of extensions.

7.1.2 Issues Based on Current Alaska Statute

In our interviews, DPA staff voiced concern that, despite limited extension criteria, there may be a month when some families meeting the extension criteria cannot be paid without violating Alaska's statutory limit that not more than 20% of Alaska families subject to the time limit have received 60 months of benefits. DPA officials also point out that Alaska's statute is more limiting than the federal statute requires. PRWORA merely forbids states from using federal TANF funds to provide benefits for more than 60 months; Section 408(a)(7)(F) specifically permits states to expend state funds (e.g. TANF maintenance of effort (MOE) dollars) to provide benefits to families headed by an adult who has received federally-supported benefits for 60 months.

We concur with DPA's assessment that, if Alaska uses only state MOE dollars to provide benefits to such families, families with over 60 months of receipt will not be counted in determining for federal purposes whether Alaska has exceeded the 20% limitation. In fact, several Administration for Children and Families (ACF) issuances specifically advise states how to use their MOE to create "segregated" or "separate" state programs, to provide benefits to classes of individuals who are prohibited from receiving benefits using federal TANF funds. For example, Temporary Assistance for Needy Families Policy Announcement, TANF-ACF-PA-97-1, January 31, 1997 specifically advises that "[s]tates may expend their MOE funds on a broad range of activities without necessarily triggering Federal TANF requirements (such as time limits)." An ACF chart attached to the Policy Announcement shows that application of the time limit on assistance provision is avoided by creating a segregated or separate state program. TANF-ACR-PA-97-1 may be accessed online at http://www.acf.dhhs.gov/programs/ofa/pa97-1.htm.

7.2 TANF Time Limit Recommendations: Alaska Needs to Ensure That Long-Term ATAP Recipients Do Not Trigger Federal Penalties

We believe that states should be making every effort to move ATAP families as quickly as possible off welfare. However, for a number of reasons we support DPA's view that Alaska's more restrictive state time limit requirement should be eliminated. First, the federal requirement that not more than 20% of current recipient families can be headed by an individual who has received assistance for 60 months, is a "Catch 22" in that the more successful Alaska is in reducing it's caseload by finding work for employable beneficiaries, the more likely that the families remaining on assistance will be hard-to-serve. Particularly if the application rate for families who have never been on assistance remained low, a state with a hefty caseload reduction might reach the point where more than 20% of its remaining cases needed more than 60 months to achieve full self-sufficiency. Although we do not believe that Alaska has reached this point yet, it is important to make the change so it can be implemented when and if the need arises, to prevent being forced to deny benefits to vulnerable Alaska families who meet statutory criteria for extension.

Second, it makes no sense for Alaska to jeopardize its federal TANF funding, and the Alaska provision could result in the state losing a full five percent of its federal TANF grant because of a miscalculation that paid benefits to a few more long-term recipients than the 20% permitted.

Although we recommend that the Alaska statute be amended to permit DPA to use narrow criteria to extend benefits to some long-term recipients, we believe that, at the same time, DPA needs to make extraordinary efforts to insure that as few families as possible reach the 60-month limit.

More in-depth and intensive services are needed for families in danger of reaching the time limits because of multiple barriers. Although DPA is starting to identify individuals who may need more counseling or referrals because they are approaching the 60-month time limit, there does not appear to be any formal process in place yet to provide such additional assistance. We believe that a process that begins with "staffings" using case managers, supervisors, employment providers, and specialists in such areas as mental health, remedial education, and substance abuse treatment should be initiated for all clients who are within 18 months of reaching their time limits. These specialists would

work with the family to design a plan to move the adult(s) as quickly as possible to an unsubsidized job, and to solve family issues that may have prevented sustained employment in the past. The family should be followed regularly to ensure that the plan is being implemented.

Alaska may also want to consider creating a segregated or separate state program for families where the adult is working full-time but earnings are not high enough to eliminate eligibility for residual ATAP payments. Currently, these families are either refusing the small dollar benefit remaining, in order to protect their lifetime eligibility period, or they are in danger of reaching their 60-month limit. This would also require a state law change.

8. Alaska's Sanction Policy

8.1 Alaska's Sanction Rules and Procedures

TANF receipt for Alaska's TANF beneficiaries is limited to 60 months in their lifetime. Many workers advised that the current sanction policy hinders them from assisting beneficiaries to become self-sufficient within this 60-month time frame.

Current sanction policy removes the benefits of the adult from the assistance unit. This results in a benefit reduction of 40% for average sized families, while larger families lose a smaller percentage of their benefits. A beneficiary can "cure" the first sanction without penalty, but a second sanction lasts for six months even if the individual cures prior to the end of the period, and the minimum period assessed for a third sanction is 12 months. The sanction amount does not increase over time; thus the same reduction is imposed whether a fist, second or third sanction is imposed. The family's 60-month time clock continues to tick while a sanction is imposed. Thus, no services will be received before the clock expires for those individuals who suffer a first sanction and never cure. Workers report that there are a significant number of sanctioned clients who choose this option. In addition, they advise that individuals who do cure the first sanction but have a second sanction imposed are reluctant to begin work participation before the six months have run, since their participation will not restore the benefit loss.

Not only does the current sanction policy reduce the services that an individual will receive during the 60 months, but it also lowers Alaska's participation rate. This is because non-complying cases must be included in the denominator for calculating participation, except for the first three months of a sanction. While it was reported that there is a state Attorney General opinion that permits DPA to continue benefits beyond 24 months to non-complying individuals, the continuation of benefits to non-complying families may violate the intention of Section 47.27.030(b) of statute, which provides that: "Unless the members of the family who are not dependent children are all exempt..., the time period for receiving assistance may not exceed a cumulative total of 24 months unless each nonexempt person is in compliance with the work activity assignment made under AS 47.27.035."

Alaska's DPA workers are using a number of strategies to bring non-complying individuals in for work services. Notices are sent, the

clients are telephoned, and, in Anchorage and Fairbanks, workers make home visits. In some cases these efforts are successful. For example, a home visit may identify a barrier to participation that can quickly be overcome, or the individual may better understand the requirements and time limits and begin to participate. Anchorage advises that they have assigned a worker who, through repeated home visits to sanctioned clients, has brought 60% into compliance. However, workers also indicated a reluctance to impose sanctions because they believe that the current system uses up months while not creating sufficient incentives to participate. That at least some workers do not impose sanctions is supported by the data: only a small percentage of cases (four percent according to performance data) are in sanction status, but a much larger percentage of clients fail to participate the number of hours required. For example, in one office only 156 of 223 individuals who were assigned countable activities met the hours of participation requirement in the most recent month for which we were provided data.

8.2 Sanction Policy Recommendation: Make Alaska's Sanction Policy More Family Friendly

We recommend that Alaska develop a progressive sanction system, resulting in an eventual full-family sanction, but that the sanction policy be designed and implemented to protect vulnerable children.

Division of Public Assistance staff suggested and we support a more family-friendly sanction policy where sanctions are progressive as to amount but the individual can cure immediately upon performance. For example, the first sanction would reduce the benefit one-third, the second would cause a two-thirds reduction, and the full benefit would be lost if a third sanction had to be imposed. A minimum period of time, such as a week of actual performance would be required to reinstate the full benefit, to prevent "churning"—where a benefit is restored based on a promise to participate, but the individual does not keep their promise. Sanctions would proceed automatically to the next level after a certain period where the individual had not cured.

We agree with staff that such a policy would be more effective in motivating individuals to participate; it is less likely that an individual can afford to ignore a loss of two-thirds of the benefit than to ignore the current adult portion loss. Families subject to a full family sanction

would be effectively terminated; thus, their family's clock would cease to run and Alaska could remove them from the denominator for calculating the participation rate.

Many states have adopted similar policies. According to a recent report by the U.S. General Accounting Office (GAO/HEHS-00-44, Welfare Reform: State Sanction Policies and Number of Families Affected, March 2000), 37 out of 50 states terminate the family's entire cash benefit if a family member who is required to participate fails repeatedly to comply with work requirements, but the full family sanction is applied the first time that a family does not comply in only 15 of these states. The majority of these states (22) use a progressive sanction sequence before they reach the full-family sanction level.

The GAO and other reports about state sanctions also recommend methods to ensure that sanctions are not taken inappropriately and that vulnerable families are protected. According to the GAO report: 16 states require supervisory or other review of caseworker's sanction decisions; 31 states require caseworkers to attempt to contact family members to try to resolve the non-compliance; and five states require caseworkers to visit the homes of TANF families to discuss how to resolve the noncompliance. Tennessee uses a customer Service Review process to protect families from incorrect case closings; Kentucky provides a special review and services to sanctioned families (Welfare Information Network Issue Notes, The Use of Sanctions Under TANF, April 1999); and Delaware uses performance-based contracts to provide incentives for employment contractors to make home visits to attempt to convince no-shows to accept their services, has a contractor review case closings, and has developed a program of services for families permanently barred from TANF because of repeated non-compliance. (Chassman Barnhart Consulting program review). Because some states that conducted studies of sanctions found that non-complying adults were more likely to be "hard-to-serve" (GAO), some special services are recommended. Although admittedly these actions are labor-intensive, only a few families reach this level of sanction in a progressive system.

9. Providing TANF Services to Native Alaskans

9.1 Native Alaska Family Assistance Programs

Congress gave Native Alaskans the opportunity to operate their own TANF programs. Alaska has gone much further than most other states in making it economically feasible for Native Alaskans to operate TANF programs by providing state matching funds to Tribes that elect to run their programs. Although PRWORA does not require states to provide any funds to supplement federal TANF dollars that are diverted to Native Alaska Family Assistance Programs, the lack of state funds would result in less money per individual served available to Tribal TANF programs than was available under the old AFDC program, and less money per individual than is available to Native Alaskans who are served by the state rather than a Tribal program.

By agreeing to provide an equivalent state match, Alaska is both encouraging capable Native Alaskan groups to operate their own programs and assisting their efforts to run successful programs. The grants also attempt to provide for more accountability on the part of the Native Alaskan Family Assistance Programs and, by providing for equivalent assistance time limits and work participation requirements, help to ensure that self-sufficiency is a major goal of Native Alaska Family Assistance Programs. In addition, the agreements signed between the Native Alaskan groups operating TANF programs and DPA require Native Alaskans who fall within the defined groups being served to seek service from the Native Alaskan program rather than the state's TANF program. This avoids a difficult problem in other states, whereby the Tribes accept TANF dollars to operate programs but Tribal members are permitted (and may be encouraged) to seek TANF from the state instead. Further, the DPA grants avoid the problem of auditing merged state and other funds, discussed below, by providing that the state supplied funds are used only for cash benefits and administrative costs.

During this brief review of Alaska's state TANF program, we did not have the opportunity to observe the operation of the TANF programs operated by Native Alaskans. However, we were impressed by the understanding of the issues evidenced by the program administrators with whom we met and with their commitment to DPA's program goals, such as self-sufficiency.

9.1.1 State Provided Services to Native Alaskans

Where TANF is directly operated by the Native Alaskan organizations, the onus of performance is somewhat shifted from the state to the Native group. For example, Tribal statistics do not have to be included in state statistics. We recognize that the results of failure will nevertheless plague the state down the road, if failure means that the families served remain dependent and economic development is slowed. Further, TANF is being reauthorized in fiscal year 2002, and Congress will utilize data from Tribal programs to determine whether to continue the program operations in its current form.

Failure to serve Native Alaskans adequately who depend on the state for self-sufficiency services may have more serious consequences. Not only will the progress of Tribal members lag because of failure to provide adequate services, but since the relative performance of these Tribal families is merged with performance for other Alaskan families, Alaska's state program will show lower achievements.

In addition, it is extremely difficult to audit funds provided to some Native Alaskan organizations because they are permitted to merge funds from different sources to meet family needs holistically.[2] For example, funds from several sources can be used to fund TANF case management services, without a rigorous accounting requirement for each funding source. Other non-profits receiving the same amount of funding from the same number of sources would ideally try to make the program delivery appear seamless to the recipient, but would be required to strictly separate funds for accounting purposes. Although the ability to combine funds more easily can assist Tribal program operators to achieve good results, this same ability means that a monitoring agency must concentrate more on outcomes and less on fiscal integrity and process steps in its review of the programs.

DPA administrators indicated that they believe TANF services should be provided by Native Alaskan organizations if at all possible. Thus, where a Native Alaskan group does not choose to operate a Native Alaska

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[2] P.L. 102-477, the Indian Employment, Training, and Related Services Demonstration Act of 1992, allows tribes to consolidate formula-funded employment, training, and supportive services into an integrated set of services. These "477 Programs" can be delivered through a single plan, budget, and reporting system.

Family Assistance Program, providing both TANF cash benefits and self-sufficiency services, DPA takes over the benefit part of the program but attempts to provide grants to the Native organization to provide the self-sufficiency services.

DPA admits that some of the Native Alaskan organizations with whom they contract have not furnished the services promised by the grant provisions to their populations. This problem appears to exist with Maniilaq Manpower, which currently holds the grant to provide case management services to the Kotzebue villages. As we documented above in Section 5, Native Alaskan clients who are supposed to be case managed by Maniilaq receive very few services. It was reported to us that Maniilaq is poorly managed, and because of its animosity to the state, is unwilling to commit resources to this grant. In addition, some of the villages served by Maniilaq (e.g. Selwick) are reported to be uncooperative; therefore, even if a competent grantee was on board, we were told that it would be difficult to achieve results in such villages.

An Alaska Regional official advised that if DPA didn't use Maniilaq the situation would be even worse because Native Alaskans will refuse services offered by non-Natives. However, the DPA Administrator does not concur. It does not appear that all other State Agencies have the same reluctance to provide services using non-Native non-local personnel. While in Kotzebue, we had the opportunity to talk with several non-local non-Native mental health workers who stated that believe that their services are accepted in the community.

However, where DPA uses a non-Native provider, DOL, in five Nome villages because no Native group agreed to accept the grant, the limited performance data we have (May, 2001 Overall Participation Rate by JAS Office) shows that DOL is only just about as successful as Maniilaq Manpower, with the overall participation rate for Nome DOL at 27.1% and for Maniilaq Manpower at 27.9% (however, the Maniilaq data does not appear to include the 16 mandatory Kotzebue families). Our limited time in these Coastal areas did not permit us to determine why DOL was unsuccessful.

In some Native Alaskan villages, there is not even an agreement to provide case management services. DOL only contracts for five of the15 villages in the Nome area. In the other villages state eligibility staff, without case management training or officially assigned duties in this specialty area, work with clients to develop Family Self Sufficiency Plans,

and then provide only limited monitoring of compliance. The Nome eligibility staff with whom we met indicated that they are not able to provide the services needed to assist these clients adequately.

9.2 Recommendations Related to TANF Services for Native Alaskans

It may be that Alaska is between the proverbial rock and hard place in regard to providing TANF services to Native Alaskans, but we believe that DPA needs to do more both to identify and evaluate the issues and to experiment with solutions. Although we cannot provide ideas for a sure-fire cure to the problems Alaska faces operating successful programs in Native Alaskan villages, we are making some recommendations that may move the state forward.

First, if DPA will continue to award grants for case management and other TANF services to Native Alaskan grantees, a substantial amount of technical assistance should be provided to the grantees. Federally approved Tribal TANF grantees have the opportunity to attend federal Administration for Children and Families (ACF)-sponsored Tribal TANF workshops, like the April 17, 2001 workshop on Substance Abuse, but funding is not provided in DPA case management and other service grants for attendance at federal technical assistance meetings, and we agree that paying for every village program to attend would be too costly. However, if DPA holds workshops for Native Alaskan grantees, they should feature successful practices from high performing Native Alaska grantees. In addition, DPA should ask ACF to participate in state-sponsored workshops and should work with ACF to secure technology transfer funding to invite representatives of successful Tribal programs in other states to present at Native Alaskan workshops.

Where it is determined that Native Alaskan providers are unable and/or unwilling to provide adequate services, DPA should attempt to secure the services of the best available other contractor or should attempt to provide these services using state workers. DPA should meet with other agencies (e.g. mental health) which have hired non-Native, non-local service providers and discuss what methods these providers have used to overcome cultural and other barriers to serving clients in Native Alaskan villages. To make it more feasible that non-Native contractors or state workers are able to succeed, we recommend that DPA ask its training staff to attempt to develop a training module on cultural diversity, that uses successful practices in other Alaskan programs and/or in other states. For example, although Oregon uses state TANF case managers to

work with Native American recipients, the state case managers are out-stationed on reservations and receive special training on developing case plans that take into account the particular needs and circumstances of their Native American clients (Welfare Information Network, Welfare Reform in Indian Country: Current Trends and Future Directions, June 2001).

10. Food Stamp Program

10.1 Background/Findings Related to the Food Stamp Program/TANF Program Coordination

A common complaint nationwide among public assistance administrators and analysts is the misalignment of many aspects of the Food Stamp Program to TANF. While the federal government has granted states a great deal of flexibility in designing their TANF programs, until recently very little flexibility has been granted with regard to the Food Stamp Program. This has resulted in conflicts in both eligibility standards and the underlying philosophies of the two programs.

While the primary focus of TANF is assisting people to become self-sufficient through employment, the Food Stamp Program does not view supporting employment as a primary role. Rather, its primary goal is to provide a nutritional safety net to those eligible. As a result the eligibility process in TANF has become much more streamlined and consistent with ways to motivate people to work. On the other hand, the Food Stamp Program has become increasingly complex to administer and often undermines the work goals of TANF.

For example, the Food Stamp Program reporting requirements actually increase for working clients versus non-working clients. This is because working clients must report even very small changes in income on a monthly basis. It is entirely possible that many working clients opt out of the Food Stamp Program because of the complexity of eligibility rules and/or interruption to their work schedule required in order to comply with mandated food stamp administrative office visits. Yet failure to access Food Stamps could put the stability of an entry-level employment situation at risk.

While encouraging employment is not the primary goal of Food Stamps, there is a relatively small Employment and Training (E&T) component in the program. However, the requirements and the activities are quite different from TANF. The experience derived in TANF with regard to work preparation and ways in which to motivate clients could be very advantageous to the populations served by the Food Stamp E&T component.

While we believe a major overhaul of the Food Stamp Program is in order at the federal level, there has been some positive movement in allowing more state flexibility. Our recommendations below are in line with those opportunities.

10.1.1 Alaska's Organizational Structure Is Not Optimal for Food Stamp/TANF Coordination

An additional issue in Alaska which further exacerbates the disconnect between TANF and Food Stamps is a structural one. Within DPA there is a policy unit that oversees all the DPA programs except Food Stamps. Food Stamps is housed in a separate unit under a different manager. Managers of both units reported that communication and coordination are often issues. Additionally, it appeared from our interviews that there are actual philosophical differences between the managers that accentuate the programmatic differences between the TANF and Food Stamp programs.

For example, the manager of the Food Stamp Program has chosen to de-emphasize the E&T component. In fact, field staff reported that it is virtually non-existent. The other policy manager believes work should be a much more central activity for this population. Furthermore, the Food Stamp manager has not pursued the options available to better align TANF and Food Stamps, while the other policy manager believes better alignment is critical. Many of the interviewees in the field offices expressed frustration with this philosophical disconnect between the two programs.

10.2 Food Stamp Program Recommendations: Take Steps to Align Food Stamp and TANF Policies

We recommend that DPA review what other states have done either through state plan amendments or waivers to better align the Food Stamp Program and TANF. For example, through a waiver, Oregon was able to create a more integrated and comprehensive Employment and Training program for both TANF and Food Stamp clients.

Another example worth pursuing is the use of the concept of categorical eligibility to align the eligibility rules for TANF and Food Stamps. For any population reached by a TANF funded service, the state is allowed to use less restrictive TANF eligibility rules in areas such as resources and vehicle exemptions. The state of Delaware has been particularly creative

and expansive in its use of categorical eligibility to eliminate Food Stamp resource requirements for all residents with incomes under 250% of the Federal Poverty Level. This permits residents (with incomes low enough to qualify) to receive Food Stamps even though they have resources such as automobiles needed for employment, that might otherwise make them ineligible.

A third example is the ability for states to provide a transitional Food Stamp benefit for clients moving from TANF to work. This greatly reduces the reporting requirements for the working client and ensures a stable benefit amount for a set period of time. It has the additional side benefit of potentially significantly reducing a state's quality control errors and thereby reducing the chances for a federal monetary penalty.

The final recommendation is to merge the Food Stamp Program into the policy unit at DPA. This will better ensure a common philosophical approach across all programs. Short of restructuring, we recommend that the Director and/or the Deputy Director play a much stronger role in ensuring appropriate communication and coordination is taking place and to resolve philosophical differences. We recommend that, in concert with the work-first approach of the TANF program, the E&T component of Food Stamps be emphasized and utilized.

AMERICAN INSTITUTE FOR FULL EMPLOYMENT
ASSESSMENT OF ALASKA'S WELFARE REFORM PROGRAM

SUMMARY OF RECOMMENDATIONS

Introduction

The American Institute for Full Employment (AIFE), is a non-profit research and education institute located in Klamath Falls, Oregon, whose mission is to promote full employment—universal access to jobs with career potential for all who can work—especially those who are receiving public assistance as a substitute for the opportunities and rewards of paid work. Over the summer, at the request of Senator Green and Representative Dyson, AIFE prepared an assessment of Alaska's Welfare Reform Program. Completed in September 2001, the assessment identified recommendations in each of ten specific program areas.

Below is a summary of recommendations in which the recommendations have been organized in priority order within 3 categories. The categories—Legislative Priorities, Policy Priorities, and Management Priorities—denote the type of recommendations and which entitities should be responsible for implementing them. Page references (in parenthesis) refer to the original report "Assessment of Alaska's Welfare Reform Program." The assessment includes more detailed explanation of each of the recommendations.

I. Legislative Priorities

Rec.#	*Page*	*Task*
7.2	(34)	Amend the state statute to allow Alaska to use full flexibility allowed under federal law to expend benefits to some long-term recipients.
8.2	(37)	Develop a progressive sanction system which results in full-family sanction.
7.2	(35)	Consider using state MOE funding to create a separate state program for full-time working clients who remain elegible for ATAP benefits.
2.2	(10)	Strengthen the diversion program.

1.2	(8)	Authorize a more complete wage subsidy program.

II. Policy Priorities (Does not require legislative action)

Rec.#	*Page*	*Task*
6.2.3	(31)	Change the child care co-pay schedule to eliminate "cliffs".
1.2	(8)	Revise policy and practies for treating individuals limited by incapacity from full participation in work activities and require mental health/substance abuse treatment when needed.
1.2	(8)	Require ATAP clients claiming a disability to file for federal disability benefits.
1.2	(8)	Reduce the 12-month exemption period for parents of infants to 16 weeks.

III. Management Priorities (Does not require legislative action)

Rec.#	*Page*	*Task*
7.2	(34)	Develop and implement in-depth and intensive services for families reaching the time limits.
3.2	(15)	Develop and implement clear outcome based performance standards for DPA staff and contractors.
5.2	(26)	Initiate true performance based contracting.
4.2	(20)	Strengthen the case management system.
5.2	(26)	Develop contracts that are multi-functional.
5.2	(26)	Award multi-year contracts with only the first year guaranteed.
5.2	(27)	Charge local DPA managers with greater responsibility for overseeing contract performance.

1.2	(7)	Strengthen the "up front" process by engaging clients in employment activities as close to the first day of contact as possible.
1.2	(7)	Develop a standardized strength based assessment approach.
1.2	(8)	Increase utilization of work site training, e.g. subsidized work and community service.
6.2.1	(30)	Streamline movement between PASS I, II and III child care.
6.2.2	(30)	Increase efforts by EED to expand availability of providers for infant and extended hour child care.
10.1.1	(45)	Merge the Food Stamp Program into DPA's Policy Unit.
9.2	(42)	Increase accountability of some Native Alaskan grantees.

Bioterrorism Preparedness & Response in Alaska

Prepared by the Alaska Division of Public Health
For Presentation November 8, 2001

The terrorist attacks of September 11 and subsequent bioterrorist attacks on the United States utilizing anthrax bacterium as the agent of destruction has called into the play the resources and capabilities of the Alaska Division of Public Health.

The Division recognizes and wishes to acknowledge the support of the Alaska legislature for improvements to our state's basic public health infrastructure in recent years. Support for building the new state-of-the-art Biosafety Level III laboratory in Anchorage has been vital to our ability to respond to threats here in Alaska. If the laboratory (which opened in January 2001) were not available, we in Alaska would have had to send specimens suspected of anthrax contamination out-of-state for testing, which would have meant delays and heightened concern.

It is also fortunate the legislature provided funding for one-third of the Back-to-Basics initiative. While needed to combat issues related to infectious disease, the funds have been invaluable for strengthening our capacity to respond to situations where anthrax is suspected (consultation; lab testing; etc), for providing training to hospitals, private physicians, and other health care providers to learn how to recognize the symptoms of anthrax exposure and infection; for responding to questions from the public and private industry; for dissemination of health alerts; for development of anthrax protocols for emergency medical service providers; as well as other activities this situation has required.

The Division is also grateful for the State Legislature's support for our receipt of a Bioterrorism Preparedness grant from the Centers for Disease Control and Prevention these past two years. Participation in this program has paid off for Alaska. One of the major benefits has been meeting key partners in other state, federal, military and private agencies that were also preparing to respond to an event. Knowing key players streamlined our ability to respond to the current crisis.

PUBLIC HEALTH RESPONSE

- The events of September 11 activated the Alaska Public Health Alert Network (AK PHAN), which sent notification that afternoon to health care and public health workers across our state to be on heightened alert status to monitor for any possible unusual disease patterns. Following the subsequent identification of anthrax infection in Florida in early October, AK PHAN has been utilized numerous times to provide updates and additional information to health providers in Alaska. (Note: this network is brand new and was still under development when disaster struck. Additional work is required to complete it so it reaches every health worker in the state).

- The Epidemiology Response Team has manned it's 24-hour call-in service (toll-free number), responding to over 132 after-hours calls requesting medical guidance on anthrax issues during the last two weeks of October.
- The Alaska Public Health Laboratory in Anchorage has been on-call with services available 24 hours a day/7days a week. Microbiologists and laboratory technicians are working 18-hour shifts, and to-date have processed at total of 88 specimens from 46 incidents in which anthrax was suspected. Tests are performed on human samples (blood, sputum, nasal swabs) as well as suspicious substances found in mail and at various public locations.
- Public Health Nurses across the state have also been actively involved in gathering specimens for analysis by the lab (e.g., conducting nasal swabs) as well as responding to questions from the concerned public in their communities.
- The division has been coordinating response activities and developing response protocols with law enforcement (FBI, Alaska State Troopers, local police departments), the State Emergency Coordination Center (SECC), the AK Division of Emergency Services (ADES), local fire department HAZMAT teams, and the military.
- The Alaska Public Health Training Network, developed with resources from the Bioterrorism Preparedness grant, has sponsored the delivery of anthrax training courses put on by CDC for private medical clinicians and public health workers across the state.
- The division's Emergency Medical Services program developed and disseminated anthrax protocols for Alaska's emergency medical services (EMS) workers.
- The division has worked with the Department of Administration to develop mail processing protocols for state government offices.
- The division has also been in regular communication with the U.S. Centers for Disease Control and Prevention and other state health officials across the country to monitor this situation and share information.

LESSONS LEARNED FROM THE CRISIS SO FAR INCLUDE THE FOLLOWING:

- **Communications Systems** are vital to an effective response. Communications that do not rely on telephone technology or cellular technology are critical to assure the ability to coordinate a response.
    - Although we have come a long way, we need improved communications links between public health and EMS centers around the state.
    - The communications between ADES and the SECC and the Division of Public Health has been enhanced dramatically through the use of First Class, a secure Internet based communications platform maintained by ADES.
    - The Alaska Public Health Alert Network (AK PHAN) is only partially developed. This system, when completed, will deliver emergency public health information to health care providers, laboratorians, health administers and first responders around the state. Without this there is no uniform way to reach all individuals, organizations and agencies.

- The **Isolation** of Alaska could potentially cause a problem in a bioterrorism event. Alaska may have unique challenges in responding to bioterrorism because of dependence on air travel and transport. For example, without air transport, we could run out of critical medical supplies or medications. If all flights were grounded, would we still have access to the National Pharmaceutical Stockpile within 12 hours?

- Rapid access to **medical supplies, medications, and antidotes** is critical in the event of a bioterrorism event:
    - The Division of Public Health must have real-time information about the amounts of key antibiotics available in pharmacies around the state, and a plan to mobilize these resources if needed.
    - We need to develop our plan to request, receive and distribute the National Pharmaceutical Stockpile.
    - Should Alaska have its own pharmaceutical stockpile? If so this will require not only resources to purchase the medications, but also personnel to maintain and rotate expiring drugs, and a secure site for storage.

- The existing **public health infrastructure in Alaska** is stretched thin and has gaps:
    - The state's public health workforce (epidemiologists, laboratory workers, public health nurses, emergency medical services coordinators, public health emergency planners, training coordinators, etc.) in order to respond to suspected anthrax incidents; to respond to public, health care provider and EMS concerns; and, to engage in required protocol development, coordination, and planning activities; have been unable to continue other important public health activities. Examples of specific weaknesses in the workforce include:
        - The Alaska State Public Health Laboratory in Anchorage is severely understaffed due to an inability to fill vacant positions due to low compensation levels. Vacant positions must be filled and additional microbiologist positions are required.
        - The Epidemiology Response Team requires additional staff in order to maintain the current pace and volume of inquiries from clinicians, law enforcement, private industry, and the general public.
    - The existing communication system needs to be enhanced to complete development of the Alaska Public Health Alert Network.
    - Alaska must maintain an adequate pharmaceutical stockpile with sufficient oversight by a trained pharmacist.
    - Sufficient equipment and protective gear for communication and investigative purposes is required.

- **Training** for health care, public health, and law enforcement personnel is critical.
    - The division developed the Alaska Public Health Training Network (APHTN) over the past couple of years using the federal Bioterrorism grant funds and program resources. The network enables us to rebroadcast

satellite programs over cable television to a number of communities across the state making participation in educational program, such as recent programs on anthrax detection and response, available in Alaska. We are currently working to expand access to communities that cannot receive programming via cable.

- Additional training requirements include:
  - HAZMAT training for public health personnel who might be involved in investigating a contaminated site
  - Additional bio- and chemical terrorism training for Division personnel to allow them to provide direct training for other health care personnel around the state
  - Ongoing in-state public health training through APHTN
  - Ongoing attendance and training for public health personnel at national meetings

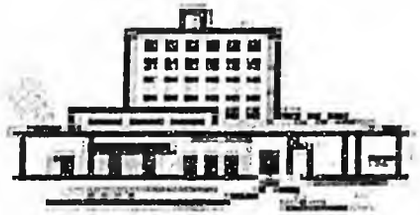
CERTIFICATE OF NEED

The Alaska Certificate of Need Program



Department of Health & Social Services
Division of Administrative Services
Facilities & Planning Section
Juneau, Alaska

Introduction

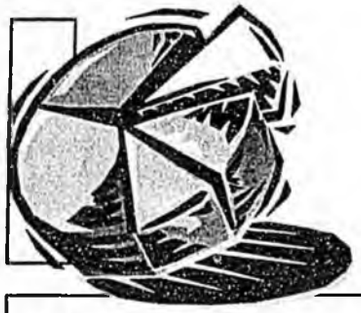


- A review process since 1976
- For Capital projects
- Applicants must show need
- Most projects approved, but extensive costs avoided
- 74% of States have CON
- States without CON regulate health care development by other processes
- State to state variation based on local factors

The Need for the Program



- **Development Perspectives -**
  - There is a need for regionalization of services to ensure quality care and cost effectiveness
  - There is a need for public involvement
- **Payment Perspective -**
  - Medicaid pays 86% of Long-Term Care & about 20% of Acute Care costs
  - Total Medicaid expenditures in 2000 = $467.4 million
  - Hospitals & Nursing Homes = $148.5 million; 25% Acute Hospital; 11% LTC; 10% Inpatient Psych
  - Hospital & Nursing Home costs increased 38% since 92



Certificate of Need Goals

- Improved Decision Making/Regionalization
- Increases Choice/Considers Alternatives
- Stretches Limited Resources
- Decreases Duplication
- Ensures Public Process
- Promotes Quality
- Cost Containment
- Promotes Program Stability
- Promotes Balance/Continuum of Care





CON Program History

- Hill/Burton, 1122 Rev.
- 1976 (PL 93-641 - Health Planning & Resource Development Act, 1974)
- 1983 - $1M Threshold; Last Health Plan
- 1988 - HSAs Close; Planning Reduced
- 1990 - Routine Replacement Clause
- 1995 - Conversion of Assisted Living Beds
- 1996 - Moratorium on New Nursing Beds
- 1996 - Internet Page
- 1998 - Electronic Notification
- 1998 - CN Education
- 1999-2000 - Law & Regulations Changes



Changes in CON Law - 1999

- **All LTC bed conversions must submit a CON application, regardless of the cost**
- **New LTC review standards include:**
  - **Consideration of alternatives such as Assisted Living**
  - **Minimum use rates**
  - **Minimum number of beds**
  - **Financial feasibility, and**
  - **The financial effect on consumers and the State**
- **2000 – Ambulatory Surgery allowed to move without a CON**



The Application Process

- **Who must Apply?**
  - $1 Million Cost
  - Health Care Facility
  - All LTC Conversions



- **How to Apply:**
  - Letter of Intent
  - 60-Day Wait
  - Pre-Application Conference
  - Application Packet

The Review Process

- **Review & Analysis**
  - Site Visit
  - Criteria & Standards
  - Findings & Recommendations
  - Criteria & Standards





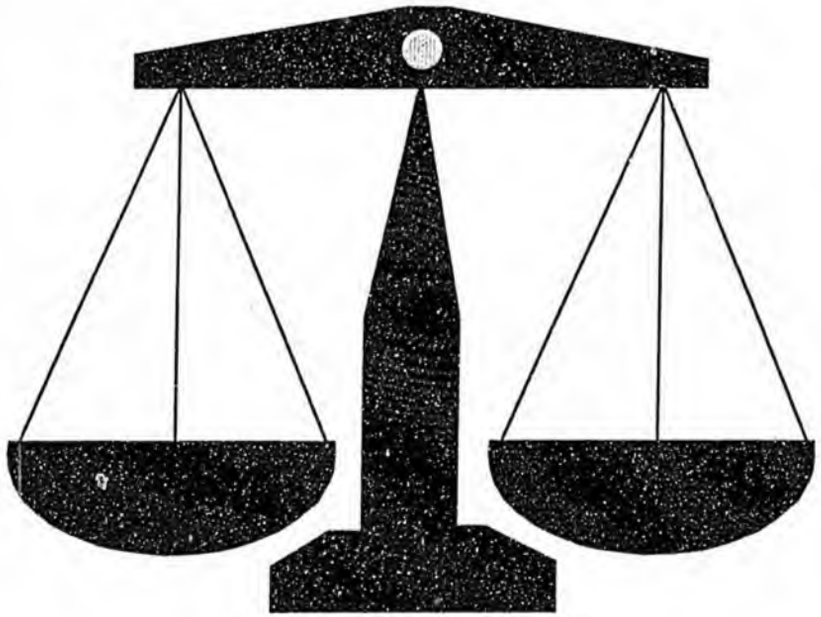
- **Public Process**
- **Commissioner's Decision**

THE PUBLIC PROCESS



- 30-day written comment Period
- Public Meeting
- Notification of interested individuals
- Notice published in two consecutive issues of one statewide & one local newspaper

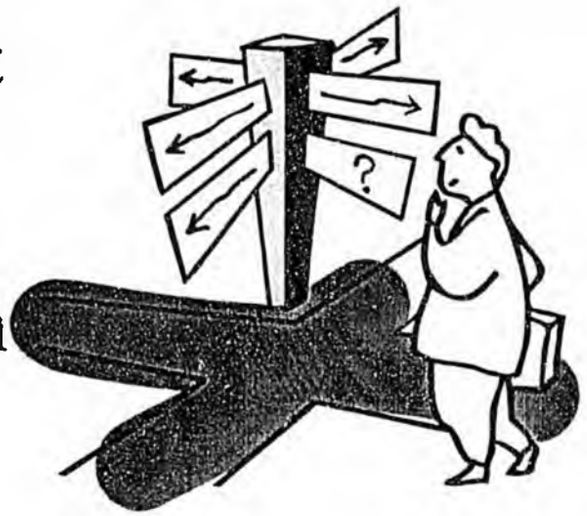
APPEAL



- Must be written & submitted within 30 days after notice
- Must be sent to the Commissioner
- Levels of Appeal: hearing, legal case
- Solution attempted at lowest level

Effectiveness of the Program

- **CN is one of many tools for effective system development**
- **Since Program Inception, Over 500 additional beds prevented over $75 million in construction costs avoided, plus millions in operating costs.**
- **Some facilities developed better systems.**
- **Increased choice/balance in system.**





Applications Under Review/Expected

Sitka 5 Nursing Home Beds	$25,000
Ketchikan MRI Scanner	$1 Million
Providence 60-bed child/adolescent psych facility	$21 Million
Valdez Hospital Replacement	$24 Million
Providence N. Tower CON Modification	$ 6 Million
Expected 2001-2002:	
- API Replacement	$42 Million
- Fairbanks Kidney Dialysis	$ 1 Million
- Maniilaq 15-bed LTC Unit	$ 4 Million
- Wesley Rehab & Care Unit	Unkown

INSURANCE ACCESS

The Anchorage Access to Health Care Coalition

Summary of Activities and Data Findings

October, 2001

Prepared by Catherine Schumacher, MD, MSPH[1]
Chair

[1] Contact Information
Address 3027 Wentworth Street, Anchorage, Alaska, 99508. Telephone 907-272-7778. Email schukalt@gci.net

Background

The Anchorage Access to Health Care Coalition was formed in 1998 with the purpose of improving access to health care for the medically underserved in the Municipality of Anchorage. The Coalition grew out of the efforts of the Anchorage Healthy Future project and the Anchorage Health and Human Services Commission. The Coalition has members from a broad base of the Anchorage Community, including Providence Health System, the Anchorage Neighborhood Health Center, the Anchorage Department of Health and Human Services, the Alaska Primary Care Association, the Alaska Department of Health and Social Services and Alaska Health Fair.

The Coalition has been concentrating on three main goals:

1. Collect accurate information about health care access in Anchorage
2. Educate policy makers and the general public about health care access in Anchorage
3. Provide a forum for discussion about various options for improving health care access in Anchorage.

The Coalition's findings are summarized in the following pages.

During the next year, the Coalition would like to concentrate on developing a network of health care providers to provide care to the low-income uninsured population in Anchorage, using models developed successfully by other communities.

The Coalition is grateful for the financial and in-kind contributions from United Way of Anchorage, Providence Health System, Robert Wood Johnson Foundation, National Bank of Alaska, Alaska Primary Care Association, State of Alaska, Collins & Associates, and Anchorage Neighborhood Health Center.

Anchorage Access to Health Care Coalition Steering Committee

Catherine Schumacher, MD, MSPH (Steering Committee Chair)	Epidemiologist	272-7778
Joan Fisher, Vice-Chair	Anchorage Neighborhood Health Center	792-6528
Marilyn Kasmar	Alaska Primary Care Association	272-6131
Judith Muller	Alaska Health Fair	278-0234
Barbara Symmes	Providence Health System	261-3190
Cathy Feaster	Anchorage Dept Health and Human Services	
Terry Hamm	AK Dept Health and Social Services	269-7854
Anita Halterman	AK Dept Health and Social Services	334-2431
George Conway, MD, MPH	NIOSH	271-2382
Patricia Atkinson	Community member	269-3639
John Riley	Anchorage Neighborhood Health Center	257-4615

Key Facts about Access to Health Care in Anchorage

WHO ARE THE UNINSURED?

- At least 26,000 Anchorage adults (14%) have no health plan[2]

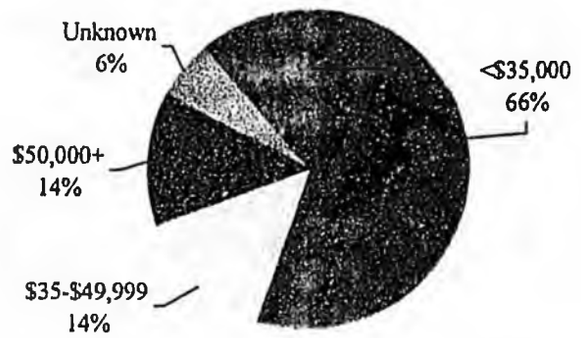
Most of the uninsured are low income and are employed

- Among the uninsured in Anchorage, 66% live in households where the annual household income is less than $35,000. Individuals working in low-income jobs are less likely to be offered health benefits. If benefits are offered, the low-income worker is often unable to pay his or her portion of the monthly premium.

- Among the insured in Anchorage, 71% are employed. The high cost of medical care leads to a high cost of insurance premiums. Therefore, many employers, especially small businesses, are not able to offer health benefits.

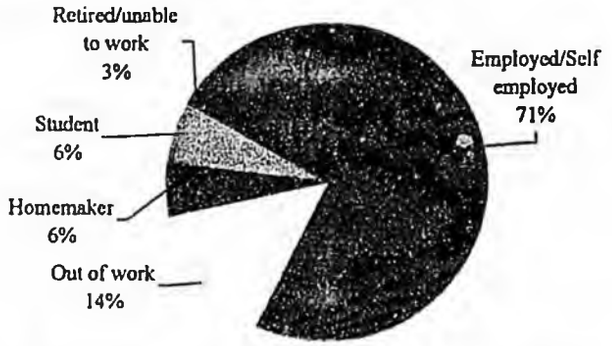
- Even individuals with a moderate income have difficulty purchasing health insurance if it is not offered through an employer. The least expensive individual family policy available in Anchorage costs $443/month with a $1000 family deductible.[3]

Annual Household Income
Income Distribution of Uninsured Population in Anchorage 1991-1998



Data source: Alaska Behavioral Risk Factor Surveillance System, Alaska Division of Public Health

Employment Status of the Uninsured
Employment Distribution of Uninsured Population in Anchorage 1991-1998



Data source: Alaska Behavioral Risk Factor Surveillance System, Alaska Division of Public Health

Do the uninsured get the health care that they need?

For many, the answer is **no**.

- Among the uninsured in Anchorage:
  - Almost half (43%) have been unable to see a doctor at least once during the past year due to cost
  - Nearly one-quarter (22.5%) have not had a routine checkup in the past five years

Is lack of health insurance a "temporary" problem for people?

For many, again the answer is **no**.

- Among the uninsured in Anchorage, more than seventy percent (70.6%) reported that it had been at least one year since they had health care coverage

Many of the uninsured have chronic conditions that require regular medical care

- Among the uninsured in Anchorage, 40% have high blood pressure, and 22% have elevated cholesterol levels.

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[2] Data are from the Alaska Behavioral Risk Factor Surveillance System, 1991-1998. Diane Ingle of the Alaska Department of Health and Social Services performed special analyses to obtain Anchorage statistics.

[3] Individual policy rate quotes obtained from Hagen Insurance, Blue Cross Blue Shield of Alaska, Alaska Employee Benefit Specialists, and Mutual of Omaha, in Anchorage, April 2001

HOW ARE PEOPLE AFFECTED BY LACK OF HEALTH INSURANCE AND OTHER ACCESS ISSUES IN ANCHORAGE?[4]

- **Many have experienced illness and high medical bills.**

> *"....And I was hospitalized. And the hospital bill was $8,500. Then I have no insurance. So I applied for public assistance. But I was denied. And the reason is that I'm not quite 65. I start to pay $50.00 every month to the hospital, but that is my problem. My income is only, you know, $800 [a month]. [I have] no idea how to pay off that much money."*

- **People who don't have health insurance experience a great deal of anxiety and concern about their lack of insurance.**

> *"Thank goodness I'm healthy. And take no medication. But it is a scary feeling. Because any minute that could turn around."*

- **Many see a doctor on a crisis basis only.**

> *"I ended up in the hospital with triple bypass surgery. And why? Because I didn't have the money to go and see a doctor and see how I was doing. You have to decide to go to the doctor or eat."*

> *" I don't go to see specialists because when I call and ask them what their fee schedule is, the average I've seen in town is $250 to $275 cash. CASH! On your first visit. That's when they'll see you."*

- **They frequently compromise on the services they need.**

> *"When my mother-in-law was under Elmendorf's hospital care, they changed the policy so that they would no longer take anyone who was over 65, so I went looking for someone who would take her as a Medicare patient. I applied to 21 different doctors before I found someone,...before I could find someone to see her and oversee her medication."*

- **They must spend time finding doctors who will see them.**
- **They look for ways to save on prescriptions**

> *"Are we going to buy prescriptions or are we going to buy groceries?"*

- **They go without dental care.**

> *"My girls missed their cleaning this time because our regular dentist didn't take Denali Kid Care. So they didn't go. I couldn't afford to pay it out of pocket."*

> *"Right now I'm utilizing all the free or reasonable clinics I can."*

- **They get creative about preventive care.**
- **They develop alternatives to going to the doctor.** Examples include using over-the-counter medications and following behavioral ways of maintaining their health, such as getting exercise and eating well. Others admit they simply ***"keep my fingers crossed."***

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[4] Information on this page obtained from the report "On the Edge: Living without Health Insurance in the City of Lights." The Coalition commissioned researchers Cathy Colwell and Diane Hoffbauer to conduct a series of focus groups with the uninsured and underinsured in Anchorage. The report presents their findings.

Employer Based Coverage in Anchorage[5]

- The majority of Alaskans obtain health insurance through employer-based coverage[6].
- As the cost of health care and health insurance increases, Alaska businesses are finding it more difficult to offer benefits[7]

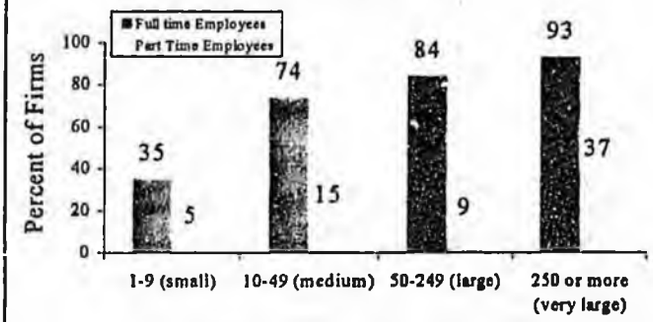
In the spring of 2001, the Anchorage Access to Health Care Coalition conducted a survey of private Anchorage employers in order to determine how many were able to offer benefits and if offered, the costs to both the employer and the employees. Below are some of the key findings.

Key Points from the Survey

- Overall, only 47% of Anchorage firms offer health benefits to full time employees
  - 46% offer major medical coverage
  - 38% offer dental coverage
  - 26% offer vision coverage
  - 42% offer prescription drug coverage
  - 37% offer some mental health coverage

- The ability to offer health benefits increases with firm size (Figure 1).

Figure 1: Percent of Anchorage Employers Offering Health Benefits to Employees Anchorage 2001



- The majority of Anchorage employers (70%) are small firms (1-9 employees); of these, only 35% offer health benefits to fulltime employees.

- Far fewer Anchorage small firms are able to offer health benefits than would be expected based on national data (60% nationally compared to 35% for Anchorage).[8]

- Overall, of firms that offer health benefits, 47% paid the full cost of premiums for health benefits for their employees, compared to 64% in 1993, indicating that the costs are now being shifted to the employee.[9]

- Overall, 43% of Anchorage firms offer benefits to dependents of full time employees. Few firms (19% of those offering benefits) pay the entire cost of insuring dependents of fulltime employees.

- Overall, only 16% of firms indicated that they offer any health insurance benefits for part time employees.

- The average costs reported by employers were $378 per month for employee coverage alone, and $711 per month for family coverage.

- The high cost of premiums was the primary reason given for not offering health benefits (64% of those not offering benefits).

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[5] Data are based on the Employer Benefits Survey conducted by the Coalition during the spring of 2001
[6] Alaska Behavioral Risk Factor Surveillance System, unpublished data
[7] Myers DJ. The high cost of health insurance. Alaska Business Monthly 2001;August:16-21.
[8] Kaiser Family Foundation and Health Research Educational Trust: Employer Health Benefits 2000 Annual Survey.
[9] Alaska Department of Labor, 1993 Employee Benefit Survey. Data are for entire state.

FACT Sheet

People Without Health Insurance In Anchorage

Prepared by the Anchorage Access to Health Care Coalition* 903 W. Northern Lights Blvd, Suite 202 Anchorage, AK 99503-2400

April 2001

The facts in this sheet refer to the uninsured who have no public or private health benefits, including no Medicare, Medicaid, Blue Cross, TriCare, Indian Health Service, or any other means to pay for health care, other than out of their own pockets.

Who are the uninsured?

- **Young:** 56% of the uninsured are between 18 - 34 years old[1]. Among children in Anchorage approximately 10% are uninsured[2].
- **Employed:** 71% of the uninsured are working, either employed by someone else or self-employed[1]. Because of the high cost of premiums many employers are not able to offer health benefits, or the employee portion of the monthly premium can be as high as 50 - 100% of the total cost[3].
- **Male:** 57% of the uninsured are male[2].
- **Low Income:** 66% of the uninsured live in households where the annual household income is less than $35,000[1]. However, even people with moderate incomes may not be able to afford insurance. The least expensive individual family policy available is $443/month with a $1000 family deductible[4].
- **Your Friends and Neighbors:** 13% of all people in Anchorage are uninsured[1].

What is the cost of not having health insurance?

- **Fewer doctor visits:** 43% of the uninsured have not seen a doctor in the past year due to cost[1].
- **Less preventive care:** 23% of the uninsured have not had a routine checkup in over five years[1]. People without insurance are less likely to undergo routine screening tests such as mammography, Pap tests, blood pressure checks, cholesterol testing and colon cancer screening[5]. Many only see a doctor on a crisis basis [6].
- **Worse overall health:** Compared to people who report their health as "exceilent" or "very good," adults who report "good, fair or poor" health were between two and three times as likely to have lacked insurance for at least one year [5]. Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance[7].
- **Less access to comprehensive care:** A two-tiered system of care exists for chronically ill patients: the top tier for those who have the means to buy state-of-the-art medications and technology, and the bottom tier for those who do not[8]. Uninsured patients with asthma, diabetes, or hypertension are often denied the care readily available to those who have insurance[9]. Uninsured chronically ill people often compromise on the frequency and quality of their visits[6].

* Supported by financial and in-kind contributions from United Way of Anchorage, Providence Health System, Robert Wood Johnson Foundation, National Bank of Alaska, Alaska Primary Care Association, State of Alaska, Collins & Associates, and Anchorage Neighborhood Health Center

- **Higher costs:** Uninsured patients may be charged more for services than insured patients[10]. Insurance companies often negotiate volume-based discounts for their participants. These discounts are unavailable to people who do not have insurance.
- **Less choice in providers:** Uninsured patients must spend time finding doctors who will see them without insurance. There is no system in place to spread the burden of providing care for the uninsured. Programs that do provide free or low cost care often have lengthy waiting lists.
- **Unreliable access to prescription drugs:** 30% of the uninsured cannot fill prescriptions because of the cost[9]. They may rely on doctors dispensing free samples, or try to enroll in pharmaceutical companies' indigent care program, a time-consuming and limited option[6].
- **More hospitalization:** The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes[7].
- **No dental care or hearing aids:** The uninsured are more likely to go without needed dental care or hearing aids, impacting their quality of life[6,9].
- **Bankruptcy:** One out of four families filing for bankruptcy identify an illness or injury as a reason for filing[8].
- **Fear of illness or injury:** Uninsured people are financially vulnerable and live with a constant dread of major illness or injury[6].

The costs are unacceptably high. Meaningful health coverage expansions must be found which have a broad base of support, transcending ideological, partisan, and interest group boundaries.[11]

---

1. Ingle D. "Behavioral Risk Factor Survey (BRFSS) Data and Health Care Access: A Look at Results in Anchorage, Alaska." Anchorage Access to Health Care Coalition Meeting, December 2000, Fairview Rec Center, Anchorage.
2. "Distribution of Persons by Health Insurance Status and Demographic Characteristics in 1998." Lewin Group estimates using the 1997-1999 Current Population Survey. NACHC 2000.
3. "Anchorage Employee Benefits Survey." Anchorage Access to Health Care Coalition, February - April, 2001.
4. Individual policy rate quotes obtained from Hagen Insurance, Blue Cross Blue Shield of Alaska, Alaska Employee Benefit Specialists, and Mutual of Omaha, in Anchorage, April 2001.
5. Ayanian J, Weissman J, Schneider E, Ginsburg J, Zaslavsky A. "Unmet Health Needs of Uninsured Adults in the U.S." *The Journal of the American Medical Association.* 284(Oct 25): 2061-2069, 2000.
6. Colwell C and Hoffbauer D; *On the Edge: Living Without Health Insurance in the City of Lights.* Report submitted to Anchorage Access to Health Care Coalition, December 2000.
7. "The Uninsured and Their Access to Health Care." Kaiser Commission on Medicaid and the Uninsured, May 2000.
8. Landers S. "Uninsured Often Get Second-Class Care" in *American Medical News,* August 28 2000 issue, *amednews.com.*
9. "Second Class Medicine" in *Consumer Reports Online,* September 2000 issue, *www.consumerreports.org.*
10. Kolata G. "Medical Fees Are Often Higher for Patients Without Insurance." *The New York Times,* April 2, 2001 *www.nytimes.com.*
11. Kahn C and Pollack R. "Building A Consensus For Expanding Health Coverage." *Health Affairs,* Jan/Feb 2001.

Anchorage Access to Health Care Coalition
2001 Health Insurance Benefits Survey

Preliminary Results

During the spring of 2001, 403 employers in Anchorage, Alaska were contacted by telephone and asked to participate in a survey about health insurance benefits and costs. The employers were selected from a sampling frame of Anchorage-based employers provided by the State Department of Labor. The sample excluded federal, state, and local governmental employers, and all employers who reported no employees for the past three months. The 5,992 remaining employers were then stratified by number of reported employees. A sample from each of four strata was then selected, using established sampling methods. Selected results of the survey are reported below.

Many of the results are reported by firm size. Total numbers (N) of private employers in Anchorage and employers surveyed is reported below:

Strata	Total N	Sample N
Small (1-9 employees)	4,202	112
Medium (10 - 49 employees)	1,423	109
Large (50 - 249 employees)	311	126
Very Large (250 or more employees)	56	56
Total	**5,992**	**403**

Approximately 76% (N = 305) of the employers surveyed responded to the survey. Of the non-respondents, 4% were found to be out of business, 9% refused to participate, 9% were part of another company, and 2% could not be contacted.

Following are some of the survey questions and answers:

"Does your business offer group health insurance benefits to employees?"
Only 47% of Anchorage firms offer health insurance benefits. The size of the firm is an important factor in whether health insurance benefits are offered; 34.5% of small firms, 74.4% of medium firms, 84.2% of large firms, and 92.7% of very large firms reported offering health insurance benefits to employees.

If the business does NOT offer group health insurance benefits to employees (N = 94):

- "Have you ever offered health insurance benefits?" *16% offered health insurance benefits in the past.*
- "Do you offer cash assistance for individual policies?" *Only 7% offer cash assistance to employees to purchase individual health insurance policies.*
- "What is the primary reason for not offering group health insurance benefits?" *The primary reason offered is that premiums are too high.*

209 employers indicated that they offer at least some health insurance benefits.

Major Medical
Overall, 33% of small firms, 74% of medium firms, 83% of large firms, and 93% of very large firms offer major medical coverage to full time employees. For part time employees, only 5% of small firms, 15% of medium firms, 9% of large firms, and 37% of very large firms offer major medical coverage to part time employees. Dependents of both full and part time workers are generally offered benefits slightly less often than employees.

Dental
Fewer firms offer dental coverage. In all, 25% of small firms, 65% of medium firms, 76% of large firms, and 90% of very large firms offer dental insurance to full time employees.

Vision

Vision insurance is even more uncommon. 20% of small firms, 37% of medium firms, 50% of large, and 71% of very large firms offer vision insurance to full time employees.

Who pays for benefits for full time (FT) employees and their dependents?
If major medical benefits are offered, the cost is usually either shared between the employer and employee (47%), or paid entirely by the employer (47%). Although almost half of firms still pay the full cost of benefits for their employees (if they offer them), the percentage has slid significantly since 1993, as shown below:

Percentage of Firms Paying the Full Cost of Major Medical Premiums for FT Employees

Year	Small Firms	Medium Firms	Large Firms	Very Large Firms
1993	77%	63%	58%	47%
2001	53%	46%	19%	24%

Very few firms pay the entire cost of insuring dependents of FT employees; it is far more likely that the employee pays the entire cost or it is a shared expense. Many firms indicated that their employees choose not to purchase the available insurance for their dependents.

Dependent Major Medical Premium Costs

Who Pays?	Small Firms	Medium Firms	Large Firms	Very Large Firms
Firm 100%	30%	8%	5%	3%
Employee 100%	33%	44%	38%	26%
Shared	23%	39%	48%	63%
Benefit Not Offered/Unknown	13%	8%	10%	11%

For part-time employees, only 16% of firms indicated that they offer any health insurance benefits.

What is the total monthly premium per employee for major medical coverage (employee plus employer contribution)?

Cost of Premium

Firm Size	Employee Only Premium	Full Family Premium
Small	$400.90	$701.10
Medium	337.10	736.10
Large	280.10	668.10
Very Large	269.50	649.30

Have your rates increased in the past 12 months?
64% of employers reported that they had a rate increase in the past 12 months; 90% of those were small and medium size firms.

What is the total annual cost of health insurance premiums to your business?
Only 55% of survey respondents were able to give a usable response to this question. The results are summarized below:

Firm Size	Sample N	Mean	Minimum	Maximum
Small	16	20,801	$4,524	$119,908
Medium	41	109,104	2,500	2,000,000
Large	43	404,278	15,000	3,600,000
Very Large	15	3,255,410	44,460	13,763,597
Total	**115**	**$132,059**	**$2500**	**$13,763,597**

Have you changed insurance carriers or become self funded in the last two years in order to contain costs or get better benefits?
34% of employers changed insurance carriers or became self funded.

On the Edge

Living Without Health Insurance In the City of Lights

A Report Submitted to

Anchorage Access to Health Care Coalition

December 18, 2000

Catherine Colwell, M.A.
Diane Hoffbauer, Ph.D.

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INTRODUCTION

Concern about access to adequate health care, both on a national and a local level, has set in motion strategies to explore ways to increase access to health care as well as to document the perceptions, attitudes and knowledge of the general public about the needs of the uninsured. The findings from two recent surveys[1] indicate that while the general public supports safety-net medical care for the uninsured, the knowledge of who makes up the population of the uninsured and what solutions are available or possible lags behind that support. The Anchorage Access to Health Care Coalition (Coalition) is an organization designed to improve access to health care for those who are uninsured or in other ways medically underserved. It is particularly interested in understanding better the issues, problems and identifiers of those residents who make up the 15% estimated to be medically uninsured in the Municipality of Anchorage. To gain more insight into this topic, the Coalition commissioned this study to explore in depth the experiences and perceptions of those who are currently working but do not receive health benefits as well as the knowledge, perceptions and attitudes of those who provide programs or influence funding for access to healthcare.

The goal of this project was to examine the level of knowledge as well as the perceptions and experiences that influence the behavior of those who are uninsured or underinsured as well as those who establish policies and programs to assist in quality of life for Anchorage residents. Using the qualitative research method of focus groups and interviews, this study explored: (1) the range of employment of the uninsured; (2) the medical experiences they have had and the choices they have made as a result of being uninsured; (3) the perceptions of available medical programs to meet the needs of the uninsured; and (4) the perceptions of barriers and possible solutions to helping the uninsured meet their health needs.

Focus group research is intended to identify patterns and trends in the perceptions of a particular area of interest. It has as its structure a guided discussion of between six and ten participants who all share a common characteristic necessary to relate to the topic that is being discussed. The focus group is designed to be a permissive, non-threatening environment that allows participants to feel safe enough to share their perceptions, as well as agree and disagree with other members. It is understood that focus group participants, through their responses to each other, will influence the outcome of the discussion. Therefore, each focus group becomes a unique picture of the perceptions generated by a dynamic group interaction of people who identify with each other and feel comfortable disclosing emotions as well as thoughts regarding experiences and perceptions. Because of the qualitative uniqueness of each group, the focus group is repeated several times with different people to glean as much unique information as possible about the topic under investigation.

[1] Results of these surveys are summarized in "Bolstering the safety net: A top priority for health care reform" in the September/October 1999 issue of Health Affairs.

This report is divided into three sections. The first describes the focus group research that was conducted. This section describes the uninsured and underinsured residents who attended the focus groups, the methods used to solicit information from these participants, and the findings of the five focus groups conducted.

The second section describes the investigation of awareness, attitudes and concerns of Anchorage community leaders. It describes the interview process used to collect data from established policy makers, business leaders and program directors and describes the findings from fifteen business leaders, policy makers, health providers and other community advocates.

The third section offers conclusions and implications for increased access to healthcare for Anchorage residents based on the perceptions of focus group members and community leaders.

SECTION I: FOCUS GROUP RESEARCH

Focus Group Participants

Twenty-seven men and women participated as members of one of five focus groups. All focus groups had a mixture of men and women and had from three to seven participants per group. Participants were predominantly Euro-American in ethnicity with the exception of one Asian, two African-American, and one Latino.

Four of the five groups were designed to include a range of ages and work situations. Participants in these four groups ranged in age from 22 to 67. These four groups reported an estimated income range from below $10,000 to between $41,000 and $50,000. The average income fell in the $21,000 to $30,000 category. Participants also ranged in education completed from some high school to college graduates. Both single and married adults were represented as well as single and married parents of dependent children.

Because we screened for those with no health benefits at all, we were surprised to find members of the groups who had some insurance. One had a medical plan through retirement from the state of Alaska, one with the Veteran's Association and one with the military. Several single parents had no insurance but did have Denali Kid Care for their children. One participant was operating on Cobra after leaving his place of employment to begin his own consulting firm, knowing that would end shortly. A last participant had health insurance with a $1300 deductible that he considered "worthless". All participants, regardless of whether or not they had some "safety-net" insurance plan for themselves or their children identified themselves as not having or anticipating not having adequate insurance to take care of medical concerns. These participants are identified in this report as being underinsured.

The fifth focus group was more homogeneous. Members of this group were men and women over the age of 55. All were working and had no health benefits at work. All but two were not eligible for medicare. This focus group was designed to identify specific concerns of the older worker who is either uninsured or underinsured for their needs. The majority of this group had incomes of less than $10,000. They had a similar range in education to the other focus group members; from having some high school to being a college graduate.

Focus Group Procedures

The following research procedures were used in the focus group research:

1. Recruiting and Selecting Appropriate Focus Group Members

Focus group members were recruited in three ways. First, an advertisement was placed in the Anchorage Daily News urging anyone who was working but not insured

and who would like to discuss his or her experiences in a small group to contact the Coalition. Telephone numbers received from this advertisement were followed up with a call from the researcher. A focus group information form was filled out over the telephone to collect demographic data and to determine if the interested respondent was an appropriate candidate for a focus group. Participants were considered appropriate if they were working at least part time and receiving no health benefits at work.

In addition, focus group information forms with an introductory letter by Joan Fisher, CEO for the Anchorage Neighborhood Health Center, were placed at each Neighborhood Health clinic. Patients were encouraged to complete the form if they wished to be part of a focus group. These forms were gathered and given to the researcher. Follow-up calls were made to those respondents who indicated that they did not receive Medicaid. Finally, one group was formed through the Older Person's Action Group (OPAG) recruiting working seniors who were over age 55.

The small number in each focus group was due to a high number of people canceling or simply not coming to the focus group. The lack of attendance at the focus groups surprised us. While we can only speculate on why this occurred, it may indicate a degree of fragmentation those without health insurance may encounter in their daily lives. This was just one more thing to do, to get transportation, make the time, etc. It indicates the difficulty in connecting with this group of people. We worked hard to hear from them. It is no wonder they are generally not heard.

2. Collecting Data

A focus group discussion guide was designed and used with all five focus groups. Members of the steering committee of the Coalition reviewed the questions. Questions about specific kinds of medical service, such as dental care and hearing aids were added as new issues emerged during on-going focus groups.

Groups were held in three locations. One focus group was held at the Anchorage Neighborhood Health Clinic on 10th Ave. A second focus group was held in the conference room at OPAG. The other three groups were held in the conference room at the United Way Offices. In each location, the participants and the researcher and research assistant sat at a table where there was ample room to talk.

Special consideration was taken to make sure the noise level was low and other distractions were minimized. All focus groups used a moderator to facilitate discussion and an assistant moderator to take notes and to observe the flow of conversation, non-verbal cues, and other group dynamics. All sessions were audio taped.

Focus group members received an introduction at the beginning of the session advising them that their responses were voluntary, and that they could choose not to answer any questions presented to them. Confidentiality was explained and all participants and researchers agreed to abide by it. During this introduction time participants received instruction on how focus groups worked, what to expect in a focus

group, and an invitation to ask questions about the process at the conclusion of the session. A discussion guide was used to keep the conversation focused on the information pertinent to this study.

Following the session, participants were given a $20.00 honorarium for their time.

3. Analyzing the Data

Audiotapes were transcribed for analysis. Written focus group session notes were used to assist with the transcription. All records were maintained on file for further reference. The researchers developed coding categories based on the questions asked during the focus groups, and the five transcripts were marked accordingly. Using appropriate qualitative analysis techniques, the focus group and interview information was organized into systematic categories that could be reported in a meaningful way.

4. Summarizing the Results

This report includes summarized findings, representative participant quotes and conclusions.

Focus Group Findings

1. Work and Health Benefit Background of Participants

There was a large diversity in the kinds of jobs in which these participants worked. Few participants held the same kind of job. Truck driving, clerical work, temp services, auto mechanics, sales, telephone surveying, medical assisting, convenience store work, office management, courier service, food service, janitorial service, engineering consulting and music performance were all mentioned by at least one participant. While several participants were self-employed, most worked for small businesses that could not afford to provide health benefits. Interestingly, two participants worked for small companies who contracted their services to the municipality or the state. Several participants worked two or more part-time jobs, none of which offered benefits.

For about one third of focus group members, the job they are currently working in is the first that has not offered them health benefits. This was particularly true for the seniors who were working. One company used to offer health benefits but was unable to continue due to high costs. For those who had been self-employed for a while, not having benefits was nothing new. However, it was a great concern to those who were just now going into business for themselves. One participant who is currently using his Cobra has been unsuccessfully exploring other options. He is very concerned about what will happen when his Cobra ends. This concern was also expressed by those who have recently stopped receiving health benefits due to a move, or to their company canceling health benefits due to increased cost.

2. The Importance of Health Care Coverage

Every focus group participant voiced their perception that health care insurance is extremely important; that it offers "security" and "peace of mind." Even those who see themselves as healthy, worry that some day they will have a major medical problem that they do not have the resources to handle

> *"Thank goodness I'm healthy. And take no medication. But it is a scary feeling. Because any minute that could turn around."*
>
> *"It is just second to daily needs. I'm keeping my fingers crossed that nothing serious happens."*
>
> *"It's a balancing act between reality and fear."*
>
> *"I worry because my family history is full of cancer."*
>
> *"Now it feels like tap dancing through a minefield. It is a daily grind because I am one accident from devastation."*

Others have had significant health problems that have required expensive medical care, and have cost the participant a great deal of money. Their understanding of the importance of health care comes from having to deal with their health and their medical costs on a daily basis.

> *"There's a physical, emotional, and economical effect."*
>
> *"I think a lot of it is having the security of knowing you can take care of emergencies"*
>
> *"Well, when you skip the physicals and stuff, because you can't afford it, when something happens you're scared."*

The reality that health can take a turn for the worst was of gravest concern to the seniors' focus group. While some seniors reported feeling fortunate that their health is still good, others have had serious problems. The contrast between being healthy and having something go wrong was most apparent in this group.

> *"If you're maintaining your health, you know, doing the things you're supposed to be doing, you know. I haven't had any problems that way."*
>
> *"Before 1998 my wife and I had regular insurance, so that in 1998 we retired, then I got a job ...had no insurance benefits. I had problems with my breathing. And I was hospitalized. And the hospital bill was $8,500. Then I have no insurance. So I applied for public assistance. But I was*

denied. And the reason is that I'm not quite 65. I start to pay $50.00 every month to the hospital, but that is my problem. My income is only, you know, $800 [a month]. [I have] no idea how to pay off that much money."

3. Participants' Medical Experiences

Participants were asked how long it had been since they had seen a doctor and how they currently meet their medical needs. Seven different themes emerged from their experiences with accessing medical attention.

A. Many see a doctor on a crisis basis only.

Most participants reported that they do not go to a doctor regularly or for what they consider to be minor concerns. They wait until they feel like they have no choice before they go, and frequently that means they go to a hospital emergency room or an urgent care clinic.

"I ended up in the hospital with triple bypass surgery. And why? Because I didn't have the money to go and see a doctor and see how I was doing. You have to decide to go to the doctor or eat."

"A lot of time I haven't gone to the doctor when I think I have the flu, I think I have a urinary infection, or even sometimes when I have seizures because they send you a note if you're behind in payments, or they send the bill collector after you."

"I don't go [to the doctor] unless I'm dire sick, and the problem with that scenario is that you could be causing more damage to yourself than if you had equal access."

B. They frequently compromise on the services they need.

For those with serious health problems, going to a doctor is a must. Conditions of diabetes, high blood pressure, a heart attack, cancer, or major surgery all keep participants going to see a doctor regardless of the cost. What they do instead of giving them up is to compromise on the frequency and quality of their visits. One compromise is to go to a "cheaper" doctor instead of a specialist. The general perception of each focus group was that, unlike a general practitioner, specialists were not willing to work with their patients.

" I don't go to see specialists because when I call and ask them what their fee schedule is, the average I've seen in town is $250 to $275 cash. CASH! On your first visit. That's when they'll see you. And after that they may or may not bill insurance. Depends on how they feel about it.

But you must provide them with payment up front before the doctor will see you."

That's right. There's a sign on the counter. Payment in full due at time of treatment."

"I go to the regular doctor, but not to a specialist...It puts a risk on my kidneys. I know I could get better treatment, or that's what they lead me to believe."

The seniors reported more support from specialists than did younger participants.

"I went to the clinic to have a Pap smear. And they sent me to a gynecologist. And I told them when I went in, 'if this isn't necessary, I can't afford it.' So they said, 'come in, he wants to look at you anyhow.' And the doctor didn't charge me for the visit. He gave me an exam, and he gave me a procedure that he ordinarily charges $800 for. And he didn't charge me a dime."

Another compromise is to only get part of what is needed.

"I have to take pills, so I had to go in to get my med(ication) refills, and they did a quick exam, you know. But even at that, my lab work, I asked to postpone. So I didn't have any of my blood work done which monitors the level of the meds I'm taking."

A final compromise is simply not getting preventative care at all.

"I'd really like to have the benefit of preventative health care coverage. Just to have a little security. I'd like to go in and have all the tests they recommend. Be able to have the bone scans, to see if osteoporosis is a problem right now. I'd like to be able to have the regular tests of a yearly physical that costs well over $500 to $600. Even if you utilize the free clinics that they have for your shots, if you want to, your mammograms, pap smear, the blood work. You are still paying $65 a shot at some of these places. Even though it's cheaper, you still have to end up with a doctor's visit in order to evaluate them all. So there is no way that you can do preventative health care for under $500. That would be the very minimum using all the things that are free or cheaper."

C. They must spend time finding doctors who will see them.

These participants look for doctors who will work with them. For the seniors, this meant doctors who take Medicare. For others, it meant allowing them to make payments on the services they receive. Moving from having health insurance to being dependent on

Medicare brought mixed stories from the seniors. For some, having an established doctor provided the transition from insurance to Medicare payments.

> *"You need to establish a physician now that will carry you on. My husband is in that situation and his doctor is seeing him on consignment. And that is because he was an established patient and he was unwilling to pawn him off on someone else. And I think that's the only choice we have right now: to establish yourself with a physician who will see you after Medicare takes affect. "*

Being a long-term patient isn't always a guarantee of continued services, however. As one senior woman explained, much to the group's horror:

> *"My husband's doctor who was treating him for a number of years, when he turned 65, he wouldn't see him as a Medicare patient."*

And others have extenuating circumstances that find them searching for a doctor who will take Medicare when they don't have a regular doctor.

> *"When my mother-in-law was under Elmendorf's hospital care, they changed the policy so that they would no longer take anyone who was over 65, so I went looking for someone who would take her as a medicare patient. I applied to 21 different doctors before I found someone...before I could find someone to see her and oversee her medication. So there are a lot out there who will not donate their services."*

D. They look for ways to save on prescriptions.

The cost of prescriptions is another area where the uninsured, particularly seniors and those with chronic medical conditions, feel especially vulnerable. In the senior focus group, a discussion centered around the choices each must make on a daily basis:

> *"Are we going to buy prescriptions or are we going to buy groceries?"*
>
> *"Or pay the rent"*
>
> *"Yes, it's an either- or thing"*

Again, seniors were more aware of ways to save on prescriptions than were younger participants.

> *"When I didn't have money for insulin, I called the Diabetes Association and they paid for my insulin."*

"I have a booklet listing the pharmaceutical companies and what their criteria are. Your doctor has to say that the doctor will provide free health care if they provide the free medication. That's not the norm. If your doctor'll write a letter and say you need this medicine and can't afford it, they will provide it for you. Like a three months supply, and then it's renewable."

However, in all focus groups participants reported relying on their doctors' sample medications to treat many of the medical problems that sent them to a doctor. This catch-as-catch-can method of getting their prescription needs met was indicative of all the focus groups. They are at the mercy of kind doctors, safety-net programs that may or may not help them with prescriptions, and information that is not always available.

E. They go without dental care.

A particular form of preventative care that all focus group respondents agreed was cost prohibitive is dental work.

"When I had insurance, I went, but I don't go now."

"My girls missed their cleaning this time because our regular dentist didn't take Denali Kid Care. So they didn't go. I couldn't afford to pay it out of pocket."

Still another cost-prohibitive, but often necessary medical expense for seniors is a hearing aid.

"Without a hearing aid, your quality of life just goes down. I know so many seniors who are depressed because they can't hear, but they can't afford a hearing aid. Why isn't that covered under some program?"

F. They get creative about preventative care.

Some focus group participants, mostly in the senior focus group shared how they combine the different preventative types of opportunities they come across with overall medical attention.

"Right now I'm utilizing all the free or reasonable clinics I can. For instance, they are giving flu shots at the senior center. Or if they do blood work. Drawing the blood work. They charge a $10 or 20 fee. The Mobile mammary gland testing is done on a sliding fee—a reasonable sliding fee scale. And then I do one doctor's visit a year to have her coordinate all that."

"I go to the University to get my teeth cleaned. It costs me $15.00. And they did a very thorough job. I know they're students, but they do a thorough job every time."

Quite a few participants must get a yearly check up for either health or work reasons. Those who do so for their work do not have to pay for this and this provides them with care they otherwise would not get.

" I have a CDL (commercial drivers license), so I have to get checked once a year. But the company pays for that."

"I'm a weekend warrior. So every three years I have to get a physical and they pay for it."

Another way to get a check up that is paid for was to give blood.

"For me, giving blood means getting some basic checkups."

Participants reported several alternatives to going to the doctor. One single mom reported, and others agreed, that watching what is going on in the neighborhood helps them make a decision about their medical care.

"Like just happened a month ago. In that particular situation I relied on a friend of mine. Her kids were sick, and she took them to the doctor. It was a virus, going around school. So I figured. Play the odds. Chances are pretty good that my girls have is the same thing. And I waited a week and it went away."

A few participants use alternatives like homeopaths, herbal medicine, etc. However, most rely on over-the-counter medications and follow behavioral ways of maintaining their health, such as getting exercise and eating well.

"Certain stuff you take to keep well. I take a lot of vitamins now. A lot of natural things that have helped me. Like teas and stuff."

Others admit they simply

"Keep my fingers crossed."

4. Safety-Net Programs Currently Being Used

Participants reported a wide array of programs they utilize and for the most part, have had positive experiences with these safety-net programs. Seniors reported more knowledge of how to get their medical needs met than did the younger participants. This could very well be due to a more organized awareness campaign focused on the agencies

these participants are involved with. Programs seniors were aware of or used included preventative services offered at senior centers, the Diabetes Association, the University of Alaska Dental Clinic, the HAPI program and services through pharmaceutical companies and health organizations such as the Lung Association.

"I'm aware if you have a specific problem, like if you're a hemophiliac or a diabetic, or you can identify a lung disease, that those associations will help you. They have their own programs. But first you have to reach that diagnosis. And getting to that diagnosis is hard. So lots of people out there could be getting help through a particular organization but they aren't because they have to be properly diagnosed."

Members of the other focus groups also were aware of or had used a few safety-net programs, particularly the Anchorage Neighborhood Health Clinic, Denali Kid Care and programs through Providence Hospital or the YWCA.

"I was near death when I went to the Neighborhood Health clinic. I went about a year and a half ago, and they said they let me slip through the cracks. I had started going to the chiropractor, had started having real pain in my neck, then I started getting dizzy spells and double vision, and went back to the health clinic. They spinal tapped me and . . . put me in the hospital immediately. She saved my life."

"You know, I love the Anchorage Neighborhood Health Center. Before I had any insurance or anything, I didn't have a good job, I didn't have a good income, and you know, they sent me there. But for the first year, they really helped. Only cost me $15.00 every time I go there. So they really help people. Now I have more money, I pay more. But it is worth it."

"The hospital put me into some kind of program from the pharmaceutical company. And they sent me a whole bunch of pills, free. 'Cuz I didn't have any money. And when I had the surgery. I didn't work for 3 months. And they gave me the pills. And that was pretty helpful. I didn't have to come up with that."

"I'm a newcomer to Alaska and I've had 2 emergencies where I had to go the Providence Hospital on emergency. But I could not believe the way they treated me. It was great."

"They (Providence Hospital) treat you like a real person, even when you don't have insurance."

"The YWCA Encore Program is wonderful, and the help shoehorn people in so they qualify."

5. Barriers to Using Programs

Focus group participants identified three different types of barriers to receiving safety-net services.

A. The Discontinuation of Programs

"There used to be a program you could sign up at the health department to get dental work done. They won't even let you sign up anymore. The waiting list is so long. So actually they are only taking emergency dental people now."

"I was eligible for the HAPI program...but that's been discontinued. I have just got reinstated in August, but I think in January, at the new year, it will run out and they won't have a HAPI program any more. And I'll be back without any benefits at all.

"I was told I was eligible (for the HAPI program), then yesterday I got the letter. It said there is no more budget so they are closing the program. So no one can be enrolled. So I cannot go to the doctor."

B. The Difficulty of Getting into Programs

They also expressed frustration at the difficulty of getting into a program.

"The state places a lot of responsibility on the person to jump through hoops to qualify for medical care."

"I think programs actually make it tough for you. Just having them (the programs) makes the state look good, even if it is hard to get into it. Here's a program, but to qualify for it, Oh, my God."

Yeah, and then if you don't get signed up, you do look irresponsible."

"I was on the waiting list for Denali Kid Care for 7 months."

C. The Lack of Knowledge about Available Programs

In every focus group there was a sharing of information about programs that members had found. Participants asked each other,

"How do you find out about these programs?"

"Is there a list of safety net organizations out there?"

6. Who Should Be Involved In Providing Health Care Coverage And How?

Although most participants want to see changes in accessing health care, most, but not all, are skeptical about the role of government in making it happen. Some would like to see the government regulate the high cost of health benefits, as well as the high costs of medical attention.

> *"I don't want to see the government controlling my health or my health care. But I cannot come up with another solution. Because physicians and hospitals and insurance companies are not going to police themselves. They've already shown us that."*

One member told a story about the medical treatment he received in Canada and wondered why the United States couldn't follow that example.

> *"My baby was only 6 months old. We were traveling and my baby developed a fever. So we stopped in Vancouver and we went to the hospital. They did not ask me, 'do you have money?' They didn't ask me 'do you have health insurance?' They didn't ask me 'Are you a Canadian citizen?' They didn't ask me nothing. They took the baby and they went....and they said, 'Please sit down.'. Right here (in U.S.) you go to the hospital, the first question is "do you have insurance?"*

However, others point to Canada as an example of problems with government controlled and regulated health care.

> *"In Canada, they say is the highest taxed place on the planet, because of their medical"*
>
> *"I also wonder if Canada has as good of quality of doctors as we do."*
>
> *"Yes, there's no incentive for doctors to be better."*
>
> *"I think we can learn from other countries though. See what they've done wrong. You know find out what they done wrong and not do it."*

There is a perception among these participants that the government is too corrupt to manage health care. When one participant suggested a possibility of governmental insurance, the group shook their heads. One member spoke for the rest of the group when she added, "*Uh uh. Like the scandals with the HMO's?*"

Many participants see government bowing to the special interest of the insurance companies.

> *"I don't think the government can do it because they're being paid by all these guys. And I don't think they will make good decisions."*

"Lawmakers cater to those who contribute to their campaigns. They're going to dance to the beat of the insurance drum."

"I think it could be regulated to some degree, but that requires the backbone at the congressional level. And the insurance companies have enough of a lobby that it isn't advantageous for them to take that step. Right now, there are too many rewards on the other side of that. And until that changes, until it becomes more advantageous for the government to regulate, you know, then it isn't going to happen."

Another perception is the tendency of the government to bureaucratize programs.

"I don't think that the government would do a good job. They think in categories. You make this much, you go over here. It's all in how much you make. That seems to be the way it is. You know. They say everything is going so good for single parents. So single parents who've got 2 kids should have their kids on Denali care, right? I was on assistance, and I got 2 jobs, 2 part time jobs and they kicked me off because now I make too much money. So I couldn't afford the day care and pay for doctor's bills. So I dropped one job and they would not take me back. They said 'sorry, that was your own responsibility. You should have kept the daycare.' The government is screwing up. And they're going to do that. They're going to do that if they get more control than they have right now."

7. Paying for Health Insurance

For many of these participants, it is simply the lack of accessibility to health insurance that they want to see changed. They are willing to pay for insurance if they could simply access it. No one in any of the focus groups advocated for free health insurance. They were all aware of their need to pay something. What they could afford to pay, however, ranged from under $10.00 a month to over $300.

"I paid $250 out of every paycheck when I worked at the dealership. And then I still had to pay a $100 deductible. But it was right there."

"I would even say $300 per month...Even $300 a month is not outrageous. Compared to $3000 for the...But 5, 6, 7, 800 dollars. That's just too much. That's just ridiculous."

For others, the gap in the services that health insurance policies provide is an additional problem. These participants want to see health benefit packages that are uncomplicated and easy to use as well as affordable.

8. General Perceptions of Uninsured

To a person, these focus group members agreed that there is a general perception of people who are uninsured as low class, or less of a person, or at least, "doing something wrong." These participants see the general public view that people are responsible for having health insurance and to not have it is irresponsible, or not being a good citizen.

> *"Yeah, they didn't take the right job. You know, they didn't wait for the right job"*
>
> *"Or they should have gone to college."*
>
> *"They think you're low class if you're not insured. It's like everything else. And that's the way Americans think. You know, you're down at the bottom if you're not doing all the things that the majority are doing."*
>
> *"People look at you. Get off the bus. Get yourself a car. Get yourself a job that gives you good health benefits."*

A different version of this perception is that people know there are programs out there and so think everyone is being taken care of. However, as one focus group discussion concluded,

> *"The state places a lot of responsibility on the person to jump through hoops to qualify for medical care."*
>
> *"I think programs actually make it tough for you. Just having them (the programs) makes the state look good, even if it is hard to get into it. Here's a program, but to qualify for it, Oh my God."*
>
> *"Yeah, and then if you don't get signed up, you do look irresponsible."*

Summary of Focus Group Findings

The experiences and perceptions of these uninsured and underinsured focus group participants can be summarized as follows:

1. Range of Employment

The range of employment of these participants demonstrates the diversity of those who are uninsured or underinsured. While many of the participants would be considered low income, particularly those seniors represented, a substantial number would easily be considered middle-class. Self-employment accounted for part of the lack of health benefits. However, most of these participants worked for small companies that did not have the financial capability or numbers of employees to offer health benefits or, in the

case of the seniors group, were involved in a program that could not support health benefits.

2. Attitudes about the Importance of Health Care Coverage

Health care coverage is a valued and desired commodity, according to these participants. Their lack of insurance caused them to be uneasy or nervous about their health. Those who had suffered major medical problems had first-hand knowledge of the effects of not having adequate insurance to cover the expenses. They certainly do not have the luxury of taking medical care for granted for themselves or their children.

3. Medical Experiences and Choices

Lacking health insurance frequently keeps people who consider themselves healthy from seeing a doctor or getting health exams on a regular basis. When healthy participants do choose to take preventative care, they tend to do it creatively. When a job pays for a periodic health examination as a requirement for employment, for example, these participants take advantage of it, and consider it a nice benefit. Others get creative and use programs designed to help keep people healthy. Getting flu shots and blood work done in community centers, finding inexpensive ways to get teeth cleaned, and taking advantage of mobile mammogram clinics are examples of how some of these participants stay healthy.

Health problems demand that people seek medical attention regardless of the cost. Those who must get medical attention on a regular basis for a condition such as diabetes, high blood pressure, etc. find that they look for ways to compromise between cost and necessity. Staying away from specialists whenever possible, getting the minimal amount done to stay healthy, and cutting back on the frequency of visits are all ways those with chronic health problems seek to maintain the balance between health and financial solvency.

Seniors looking forward to Medicare health coverage are concerned about choosing a doctor who will see them once they are eligible for Medicare.

Dental care is the most compromised, according to these focus group members. The prohibitive costs and the unwillingness of many dentists to work with payment plans keep the uninsured from taking care of their teeth. What care is done, is frequently done through inexpensive teeth-cleaning clinics rather than go to a dentist for a more full-service exam.

Hearing aids are another expense that seniors cannot afford frequently and the loss of hearing reduces the quality of a senior's life significantly.

The cost of prescriptions is very troubling to the uninsured, particularly the elderly who rely on many prescriptions for their quality of life.

The uninsured and underinsured compensate for infrequent or basic medical services or their inability to get prescriptive drugs by using over-the-counter medication, and watching their lifestyle. Taking vitamins, exercising, using herbal remedies and "eating right" are all alternatives these participants used to stay healthy.

These focus group members could be divided into two groups. One group is focused on hoping they stay healthy. This group keeps their fingers crossed, and simply does not get medical attention. They feel no control over their health needs. The second group takes action through trying to maintain a healthy lifestyle, both behaviorally and through alternative medicine, in order to postpone costly health care needs. Not having an insurance policy to take advantage of, this second group works at controlling their health care the only way they can.

4. Programs that Meet the Needs

Safety-net programs make a big difference to the uninsured and underinsured, these participants report. They were able to list several programs that help them stay healthy, or receive treatment they can afford, and they are very grateful for these programs. The Anchorage Neighborhood Health Clinics, Providence Hospital, and programs such as HAPI, Planned Parenthood and the YWCA's Encore program were the most frequently cited programs. Participants agreed that they do a good job and make the lives of those who use their services better. Some of those who have had to find inexpensive medications were familiar with programs that provide low-cost or free prescriptions.

Private clinics who cater to those with inadequate insurance or Medicare, such as the Anchorage Medical and Surgical Center, and community services such as the dental cleaning clinic provided at the University of Alaska, Anchorage are deeply appreciated. Finding a good doctor or good services, according to these participants, means finding people who are respectful to those without insurance, who take time, and who are willing to dispense samples and find other ways to lower the costs of medical care.

The greatest barrier to using these services frequently is simply not knowing about them. Having more information and a place to go to learn about programs would be useful, according to these participants. Sometimes, however, programs are difficult to get into, or a bureaucratic to the point of not being useful. And sometimes programs lack funding and are discontinued, as is the case with HAPI, or cannot keep up with demand.

SECTION II: INTERVIEWS WITH COMMUNITY LEADERS

Community Leaders

Fifteen community members were interviewed in a two-part process. Ten assembly members, business leaders, and health and social service providers were initially interviewed by the steering committee of the Coalition. An additional five people were interviewed during the time period of the focus group research. The mayor of Anchorage had been previously interviewed when he was an assemblyman. A second interview was conducted with him later to see if being mayor had changed or added to any of his perceptions.

Procedures

The following research procedures were used in the community leader research:

1. Recruiting Appropriate Community Leaders to be Interviewed

Community leaders were selected by discussions with the steering committee of the Coalition about the kinds of information they wished to gather. Community leaders selected during the time of the study were chosen to complement those leaders already interviewed by the Coalition earlier. A representation of government officials, private non-profit organization directors and public, municipal leaders was sought.

2. Collecting Data

A semi-structured interview protocol was developed consistent with the interview questions asked to previous community leaders. Interviews were conducted face-to-face or over the telephone depending on the accessibility of the community member being interviewed. Each interview took approximately twenty minutes to one half-hour.

3. Analyzing the Data

Written notes and summaries were analyzed. All records were maintained on file for further reference. The researchers used categories based on the questions previously asked. Using appropriate qualitative analysis techniques, the interview information was organized into systematic categories that could be reported in a meaningful way.

4. Summarizing the Results

This section includes summarized findings of the interview data.

Findings

1. Health Care Access Trends

Those who were interviewed agreed that there is a definite trend in more costly health care services and that these costs are getting more and more problematic for the general population. Even for those people who are insured and who have access to health care, the care is expensive. The majority of those interviewed also see a trend toward less access. As jobs get outsourced or contracted out, health care benefit packages get reduced or eliminated altogether. As jobs increase in the "big box" retail business and decrease in the oil industry, there will be more people making less money. Several already see changes. Providence hospital has seen an increase in charity care and a small business owner quoted a statistic of a 37% increase in medical insurance costs this year.

2. What is the Current Situation?

Health care providers and social service delivery providers were more apt to be aware of the current situation for those who have few to no health benefits. Government officials, both at the state and local level, knew very little about the situation for the most part. The two legislators interviewed both agreed that while they have constituents who have talked about this with them, they are not aware of any changes since the last legislative session. They deferred to the health and social services providers as the experts in this arena. One assembly member argued that health is a state issue and needs to be addressed as such.

The uninsured in Anchorage were described as those who have lost their oil industry jobs, those who are working in small businesses or younger people who choose not to spend their money on health insurance. Others referred to the indigent or the very poor when they described whom the rising cost and inaccessibility of health care affected. One businesswoman admitted that she believed Americans are spoiled with the expectation of health care coverage. This view was affirmed by one legislator who pointed out that not all American society believes that health care coverage is an entitlement.

Another aspect of the situation of health care access, brought out by health care experts, was that more and more people are not developing a sense of wellness or preventative care. According to one social services director, " Getting a check up is not in the developmental psyche [of those who do not have easy access to health care]. "

3. Barriers to Accessing Health Care

The community members interviewed identified four different barriers to accessing health care.

A. Cost

For some, the greatest barrier is cost. The cost of health benefits keeps employers from being able to offer benefits at all. When they are able to offer them, the cost of the deductible frequently keeps people from using their benefits. Finally, the cost of medical attention itself keeps people away from doctors for preventative and primary care.

B. Lack of Information

For those who do qualify for special programs, there is not enough information about those safety-net programs, according to some of those interviewed. Special populations, in particular, are excluded from the main information loop.

C. Lack of Trust in Health Care and/or the Government Agencies that Sponsor It

For some persons, particularly the new immigrants, a general distrust in government keeps some people from accessing services they could have. There may be language barriers or cultural differences in medical practices that keep these groups from feeling comfortable using the programs that are available to them.

Social Service providers and others who worked with low-income families pointed out that there is a perception among the poor that they will be stigmatized or judged if they use governmental programs. These suspicions keep people away.

D. Social Issues

Those who work the most closely with safety-net programs and their recipients included the many social factors that prevent people from getting good medical attention. Dysfunctional family structures, substance abuse issues, employment struggles, even transportation issues all prevent people from taking the time and effort to visit a doctor for a primary checkup.

4. Resources Available?

Most of those interviewed were aware of at least a few safety-net programs. Medicaid was mentioned as a way to access health care. In addition, Denali Kid Care was just about on everybody's list. Health care and social service providers were more aware of programs than their business or government counterparts. Providence Hospital, The Anchorage Neighborhood Health Center, and the University program for students were all mentioned. Some care providers were aware of special funds at social service agencies that were earmarked for emergency medical care. One legislator mentioned faith communities who support the health care of their membership. Only one businessman had no idea of any resources. He thought that perhaps if people had no coverage they were simply out of luck.

According to our government officials, we need to continue to talk about this problem. For legislators, assembly members and the mayor, having potential programs and solutions brought to their attention would be useful. They tended to talk more about the "big picture", keeping dialogue open, looking for solutions for different aspects of the problem. Using the permanent fund as a resource to make sure all Alaskans had major medical coverage was one solution that came from the legislators interviewed. Another solution voiced by several government officials was the need for small businesses and nonprofit agencies to come together to pool their resources to receive good health insurance benefits. Out of this group also came the concern that building government programs would be dangerous because it would allow for a lack of individual responsibility towards taking care of personal health needs.

Social service providers were more likely to talk about funding and education. The funding of preventative care was an aspect several providers agreed could be improved upon. One assembly member also advocated for the coverage of all health care for children. All the service providers and several business and government leaders discussed education as well. Education meant both educating the consumers as to what is available for them and the small business owners as to their options about offering benefits. Perhaps, suggested one assembly member, it is time to also start educating the insurance companies.

5. Necessary Partners

The legislators, as well as some municipal leaders, saw the main players in solving the problem of access to health care coming primarily from the ranks of the health providers. Most assembly members, however, not only saw providers but also employers, insurance companies and the uninsured themselves as necessary informants to this process. Others want to see "powerful people", not necessarily direct service providers, taking the initiative. Finally, churches, and other community organizations committed to quality of life, would be good partners in working on health care access.

Summary of Findings

Community leaders are also in need of knowledge about programs. Their interviews suggested that information and education about what is available is a critical part of changing this problem.

SECTION III: CONCLUSIONS AND IMPLICATIONS

While focus group participants and community members focused on different aspects of the health insurance dilemma, some common ground emerged. Both focus group participants and community leaders question who should be involved in providing programs for access to health care. Both focus group participants and community leaders share a belief that society frowns on those who are uninsured. These two conclusions are addressed separately below.

Who should be Involved in Providing Programs?

Participants and community leaders alike were leery of too much government control of health needs. In addition, while focus group members believed health insurance companies need to be regulated to keep medical costs down, they were skeptical that politicians will use their influence to force this issue. The general perception was that the government is in the pocket of high-powered lobbyists and special interest groups, and that the people who need changes in health care delivery and coverage will not be listened to. State and local governmental leaders, on the other hand, reported their eagerness to hear about strategies for changing the situation of health care access.

Instead of government involvement, many participants as well as community leaders urged more support for businesses to offer reasonable health benefit packages, or for the government to support a way for those without work-covered health benefits to tap into health benefit packages available to state and local employees.

Perceptions of the Uninsured

The belief that being uninsured represents something wrong about a person was shared by members of all the focus groups and several of the community leaders. They believe the general feeling of American society is that the responsibility for health care belongs to the individual, and when someone isn't insured, it means they have not gotten the right job, or the right amount of education, or are somehow to blame. This prevailing belief among those who are uninsured adds to the discomfort of not having insurance, and separates them from the "insured" in status as a citizen. A legislative and business view from the interviews confirmed that there are city and state leaders who agree with the philosophy that health care coverage is an individual responsibility. While no community leader agreed that the uninsured are "at fault" for their uninsured state, there were some leaders who spoke about people being "spoiled" by their expectations of health coverage, or question whether society truly believes in the entitlement to health care.

Implications from the Research

It appears clear from the focus groups that health care access for the uninsured or underinsured tends to be random and scattered. It tends to be personality driven, unpredictable and inconsistent. Far more than their insured counterparts, those who are uninsured must become dependent on a doctor's "goodness of the heart" in providing samples or reduced cost for service, or even seeing them at all. They also must be persistent to get the services that are available by getting on lists, calling around for information and filling out the necessary paper work. These participants need access to a system that is not piecemeal, fragmented, or at the whim of a care provider. Community leaders add validity to these perceptions by their own confusion or lack of awareness about programs and what is available.

There are programs that are working and both focus group members and community leaders were aware of some and not aware of others. Instating, or reinstating programs that provide access to comprehensive care much like the Denali Kid Care program would help reduce some of the unpredictability of the current practice of the uninsured. Investigating programs that would allow insurance opportunities for workers by pooling through the chamber of commerce or nonprofit organizations are also important as are keeping dialogue open between the business community, health providers and governmental agencies. Community leaders interviewed want to see this problem solved. They want to continue a dialogue to determine strategies, both in the private and public sector. Focus group members are eager to find working solutions and are willing to pay for them. More information, continuing safety-net programs, and an effort at raising the consciousness of society about the problems of the working uninsured must continue to be explored.

Appendix A

Insurance Group Information Sheet

Thank you for taking a minute to provide us with the following information about yourself. This information is strictly confidential and only will be used to help us form discussion groups for looking at health care and insurance concerns within the Anchorage area. Once we have contacted you about joining one of our discussion groups, you will become anonymous and this information sheet will be destroyed.

Name: _____ Phone: _____

_____ Male _____ Female Age: _____

Occupation: _____ Hours Per Week: _____

Ethnicity: _____ Number of Children: _____ ___

_____ Single _____ Married _____ Separated _____ Divorced

Education:

_____ Some High School _____ High School Graduate or GED
_____ Some College _____ College Graduate
_____ Technical training _____ Other

Estimated Income During 1999:

_____ Below $10,000 _____ $31,000 to $40,000
_____ $10,000 to $20,000 _____ $41,000 to $50,000
_____ $21,000 to $30,000 _____ Above $50,000

Insurance Provided By: _____ Employer _____ Self ___ __No One

Currently Receiving: _____ Medicare _____ Medicaid _____ Neither

Medical services used during past year:

_____ Clinic (appointment) _____ Clinic (walk-in)

_____ Hospital (appointment) _____ Hospital (emergency)

_____ Private Doctor _____ Other (what?)

The Anchorage Access to Health Care Coalition thanks you for your help.

Appendix B

Focus Group Protocol

Introduction

I want to thank you for coming today and tell you a little about what we're going to be doing in this focus group.

Has anyone been part of a research focus group before?
[If yes, ask if they enjoyed it]

Most people find focus groups very enjoyable. It is similar to a group discussion about a particular topic. I think you will enjoy it too.

You will notice that there are two of us here. I am the moderator. My job is to ask you questions and listen carefully to what you have to say. It is important that everybody have a chance to be heard. Therefore, sometimes if **[pick name]** is sitting quietly listening, I may say, "**What do you think about this?** If you have something to add, you can say so then. If you don't have anything to say at that particular time, that's OK too. In a focus group you never have to say anything unless you want to

On the other hand, if **[choose another participant]** has a lot to say about a particular issue, I might stop him (her) and check to see if others have something to add. Also, let's say that the whole group is agreeing about something, but you disagree or have something different to tell us. That is important. I am interested in different opinions and thoughts about the topic.

You see that I have a tape recorder on the table. By taping what you say, I can listen carefully and don't have to worry about taking notes. I will listen later to the tape to remember better what you all said. No one but my research team and me will ever hear this tape.

I also want to introduce _____ who is the assistant moderator. Her (or his) job is to listen and to take notes as we talk to add to the information on tape. If you're all nodding agreement, for example, she will record that.

Today we are going to talk about some issues about health care insurance benefits. You are all a group of people who are working, but do not receive health benefits. We are interested in your opinions about this very important topic. Everything you tell us in this hour will be totally confidential. No names will ever be used to identify who said what. For example, when we report our findings, we will refer to you as "a woman in the focus group" or "a man in the focus group." If you have any questions about the research we are conducting, we will be happy to talk to you about it after the focus group is over. Now, we know your time is valuable, so if it is OK with everyone, let's begin. **[Turn on tape recorder.]**

Warm up

1. To begin, let's talk a little about your situation. What kind of work do you do? Do you receive any benefits at your job? Have you ever received health benefits in your work? Or been on anyone else's health care coverage (husband, parent, etc.) [IF SO] How long has it been since you had health care benefits?

2. How important to you is health care coverage? How has not having health care coverage affected your life?

Access

3. How long has it been since you visited a doctor for a routine check up?

4. How do you currently meet your medical needs? [probe for over the-counter medicine, home remedies, etc] Where do (would) you go to get your medical needs met?

5. How important do you feel it is for all people to have access to doctors and hospitals? To have safety-net hospitals for people who are uninsured?

6. What safety-net health care are you familiar with here in Anchorage?

Cost

7. Have you ever, in the last 12 months, wanted to go see a doctor but didn't because of the cost?

8. If you could buy health care insurance, would you buy it? What could you afford to pay per month for health care insurance [or how much would you be willing to pay a month for health care insurance?]

9. If you had to give up another benefit to have health care, what might you give up? [sick leave, employee discounts, etc.]

10. Who do you think should pay for providing health care insurance? Your place of employment? The Government? Would you support the idea of public dollars being used to provide you with health care insurance?

Perceptions of the Uninsured

11. Who do you think the general public perceives as the uninsured? Why they don't have insurance? What about the government's perception? Are these perceptions similar or different to those who are currently working and uninsured?

Government Involvement

In a recent survey it was found that 49% of the public think the government should get involved with health insurance. Obviously, that means about half think the government should not get involved.

12. Do **you** think the government should be involved in providing health insurance? If it did so, what should its involvement look like? What concerns might you have about government involvement?

13. How much of an issue do you believe health care is currently to our governmental agencies (federal, state, local)? In thinking about such concerns besides health care as education, crime and violence, the economy, jobs, taxes, etc. where would you like to see health care coverage be placed as a priority? [RANK ORDER]

Wrap-Up

14. To finish our time together, what one thing would you like the Health Care Alliance to know about your feelings regarding health care insurance?

Appendix C

Interview Protocol

1. What do you see are the current trends in accessing health care?
2. How do you see the current situation of access to health care in Anchorage?
3. What are the barriers to accessing health care in Anchorage?
4. What resources do the uninsured have that allow them to access health care?
5. What improvements would you like to see in the access to health care for the uninsured?
6. Who should be involved in solving the problem of providing better access to health care in anchorage?

Appendix D

Research Participants Wanted

Are you working more than half time with no medical coverage? The Anchorage Access to Health Care Coalition wants to hear about your health care access problems and concerns. If you are interested in joining a small group of people like you for one hour to discuss these issues, please call 272-6131 (Alaska Primary Care Association). Your ideas are valuable.

PUBLIC TESTIMONY

State of Alaska Senate Health, Education and Social Services Committee: Subcommittee on Health Care and Welfare

Testimony Presented at the
Mat-Su Legislative Information Office
November 8-9, 2001
By Daniel J. Winkelman, Legal Counsel
Yukon-Kuskokwim Health Corporation

Good afternoon Chair and Subcommittee members. My name is Dan Winkelman, I am Legal Counsel for the Yukon-Kuskokwim Health Corporation located in Bethel. Thank you for this opportunity to participate at this Subcommittee meeting, to discuss the future of our State's health care and welfare.

YKHC is comprised of 58 federally recognized tribes operating pursuant to Compact with the federal government under the Indian Self-Determination Education and Assistance Act. We operate the only hospital in Bethel as well as 49 village-based clinics staffed with community health aide practitioners; and 3 sub-regional clinic's staffed with community health aide practitioners, registered nurses and mid-level practitioners.

YKHC urges this Subcommittee, that when considering Medicaid cost-containment measures for the next fiscal year, to understand that under the Indian Health Care Improvement Act, the Federal government subsidizes 100% of the cost of providing medical services to Medicaid-eligible Alaska Native patients through Alaska Native tribe or tribal health organization facilities.[1] Alaska's Federal Match Percentage, otherwise known as the Federal Medical Assistance Percentage or "FMAP", is 100% for health care services provided to Medicaid-eligible Alaska Native patients.[2] Indeed, when Congress

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[1] *See* 25 U.S.C. 1601 *et seq.*(2001); *see also* S. REP. NO. 101-508 (1990).
[2] *Id.*

enacted this law, the U.S. Senate Select Committee on Indian Affairs stated in its Senate Report, and I quote:

> Thus, the Federal Government would pay for 100% of the reimbursements to tribally-owned health facilities for services provided to Medicaid-eligible Indian patients. *This, in turn, would reduce the states' current share of Medicaid expenditures to 0% for these same facilities.* As a result, Native Americans will have better access to health care services and will be able to more fully utilize third party resources to which they are entitled.[3]

Therefore, 100% of Medicaid costs for Alaska Native patients is 100% Federal pass-through monies resulting in a State Medicaid experditure of 0%. Accordingly, any reduction in Medicaid rates proposed by this Subcommittee would be a reduction of Federal, not State monies for Medicaid eligible Alaska Native patients resulting in a decrease of health care services to Alaska Natives and contrary to Congress' intent. For the foregoing reasons, YKHC strongly urges this Subcommittee to *not* reduce the State's Medicaid Program.

Lastly, I would like to invite the Subcommittee to personally tour YKHC and meet with your rural constituent's *before* the Subcommittee proposes health care legislation that would negatively effect rural Alaska.

Thank you.

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[3] S. REP. NO. 101-508 (emphasis added).

Alaska Native Health Board

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Anchorage, Alaska 99508

Phone: (907) 562-6006
FAX: (907) 563-2001

Written Testimony for the
Healthcare and Welfare Reform Subcommittee

Presented by: Cynthia J. Navarrette, PHR

November 8, 2001
Wasilla, Alaska

My name is Cynthia Navarrette. I am the President and CEO of the Alaska Native Health Board (ANHB). ANHB is a statewide non-profit corporation that was established more than 30 years ago for the purpose of "promoting the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native people." The Board of Directors of ANHB include Alaska Native regional and village health providers from across the State. In most cases, these organizations are the only health care providers for their region, serving both Alaska Natives and non-Natives who would otherwise have virtually no access to health care services.

I am going to provide my testimony in ~~three~~ 4 parts: 1) An overview of the Alaska Native Statewide Health Care Delivery System; 2) An overview of the funding provided for operating the programs, functions, services, and activities throughout the health care delivery system; 3) An overview of Medicaid, and; 4) The effects of IHS Beneficiaries use of the Medicaid Program.

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
EASTERN ALEUTIA. TRIBES
KETCHIKAN INDIAN COMMUNITY
VALDEZ NATIVE TRIBE

MANIILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
KODIAK AREA NATIVE ASSOCIATION

NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTH CENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION
NORTH SLOPE BOROUGH

Overview of The Alaska Native Statewide Health Care Delivery System

The heart of the Alaska Native Health System is the 468 Community Health Aides working in 178 village clinics throughout rural Alaska. The IHS beneficiaries in remote villages do not have daily access to physician care. They rely on the medical attention of the Health Aide.

There are six regional hospitals operated by the following Native regional organizations.

- Maniilaq, Inc. located in Kotzebue, Yukon-Kuskokwim Health Corporation located in Bethel, Norton Sound Health Corporation located in Nome, Bristol Bay Area Health Corporation located in Dillingham, Arctic Slope Native Association located in Barrow, and Southeast Alaska Regional Health Consortium located in Sitka.

The Alaska Native Health Care Delivery System consists of both consortiums and individually operated service units. A typical consortium infrastructure includes village clinics, possibly several sub-regional clinics, and a regional hospital. The rural health organizations typically serve areas as sole community providers. They may also serve the entire population, regardless of race.

The Alaska Native Medical Center (ANMC) is located in Anchorage and provides essential tertiary care, acute care and specific statewide health services for all Indian Health Service beneficiaries. The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly manage the facilities that provide the full continuum of care within the Alaska Native Health Campus.

The AK Native Health System reflects levels of care available within the village, the regional hospitals, and the Alaska Native Medical Center (ANMC), located in Anchorage. The Medivac is essential to receive the next step up of care from the village to the regional hospital. If the case is deemed serious enough, a Medivac can be directed from the village straight to ANMC. There are

Medivac call-outs from Regional Hospitals to ANMC, and also from ANMC to more specialized hospitals in the lower-48.

Overview Of Funding

With the construction of the new Alaska Native Medical Center and the Primary Care Center, there is a perception that Alaska Native Health Services are amply funded. The reality is that the system is significantly under-funded. Indian people have long experienced disproportionately low health status and a large gap in health care resources compared to other Americans. Recently, Congress requested a health status and resource deficiency report for each Indian tribe or service unit. The IHS charged a Level of Need Funded (LNF) Workgroup to develop the necessary methodology. This report, published April 2001, states that Alaska is only funded at 61% of the total need compared to the Federal Employee Health Benefits Package. It is important to know that the Medicaid reimbursement funding is included in this percentage.

Overview of Medicaid

The Medicaid Program is not out of control. It is a large cost in every State, second only to Public Schools. To save the Alaska Legislature money by reducing the Medicaid Program would actively harm people receiving care – either by eliminating services for adults, or cutting reimbursement to providers, which will reduce access. Medicaid provides insurance to individuals and families that have no other access to health care services. Reducing the program would be a huge detriment to the health of Alaskan citizens.

Additionally, there is the economic impact that would be imposed on private health care providers to consider. 17% of the employees within the private sector are funded due to the Medicaid Program. Realistically, Medicaid within the State of Alaska is not a comparatively generous

program. Other States in our nation provide more services and that should be the direction in which the Alaska Legislature heads as well.

The Effects of IHS Beneficiaries Use of the Medicaid Program

IHS Beneficiaries are a large user of the Medicaid Program. However, the fiscal reality this imposes on the Medicaid Program is not what one would think. The State of Alaska receives 100% reimbursement from the Federal Government for IHS Beneficiaries that utilize Medicaid. This results in broader user access to a non-IHS Beneficiary population. Additionally, the IHS Beneficiary who utilizes the Medicaid Program actually has a positive impact on our States economy. The federally reimbursed dollars create jobs in the private health care sector that may not be otherwise available.

The Alaska Native Health Care Delivery System encourages the Alaska State Legislature not to cut the Medicaid Program and lower the wellness of Alaskans for the benefit of fiscal conservation.

Bill Hogan, Lifequest & Alaska Mental Health Board

Alaska Mental Health Board

Talking Points
Senate HESS Subcommittee on Health Care and Welfare
November 2001

Welfare

Programs such as the Alaska Temporary Assistance Program, Adult Public Assistance, and General Relief provide basic support for many Alaskans, helping them to meet fundamental expenses such as food, shelter, clothing, and transportation. Whether transitional or long-term in nature, these programs allow participants to live as independently as possible and with dignity in their community of choice. These programs also help Alaskans avoid homelessness and minimize higher cost, more restrictive settings, including hospitalization, nursing home placement, and incarceration. As the subcommittee reviews these programs, the AMHB requests that it keep in mind the following principles:

- All Alaskans have the basic human need to achieve and maintain the highest possible level of independence.
- The State has a responsibility to address the basic human needs of individuals who do not have other means to meet those needs on either a short or long-term basis.
- Support levels should to be sufficient to allow individuals to live with dignity in the community.
- Support levels should be consistent and predictable to provide stability for individuals as well as for the service providers.
- Programs should be readily accessible to eligible applicants.
- All eligible individuals should be treated on a fair and equitable basis.
- Programs should be flexible enough to respond to the evolving needs of recipients and should not impose unnecessary and rigid barriers to support and community integration.
- Programs and services should be managed to promote efficiency and maximize resources.

Review of these programs should be conducted in a thoughtful manner. At a minimum, this process should include the following features:

- No changes should be made that negatively impact the ability of participants to meet basic living needs.
- Review of these programs should be on a program-by-program basis.
- No major changes should be made without meaningful input from program recipients.
- Any review or revision of a program must consider the full impact of the program and any proposed changes on recipients. The impact of reductions to other programs and services (grant programs, revenue sharing, etc.) on the ability of Alaskans to meet basic life needs must also be carefully considered.

Health Care

Review of health care programs, such as Medicaid and other publicly funded health care programs, aimed at cost containment, access, and coverage is appropriate and necessary periodically. The review should involve a broad group of those affected by possible changes, including the Alaskans these programs directly serve. Some points to consider:

- The subcommittee has limited time to address a number of complex issues.
- Access to health care should be carefully considered. Publicly funded programs represent the only source of health care for many Alaskans, providing vital services unavailable elsewhere. Private insurance has historically provided limited and lesser coverage for persons with mental illness (and substance abuse disorders) compared to coverage for other health conditions. The U.S. Senate recently passed a comprehensive mental health parity measure that, if it becomes law, will help reduce reliance on Medicaid and other forms of public assistance (many with mental illnesses would work if their illnesses were covered by private insurance).
- Public health care and welfare costs represent a relatively small portion of the State's direct budget costs and attract significant amounts of matching Federal funds. Our rough estimate is that State General Fund expenditures for health care and welfare totals about 7% of all FY 2002 State expenditures (including the Permanent Fund).
- The U. S. Surgeon General's 1999 report on Mental Health and subsequent supplements assessed the nation's response to mental illness and called for positive, proactive engagement. We urge that the Legislature to take leadership in addressing mental health issues:
  - ✓ Mental health and physical health are inseparable.
  - ✓ Mental disorders are real health conditions that can be disabling—more years of life are lost to mental illness in our society than all forms of cancer combined.
  - ✓ Mental health treatment works! Many forms of treatment now effectively address the symptoms of mental illness with fewer ill affects.
  - ✓ Up to 50% of those with severe mental illnesses do not seek treatment as consequence of stigma - fear, stereotyping, and discrimination.

  We must increase efforts to reduce and eliminate barriers to effective treatment of mental illness by eradicating stigma, educating others and ourselves about mental illness, and ensuring that mental health services are available when and where people need them.

OUR PRINCIPLES

Zero tolerance for fraud -- America's hospitals and health systems are rooted in a tradition of ethics and caring. We're committed to preventing, uncovering, and eliminating health care fraud and abuse. Hospitals across the nation are voluntarily adopting plans to ensure compliance with complex and confusing Medicaid laws and regulations.

However, Medicaid billing errors often result from confusing and conflicting regulations and instructions that are part of the Medicare reimbursement system. These are not intentional acts. Yet some would have you believe that mistakes and fraud are the same.

Providers who make billing mistakes after attempting to comply with the complicated and frequently changing rules of Medicaid payment should be treated in a fair, equitable and civil manner and granted appropriate due process rights -- rights that are guaranteed to all Americans.

Compliance -- The AHA Board of Trustees recently issued a statement urging all hospitals and health systems to voluntary adopt regulatory compliance programs "as a way to minimize errors in conforming to highly technical and complicated rules," and urged hospitals and health systems to "develop and implement or strengthen a formal compliance program to ensure that regulations are accurately followed."

THE SOLUTION

To solve this problem, we need to return to the partnership we once had with the government. By rebuilding this partnership, we can go a long way toward ensuring compliance and fairness.

We would propose:

- imposing a "de minimus" standard. Under the standard, as defined by the American Institute of Certified Public Accountants, Medicaid overpayments to providers of less than a specified percentage would result in penalties of no more than the amount of the claim plus interest.
- establishing a "safe harbor" for hospitals that submit a claim based on advice given by fiscal intermediaries and carriers. Such hospitals would be subject to fines limited to actual damages and interest.
- raising the burden of proof from a "preponderance of the evidence" standard to a "clear and convincing evidence" standard.
- establishing a "safe harbor" for hospitals that have adopted effective, good-faith compliance plans in which they are, if found in violation, subject only to actual damages plus interest.

Rebuilding the hospital/government partnership -- Hospitals and health systems want a new partnership with the State. Working together, we can do more to prevent hospital billing errors, and to prevent government over-reaching as it tries to account for those errors.

The AHA is willing to help find other ways in which the State government can make the billing system more workable. We have proposed a "best practices" process. Under this process, the AHA would identify vague laws, regulations, carrier instructions, etc., and go to the State with our best view on how they can be implemented. The State in turn would consider the problem and our suggestions, and get back to us with proper guidance. Through this process, disputes related to interpretation of laws, or individual concerns, could be solved without antagonism.

In addition, we have talked to the Attorney General's office about a mechanism that would give us an "early warning" about potential areas of concern. We respectfully disagree with the Attorney General's office that our members have received reasonable notice of problems in the past.

Also, we need to look at a dispute resolution system that could remove some of the adversarial relationship between the government and the hospital field. If we can develop an administrative mechanism to resolve disputes over both broad policies and specific disagreements, we can diffuse a potentially volatile situation.

At a minimum, we need to return to a system in which [***the Alaska Medicaid payment authority***] exercises its authority to review and discuss billing disputes with hospitals. Only after the failure of those efforts should Attorney General's office become involved.

- ✓ Develop clear and objective standards that differentiate between a regulatory overpayment and a civil/criminal fraud and publish these standards so that the AHA may advise its members on the standards.

The DOJ needs to speak clearly and precisely to retain its enforcement credibility, which is now at risk as it tries to stretch its enforcement resources with collection efforts of this sort.

- ✓ develop a self-disclosure program for regulatory overpayments that encourages compliance and not fear of unreasonable claims of penalties and damages, and would not require payment of penalties beyond standard interest penalties absent specific evidence of fraud or reckless disregard of overbilling.
- ✓ develop a "safe harbor" treatment for hospital overpayments that occur as a result of inaccurate or incomplete fiscal intermediary/carrier instructions.

CONCLUSION

We understand and agree with the government's determination to investigate and punish those who would abuse the system.

But the government is doing the right thing in the wrong way.

The overwhelming majority of Alaska's hospitals and health systems work hard to comply with the mountain of rules and regulations that govern Medicaid payment. When a mistake is made, it should not be treated as fraud. It should be treated as a mistake.

Through a rebuilding of the health care field's partnership with the government, we can make things fair again -- for hospitals and health systems and the people they serve, and for the government as well.

Note: based on "Testimony of the American Hospital Association before the Subcommittee on Immigration and Claims of the Committee on the United States House of Representatives on Health Care Initiatives Under the False Claims Act which Impact Hospitals April 28, 1998" delivered by Gordon Sprenger

http://www.aha.org/ar/testimony/test980428a.asp

November 8, 2001

Senator Green,

I would like to take this opportunity to speak to the issue of Denali Kid Care. I was introduced to the Denali Kid Care program through a personal heartbreak. My son attempted suicide through cutting his wrists and forearms. After a series of events I eventually had to place him in Providence Hospital's Adolescent Mental Health Unit. After 12 days of treatment, medication and counseling it was their recommendation that he be placed in a long-term residential treatment program.

We are a family of 5, my husbands health care program through his employer does not provide for residential treatment. I was consumed by panic. How could I bring my son home under his current frame of mind? How do you explain his actions to my other 2 daughters, of 6 and 4 years of age? It was impossible to fund something of this magnitude on my husband's salary and fall ultimately into bankruptcy. If I brought him home would I wake up one morning to find him dead in his bed? Or maybe even one of his sisters finds him that way.

Why wasn't the birth of my son followed by an owner's manual that would allow me to prepare for something so tragic that even foreknowledge could not ease or truly prepare you for? My thoughts were my adversary, my terrorist within. Until the staff caring for my son at Providence introduced me to Denali Kid Care. I had never considered this as an option for our family because my husband carried insurance through his employer for us, however because of my son's situation and other factors he qualified for this coverage. He has been in a residential facility in Utah for 14 months, as there were no facilities available for him in Alaska. After nearly 8 months of complete indescribable torment and anguish, for myself as well as him, the wonderful person I knew he could be, is emerging. It is unimaginable what our lives would be like today had Denali Kid Care not been there for us.

Respectfully,

Carolyn Sue Drouce

OCT 19 2001

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DENALI COMMISSION HEALTH CARE STEERING COMMITTEE

Recommendations for Restructuring

October 11, 2001

The Denali Commission Health Care Steering Committee was formalized by action of the Commission in the September 14, 2000 quarterly meeting. Prior to being formalized, the Steering Committee was established on an ad-hoc basis to assist the Commission in completing a statewide needs assessment and prioritization process for primary health care facilities.

Over the past year the formalized Steering Committee has been instrumental in helping the Commission to get the Health Care Program into operation. Now that the Program is in the operational phase, we believe it is time to sharpen the focus of the Steering Committee and to refine the Committee organization to best achieve the defined purposes.

Steering Committee Functions:

1. Provide general policy advice to the Commission
2. Provide advice on funding guidelines and funding allocations
3. Establish objectives for outreach and constituent input and actively facilitate both
4. Provide advice on approaches necessary to ensure sustainability of facilities and services
5. Provide direction regarding assessment and training needs relative to health care delivery and facility issues

Current make-up of the Steering Committee:

1. Director of Department of Health and Social Services Division of Public Health (DHSS-DPH) serves as chairperson
2. Representative of Alaska Native Tribal Health Consortium (ANTHC)
3. Representative of Indian Health Services (HIS)
4. Representative of USDA Rural Development Agency (USDA-RD)
5. Representative of Alaska Mental Health Trust (AMHT)
6. Representative of Alaska Center for Rural Health
7. Representative of Alaska Primary Care Association (APCA)
8. Representative of the DHSS-DPH
9. Representative of the Denali Commission

Proposed restructuring of Steering Committee:

1. Chairperson would remain the same
2. ANTHC – representative would be the President or board member
3. IHS – representative would be Deputy Director and Chief Medical Officer
4. AMHT– representative would be the Executive Director
5. University of Alaska – Vice President for Health and Social Services
6. APCA – representative would be the Executive Director
7. Alaska Native Health Board (ANHB) – represented by the Executive Director or board member

Proposed sub-committee for funding agencies:

1. USDA-RD
2. Housing and Urban Development

3. IHS
4. State of Alaska
5. MHTB
6. Other organizations at discretion of Committee Chairperson

Rationale for restructuring:

The intent is to reorganize the Steering Committee so it is able to accomplish its purposes more effectively and expeditiously. Subcommittees, both standing and ad-hoc, established at the discretion of the chairperson, would support the restructured committee in dealing with technical and procedural issues. (At this point it is clear that a funding agency subcommittee is needed to assist in the allocation and integration of the various funding streams and preliminary discussions are underway regarding a data committee.) The Steering Committee can then focus on providing policy level advice and reviewing and acting on recommendations from the subcommittees. The proposed make up of the new Committee reflects this policy level focus.

The proposal to include the University of Alaska Vice President for Health and Social Services will allow us to continue to tap the input of the Alaska Center for Rural Health, which is a unit of the University of Alaska, as well as other expertise contained within the University system, by having this representative of the University President.

We believe that USDA-RD can serve best as a member of the funding agencies subcommittee, and may be utilized in other subcommittees as appropriate.

The DHSS-DPH and Denali Commission will continue to provide staff support to Steering Committee.

Concurrence with recommendation:

Jeffery B. Slaser, Federal Co-chair

Fran Ulmer, State Co-chair

Alaska Division of Insurance
Presentation to the
Senate Health Education and Social Services Committee
Subcommittee on Health Care and Welfare

Who is writing health insurance in Alaska?

- Self-funded employer plans (i.e. most large employer plans) are preempted under federal law from state regulation and therefore the Alaska Division of Insurance is not able to collect information on these plans
- There is not a competitive health insurance market in Alaska
- Results of the Division's 2000 health insurance survey indicate that
  - 1 insurer (Blue Cross) writes almost 90% of individual health insurance in Alaska and 1 other insurer (Mutual of Omaha) writes about 9%
  - 3 insurers (Blue Cross, Principal and Aetna) write over 85% of the small employer health insurance in Alaska
- Very limited choice of insurers and health plans

What are the barriers to insurers writing health insurance in Alaska?

- Small remote population: small base over which to spread administrative costs making it difficult to be competitive and make money
- Alaska's health insurance market represents less than .2% of the indemnity market in the U.S.
- Difficult to establish relationships and contracts with health care providers making the cost of health care even more expensive and more risky for insurers to write in Alaska
- On a national level and in Alaska insurers are pulling out of the individual and small group markets because they are not profitable for the them

What are the barriers to the purchase of health insurance by Alaskan's?

- Alaskans with health conditions are guaranteed coverage through the CHIA however many are not able to afford the premiums
- Healthy Alaskans would be able to purchase coverage in the standard market however their choices are limited to basically two insurers and many are not able to afford the premiums
- Cost of individual and small employer health insurance is high. Individual and Small employer premiums are high due to the high cost of health care, higher risk nature of the individuals insured (smaller pool and anti-selection) and administrative costs for both the insurer and the small employer. Therefore, many small employers can not afford to cover even a portion of the premium.
- **COST**

What can the state do to decrease the number of uninsured Alaskans?

- According to the latest US Census Bureau survey data the number of uninsured in Alaska is growing (at 19% in 2000)
- Lack of affordability appears to be the reason
- Direct or indirect premium subsidies or assistance programs
- Create a pool for lower income individuals and small employers currently without insurance and subsidize premiums or provide funds to cover excess losses of the pool

The Right Way to Replace Welfare

By Marvin Olasky

Policy Review
March-April 1996, Number 76

Over the past few decades, government welfare programs have been designed to lift the burden of caring for the poor from ordinary people, by allowing them to write a check to pay the professionals who would solve problems. It is time for government to reassert a healthy pressure on the American people: Congress should phase out federal-assistance programs and push states to develop ways for individuals and community-based groups to take over poverty-fighting responsibility.

Our predecessors understood the Constitution's charge to provide for the common defense but to promote the general welfare -- by ensuring an environment in which individual and community action could flourish. When, for example, Congress in 1854 passed a bill for federal construction and maintenance of mental hospitals, President Franklin Pierce vetoed the bill. "Should this bill become law, that Congress is to make provision for such objects, the foundations of charity will be dried up at home," he said.

Pierce's veto was sustained. His concern about "dried up" charity was typical of the era: Municipal aid to the poor could dry up private charity; state relief could dry up city aid; federal programs could dry up state efforts. Hardly the way to promote the general welfare.

But the mood of that era -- not to mention the Constitutional vision for addressing social needs -- has been lost. The concept of the modern welfare state placed responsibility for fighting poverty not at the lowest level but the highest. National entitlement programs came to dominate the social-services scene. The reversal of Pierce's doctrine was so complete that even conservatives in the 1980s, who favored reducing the growth of welfare programs, still talked of the importance of maintaining a federal safety net. They did not understand that the federal safety net was not only inefficient, but conceptually mistaken.

What? Criticize the safety net itself? Yes. When I took my children to the circus recently, I realized how infrequently the Ringling Brothers safety net is used. For an acrobat, a fall to the safety net is a failure; if he falls stunt after stunt, he will be fired. Most people during the Depression had the psychology of the acrobat: The newly installed federal safety net was to be used only when the choice was between it and a hole in the ground. But over time, as attitudes soften[illegible] welfare programs expanded, that desire to avoid using the safety net was often lost. The destigmatizing of welfare in the 1960s meant that the acrobats no longer needed to strain for those extra inches, because the audience would still applaud even if they fell into the safety net every time.

What America needs is not a safety net but a vast variety of small trampolines, suited to individual needs, movable so as to be present for individual crises, and providing a level of bounce fitted to the skill level and psychology of the individuals they are designed to save. Government's role under such a plan is clear: Get rid of constraints on the construction and movement of trampolines, and -- if it does not appear that enough trampolines will be produced -- provided incentives to get more. In that way, government can promote the general welfare.

What would this mean in terms of practical policy? Nothing short of a revolutionary proposal: We must place in the hands of state officials all decisions about welfare and the financing of it, and then press

provided by Representative John Coghill's office 10/29/01 3:37 PM

them to put welfare entirely in the hands of church- a... ...ity- based organizations.

Under this radically decentralist proposal, Congress would acknowledge that even the block-grant concept violates common sense -- far better to leave the money in the states in the first place. Congress would acknowledge that block grants reduce accountability, for the goal of block grants is to free state governments from centralized control, but it also tends to free them from taxpayer control because the funds are viewed as "free money" blown in from Washington; Congress would acknowledge that block grants tend to breed scandal; without real accountability to either the national capital or the state's citizenry, funds are wasted and pressure mounts for Congress to attach not just strings but ropes to hold the sides of the box together.

In this scenario, a bold Congress, pushed hard by the newcomers of 1994 and 1996, would not fall into the same old trap and recentralize. Instead, Congress would pass, effective at the end of the block-grant era, a massive tax cut, with federal taxes decreasing by the amount no longer block-granted. (A side benefit: If Congress moves toward a flat tax, the tax rate could be set lower than is currently anticipated.)

States would then use their own taxing authorities to implement new programs, or duplicate the old ones if they choose to do so. If a new Congress were to make that decision in 1997, states would have four years to plan for the post-federal welfare era. They could tax residents adequate amounts to care for the poor, but provide incentives for citizens to contribute sizable amounts of time or money to local poverty-fighting charities by providing exemptions to the ... ...

It is not as if a dollar-for-dollar replacement for the $350 billion annual cost (in 1994) of federal and state welfare spending (70 percent of it coming from Washington) is necessary: We know that much money is wasted and worse than wasted, actually causes harm. Yet, if more trampolines are needed, we should not be opposed theoretically to governments, once they have worked to reduce barriers, also working to promote the general welfare.

The best way for legislatures to do this would be to offer the average taxpayer a deal as follows: "Come the year 2001, under the Welfare Replacement Act of 1997, your federal tax burden will be reduced by an average of $3,000. We certainly do not want to be accused of being cruel or mean-spirited, so we will raise state taxes by an average of $2,500. However, we also want to promote personal involvement with community-based organizations that offer effective compassion to the poor, and if you provide to such an organization a combination of money and time totaling at least $3,000 -- thus leaving the quantity of societal commitment to the poor unchanged -- you will be exempt from the new tax."

This would obviously represent a sweeping change from the current system. Now, taxpayers who itemize can deduct from their taxable income the contributions they make to a wide range of religious, charitable, and educational organizations, at their marginal tax rate (the lowest is 15 percent, the highest is 39.6 percent). This is helpful, but not good enough, and movement toward a flat tax might eliminate that deduction anyway. Under the new system proposed here, states would push taxpayers in a massive way to become involved with groups that provide direct social services to the poor, and offer exemption from taxation for such purposes to those who were helping others in their own way.

At least 11 critical questions about such a revolutionary departure from current practice immediately arise:

Q: ***What percentage of taxpayers would choose to support local charities and thereby gain exemption?*** That is very difficult to predict, but with four years of preparation it is likely that many would, resulting in

a tremendous boost to nonprofit finances and a large increase of citizen involvement. Those who did not become involved would pay the new tax, and states could use that fund to pay for any missing trampolines.

Q: ***Would church-based and community-based organizations be ready to expand or replicate themselves in order to make use of their new resources in a new century?*** They would have time to prepare, and the encouragement of a new system would ... the "compassion fatigue" that has built up over the years.

Q: ***Would acceptance of exemption-creating contributions force poverty-fighting charities to accept governmental control?*** At the moment, charitable organizations that seek government grants come under government oversight; some church-related programs have gained financially but lost their souls in the process. Even nonreligious charities accepting public funds have been forced to treat all of their clients bureaucratically, within the parameters set by law and regulation, rather than dealing with each human being on an individual basis.

The advent of "new tax" exemptions would not automatically free up religious groups and other community-based institutions to participate as equals in the social services sector. Despite precedents set by the GI Bill and other programs that allowed consumer choice, the ACLU would not be amused by the removal of secular liberalism from its established, privileged place.

Still, the offer of an exemption (signifying a right not to pay because of other services rendered) is as clear a hands-off statement as a legislature can make. Exemptions offer a greater degree of protection than deductions, credits, or especially vouchers, since the latter requires government not only to overlook revenue but to send out checks. A political coalition strong enough to obtain tax exemptions should be strong enough to keep them from being abused by antireligious zealots.

Q: ***Wouldn't some exemptions from taxation go for funds sent to phony, needless, or simply ineffective projects? Wouldn't these cases be cited by partisans of the welfare state as reasons for opposing the exemption system?*** Certainly, and those cases would make an impact on people who are startled to find that some among their fellow human beings are foolish, incompetent, or gullible.

Markets work not because everyone exercises perfect judgment, but because, on balance, most people make good judgments most of the time. Even with all the anticipated human error, a charitable sector in which the funds are allocated by individual private decisions is likely to be less wasteful than the current system. Besides, with more resources at stake, more careful analysis of charitable effectiveness is likely to become common. Publications that examine charities the way a Consumer Reports examines products would emerge.

Q: ***Wouldn't acceptance of volunteer time as part of the exemption-creating contribution open the door to fraud?*** It is true that proof regarding the giving of money tends to be clearer than that concerning time, the valuation of which can be complicated. Still, emphasis on the crucial meaning of compassion -- suffering with -- is vital, and a plan that provides incentives for contribution of money but not time is incomplete.

Many groups already keep records of volunteer hours, so bookkeeping would not be an insurmountable problem. Corruption could be kept to a ... keeping the general credit for exemption purposes at the level of the minimum wage -- enough to provide a bit of compensation for work time lost and to signify societal commitment to compassionate action, but not enough to promote

widespread cheating.

Q: ***What would happen to health care for the poor?*** Medicaid is the single biggest element of current federal and state welfare expense; of the $324 billion that federal and state agencies spent on welfare in 1993, $132 billion went for that one program. And yet, many cities have free or sharply-reduced-price clinics where some dedicated doctors and nurses volunteer their time. What can governments do to help such organizations?

In Jackson, Mississippi, the Voice of Calvary Family Health Center sees about 8,000 patients each year, and would like to expand its operations or start other clinics like it. Center director Lee Harper contrasts her clinic with higher-budgeted state operations and concludes, "When you have more money, you tend to waste more." Still, she needs more funds. Job one, however, is getting more hours from volunteer doctors, dentists, and nurses. "If we get the health professionals, we'll get the money."

Such an urgent need translates into a specific proposal that could be implemented at the federal level in lieu of all the macro-reform proposals of the 1990s: Give medical professionals tax credits for hours regularly worked at clinics. If a typical doctor, dentist, or nurse worked one day every two weeks at a clinic or in a similar way spent time to provide health care to poor individuals, billions of dollars in medical expenses could be saved. Participating health personnel, in return, could receive a tax credit equivalent to 10 percent of their salaries. Such a credit could be the cornerstone of the personal alternative to bureaucratic health-care plans that are rightly regarded with skepticism.

Q: ***Why substitute a state tax (with exemptions) for a federal one? Why not simply reduce taxes and allow individuals to spend the money as they see fit?*** Advocates of individual rather than governmental responsibility have the personal emphasis right, but will a reliance merely on individual goodwill and effort lead to the production of enough trampolines? For those who emphasize original sin rather than natural goodness, there is a middle ground between government and individual: Call it societal responsibility, within which government requires payment but leaves to the individual taxpayer how the money shall be spent.

Q: ***Will it be possible to restrict tax-exempting contributions to those organizations that are actually engaged in fighting poverty and its associated pathologies?*** In some cases the correct category will be obvious, but in others careful judgment will be required. For example, it would seem that general donations to a college or a private school should not be used for exemption purposes, but donations to a college or school scholarship fund for poor students should be. General donations to a church should not produce an exemption, but those to the church's specific poverty-fighting endeavors (an anti-addiction program for example) should be. General donations to a hospital should not; donations to a free or reduced-rate clinic for the poor should.

Such categorization would be necessary, even though it could cut into the individual flexibility that straightforward tax reduction would allow. No matter how carefully state legislatures define the new tax category for poverty-fighting organizations, officials would have to write and apply regulations implementing the new tax. That authority potentially could allow a state agency to exclude organizations that it did not favor for ideological, theological, or political reasons. Some organizations might change what they do and the way they do it in order to conform to the regulatory standards.

Such a threat does not mean that the new system could not work. It does mean that eternal vigilance will continue to be the price of liberty.

Q: ***Why not rely on pure voluntarism to do what is necessary?*** The seeds of welfare replacement are already planted; if we wish to move quickly enough to save a generation of children during the first decade of the 21st century, those seeds need lots of water. If men were angels, no incentives for goodness would be necessary, but devolution to the states and further devolution through an exemption system is a good way for human beings to shift resources from the public sector to the private sector. Such a shift would provide a pool of capital for worthy charities to use in replicating themselves and thus replacing the welfare state.

The stimulation of voluntarism through tax exemption is an impure tactic, but our predecessors in this country, with their realistic view of human nature, were not above using impure motives to promote virtue. Colonial settlers who took in a poor person received compensation from the township, and some of them may occasionally have profited a bit (although that would be more than made up for by the time they spent mentoring the needy person). A farm family that adopted an orphan gained a farm hand, though the economic advantage was outweighed by the hard task of being new parents to someone who had grown up under tough conditions.

Q: ***Why require $3,000 to receive the exemption from payment of $2,500?*** If some people hesitate to give (in money or minimum-wage time) the greater amount necessary to receive an exemption, that is fine; the quality of their giving would probably be low. Some personal contribution by the taxpayer is important to build a sense of involvement with and responsibility for the work of the charitable organization. The goal is to have as many taxpayers as possible think through their giving, and not merely respond to direct-mail appeals.

Q: ***Why would taxpayers be expected to make better decisions on groups to support than government officials have?*** Competition has made the American economy the strongest in the history of humanity, and the American political system the envy of the world. The American people have proven themselves capable, on average and over the long haul, of making good economic and political judgments. Taxpayers who invested $500 of their own money and time in order to direct $2,500 to satisfying projects would be likely to make equally good judgments in the charitable sphere.

Decisions about where funds shall go would no longer be a function of political struggles over the budgets of government agencies, but would result from the decisions of millions of individual donors. Independent charitable organizations would for the first time in generations be on a level playing field with those groups favored by government. Some errors would occur, but there is every reason to expect this system of delivering assistance to the needy to be far more effective than the current model of top-down government monopoly.

Yes, some innovators would fall, but isn't it better to win a football game 50-14 than to play so defensively as to fall into a 3-3 tie? Given the growing number of damaged children and ruined adults under our current regime, isn't it better to take the rational risks that could liberate millions, rather than suffer constant winter without Christmas?

In general, decentralization offers the best shot for each state to innovate in the way that is right for its unique population and specific problems. Since we do not know precisely which legislative plan would best promote the offering of individual compassion, an emphasis on state-level action maximizes the opportunity to find out for sure which tactics work best. Furthermore, there may be greater opportunity to move quickly in some states than in Washington.

While each state would have to sort out its particular problems, all must face, for example, rising

rates of illegitimacy. Abstinence programs are a start. When pregnancy nevertheless results and marriage does not, states should foster group-living arrangements for women while pregnant and during the year or two afterwards, so that those who would otherwise be alone will have a support network. States should challenge biases against adoption, and stress the advantages to the child of adoption at birth (or up to age two, at the latest). Having a baby out of wedlock should not bring with it the reward of any governmental cash payments.

No public-policy measure can take the place of the personal changes that are necessary to raise high the standard of American compassion. With supportive laws and rules compassionate individuals can make real progress toward reducing some of our most serious social pathologies, but the crucial change is still the one that goes on in each individual soul, not in the federal or state capitols.

Marvin Olasky is a professor of journalism at the University of Texas at Austin and the author of The Tragedy of American Compassion. *This article is excerpted from* Renewing American Compassion *by Marvin Olasky. Copyright 1996 by Marvin Olasky. Reprinted by permission of the Free Press, an imprint of Simon & Schuster, Inc.*

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Policy Review is published by
The Heritage Foundation

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Karen Lynn McNaught
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My Name is Karen Mcnaught, I have been a resident of Alaska for the past 11 years. My Husband and I have a one year old daughter called Isabel.

Whilst I was pregnant with Isabel we lived in a remote area behind Denali State park. We both worked for princess hotels.

In the 19th week of my pregnancy I slipped on ice and fell causing a placenta abruption and internal bleeding.

I was taken to hospital where I was told the bad news that there was only a 6% chance that I would carry Isabel to term.

They felt that I would either miscarry or have to be induced at 23 weeks.

I was referred to a perinatologist that specialize in high risk pregnancies. There are only 2 in the state

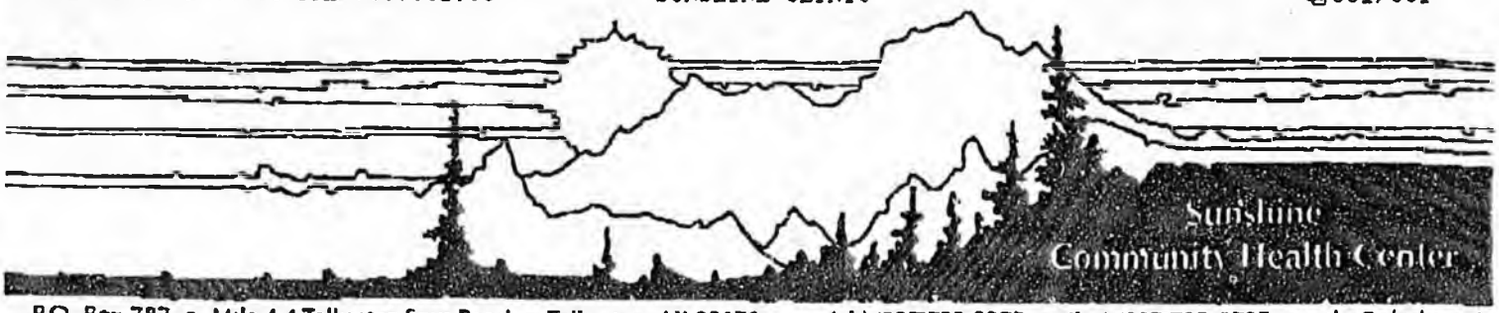
My Husband and I have what we thought was good medical insurance. That covered maternity, we where shocked to find that it only covered the perfect pregnancy.

Thankfully I had denali kid care that helped pay for what the insurance company did not cover.

I was underdose observation my whole pregnancy with numerous doctor appointment, ultra sounds and test monitoring me and Isabel.
The last 6 weeks of pregnancy where spent staying next to the hospital at providence house all of what was paid for by denali kid care.
on oct 1st Isabel was born by C. section.
(not covered by insurance)
She is the Joy of our life, we daily thank the Grace of God, providence hospital and Denali kid care for her.
I am one of many people who have such stories to tell of the importance of denali kid care
The children of Alaska are it most precious asset, more so the all to God. We need to protect them with all we can as they are our future.

Thank you for taking the time to hear my comment.

Nov. 9. 2001.



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PUBLIC TESTIMONY FOR LEGISLATIVE HEARING ON STATE MEDICAID THURSDAY AND FRIDAY, NOVEMBER 8, 9 2001

Testifying for Sunshine Community Health Center

Sunshine Community Health Center is a non-profit, federally qualified health center serving the residents of the Upper Susitna Valley. We provide comprehensive primary care services regardless of ability to pay. We have recently received a federal expansion grant to extend our services via a mobile clinic, to Willow and Trapper Creek.

We are a critical safety net provider for the northern region of the MatSu. Census 1990 data indicate that 35% of Willow and 26% of Trapper Creek residents lived below 200% of the poverty level. Analysis of our patient data indicates that fully 40%-50% of our patient population have no medical insurance. We also have an increasing number of patients who are "under-insured," meaning that they only have catastrophic insurance coverage or their deductibles are so high (over $1500) that they are virtually without insurance. Approximately 20% of our patients have Medicaid, 10% have Medicare.

Obviously, with a payor analysis such as the above, most private providers are not interested or able to locate a viable practice in this area. This is a critical and growing problem for rural Alaska. Safety net providers play a crucial role in the overall health care of Alaskans. Medicaid coverage, based on reasonable costs, for safety net providers such as rural health clinics and FQHC's (federally qualified health centers) is a key component of our survival.

I applaud this committee's commitment to ensuring careful and comprehensive planning for our State Medicaid plan. I would urge you to carefully consider potential negative impacts to safety net providers of any cutbacks to Medicaid coverage.

OPENING STATEMENTS FOR PCA VIDEO

Hi. I'm Bonnie Johnson. I am a Registered Nurse who has practiced for over 30 years in Alaska. Because I am concerned with long term care issues, I became a member of the "Gaps in Health Care Task Force". The task force is a group of nurses, social workers and health care providers who identify gaps in health care and find solutions that will better meet the needs of our clients. There are many problem areas that contribute to gaps in health care, and one key improvement for the State of Alaska will be enhancing the Personal Care Attendant (PCA) Program. This program, in existence for those eligible for Medicaid since 1987, provides services by trained health care paraprofessionals in a client's home, with supervision by a registered nurse. The State PCA Redesign Committee is working to improve the program. Perhaps videotaped testimony from clients may best express their needs to the Committee and the legislature.

Long term care is an important subject for Alaska.

- Alaskans are aging. The fastest growing population in Alaska is the 65+ age group.
- Aging successfully-Alaskans love their independence. Most of us want to stay in our homes as we age.
- The need for long term care is complex, increasing, and expensive.
- We need a system that allows for a continuum of care from complete independence to full dependency.
- The PCA program is an important program in this continuum.

The PCA program provides direct personal care services to individuals in their home. Although many have needs that would qualify them for placement in a long-term care facility, they prefer to stay at home and receive this care. These services help the client remain as independent as possible, and provide support to the families.

Claudia Andersen, a Registered Nurse with many years of experience, will be interviewing several clients with the PCA program to familiarize you with the service. These are the fortunate ones, as they have PCA service.

CLOSING SUMMARY OF PCA VIDEO

The GAPS in Health Care Committee has identified the following concerns as those that need to be addressed to increase the effectiveness and safety of the PCA program.

1) Recruitment and Training of PCA's: **The PCA is responsible for the cost** of training, as well as a State and Federal background check via fingerprints(some contract companies reimburse after 6 mos of employment). The minimum training required is 75 hours, the cost : $450.00-$1,200.00

Recommendation:

- More funding saurces to support the cost of training.
- Childcare to allow training; and/or a pay-back system.

2) **Retention of PCA's: There are currently no benefits for the PCA.**

Recommendation:

- The State contract could require a benefit package that might include : health insurance, vacation time, overtime, transportation cost reimbursement, pay raises, a career ladder. e.g. progressive "ranks" according to experience and hours of continuing education.

Continuing Education opportunities would increase knowledge base, skills, confidence, pride in vocation, and of course improve the quality of care for Alaskans.

3) Accessibility: **The current waiting list for PCA services is 153 names** long. These are our disabled and/or elderly Alaskans who simply ask to be maintained in their homes as long as possible. The cost of this care is less than any other option our state provides.

Recommendation:

- The program focuses on Medicaid eligible clients. We need to expand services to include non-Medicaid clients, with a sliding fee scale.

- Dual diagnosis clients are not accepted. We need a service that will accept and provide services to those with mental health diagnoses.
- The time between referral, paper ssment, approval, and delivery of services is 6-10 weeks long. The paperwork process is outdated and redundant.
- We need efficient tools, an application could be e-mailed, signatures fax'd, a minimum approval time respected.
- We need to attract and hire more PCA's.

4) **Safety: The PCA works with little supervision.** Currently, after the initial RN assessment, there are provisions for a second visit in a year, and one telephone call in 6 months.

Recommendation:

- Nursing visits, mentoring, and supervision need to be increased. The lowest paid, least trained PCA is working with our most frail and vulnerable population.
- There needs to be an agency back-up plan to provide services to clients when the PCA is unavailable.

The PCA program can preserve and support Independence and safety of Alaskans. It can provide quality care in a cost effective manner to Alaskans in their homes. Our priority must be to provide this service in a system that protects Alaskans from abuse, neglect or exploitation.

November 9, 2001

To whom it may concern.

I want to take a moment of your time to write about the benefits of Denali Kid Care for my family. I am the single working mother of two small children, Joseph who is 4 and Megan who is almost 3. I have recently looked into the cost of health care for my family. For my children and I it would be $150.00 per month plus a $350.00 deductible per family member. As for me the cost of health care is very expensive. But, I would like you all to know how fortunate I am. My children are extremely healthy and I contribute a lot of that to Denali Kid Care. I believe in preventative medicine. My children are up to date on their shots and on their physical check ups. My son for the first time went to the dentist to get his teeth cleaned and checked. Without Denali Kid care this would not have been possible. It is also the piece of mind that if one of my children were to get sick or injured, that there is some help out there to cover the costs of outrageous medical expenses. In conclusion, I would like to personally thank everyone involved in the Denali Kid Care program. They have given many parents the opportunity to provide preventative health measures to their children and piece of mind knowing that in the case of an emergency that there is someone to help. I would like to say thank you again for keeping our children happy and healthy, especially mine ☺.

Thank you,
Joleen M. Adair

Joleen M. Adair

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A Resolution of the Alaska State Hospital and Nursing Home Association (ASHNHA) concerning Medicaid Funding

Directed to: Alaska Legislature Subcommittee on Healthcare and Welfare—Senator Lyda Green Chair

Whereas: The ASHNHA member organizations provide multiple services to the state's Medicaid beneficiaries, and

Whereas: ASHNHA members have worked closely with the legislature and administration to secure new programs including Denali Kid Care and Breast Cancer treatment among other worthwhile endeavors, and

Whereas: ASHNHA members are concerned about potential decreases in the Federal matching funds as well as the significant changes to federal Pro-share, and

Whereas: A part of the increased cost of health services relates to the shortage of trained staff including Licensed Nurses, Allied Health Professionals, Certified Nursing Assistants, IT professionals and other health professionals, and

Whereas: The DHSS and ASHNHA have worked cooperatively in the past 2 years to develop new methodologies to stabilize the rate setting process

Therefore Be It Resolved, That:

ASHNHA strongly encourages the subcommittee to fully fund the incremental increases in Medicaid in the SFY 2002 budget, and

Further Be It Resolved, That:

ASHNHA asks that the Legislature address the shortage of Alaskans trained in health professions by:

a) Prioritizing technical/vocational education in the funding of K-12
b) Supporting the development of a second accredited program for RN nursing utilizing UAS as the distance delivery expert and expansion of UAA's LPN, RN and BSN programs at the Anchorage campus
c) Provide student loan forgiveness for those who complete LPN-RN training in Alaska and work in Alaska facilities.
d) Expand Certified Nursing Assistant and Allied Health professional training throughout UA with a focus on distance delivery models

Approved this _____ of _____ 20__ by the ASHNHA membership

Attest:

Dennis Murray, Chair

Charles Franz, Secretary

cc. Alaska State Legislature, Governor Tony Knowles, Jay Livey, DHSS

November 9, 2001
To the HESS Committees of the Legislature:

Tomorrow is my 57th birthday and I received a birthday present from my health insurance company—a notice that as of December I will be paying $830.88/month in premiums for a policy with a $2500 deductible, an increase in rates since May of 2000 of $293.57! My rates each month are more than my daughter pays for rent. They are quadruple the amount of my car payment. They are twice as much as my monthly food allowance. They have had the effect of limiting my retirement contributions and savings. I have been outside on a pleasure trip one in the past five years. My insurer will collect from me $12,470.56 per year before they will have to pay an extra dime in claims from me.

There is a silent insurance crisis in this state in the individual health insurance market. Those in my age bracket are particularly hard hit, but there are many younger people who are self-employed, RIFFED, or work for small employers who offer no health insurance. Our plight affects ALL Alaskans who

Alaskans who face the rising cost of health care, in part caused by unpaid medical bills from non-insured and underinsured people.

I have lived and worked in Alaska since 1978. I try to keep myself healthy. To try to avoid additional medical bills, I have to take shortcuts. My internist prescribes my asthma medication telephonically. My gynecologist prescribes anti-inflammatories for my shoulder. That is what happens when my premiums are too high for me to utilize my insurance correctly and pay for it at the same time.

It all began when Principal Mutual suckered me into a particular pool at a reasonable rate in or about 1993. I don't have a record of those rates but I can tell you that in May 1996, I paid only $188.13 per month. In April 1997 I paid $226.79/month when Mutual of Omaha bought Principal Mutual's book of business and closed my pool. Mutual of Omaha then placed the next group of health insurance buyers during another short timeframe in a different pool. With no new blood coming in, my pool began to age. The healthier members of my pool, who had no pre-existing conditions, switched to cheaper policies with other

insurers. The people who could find no alternative insurance companies willing to honor their pre-existing conditions, remained in my pool and so the pool shrank and had a larger percentage of people with health problems. While average claims increased, premiums skyrocketed. (I've prepared a handout to show you the increases in my premiums. You will note that my insurance premium was raised 30% over the previous year in 1999 when medical care costs in this state rose only 2%! You will note that by December 15, 2001, my premiums will be 441% of what they were in 4/96!)

These raises have had the effect of drastically reducing the number of policyholders in the pool. According to Mutual of Omaha, there were 12,591 policies in force in my pool in 1997. By the year 2000, there were 5,757 policyholders. Today, the number in my pool is probably even smaller.

When I complained about my rates, Mutual of Omaha cavalierly invited me to "shop in the open market" for other insurance. **As I found out, in Alaska, there is no "open market" for individual health insurance.** No insurer will

cover my pre-existing conditions—asthma and an arthritic shoulder—the two conditions for which I need ongoing treatment!

Moreover, I found out that there is no regulatory body on rates here. The Alaska Division of Insurance has no authority to oversee this price gouging that particularly affects middle-aged Alaskans.

Thus, **my only recourse is to turn to the Alaska Comprehensive Health Insurance Association (ACHIA) for coverage.** It will mean a waiting period of six months for my pre-existing conditions to be covered, but I'll have to take that chance.

Unfortunately, **the health of ACHIA is also at risk. You see, ACHIA has become the dumping ground for persons who are in my boat and age group and who are being priced out of the market.** As I understand it, ACHIA operates on premiums from its policyholders and assessments on large insurance companies doing business in this state. Self-insured plans are exempted from these assessments. Before the State became self-insured, its

insurer, Aetna, was contributing to ACHIA. Now, one insurer, Blue Cross, is bearing the majority of the load of subsidizing this federally mandated program.

Obviously, ACHIA needs additional mechanisms for its funding. One representative wants the State to pay an assessment. Other folks have suggested that the self-insured employers also contribute.

Thus, I implore you. Please put preserving ACHIA on the front burner this legislative year! While you are at it, please, please do something about the price gouging by and limited access to individual health insurance plans. Investigate other ways of sharing the risks so the pools for individual/non-employer sponsored health insurance plans are larger and not so age and time-sensitive and exclusive. Consider having the state plan for all non-employer insured people to purchase and have an insurer bid to insure that large group.

PREMIUM HISTORY
$2500 Deductible
One Person Insured

Age 51	4/30/96	188.13	Percent change of monthly premium costs from 4/96	Percent change of previous monthly premium	Percent change of medical care costs from previous year
Age 51	5/31/96	231.08	122%	22%	9.2%
Age 52	4/1/97[1]	226.79	121%	-2%	
Age 52	6/16/97	263.56	140%	16%	7.7%
Age 53	6/15/98	292.74	156%	11%	2.7%
Age 54	6/15/99	380.95	202%	30%	2.0%
Age 55	6/15/00	537.31	285%	41%	4.3%
Age 56	6/15/01	764.89	406%	42%	unknown
Age 57	12/15/01	830.88	441%	8%	unknown

[1] Date Mutual of Omaha purchased book of business from Principal Mutual

when the housing market is in flux. When rental or housing prices are changing fast, the inflation rate for the housing portion of the CPI may be exaggerated. This occurs because many homeowners have long-term fixed interest rate mortgages, which reflect past housing market conditions. So in times when the local housing market became overheated and prices rose rapidly, property owners with fixed rate mortgages were not affected. In such an environment, the rate of inflation would be overstated. The opposite scenario develops in a down market.

To evaluate the influence of the housing market on the CPI, the bureau produces an index that excludes housing. It is referred to as the CPI-U All Items Less Shelter component. (See Exhibit 4.) Using the All Items Less Shelter index for comparison between Anchorage and the nation shows that the difference of the indexes over the years is much smaller.

Medical care costs rose the fastest

Although medical care costs are a fairly small component of the CPI and are unable to push the overall index around very much, their meteoric rise in Anchorage over time has caught people's attention. (See Exhibit 5.) No other component of the CPI has come close to matching the increases in health care prices. The national experience has been similar to Anchorage's. During the past decade medical care costs in Anchorage have grown by 68.8%, much faster than the overall index, which increased by 27.2%. In 1998 and 1999 health care cost increases fell below three percent, but in 2000 this index regained its former momentum. As the state and national population continues to age and the need for health care expands, ever-rising costs will continue to challenge affordability for these services.

Selected Components CPI-U Anchorage and U.S. City Annual Averages 1983-2000 (continued) 4

	TRANSPORTATION				MEDICAL CARE				APPAREL & UPKEEP			
Year	U.S Avg.	Percent Change from Prev. Yr	Anch. Avg	Percent Change from Prev. Yr	U.S Avg	Percent Change from Prev. Yr	Anch. Avg	Percent Change from Prev. Yr	U.S. Avg.	Percent Change from Prev. Yr	Anch Avg.	Percent Change from Prev. Yr.
1983	99.3	2.4	98.5	1.6	100.6	8.8	99.7	5.2	100.2	2.5	101.6	5.2
1984	103.7	4.4	104.6	6.2	106.6	6.2	105.5	5.8	102.1	1.9	101.7	0.1
1985	106.4	2.6	108.2	3.4	113.5	6.3	110.9	5.1	105.0	2.8	105.8	4.0
1986	102.3	-3.9	107.8	-0.4	122.0	7.5	127.8	15.2	105.9	0.9	109.0	3.0
1987	105.4	3.0	111.3	3.2	130.1	6.6	137.0	7.2	110.6	4.4	116.6	7.0
1988	108.7	3.1	113.0	1.5	138.6	6.5	145.6	6.4	115.4	4.3	119.1	2.1
1989	114.1	5.0	116.7	3.3	149.3	7.7	154.4	5.9	118.6	2.8	125.0	5.0
1990	120.5	5.6	120.7	3.4	162.8	9.0	161.2	4.4	124.1	4.6	127.7	2.2
1991	123.8	2.7	121.7	0.8	177.0	8.7	173.5	7.6	128.7	3.7	126.6	-0.9
1992	126.5	2.2	123.3	1.3	190.1	7.4	183.0	5.5	131.9	2.5	130.2	2.8
1993	130.4	3.1	128.8	4.5	201.4	5.9	189.6	3.6	133.7	1.4	131.2	0.8
1994	134.3	3.0	136.9	6.3	211.0	4.8	197.8	4.3	133.4	-0.2	128.9	-1.8
1995	139.1	3.6	143.8	5.0	220.5	4.5	211.6	7.0	132.0	-1.0	130.0	0.9
1996	143.0	2.8	147.2	2.4	228.2	3.5	231.1	9.2	131.7	-0.2	128.7	-1.0
1997	144.3	0.9	147.0	-0.1	234.6	2.8	248.9	7.7	132.9	0.9	127.0	-1.3
1998	141.6	-1.9	144.9	-1.4	242.1	3.2	255.7	2.7	133.0	0.1	125.6	-1.1
1999	144.4	2.0	143.7	-0.8	250.8	3.5	260.8	2.0	131.3	-1.3	125.8	0.2
2000	153.3	6.2	150.5	4.7	260.8	4.1	272.1	4.3	129.6	-1.3	124.5	-1.0

Source: U.S. Department of Labor, Bureau of Labor Statistics

Food costs around the state

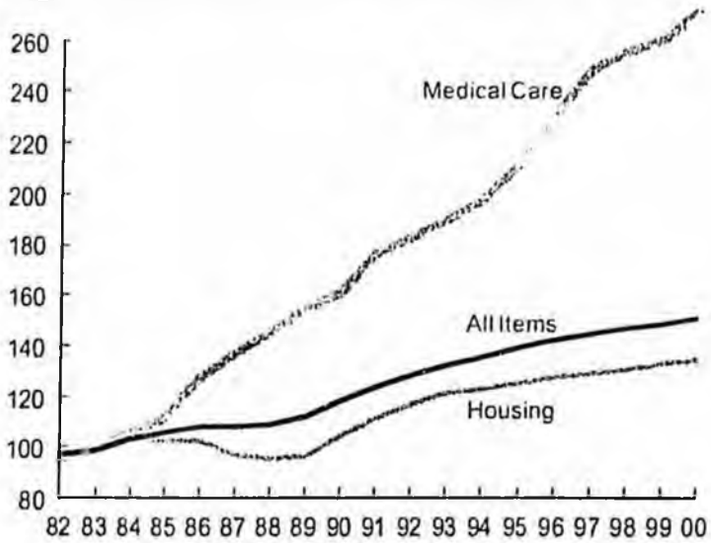
Four times a year, the University of Alaska Fairbanks Cooperative Extension Service posts results from its *Cost of Food at Home* survey for 20 communities around the state. (See Exhibit 6.) This food basket assembles items that contain minimum levels of nutrition for an individual or family at the lowest possible cost. In addition, the survey includes information on utility and fuel costs. The geographic coverage of the study is its biggest strength. No other survey in the state covers as many communities. Another strength is that it has been produced consistently for many years. The survey's biggest weakness is that it is largely limited to food, which is only a small component in the cost-of-living picture.

Other problems surface with the food cost study because many items that can be purchased in urban Alaska are not available in rural communities. The study also assumes that the market basket consists of identical items in all of the communities even though the buying habits of residents in the different places may vary dramatically. Recently the study included cost calculations of the widespread rural habit of ordering grocery items via mail from urban merchants; but other items entering the rural areas by barter or imported as baggage or private cargo are not included. Moreover, the local grocery list of base nutritional items also ignores the substitution of subsistence-harvested meats, fowl, fish, berries, and other foods for store-bought items.

According to the December 2000 *Cost of Food at Home* study, a family of four in Alaska enjoyed the lowest food costs in urban areas such as Anchorage, Fairbanks, and Juneau. The highest costs tended to be in remotely situated communities which are serviced by air and where the marketplace is small. Dillingham and Bethel belong in this category. Other high cost areas also exist in small places that lie on a major transportation system such as highways or the Alaska Marine Highway System. Grocery prices in these places often fall between the urban and remote-rural price ranges. Examples of such places are Petersburg, Tok, Delta, and Homer. But location is not everything. The size of the market, the level of competition, and the relative proximity to a larger urban area are other major determinants of food costs.

5 Medical Costs Increase Most

Anchorage CPI-U for selected components 1982-2000



Source: U.S. Department of Labor, Bureau of Labor Statistics

Rents are high in Juneau and Kodiak

Because housing gobbles up such a large slice of household income it often is a good proxy for an area's cost of living. The Alaska Housing Finance Corporation contracts with the Alaska Department of Labor and Workforce Development to collect rental housing data for 10 communities around the state. Exhibits 7 and 8 display monthly rental costs for two-bedroom apartments and three-bedroom single-family homes.

Like food and other items, the cost of housing varies dramatically among areas. The supply of housing, vacancy rates, quality of housing, condition of the local economy, building costs, and local demographics are factors that help

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News Release

STUDY SHOWS INDIVIDUAL HEALTH INSURANCE MARKET IS FAILING OLDER ADULTS, RAISING QUESTIONS ABOUT TAX CREDITS

Losing Employer-Based Coverage Leaves Adults in Midlife Years Vulnerable to High Expenses and Access Problems

back

July 10, 2001

For more information, please call:
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ANDREA ZUERCHER
at *Health Affairs*
TEL 785-842-2611

Washington, D.C.—Early retirement because of poor health or loss of a job may be risky business if you lose your employer or group health insurance coverage. A new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

The study, which appears in the July/August issue of the policy journal *Health Affairs*, makes clear that older working-age adults could face financial and access problems if they lose their employer-based health plan. The authors conclude that today's individual health insurance market "does not work well" for adults in the age 50-to-64 range who lack access to group premium rates.

The findings, based on an analysis by researchers at The Commonwealth Fund's Task Force on the Future of Health Insurance, illuminate the potential problems of implementing a tax credit system for the purchase of health insurance among certain populations. A number of legislative proposals, including one put forward by President Bush, would provide tax credits in the $500 to $1,200 range for individuals. Based on their analysis, the researchers say these would be insufficient to help older adults buy coverage. An analysis of premium costs in 15 cities showed a median cost of nearly $6,000 for a 60-year-old. "Even in states with community rating [which limits what insurers can charge], credits in the $1,000 range would pick up at most one-third of premium costs," the study finds. At a minimum, "tax credits would need to be adjusted by age and region to reflect market realities," the authors say.

The study examines the viability of tax credits to help adults without employer or public group coverage in purchasing private health insurance. The study was authored by Elisabeth Simantov, former senior research analyst at The Commonwealth Fund; Cathy Schoen, vice president of research and evaluation; and Stephanie Bruegman, a program associate, both also at the Fund. The analysis was based on a survey of 1,523 persons ages 50 to 64 between August and November 1999. The authors also analyzed a variety of premium and benefit data in the nongroup health insurance market from 15 cities.

Highlights of their findings:

- Out-of-pocket premium costs were higher in the nongroup market. Nearly half with individual coverage reported annual out-of-pocket premiums of at least $2,000. In contrast, only 16 percent of adults insured through their employer paid that much.
- Annual premium costs climb steeply with age in the nongroup market; 55-year-olds were quoted rates twice as high as those for a 25-year-old seeking comparable benefits; rates were three-to-four times higher for a 60-year-old.
- Older adults with low incomes or who are in fair or poor health are more likely to have insurance through a public program or to be uninsured. The majority of older adults who have employer-sponsored coverage or who buy individual coverage are healthy and have higher incomes.

- The currently proposed tax credits of $500 to $1,200 to encourage health insurance purchase for individuals are small relative to premium rates quoted midlife adults in the nongroup market. Even with a tax credit, low-income adults in this group would still spend one-quarter to two-fifths of their income for health insurance in the open market

- Near-elderly persons are at high risk of access problems and financial burdens if not well insured. They rely heavily on prescription medications but do not always have coverage for them.

- Nongroup coverage leaves adults in this group especially vulnerable to high out-of-pocket medical expenses. One of four adults with individual coverage had annual out-of-pocket medical expenses of at least $1,000. In contrast, only 15 percent of those with employer coverage reported comparable expenses.

The authors conclude that their study reflects the importance of risk pooling and broad-based participation to keep individual insurance markets accessible to all. For tax credits to be viable for all age groups, the authors say they must be implemented in concert with access and rating reforms that minimize or bar discrimination or that provide group coverage options.

Health Affairs, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the July/August 2001 issue will be provided free to interested members of the press. To obtain a copy, contact Jackie Graves at *Health Affairs* at 301/652-7401, ext. 255 or via email, press@healthaffairs.org. This article and selected others are available free on the journal's Web Site, www.healthaffairs.org.

###

- Marriages: 5,373
- Divorces: 2,647

Source: Unpublished data from National Vital Statistics Reports, Vol. 48, No. 19

Health Insurance

- Percent of private establishments offering health insurance to their employees: 46.2 (1993)
- Percent of private sector employees eligible for their employer's health plans: 61.2 (1993)
- Percent of private sector employees participating in their employer's health plans: 51.7 (1993)

Source: Employer-Sponsored Health Insurance: State and National Estimates DHHS Publication No. (PHS) 98-1017

- Employer-Sponsored Health Insurance: State and National Estimates. (PHS) 98-1017.

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Related Links

- **Alaska Department of Health and Social Services**
- **Healthy People 2000 State Data**

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This page last reviewed September 11, 2001

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics
Division of Data Services
Hyattsville, MD
20782-2003

(301) 458-4636

November 9, 2001

Thank you for giving me the opportunity to speak before your legislative committee regarding health insurance. Health insurance is what most employees look for when taking an employment position, even if they have to contribute some amount towards the premium. As a small non-profit that contracts with the State of Alaska to provide Substance Abuse Treatment for Alaskan's citizens, Nugen's Ranch only benefit for full time employees is health insurance. Due to raising cost of health insurance, the employees must now contribute to the premium. In October of this year our health insurance premium increase by $346.16 per month. At the present time the health insurance premium is $999.01 per employee. This was a 52% increase over last year premium. The reason given the Ranch for this increase were: the age of my employees, there use of the health insurance, the employee health problems, and the general increase in the insurance industry.

Nugen's Ranch is looking for other health insurance companies to provide our health coverage, but there are only a limited number of companies, and with a small group it is almost impossible to find a carrier. Even with the State's insurance program for person that have been denied coverage, the premiums for some of my staff would be even higher then what is being paid under our current health plan.

Nugen's Ranch is on the verge of losing health insurance coverage to do the increase in premium. Losing this coverage would mean that 15 employee would not have coverage, and could not afford to purchase health insurance coverage on their own. I myself am considered a high-risk person due to my heart condition, and the fact that four years ago, I had to have open-heart surgery. For the rest of my life I must take a drug call coumindan, due to the fact that stroke risk from my surgery.

There is a Health Insurance crisis in the State, for small to median size businesses. Somehow, there needs to be away to increase the number of companies that are doing business in the state. I am aware that Alaskan uses their health insurance if they have it and the high cost of medical care in Alaska. But there needs to be some kind of program for the average citizen to afford health insurance coverage, so that they are not at risk of losing everything if they have a major medical problem.

Karen Nugen-Logan
P. O. Box 871545
Wasilla, AK 99687

Date: November 8, 2001

To: Subcommittee on Health Care and Welfare

From: Angela Gonzalez, Member, Medical Care Advisory Committee

I am Angela Gonzalez. I am a consumer member of the Medical Care Advisory Committee. As you know, the committee advises the Commissioner of the Department of Health and Social Services on all aspects of the Medicaid program. My three children have been on Denali KidCare. DKC was important to my family because.....

I have some comments that I want to read. They are unsolicited comments from a survey of mothers of recent newborns whose children were on Denali KidCare. I believe these comments reflect how many mother s feel about Denali KidCare.

Comment #1. "The best thing that helped us have a healthy baby was Denali Kid Care. I did not put off prenatal care for fear of bills. It made it a lot less stressful for us. Denali Kid Care saved my sons life. When he was 2 months old. He got RSV and I took him to the ER to be seen. It turned out he was in respiratory distress and was taken by ambulance to Providence New Born Intensive Care Unit. He stayed 6 days. I don't think I would have taken him to the ER if I thought I would have to pay the 20% of my insurance because we were so broke. The doctor said that his respiratory rate was so high at the ER that he could have stopped breathing at anytime. He quit breathing once in the ER. Please help continue this program I feel it is one of the most important programs available to parents. "

Comment #2. "My pregnancy was not planned and even with my job and medical insurance, I would not have been able to go to doctor' appointments if it weren't f or Denali KidCare because of the cost of travel in and out of the village and the cost of what my insurance does not cover. It is very expensive and hard to make ends meet in Rural Alaska, especially when you don't have the capabilities of keeping up with the rest of the world's costs--medical and such, especially unplanned happenings. I know my baby is healthy because of Denali Kid Care and they continue to keep her healthy. Thank you."

Comment #3. "I had to quit my job due to problems during my Pregnancy and lost all benefits that went with it. I then was informed abo.. Denali Kid Care" who helped out. My husband and I appreciate the services they gave us in the labor & delivery of our baby. Thank you so much!!"

Comment #4. "Denali Kid Care is the best thing that happened in our lives. Without it my kids won't get their annual check up done because we don't have insurance. With our limited income, we can't afford each ones' dental and medical check ups. Thank you Alaska DKC."

Comment #5. "Denali Kid Care is a wonderful program. Without it, I may not have had a healthy baby. I suffered from pre-term labor and stayed at the Providence House in Anchorage for 3 months."

Thank you.

As a Catholic Social Services employee I'd like to share a story about a former family I served. She is a single mom of 2 boys one a teen and the other almost 10. She is currently pregnant with her third child. She has an in-home child care facility and earns close to $1500-$2000 per month depending on the number of children she cares for each month. She make enough money to cover her household fixed expenses and day to day expenses as they come up. She does not make enough to cover the cost of a private insurance carrier and is presently on Denali KidCare. She recently found out that this third child she is caring has an 84% chance of having down syndrome. She is still needing to undergo amniocentesis testing which she is scheduled for this Monday. If this would not be such an emotional issue she would be here to testify. She is very concerned that without the Denali KidCare she would not be able to afford the testing. She has so much trauma she is faced with and the future unsure but she is willing to deal with it. Her question to you is are you willing to deal with knowing that cutting the DKC program you could be hurting so many unborn children. Are you ready to deal with it???

Angela Gonzalez
276-3046

Jerry Nick

Greetings to panel members and other participants.

I am not here to defend the part the Health Insurance plays in the Health care picture. As student of this issue, I do not support the multi-million dollar compensation packages Insurance company executives extract and other elaborate entitlements. But, if insurance is to continue as a means of paying medical bills it needs to revert to sound insurance principles. Mandates override the basic elements that make insurance workable. That is the distillation of risk and reliance on actuarially sound costs. Ignoring these elements drive the costs and hence approach the affordability limit.

The issue of health care costs and it's continuing spiral upwards has been with us for some time. In this State Jay Kertula broached the idea of solving the problem with State and local participation I believe in the early 80's Subsequent to his initiatives, other studies and task force efforts with legislative intent and participation have been undertaken. The first of these projects commencing close to 15 years ago.

As we are all aware, no workable long range solution ever evolved either in Alaska or for that matter natioh wide based on reform efforts of the late 80's and early 90's. Efforts have divided into two fronts, either more money which expands the problem, or shaving the domain of any of the now participants in the industry. Any suggestion of change begins to raise the hackles of those that might perceive challenges to their piece of the pie.

Around the nation others have also challenged the problem of high medical costs without success Nationally and within States, various creative ideas have patched the problem c[illegible] could be described as temporary fixes. In Alaska the latest being Denali Kid Care. But one of the reasons for this meeting today is that the cost of the fixes is escalating. We all know that more and more patients are being squeezed out of decent health care because of cost. The ranks of the uninsured is continuing to rise increasingly. Hence the impact on social programs attempting to provide a safety net for those being left out is continuing to balloon the costs of the programs. That's what is happening to Medicaid.

So, here we are back at the table wondering and considering what to do about this onerous problem. Is there an answer. Probably, but not in the context of contemporary approaches which have been tried before. Most all reform efforts have involved the major players in the Health care industry,

from providers, insurers, government, and some private sector representatives. When all players contribute their interests in the solutions, nothing has changed. Everyone's economic survival dictates the design of solutions and we end back at square one. Today 15 plus years later we are still grappling with escalating health care costs.

In any public forum, especially when the legislature is involved; the goals, desires, and participation of all citizens must be weighed. That brings us back to the square one mentioned above. The elements/players of the system admit that change must be necessary; but not the part they play.

Any further task force development with the goal of reform must have an autonomous mission. Politics will be a liability to it's success. It must have a well defined mission based on a broad input from the many different players. It must be insulated from special interests and have the charge of developing a patient centered, efficient, centralized administrative design. We should be looking towards a consolidation of the many overlapping, competing, duplicative delivery systems we now have in Alaska, most of which are tax payer supported. We need to develop criteria which helps stem health care dollars exiting the state. There needs to be some real teeth in the Certificate of need process so that excess capacity which we now have big time. Mandates and their impact on costs must be understood. As I write this, the Federal Government if cooking up some more, the latest on mental health benefits. Anthrax which has infected 17 with 4 dying has prompted the American hospital assn. To ask for billions to counteract the threat. More money expands the system which we already are claiming to be too expensive. What ever is built out to counter the Anthrax threat will remain to be supported in the future. Scores of other issues could be listed here and this could go on and on. I mention few here to make the point that many options for improvements are available. And not everyone is going to like them. When we finally make the decision to make the changes and stand the heat, And I cannot tell you who we is, but it will probably come from the legislature. This whole issue is going to take some tough decisions, Only then will the beginning of reform come.

Currently within Alaska are dozens of talented knowledgeable people available to begin the process many of which have been through this whole exercise before. Margaret Mead said that all it takes to change the world is a handful of committed people. The legislature needs to empanel such a body with appropriate guidelines to start the process. It may take some funding to

meets the costs, but consider the 1.2 billion we are already spending on health and social services, and more than that on Health Care in this state over all, any costs here will be a meager contrast.

The suggestion is that the final product as a result of reform must stand on it's own merit and be owned by the people it is to serve citizens of Alaska. It must protected from special interests which will kill any effort to effect change unless it meets their vision.

In closing, if we cannot embrace change, then it is back to more money or cutting out someone's program to lower costs which is where we are today.

CATHOLIC SOCIAL SERVICES

ST. FRANCIS HOUSE
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ANCHORAGE, ALASKA 99508-3418
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November 8, 2001

Senator Lyda Green
And members of the
Subcommittee on Health Care and Welfare
600 East Railroad Avenue
Wasilla, AK 99654

Fax: (907) 376-3157

Greetings:

I am the manager of St. Francis House, a program of Catholic Social Services that has been providing basic emergency services to economically struggling families in Anchorage for over forty years. In addition to my experience in working with the families that come to St. Francis House for assistance; I help answer the 24-hour, statewide, information and referral hotline, AKINFO. St. Francis House contracts with the state of Alaska to answer the AKINFO line during the day. My conversations with the callers to AKINFO give me an even greater familiarity with the unmet health care needs of Alaskans across the state.

I am a member of the Anchorage Access to Health Care Coalition because I believe, based on my experiences, that there is a very high correlation between inadequate access to health care and poverty. I am committed to working to increase access to basic health care for everyone in Alaska.

In light of the increased spending on National Defense, I am very concerned that Medicaid and Denali Kidcare might be in jeopardy of being compromised. I would like to plead with the committee to do everything in its power to protect the minimal health programs we have in place. We need to build upon these programs, not cut back.

As it is, these programs are woefully inadequate and there are thousands of working Alaskans who do not have access to affordable health insurance and only receive health care in hospital emergency rooms after their condition has become acute. Many of the people who are treated in this way have no means to fill the prescription they receive. This is an expensive and ineffective way to deal with health needs. At least, right now, since the advent of Denali Kidcare, thousand more of our children are receiving the preventative and consistent health care that they need to thrive.

In this time of national crisis, economic upheaval and biological warfare, it is more important than ever to keep our kids as healthy and strong as possible.

Sincerely,

Sara J Jackson

Sara J. Jackson
Program Manager

Senate Health, Education and Social Services Committee
Nov 8-9, 2001

Dear Senator Green:

Please add me to the group list interested in working on the insurance issues. I would like to be part of the solution. Thanks.

Marilyn Kasmar
Alaska Primary Care Association
907. 272. 6131

3009 Northwood Street
Anchorage, Alaska 99517

November 9, 2001

Senator Lyda Green
Senate District N
600 East Railroad Avenue
Wasilla, Alaska 99654

FAX: 907 376 3157

Dear Senator Green,

Thank you for providing an opportunity for written testimony to the Senate Health, Education and Social Services Subcommittee on Health Care and Welfare.

I understand your concern for the cost of the Medicaid Program in Alaska; however, it is very important for providing minimal health care to Alaskans. As has been noted, Alaska only pays 40% of the cost of this program.

AARP has joined other Alaska organizations to encourage the Alaska Legislature to include Alzheimers and related disorders under Medicaid. Presently, Alzheimers patients must present other physical problems before they can receive Medicaid assistance.

The Medicaid Waiver Program in Alaska has reduced the cost of care by allowing many patients to receive in-home and community care instead of nursing home care. This program could provide assistance to Alzheimer patients in their home for an extended time before they would need nursing home placement.

Thank you for allowing me to present this information to your committee.

Sincerely,

Marguerite Stetson
AARP Alaska Executive Committee Member

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

November 2, 2001

Senator Lyda Green, Chair
Subcommittee on Health Care and Welfare
600 First Railroad Avenue
Wasilla, Alaska 99654

Dear Senator Green:

The Alaska State Hospital and Nursing Home Association, as you know, is comprised of all the nursing facilities and all but two of the hospitals (except Norton Sound and Samuel Simmons) in the state. Medicaid on average is approximately 20% of the hospitals business and about 85% of the nursing facilities. As you are aware from all the letters you have received from members, Medicaid is a very big concern to us. We have a wealth of information that we would be happy to share with you and are willing to work with you on all of the issues.

The Henry J. Kaiser Family Foundation recently distributed a report, "Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002." In that report, Alaska's top factors for contributing to Medicaid Expenditures in 2001 were:

- Home & community-based services (HCBS) waivers and other non-institutional LTC programs — 43% cost increase
- Pharmacy — 19% cost increase
- Hospital payments — 14% cost increase

In FY 2002, the top factors were:

- Pharmacy — 21.5% cost increase
- Home & community based services (HCBS) waivers and other non-institutional LTC programs — 19.3% cost increase
- Enrollment — 10% cost increase
- Continuing rise in disabled population
- Potential reduction in FMAP due to CPI formula changes

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The Medicaid program is an important factor in the local economy, bringing in at least $2 in federal dollars for each state dollar spent. Medicaid is designed to be counter-cyclical: as unemployment rises and incomes drop, more people become eligible for Medicaid. If the program operates as intended, states and the federal government spend more on Medicaid as a result, easing the negative effects of the economic downturn. If states respond to their difficult fiscal situations by cutting Medicaid in the months ahead, it not only will make it more difficult for newly unemployed workers to secure coverage, but it also could deepen the negative effects of the economic downturn. On average for every $1 that states cut from their Medicaid general fund budgets, the total amount of spending on the program drops by $2.33 because of the even greater loss of federal Medicaid matching funds.

ASHNHA promotes and advocates for quality care within nursing and hospital facilities where more than 80% of the patients in long-term care nursing facilities are funded by Medicaid. Many small communities within the state are highly dependent on Medicaid funding long-term care beds to support hospital and clinic services. Without Medicaid funds many small communities would not have any medical services at all.

ASHHNHA appreciates the effort you and committee are taking to understand and improve the Medicaid program in Alaska and are very willing to assist you in any way that we can,

Sincerely,

Linda Fink

Linda Fink
Assistant Director

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

ASHNHA Resolution Supporting Current Certificate of Need Legislation

WHEREAS, the Alaska State Hospital and Nursing Home Association is strongly committed to developing a coherent and comprehensive network of health care services within the State of Alaska, and

WHEREAS, the State of Alaska shares these objectives with ASHNHA,

WHEREAS, the State has developed a CON review process that seeks to ensure that new health care facility construction projects or equipment purchases are cost effective, not duplicative, are adequately planned and involve the public, and improve accessibility and quality of health care services; and

WHEREAS, the CON review process encourages adequate access to healthcare through geographical dispersion of health care facilities and services which might not otherwise be expected to develop; and

WHEREAS, the CON provides a mechanism whereby provider initiatives may be evaluated against alternatives for meeting state priorities for improving the health status of its citizens; and

WHEREAS, the need to provide health care services to an expanding population with increasingly limited funds places a premium on effective and efficient deployment of these limited resources, and

WHEREAS, the demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of healthcare services, being culturally diverse, geographically dispersed and predominately rural; and

WHEREAS, the CON helps Alaskan health care providers meet the larger objectives of society, particularly with regard to understanding and addressing the needs of under-served and indigent patients; and

WHEREAS, the CON ensures these extra-institutional objectives are adequately addressed regarding healthcare facility and program planning, and that decisions to expand or contract the health services capacity are economically sound and medically necessary; and

WHEREAS, similar programs function in the majority of other States to good effect, to the extent that several States have found it necessary to re-instate CON when it has been allowed to lapse in order to correct market imbalances arising in its absence; and

WHEREAS, the future structure of health care delivery is uncertain and repeal or significant alteration of CON legislation would threaten the ability of our members to fulfill their commitments to access, community-based health services, improved quality, continuity of care, and cost containment; and

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WHEREAS, market competition is a necessary but insufficient mechanism to achieve all of these objectives and should be supplemented by reasonable State oversight; and

WHEREAS, the shared challenge to our members and the State of Alaska is to develop a socially responsible and economically viable healthcare marketplace.

THEREFORE, BE IT RESOLVED that the Alaska State Hospital and Nursing Home Association endorses the current Certificate of Need Program, without significant alteration, as an effective way to maintain an affordable, accessible and high quality healthcare delivery system responsive to the needs of Alaskans; and

BE IT FURTHER RESOLVED that ASHNHA opposes any and all attempts to repeal or weaken the CON; and

BE IT FURTHER RESOLVED that ASHNHA remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska and that it shall remain effective and efficient in meeting its stated goals.

No matter how hard hospitals try to comply with complex, cumbersome, and confusing payment rules and regulations, it is impossible to be error-free. But they are, in fact, astonishingly accurate.

We have seen accusations of pervasive fraud leveled before. Several years ago the Federal government undertook a massive investigation under the False Claims Act into the Medicare "DRG three-day window."

How did the government's 72-hour window investigation affect hospitals?

In **Maine**, 24 hospitals settled with the DOJ. The Maine Hospital Association studied those hospitals, and found some interesting things:

- The total number of Medicare billing errors over a 5-year period was fewer than 1,000.
- Billing errors per hospital over the 5-year period ranged from 3 to 200.
- There were 2.9 million Medicare claims submitted by the 24 hospitals in the 5-year period. This represents an error rate of just .034 percent of total claims.
- During the same period only $139,000 in claims for all of the hospitals were found to be in error; this represents .005 percent of their $2.6 billion in total Medicare claims

In **Vermont**, 11 hospitals made payments to the federal government to settle $83,816 in reported Medicare billing errors that occurred between 1990 and 1995. During that period, Vermont hospitals billed Medicare for $1.5 billion. So the amount demanded by the government translates into an error rate of 1/200th of one percent. One Vermont hospital's data makes the point even clearer: the Medicare caseload at the hospital is roughly 20,000 cases a year. Of the 200 cases reviewed, the government came up with only ***one*** dispute. The government should be applauding hospitals like that, not prosecuting them.

In **Connecticut**, 34 hospitals were given demand letters on the 72-Hour Window Rule. During the period of investigation, 1990-1995, Connecticut hospitals handled more than 10 million Medicare claims. Of that total, fewer than 3,000 claims were cited by DOJ in the investigation -- an error rate of less than three one-hundredths of one percent. The government identified less than $1 million worth of payment errors out of a total of $6 billion in payments.

And here in **Alaska**, DOJ investigated two hospitals and found no errors. Still, those hospitals were assessed federal penalties. The penalties were small -- $69 and $289 -- but the hospitals' letters asking DOJ for an explanation about why they were fined have not been answered.

Most accounting firms' standards include expected error rates -- human and otherwise -- that generally fall between three and five percent. Clearly, the Federal DOJ based its investigation on a zero-tolerance-for-errors rule that is unfair and unrealistic, which raises serious questions about their purpose.

Another example: The physicians at teaching hospitals (PATH) audit. Teaching hospitals and medical schools were investigated to determine whether physician instructors billed Medicare for work performed by medical residents they supervise.

Mary Hitchcock Memorial Hospital in Lebanon, NH, spent more than $1 million in staff time and fees for attorneys, consultants and accounting assistance to perform a self audit on Medicare billing. Why? The government demanded the audit as part of its PATH investigation. What did the audit find? An error rate of zero.

The result of the Federal government's campaign? Millions of dollars are being spent on lawyers' and accountants' fees instead of patient care. Is the government finding fraud? On the contrary. In the majority of cases, hospital error rates are proving to be minuscule.

OUR PRINCIPLES

Zero tolerance for fraud – America's hospitals and health systems are rooted in a tradition of ethics and caring. We're committed to preventing, uncovering, and eliminating health care fraud and abuse. Hospitals across the nation are voluntarily adopting plans to ensure compliance with complex and confusing Medicaid laws and regulations.

However, Medicaid billing errors often result from confusing and conflicting regulations and instructions that are part of the Medicare reimbursement system. These are not intentional acts. Yet **some** would have you believe that mistakes and fraud are the same.

Providers who make billing mistakes after attempting to comply with the complicated and frequently changing rules of Medicaid payment should be treated in a fair, equitable and civil manner and granted appropriate due process rights -- rights that are guaranteed to all Americans.

Compliance -- The AHA Board of Trustees recently issued a statement urging all hospitals and health systems to voluntary adopt regulatory compliance programs "as a way to minimize errors in conforming to highly technical and complicated rules," and urged hospitals and health systems to "develop and implement or strengthen a formal compliance program to ensure that regulations are accurately followed."

THE SOLUTION

To solve this problem, we need to return to the partnership we once had with the government. By rebuilding this partnership, we can go a long way toward ensuring compliance and fairness.

We would propose:

- imposing a "de minimus" standard. Under the standard, as defined by the American Institute of Certified Public Accountants, Medicaid overpayments to providers of less than a specified percentage would result in penalties of no more than the amount of the claim plus interest.
- establishing a "safe harbor" for hospitals that submit a claim based on advice given by fiscal intermediaries and carriers. Such hospitals would be subject to fines limited to actual damages and interest.
- raising the burden of proof from a "preponderance of the evidence" standard to a "clear and convincing evidence" standard.
- establishing a "safe harbor" for hospitals that have adopted effective, good-faith compliance plans in which they are, if found in violation, subject only to actual damages plus interest.

Rebuilding the hospital/government partnership -- Hospitals and health systems want a new partnership with the State. Working together, we can do more to prevent hospital billing errors, and to prevent government over-reaching as it tries to account for those errors.

The AHA is willing to help find other ways in which the State government can make the billing system more workable. We have proposed a "best practices" process. Under this process, the AHA would identify vague laws, regulations, carrier instructions, etc., and go to the State with our best view on how they can be implemented. The State in turn would consider the problem and our suggestions, and get back to us with proper guidance. Through this process, disputes related to interpretation of laws, or individual concerns, could be solved without antagonism.

In addition, we have talked to the Attorney General's office about a mechanism that would give us an "early warning" about potential areas of concern. We respectfully disagree with the Attorney General's office that our members have received reasonable notice of problems in the past.

Also, we need to look at a dispute resolution system that could remove some of the adversarial relationship between the government and the hospital field. If we can develop an administrative mechanism to resolve disputes over both broad policies and specific disagreements, we can diffuse a potentially volatile situation.

At a minimum, we need to return to a system in which [***the Alaska Medicaid payment authority***] exercises its authority to review and discuss billing disputes with hospitals. Only after the failure of those efforts should Attorney General's office become involved.

- ✓ develop clear and objective standards that differentiate between a regulatory overpayment and a civil/criminal fraud and publish these standards so that the AHA may advise its members on the standards.

The DOJ needs to speak clearly and precisely to retain its enforcement credibility, which is now at risk as it tries to stretch its enforcement resources with collection efforts of this sort.

- ✓ develop a self-disclosure program for regulatory overpayments that encourages compliance and not fear of unreasonable claims of penalties and damages, and would not require payment of penalties beyond standard interest penalties absent specific evidence of fraud or reckless disregard of overbilling.
- ✓ develop a "safe harbor" treatment for hospital overpayments that occur as a result of inaccurate or incomplete fiscal intermediary/carrier instructions.

CONCLUSION

We understand and agree with the government's determination to investigate and punish those who would abuse the system.

But the government is doing the right thing in the wrong way.

The overwhelming majority of Alaska's hospitals and health systems work hard to comply with the mountain of rules and regulations that govern Medicaid payment. When a mistake is made, it should not be treated as fraud. It should be treated as a mistake.

Through a rebuilding of the health care field's partnership with the government, we can make things fair again -- for hospitals and health systems and the people they serve, and for the government as well.

Note: based on "Testimony of the American Hospital Association before the Subcommittee on Immigration and Claims of the Committee on the United States House of Representatives on Health Care Initiatives Under the False Claims Act which Impact Hospitals April 28, 1998" delivered by Gordon Sprenger

http://www.aha.org/ar/testimony/test980428a.asp

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

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Care Connections

Care Coordination • Social Services

P.O. Box 318
Palmer, Alaska 99645
(907) 746-2037
Fax (907) 746-2031

To: The Chair and Members of Health, Education, and Social Services Subcommittee

From: Lourdette Diamond Neuburg

Date: 11/9/01

Thank you for holding these hearings in Wasilla. I am the director of Care Connections, a small, for-profit care coordination agency located in Palmer. Our agency provides care coordination services in the Mat-Su Valley, Eagle River, and Chugiak for individuals who meet nursing home level of care. We arrange home- and community-based services to prevent or postpone nursing home placement.

Care Connections serves 61 adults, 85 % of whom reside in their own home either alone or with family members. The services provided through the Medicaid Waiver (CHOICE) program allow the individuals to continue to remain as independent as possible. As the care coordinators for these individuals, we are able to advocate for and arrange services, assess the situation and needs, plan the care, provide information and referral. Services provided may include Lifeline, chore service, respite, adult day services, transportation, meals, modifications to the home, and some equipment and supplies as well as regular Medicaid services.

There is a chance that the individual may not meet either physical or financial criteria for the CHOICE program. We realize this when we begin services; consequently, care coordination agencies may provide services and support, which are not reimbursable. Individuals must qualify for CHOICE both financially and physically. This takes time. All providers in the CHOICE program are in this situation and must decide whether or not to provide service to particular clients. However, what is unique to care coordinators is that we are the only providers who do not have the ability to negotiate our reimbursement rates and we have not had an increase in pay, cost of living or otherwise, since the inception of the CHOICE program approximately eight years ago.

Care coordinators provide a vital service for clients on the Waiver programs. I am proud to work in a program that benefits individuals and families, and saves Alaska money by preventing or postponing nursing home placement. Please continue to support care coordination and the Waiver programs. Thank you.

Lourdette Diamond Neuburg

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

J Brian Barnes

Bartlett Regional Hospital
3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

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Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Shawn M. Cobb

Sitka Community Hospital

209 Moller Avenue, Sitka, Alaska 99835 Phone (907) 747-3241 Fax (907) 747-1794

November 2, 2001

Senator Lyda Green:
600 East Railroad Avenue
Wasilla, AK 99654

Dear Senator Green:

I would like to offer a few comments before your Subcommittee meeting next week at the Mat-Su LIO. I share your concern regarding Medicaid spending but my perspective is quite different. I suggest that the discussion needs to be broader than just "how can we save money." Looking for ways to make the current system more efficient or cost effective is just one part of the discussion that needs to take place.

As a health care administrator, I am well aware that the Medicaid program fails to pay its fair share. In an effort to adjust for the Medicaid related underpayments, providers shift the unfunded cost of care to individuals who have insuranc '. Most providers, physicians, and insurance companies will tell you that the insured population covers the shortcomings of the Medicaid program.

As a nation, our funding priorities are not aligned with our care expectations. We want the best in health care, whenever we need it, regardless of our ability to pay. Such expectations have been translated into federal and state regulations that have put providers at odds with patients and residents.

Although most Americans view health care as a right, there is no universal agreement as to societies obligation to fund the required facilities and services. Limiting the discussion to "ways to save money" will at best provide a short-term band-aide and at worst will jeopardize the existing safety net of providers, many of whom are struggling financially.

Healthcare funding goes against ordinary business practices and certainly does not pass the "common sense" test. Reduction of cumbersome and costly regulation/oversight, elimination of most of the paperwork we are required to complete, and coordination of state/federal inspections to reduce the number of times we are inspected would produce immediate savings.

The bottom line is: pay for what you require and do not require what you will not pay for.

Sincerely,

Bill Patten

Bill Patten, MA, NHA
CEO/Administrator

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

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Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Kathryn Callahan

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green,

It has come to my attention that you are seriously looking to reduce Medicaid spending. I could not disagree more! You should be looking at ways to increase spending and ways to make the current system more efficient.

At this point, Medicaid fails to pay their share of the cost of care. As a result, providers are forced to shift the cost to individuals who have insurance. Talk to any provider, physician or insurance company and they will tell you that the insured population has to cover for the shortcomings of the Medicaid program.

Let me offer the following suggestions. Please look for ways to increase spending on preventative care (breast cancer detection, low birth weight, mental health, programs that help people reduce their drinking or help them to stop smoking.)

Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Sheryl Washburn, MSN, RN
Patient Care Administrator

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

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We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Michelle E. Casey
Manager, Staff Development & Patient Education

Providence Alaska Medical Center

November 1, 2001

Senator Lyda Green
600 East Railroad Ave.
Wasilla, AK 99654

Dear Senator Green,

As another legislative session kicks off and budgets are discussed, I wanted to share my concerns with you about the continued Federal changes to the Medicaid program which tend to shift costs to the State of Alaska and force some people out of medical care. The Medicaid program has great value for all Alaskans, and I ask for your help in preserving these critical monies for those in need in our state. Unfortunately, what some people propose as cost savings are really only cost deferrals and the costs tend to increase the longer they are deferred.

As you are aware, Alaska has one of the highest populations of uninsured and underinsured people in the nation. For this reason alone, Medicaid funding is imperative to ensure all Alaskans have access to appropriate healthcare services when they need it. But most importantly, Medicaid dollars help ensure those who would normally fall between the cracks have access to services.

One key program that serves this purpose is Denali Kid Care. Denali Kid Care provides excellent health insurance coverage for children and teens through age 18 for both working and non-working families, and for pregnant women who meet income guidelines. **Funding cuts in this program would cost the state substantially more in the long term as primary prevention for these key populations would then be limited.** For that reason, any cuts to Medicaid that would affect this essential program should be avoided at all costs.

I would also discourage cuts in any program that gives access to mental health, women's, or home health care services; assisted living homes; or long-term care facilities. Children, women and the elderly are our most vulnerable populations and as a community we have a responsibility to make sure they have access to health care, especially preventive care that prevents costly treatment in the future. I would urge you and the committee to work with the health care providers in Alaska to find innovative ways to more effectively use what federal and state dollars are available and try to offset some of the shortfalls with increased efficiency in our health care system. This will be challenging work but working together, we can sometimes surprise ourselves.

Your support of health care programs in Alaska throughout the years has been greatly appreciated, and I hope that you will continue to show your support by ensuring Medicaid monies remain available to those in need. Spending money now invests in our future and shows that as a state we remain committed to taking care of those most in need.

Sincerely,

Gene L. O'Hara
Chief Executive

Bartlett Regional Hospital
3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

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Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

I am concerned about the unintended consequences of ceasing the Medicaid funding for Denali Kids, Breast Cancer Detection, Mental Health, and Long Term Care. I can understand how the savings in the short term would be quite appealing, but please consider the long-term ramifications of such a decision.

This decision targets those people who are least likely to have the means and skills to fend for themselves. What could end up being very expensive for the taxpayers might have been able to be nipped in the bud had funding been available for prevention.

As a nurse, I have seen long and painful hospital stays because the individual lacked the means to seek health care. The hospitalization cost is far more than what an office visit with follow-up treatment would have cost. Where is the sense in this?

Sincerely,

Valerie McCormick, RN, MS
Acute Care Manager

Bristol Bay Area
Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-9354

Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egegik
Ekuk
Ekwok
Goodnews Bay
Igiugig
Iliamna
Ivanof Bay
Kanatak
King Salmon
Kokhanok
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Newhalen
Nondalton
Oleonville
Pedro Bay
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

To promote health with competence, a caring attitude & cultural sensitivity

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, AK 99654

BY FAX AND E-MAIL

Dear Senator Green:

I'm the Clinical Director of the Bristol Bay Area Mental Health Center in Dillingham. I write this, however, not as their representative but as a Clinical Psychologist, licensed by the State of Alaska, who has practiced as a professional for over 30 years in 8 different community mental health settings. I just learned of this hearing today so my comments will be briefer, more discursive, than they would have been had I had more time.

Our clinic serves 33 Native Alaskan and Native American villages spread over an area of 40,000 square miles. These villages are essentially accessible only by air. Because of the nature of psychotherapy, geography and the culture of our clients, any number of Medicaid regulations rob them of services and us of revenue. Since this is an eleventh hour submission, I'll only discuss three issues. Also, I'll only discuss them from the standpoint of how they affect psychotherapy. Clearly there are many more counterproductive rules that affect psychiatric and case management services as well as psychotherapy.

Simply put, the problems are: (a) We take the client's time filling out irrelevant forms with him or her rather than using the time to provide services. (b) We don't receive reimbursement for critical services we do provide. (c) The rules don't take into account our geography.

We Waste the Client's time with Meaningless Activities

Medicaid requires that upon entering treatment and then every six months after that, we perform an assessment for each client.. This is a lengthy formal process done with the client that can take as much as an hour. In addition, for clients who are severely or chronically mentally ill, there is a second formal assessment as well that's done initially and then every six months. This one takes a minimum an hour of the clients time.

would like to make and what services the therapist will provide to help him/her make these changes. Like the two assessments, this has to be done initially and then every six months.

There are any number of problems with these requirements. Two of the most obvious are: (a) Study after study has shown half of all clients drop out of therapy before their fifth appointment. (I don't have the statistics for my clinic but a related measures suggests it's probably the same for us as well.) This means anywhere from twenty five to over fifty percent of a client's time is spent doing something other than treatment. (b) So far as I can tell, what they are doing is to complete documents that are totally unnecessary for treatment. The assessment that matters is done by each therapist in his or her own way; it's less invasive and time consuming than Medicaid requirements. In terms of treatment plans, my best guess is that most clients couldn't tell you their contents two weeks after they're done. I do know that many react with annoyance at having their time taken with this quasi-legal procedure. It seems out of place in what, at best, is a human relationship, rather like a prenuptial agreement is.

We can't Bill for Vital Services We Provide.

Medicaid only allows us to charge for traditional client-in-office service. For the people we serve, however, there are a large number of activities that provide a more natural context for psychotherapy. While we provide services in these settings, we can't bill for them. Steaming and berry picking are examples. We also can't bill for psychotherapy over the telephone even though we do a lot of this with people in the villages and for those suicidal people who call us in crisis, often in the middle of the night, who are too emotionally disabled to wait for bankers' hours to come to our office.

Medicaid Regulations are Geographically Unfriendly

We aren't Anchorage or Austin. We're bush Alaska with very few professionals attempting to help people in very isolated small villages spread over an area the size of Ohio. This means the problems I've discussed so far are magnified ten-fold. For example, our professionals can only visit the villages every three months and for a brief time. This further means each client can only be seen for an hour or so each visit. Simple math then shows that half of our contact hours are spent doing treatment plans or formal assessment and only half are devoted to therapy. If we see a client, say, four hours a year at least two are spent filling out forms. As another example, in the harsh and close living conditions of the villages, crises predictably occur. These crises must be dealt with immediately and not when the next visit is scheduled. This means extensive telephone work which isn't reimbursed.

None of these problems are unsolvable but all require a somewhat different

mind-set. That is, all can be solved if you don't assume providers are trying to cheat the system or would waste money were they not subjected to stringent oversight. These problems could be solved were you to assume: (a) Those of us in the field know better than bureaucrats what services and procedures are needed. (b) Rather than trying to cheat the system, we're dedicated professionals who work for wages much less than we would make in the private sector because we care deeply about what we do. (c) The problem with mental health services isn't that they're overused and therefore need stringent oversight (assessments, elaborate and detailed treatment plans, etc.) to eliminate waste. The problem is that these services are underused. Epidemiology tells us many more people are disabled than seek services. Our own research, over and over, shows people leave treatment prematurely, within a month, rather than staying too long. Everything we know suggests that tax dollars would be saved if instead of subsidizing an army of bureaucratic overseers, we took that money and paid for services our clients needed.

Sincerely,

Bruce Allen, Ph.D.
Clinical Director

Alaska Women's Resource Center
813 D Street ♦ Anchorage, Alaska 99501 ♦ (907) 276-0528 ♦ Fax (907) 279-6754

Medicaid Reduces Other Costs

During fiscal year 2001, Medicaid allowed over 150 Alaskan women and their children to access substance abuse treatment with the Alaska Women's Resource Center. Approximately 151 children received "drug free focused" activities and services, developmental screenings, health care, and mental health services. Without Medicaid assisting these families with their treatment costs, 140 children would be in the foster care system today at an annual cost of over 6 million dollars.

Denali KidCare

During fiscal year 2001, the Alaska Women's Resource Center assisted 900 uninsured and/or low-income families with applying for Medicaid through the Denali KidCare Program. It is important to note that the entire family was uninsured prior to Denali KidCare.

Privatization of Medicaid

Regarding privatization of Medicaid, the Alaska Women's Resource Center encourages an analysis of the existing costs including the costs associated with the current private processing of claims.

Senator Green and other members of the Senate HESS Subcommittee on Health Care

- I'm DGA MD, a pediatrician in Anchorage. I am a member of the Medicaid Physicians Advisory Committee with representatives from the state medical ass'n and medicaid officials that has been meeting for about 8 years, and I am the physician representative to the Medical Care Advisory Committee or MCAC

- We pediatricians (and the other pediatricians at our recent annual meeting agreed to let me speak for them on this) do deeply appreciate the Alaska Medicaid and Denali Kid Care Programs

- Our patients appreciate Medicaid and love DKC with it's 6 month effectiveness and the use of an ID card rather than coupons.

- Physicians have been taught to strongly believe in cost effective care. It may not be cheap, but it must not be wasteful

- Health Care costs for healthy individuals is really very inexpensive. 85% of your Medicaid dollars are spent on those 15% of the Alaskan Medicaid clients who spend more than $5000 per year. These are mostly the elderly in nursing homes or the chronically handicapped. Few, if any, of these expensive patients will ever get off the Medicaid rolls. The other 85% of recipients receive medical care that is not only less expensive, but also very cost effective because the majority of those 85% will become productive members of society.

- The state Medicaid program has been closely reviewed by your MCAC and that comittee's recommendation first and foremost is, to quote an old saying, "it's not broken, don't fix it". A couple of areas to look at in our opinion would be first, since the state pays for disaster dental care for adults it really makes sense to also fund some preventive care. It is cheaper and therefore more cost effective. And second, the payment for transportation charges needs a total review. Like, why are we "fiscal conservatives" insisting on paying top dollar for air flights because there is some obtuse policy that tickets can only be purchased if they are totally refundable. There are also problems with cabs, buses, and other conveyances.

- Now the federal government is proposing cost neutral Health Insurance Flexibility and Accountability (HIFA) wavers that would allow coverage for more adults, but only by subtracting the amount available to children and other current beneficiaries. There will even be less total money to go around because the cost of developing this rather complex program will also have to come out of the current Medicaid payments.

- We pediatricians would say this is robbing from Peter to pay Paul. Give a little to the kids two years ago, and take a lot of it back. Adding a co-pay or deductible will mean many will go bare. This will not affect the non-working families, they will continue to get full coverage. It will only affect the families who have succeeded in working and earning enough to be above the poverty level. Working at jobs with no family health insurance.

- Bottom line, health care is expensive, but the current Medicaid/DKC program IS cost effective, the patients ARE appreciative of what they get, and the ones who benefit from DKC seem to be trying to get off all state support. But they do have to take one step at a time in order to successfully get to the finish line. This group needs a pat on the back not a slap in the face and not anyone reaching into the pocketbook.

- Do you have any questions?

David B Alexander MD



Sheri Mayer
257-1120

To whom it may Concer

My name is Sheri Mayer and I have three children ages 11, 9, 5.

Denali Kid Care has been such a positive thing in my family. Two of my children have had day surgery and I was absolutly unable to pay those bills. I have no worry when my child becomes sick or needs to visit the dentist. Whas/Without this coverage a simple office visit may very well be our familys food budget I know manly families on Denali Kid Care and simply paid without it may be a child not getting the proper care of the dentist or even not going to the doctor when they are ill due to lowina

Anchorage
Convention &
Visitors Bureau
524 W. Fourth Avenue
Anchorage, Alaska
99501-2212
Ph: 907-276-4118
Fax: 907-278-5559
info@anchorage.net
www.anchorage.net

10/25/01

Senator Lyda Green;

As a nurse who has worked home health care for a number of years I would like to take this opportunity to express to you the positive impact to our community the Medicaid Waiver program for private duty nursing has provided. Many times a citizen is in need of ongoing nursing help to remain safely in their home + to avoid repeat hospitalization + emergency services. This waiver program allows a nurse, under physician orders, to monitor a clients medication use + side effects, conduct ongoing clinical assessment to catch deteriating health before they become severe + to assist citizens to access community resources. Medicare + regular Medicaid will not cover these chronic care maintenance type cases. With our aging population + lack of chronic care resources in our community this has helped a number of clients remain in their home environment + continue as productive citizens in our community. I would deeply appreciate any support you may lend to continue with this valuable service.

Sincerely,

Karen Losinski RN,C
3474 Sharon Rd
North Pole, AK 99705

cc: John Coghill

October 25, 2001

Dear Senator Lyda Green,

I am writing to express my concern regarding the issue of state medicaid funding. I understand that you and the legislature are considering reducing medicaid services for the residents of our state. I am particularly concerned with the idea being put forth to reduce funding and services for Denali Kid Care and Breast Cancer.

Denali Kid Care provides insurance coverage for children and teens, our most vulnerable residents. Providing good health care up front, prevention of disease, early discovery and treatment can save us all money in the long run. Children who grow up healthy can then become productive members of our society. This would seem to me to be a good thing.

I cannot believe I live in a state where our elected officials can be so shortsighted not to see how providing mammograms and funding for the early treatment of breast cancer can benefit us all. Spending $100.00 for early detection is a small amount to pay when compared with the costs of treating breast cancer after it has spread. Plus, the social and emotional costs can be just as high or higher.

As a woman and a mother these two issues greatly concern me. As adults it is our responsibility to protect the children. They will be the ones to make decisions about issues in the future. As a woman I cannot stand by and do nothing about issues at the state level that concern women's health. Trying to save a little money now on Denali Kid Care and Breast Cancer can and will cost us big money in the future.

Sincerely,

Corlis Taylor

Corlis Taylor

Corlis Taylor
1335 Viewpoint
Fairbanks AK 99709

Cc: John Coghill

John Cannon
3101 Whispering Woods Dr.
Wasilla, AK 99654
(907) 376-6063

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, AK 99654

Re: HESS Subcommittee on Health Care and Welfare

Dear Senator Green:

I am writing you regarding the Subcommittee meeting that will be held at the Mat-Su Legislative Information Office on November 8-9. Unfortunately, due to a schedule conflict I will not be able to attend the meeting in person. Please accept this correspondence as public testimony. Over the last twenty years it has been my privilege to work with Alaskans with developmental disabilities. During this time period our great State has demonstrated exemplary commitment to citizens with developmental disabilities. This commitment has truly made a difference in the successful community living of thousands of Alaskans. On November 15, 1997 Harborview Developmental Center in Valdez closed after 36 years of operation as Alaska's institution for people with developmental disabilities. Gone are the days when Alaskans with developmental disabilities have no choice but to live in institutions. Gone are the days when Alaskans with developmental disabilities have to move away from their community, their friends and families to obtain needed support. Gone are the days when young Alaskan children experiencing complex medical conditions have to grow up in hospitals or nursing homes.

Much of the success experienced by Alaskans with developmental disabilities and children with complex medical conditions is a direct result of funding available through Medicaid, Home and Community Based Waivers. Presently in Alaska Medicaid Waivers are providing the funding needed to make community living possible for 143 children with complex medical needs and 779 individuals with developmental disabilities. Yes, costs to the State of Alaska for these services have increased in recent years. However, each member of Senate HESS must remember that the service costs for these Alaskan citizens would be much higher if institutional care still existed.

Another important issue for the committee to consider is the fact that Medicaid is almost always the only means by which Alaskans with disabilities can access health care. The ability to live successfully in the community, even survival often depends on needed health care services. Regrettably, for Alaskans with disabilities full coverage for many needed health care services (e.g. durable medical, assistive technology and personal assistance services) is seldom available.

On behalf of Alaskans with developmental disabilities I urge you to "stay the course" in terms of your commitment to Alaskans with developmental disabilities. Please continue to be mindful of the critically important role Medicaid funding plays in successful community living for these citizens.

Should you or any committee members have any questions or require further information do not hesitate to contact me. Thank you for considering my testimony.

Sincerely,

John Cannon

John Cannon

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, Alaska 99654

Re: CHOICE Services

Dear Senator Green:

My name is Anthony Ward. I am a 65 year old retired and disabled professional, who has experienced 9 surgeries during the last 24 months most of which were performed by the excellent staff and associates at Providence Hospital here in Anchorage.

Living in Alaska for the past 19 years, I have been a patient at Providence for several extended stays including a bilateral amputation, diabetes Type II, congestive heart failure and radial palsy.

Post surgically, I required an extensive period of rehabilitation before being able to return home and required a number of services in the community to prevent a nursing home admission. Before being allowed to be released, I was visited by a Circle of Care Care Coordinator, Joy Blankinship who introduced me to the "CHOICE waiver program." This program provided me all the services needed so that I could stay in my home and remain safe and somewhat independent with CHOICE community based services.

My outstanding Care Coordinator, Joy, calls and visits frequently checking on me and coordinating the many services the CHOICE program has set-up. Services include in-home nursing, housekeeping, hospital and medical care/appointments medical equipment and supplies.

These often critical CHOICE services have greatly reduced my need for emergency admittance to Providence due to stressful cardiac incidents.

I cannot commend the CHOICE program and the services the program provides enough. I am most grateful and feel truly blessed to enjoy and continuously benefit from CHOICE services via coordination of Circle of Care which has allowed me to live in my home of 19 years safely and independently.

Please support the continuation of these services for the growing population of seniors and adults with physical disabilities.

Sincerely,

Anthony Ward

November 7, 2001

To: The Senate Health, Education and Social Services Committee

Reference: Subcommittee on Health Care and Welfare

My name is Lila Berry, and I am a social worker and the manager of Circle of Care at Providence. Circle of Care began 12 years ago in response to a terrible tragedy to a senior. An elderly woman living alone in Anchorage with many health problems was utilizing several health care providers, but no provider realized how isolated the senior was. She died alone in her home, and was not found for several days. Several providers in Anchorage and statewide came together to problem solve how to better care for our frail seniors, and that was the birth Circle of Care and care coordination in the state of Alaska. Geriatric care coordinators can be found in all parts of the United States and in many parts of the world. Care coordinators assist seniors and adults with physical disabilities and their family members in a variety of ways. We provide consultation, screenings, and assessments to help clients find their way through the maze of eligibility criteria, and become eligible for programs such as the Choice Waiver program. We help them problem solve and obtain services to have the best possible health and safety. We assist seniors and those with physical disabilities access services, and monitor to ensure that their needs are being met. We work with frail seniors, some who are close to death, some who have dementia, some who have given up hope, and assist them to meet their physical, emotional, social and spiritual needs, when their world and their options may be decreasing. We help them transition so that their care and safety needs are met. This may mean assisting the senior who cannot afford their current housing, food, medication and other expenses, due to the loss of a spouse. Or assisting a senior whom is being financially exploited. The care coordinator may assist the senior or adult with physical disabilities find housing, such as an assisted living facility. It may mean going to the doctor's office with the senior to help them understand their medical plan and to help facilitate communication so that the physician understands the day to day concerns the senior is facing. Care coordinators might need to explain the meaning of a new diagnosis to the senior, and help them set up a living will and comfort one. The role of the care coordinator is quite complex.

Waiver services include care coordination, assisted living, environmental modifications, (such as a ramp, so that the disabled person enter and leave their home), assistance with food and eating, bathing, chore services and respite. There is an array of services available and the senior, disabled adult or family member may only need some of the above services, or all of them. Hundreds of seniors and disabled adults really benefit from the Choice Waiver program. Our population of seniors is rapidly growing and is predicted to continue to grow. We need to enhance and improve our menu of services for the senior population and those adults with physical disabilities.

There are many gaps in services for those with chronic illnesses. Our state safety net for the chronically ill is not adequate to meet the needs of the residents. Circle of Care provides assistance to hundreds of clients with chronic illnesses who are not eligible for Medicaid. They might be $10 dollars over income for Medicaid, or have a chronic illness that is not covered by CAMA, (respiratory illnesses, heart disease without high blood pressure) or have not worked long enough in a given period to be eligible for disability. Other states,(Oregon being just one example), have developed innovative plans to care for those with chronic illnesses that are not covered by traditional Medicaid. I am requesting that the subcommittee consider the health care and social service needs for those whom are not currently eligible for Medicaid, and consider expanding CAMA coverage to include those who are chronically ill. I would like to focus first on those with respiratory illnesses that are not currently eligible for CAMA Medicaid.

Sincerely, Lila Berry 261-4849

Testimony of Patricia Hong, RN
Chair, Medical Care Advisory Committee
November 8, 2001

Senate Health, Education and Social Services Subcommittee on Health Care and Welfare
November 8-9, 2001

Senators Green, Davis, Taylor, and Ward; Reps Dyson, Cissna and Coghill – good morning.

Thank you for the opportunity to speak on behalf of the Medical Care Advisory Committee (MCAC). As you know, the MCAC was established in 1974, and its members are well informed about the Medicaid Program. We meet four times per year, and receive detailed briefings on the Medicaid program and related issues. We work closely with the Director of the Division of Medical Assistance and staff, and are privileged to meet with the Commissioner of Health and Social Services on an annual basis.

The MCAC is currently composed of 15 members who bring expertise as providers and consumers of care associated with the Medicaid Program. The MCAC works hard to obtain public input during each of the four meetings. We have heard from both consumers of services covered by the program as well as providers of those services. We have also heard from a variety of interested parties who have concerns about the Medicaid Program. Overall, the MCAC has heard over and over again how valuable the Medicaid Program is in enabling needy Alaskans to access necessary health care.

This past summer, the MCAC drafted budget recommendations. More than 600 individuals were contacted by postal or electronic mail and their comments were solicited. The draft budget recommendations were available on the DMA website, and were downloaded 118 times during the comment period. The following Budget Recommendations for the Medicaid Program were adopted and transmitted to the Commissioner, Health and Social Services.

#1 Priority
The existing Medicaid Program and the FY 2002 budget should be the base for the FY 2003 Medicaid program budget. This should be interpreted to mean that there should be no reductions in covered services or eligible groups, and that the Administration should not be forced to finance new services, new eligible groups, cost increases, or program changes by reducing the existing program.

We know that, in some states, those who do not have insurance coverage are twice as likely to be hospitalized for avoidable disease complications as those who have insurance. Maintaining a strong Medicaid program that covers treatment for chronic disorders, such as diabetes and hypertension, will actually decrease the cost of health care.

Testimony of Patricia Hong, RN
Chair, Medical Care Advisory Committee
November 8, 2001

#2 Priority
The Department of Health and Social Services improve geographic parity of reimbursement by developing a regional reimbursement adjustment factor or a payment adjuster for remote areas and include the cost of implementing the regional reimbursement adjustment factor in their FY 2003 budget. The MCAC believes that consideration of local cost variables will improve access to care for Medicaid recipients who live in remote areas.

The MCAC has heard testimony from providers in remote areas who are genuinely concerned about residents in those communities, but cannot afford to care for a high percentage of Medicaid recipients when reimbursement isn't enough to meet their costs. The MCAC believes that adopting a regional reimbursement adjustment factor would encourage providers to continue to give care to Medicaid recipients.

#3 Priority
The Department of Health and Social Services consider ways to simplify the authorization and billing systems for medical transportation and include the cost of implementing the changes in the medical transportation system in their FY 2003 budget. The MCAC recognizes that a simplified payment and authorization for transportation process would improve access to care for Medicaid eligibles.

The MCAC has heard testimony from providers who experience frustration when patients miss appointments, often because of unreliable transportation. Simplifying the authorization and payment process would reduce this barrier to care.

#4 Priority
The Department of Health and Social Services update dental coverage for adults to include preventive and treatment services commonly included in mainstream dental insurance. The MCAC believes that these services would improve the employability of Medicaid beneficiaries and reduce the need for oral health related emergency medical care.

The MCAC has heard testimony from dental providers who are frustrated with the current allowable treatment options because they know that tooth extraction is not the best way to improve oral health. The dental providers want to establish an appropriate treatment plan for Medicaid recipients, but are unable to do so because of current constraints. Dentists know that prevention is the key to good oral health, and the MCAC believes including preventive dental services will result in improved health for needy Alaskans.

Thank you once again for the opportunity to address the members of the subcommittee.

Robert and Bambi Gilpin
1001 Elsinore Way
Apt 3-C
Wasilla, Alaska 99654
(907) 357-9880 home/fax
alexmacks@gci.net

November 07, 2001

To Whom It May Concern:

This letter is in regards to the continuation of Denali Kid Care and the importance of it in our lives.

In May of 2000, our daughter Alexandra was diagnosed with Leukemia. When we arrived back in the state after the initial treatment in Utah, we signed up for Denali Kid Care. Because our income was not over the limit, all three of our children qualified. If we did not have Denali Kid Care, we would be in serious financial debt, even though we have another insurance. Cancer can be very expensive and we appreciate and look forward to the added security of Denali Kid Care for the portions of expenses that are not covered.

I am asking that you keep Denali Kid Care around for as long as possible. Thank You for your time.

Sincerely,

Robert Gilpin
Bambi Gilpin

ALASKA PRIMARY CARE ASSOCIATION INC

ALASKA PRIMARY CARE ASSOCIATION INC.

903 West Northern Lights Blvd., Suite 202 Anchorage, AK 99503 Ph (907) 272-6131 Fx (907) 274-6131
akpca@alaska.net http://www.alaskapca.org

Testimony

Alaska Senate Health, Education and Social Services Committee
Subcommittee on Health Care and Welfare
November 8 - 9, 2001

Introduction:

Thanks for the opportunity to speak with you today as you meet to discuss issues of relevance to the Committee. I understand that your focus during these meetings is to gather information to prepare you for the coming Legislative session.

My name is John Riley- I am the Board President of the Alaska Primary Care Association. I am also a practicing primary care clinician, and the Medical Director of Alaska's oldest community health center. *What I want to educate you about today is the importance of the federally funded community health center- or CHC- program to Alaska.* This program is growing here. In 1995, Alaska had a single CHC in Anchorage. In the last six years, CHC's have blossomed into a network of eight non-tribal and tribal organizations with 28 sites statewide. All see people who would not otherwise have access to basic primary health care.

President Bush recognizes the importance of health centers in providing access to health care for those in need. He has shown his commitment to the program with a plan to double the number of health centers in America, and to double the number of people they serve. Senators Stevens and Murkowski have also recognized the importance of health centers, and have worked with those of us here to strengthen the program in our state.

CHC's are and will continue to be a major safety net provider here. It is extremely important that the Legislature be aware and supportive of Alaska's CHC's, and that the Legislature reduce barriers to the ability of Alaska's CHC's to provide those in need with necessary basic primary health care.

Brief statistics about CHC's in Alaska:

The most recent year for which we have statistics is 1999. In that year, Alaska had five CHC organizations with clinics located in 13 communities. Those centers:

- served nearly 20,000 patients
- provided nearly 61,000 medical patients visits
- provided a signif[illegible]ant amount of dental and [illegible]ental health services as well.

In those centers, on average:

- 37% of these patients were uninsured. (Some had a level exceeding 50%)
- 34% were insured by Medicaid, Denali KidCare or Medicare
- 29% had private insurance

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Since 1999, the CHC program has doubled in size in our state. CHC's sites now provide care in 28 communities. It is too early to know numbers of patients served, number of visits provided, etc., but *it is clear that Alaska's CHC's have become a major source of quality primary care to medically underserved Alaskans.*

This is very important in a state such as ours, where the most expensive cost-of-living category is medical service (which costs 60% more then it does nationally) and where the cost of medical care has risen nearly 200% in the last 20 years. The financial barriers to obtaining health care are considerable- even if one has insurance, but especially if one doesn't.

Alaska's Health Centers save the system money:

Health centers result in cost savings. The impacts health centers have on the health of their patients include:

- lower hospital admission rates
- shorter lengths of stay
- less inappropriate use of emergency room services
- significantly lower infant mortality rates
- reduced incidence of low birth weight
- higher immunization rates, and
- better use of preventive health services that result in lower rates of preventable illness.

Studies over the last decade have found that nationally, Medicaid patients who regularly use health centers receive care of equal or greater quality and cost significantly less than those who use private primary care providers, such as hospital outpatient units or private physicians. *These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular documenting their substantial savings to state Medicaid programs.* The record is clear that health centers save the system money.

Even as they are providing important services and saving resources, Alaska's CHC's are under threat:

- the numbers of uninsured, while temporarily dented by Denali KidCare, are again escalating. This places additional burden on health center resources.
- the costs of providing health care are escalating rapidly.
- the reasonable reimbursement system for Medicaid patients previously used is changing to a system that actually cost health centers to see these patients.

Over the coming year, this Committee will be hearing more about the good health centers do, and the problems they face. Requests will be made for support for this system that provides so much good to Alaskans and assists the state in providing a health care home for Medicaid and uninsured patients. We look to the Committee, and to the Legislature to respond appropriately.

Thank you.

John Riley, PA-C
Alaska PCA Board Chair

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Additional Background Information on Community Health Centers:

Health centers have:

- been around nationally for 35 years and represent federal, state, and local community investment in primary care infrastructure for medically underserved people and communities.
- Been present in Alaska since 1974.

Statutorily, health centers must:

- Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of federal resources on areas of greatest need;
- Make services available to all residents of the community, without regard to ability to pay, and make those services affordable by offering a sliding scale fee;
- Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears) and care for illness and injury, as well as services which improve the accessibility of care (such as transportation and translation services) and the effectiveness of care (such as health / nutrition education);
- Be governed by a Board of Directors a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the needs of the community it serves. Boards also include local community leaders and others who are committed to provide access to primary health care that meets the needs of their community

Health centers:

- Provide access to quality preventive and primary health care for the medically underserved – including those without health insurance, low-income working families and rural residents.
- Serve as a prototype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable for meeting national performance standards.
- Are community owned and operated businesses- professional health care organizations providing a comprehensive range of high quality preventive and primary health care services under one roof, in a "one-stop caring" system. Health centers offer 24 hour care, both for prevention and for treatment of illness or injury, and in addition provide diagnostic laboratory and x-ray services as well as prescribed medications in many cases.
- Are individual and unique, reflecting local decision-making on how best to meet the health care needs of that health center's patient load.
- Are subject to ongoing federal monitoring of their cost – effectiveness, quality of care, and management at a level that is more stringent then that applied to any other provider.

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- Are one of the best health care and taxpayer bargains anywhere. Comprehensive services are provided at a national average of less then a dollar per day for each person served. Considering the fact that health center patients are generally poor and suffer greater health disparities, this is an astonishingly low cost.

Additional Background Information on the Uninsured In Alaska:

Did you know these facts?

Alaskans without health insurance ...

- People we all know- 16% of all people in Alaska, or nearly two in ten of your friends and family are uninsured.
- Young- between 18-44 years old.
- Employed: 71% are employed, often in small, family-owned businesses. Most small employers can't afford to cover the high costs of insurance premiums.
- Male: 57%
- Low – income: 66% (in Anchorage) make less then $35,000 annually.
- High – income: Even high-income people are often not able to afford health insurance. Insurance premiums for a standard 80/20 medical and dental plan with a $500 deductible cost between $450 / month for a single person and $1300 / month for a family. Most of us, even those of us who are highly paid, would have trouble affording the $15, 600 per year it costs to insure a family.
- Sick- Among the uninsured in Anchorage, 40% have the silent killer of high blood pressure, and 22% have elevated cholesterol levels.

Do you know that lack of access to health insurance, and thus lack of access to health care, costs society a lot of money?

- 43% of people without health insurance have not seen a doctor in the past year, when they needed to, due to cost. Less preventive care means people wait until they have a crisis on their hands before presenting for care. A problem easily resolved early on festers into a crisis situation that is much more costly to handle in the later stages. This cost is passed along to the hospitals that end up providing this emergency care, and ultimately gets passed along to those who pay the premiums.
- 23% of uninsured people have not had a routine checkup in the last five years. Again, a problem easily resolved in the early stages festers and then escalates, resulting in higher costs for resolution. This means more costs passed along to the payors and consumers.
- 30% of the uninsured cannot fill prescriptions due to cost. A treatment plan that is not carried out because the person couldn't get the drugs they needed to heal is substandard, and again, results in escalation of a problem and more costly resolution.
- 25% of bankruptcies are caused by costs of illness or injury.



ALASKA PRIMARY CARE ASSOCIATION INC.

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Alaska's Federally Funded Community Health Center Family

Anchorage Neighborhood Health Center, Funded 1974
- Fairview
- Mt. View

Interior Neighborhood Health Center, Funded 1995
- Fairbanks
- Healy

Eastern Aleutian Tribes, Funded 1998
- Adak
- Akutan
- Cold Bay
- False Pass
- King Cove
- Nelson Lagoon
- Sand Point

Sunshine Community Health Center, Funded 1999
- Talkeetna
- Trapper Creek
- Willow

Southeast Alaskan Regional Health Consortium, Funded 1999
- Angoon
- Haines
- Kake
- Klukwan
- Pelican
- Prince of Wales Island- Hydaburg, Kasaan, Klawock, Thorne Bay
- Tenakee Springs

Yukon Kuskokwim Health Corporation, Funded 2001
- Emmonak
- St. Mary's

Bethel Family Clinic, Funded 2001
- Bethel

Central Peninsula Health Center, Funded 2001
- Kenai

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Nov. 8 2001

Committee members,

My name is Kris Moore. I have four children ages 4, 7, 9, and 11, two of which we adopted two years ago. The adoption was not planned for or expected. They were my husband's niece and nephew and if we did not receive them into our home, they would have been adopted outside of the home. With an issue such as this we couldn't factor in being able to afford health coverage into the decision. We had to do it because it was the right thing to do.

Like many other families, we would like to be in a position where my spouse or myself held a job that offered affordable, comprehensive health coverage for our family. However, at our current time that is not a reality. My husband's job, that he has been at for 10 years, does not offer health coverage, and I am going through a transition due to an unexpected lay off. Unfortunately we do not see our resources changing in the real near future. Many families experience unexpected transitions such as we are facing, and if a medical emergency, or even a necessary basic care came during these times, we could be financially set back for years. Programs like Denali KidCare provide us the assurance that health care will be met and not compromised, which can lead to additional cost. I am open to evaluation of the programs offered in our state in order to insure effectiveness. We must however keep in mind that families need to be able to access health services when needed without risking neglected care for fear of financial downfall.

Last night I had to rush my four-year-old daughter to the Urgent Care Clinic because she split her head open while playing. I was able to meet her needs without a second thought. Without having our Denali KidCare coverage I would have been more willing to compromise her health by debating the seriousness of the injury and worrying about how we were going to pay for it—instead of putting my focus and attention where it should be—on comforting my child.

Please consider the needs of families and their children while evaluating and shaping their health insurance needs. Not all families want or plan to be dependent on these services, but the value of their lives would be tramadic if they couldn't access it when in need.

Kris Moore



My name is Ruth Titler I am a 61-year-old female. I have been an insulin dependent for 52 years. I also have the other major complications, which relate to diabetes. I wish to tell you what the Choice Waiver and Circle of Care program do for me. In January of 1999, before I was released from the hospital my doctor requested that Circle of Care evaluate me at home. It was determined that I needed help with everyday chores and transportation. In mid-June, 1999 upon approval by the Choice Waiver my life drastically improved. I now receive Meals-on-Wheels, weekly help with chores and shopping. I also have Lifeline and that is a blessing. I also receive door-to-door transportation and if I had to use People Mover, I would have a real problem.

As for Circle of Care, they are a blessing in disguised and a great support system. Besides helping with the yearly Choice Wavier Program my Care Coordinator and I have contact a minimum of twice a month and this includes one face-to-face visit. She monitors the service I receive and acts as a advocate for my needs. If she has concerns about how I am feeling she contact my physician immediately. When I was in the hospital last year Circle of Care was there for me and very supportive. This is very important to me since my children lives in the State of Washington and South Dakota's Air Force Base.

About 22 years ago, I was a State employee. During that time the State Union opted out of Social Security. Therefore, I received SSI and APA only. I do not qualify for Medicare and receive Medicaid. When I have a doctors visit it would cost me between $100 to $ 150 dollars for the visit and lab work. I have been told that if I had to pay for all my medical supplies, it would run $852.00 to 1,000.00. My total monthly income is less than $900.00. If I had to pay for my medical bills, pay rent, buy food, telephone bill, and transportation I believe I would be in bankruptcy court in fewer than two months. Without the help of Medicaid and Choice Waiver paying for my basic and necessary needs, I could not afford them and I would die in less than two weeks.

If it were not for the Choice Waiver, Circle of Care, and the Medicaid Programs I believe I would not be able to live independently. It would be necessary for me to reside in a skilled care facility and this I do not want, plus it would cost you more money! I pray to God that you would never have to walk in my shoes, but if you had to, consider what your life would be like. Life with dignity is a precious thing. Because of your support of health care programs in prior years, this is possible. Please, please continue to show your support by ensuring that Medicaid monies is available to those in need. Thank You!

Ruth Titler

Dawn M. Harris
Po Box 45
Talkeetna, AK 99676

Message to Lyda Green
Wasilla, AK 11/8/01
Subject: Denali Kid Care Income Guideline

My name is Dawn Harris. I am married and have 3 children ages 4, 18 months and 3 months. My husband works seasonal construction jobs and makes a modest income.

I am not employed; I work at home taking care of my family. Because of my husbands type of employment he has never been covered under a health insurance plan through his employers. We have been married 10 years and have never had health insurance. I checked into buying a policy several times over the years and found all of them to be very expensive and for us unaffordable. The bare minimum average was around $500 before we even had children a month and that only included emergency care. Not for checkups, immunizations, dental care, pregnancy coverage, prescriptions or in cases where my child has an ear infection and needs to see a doctor and get antibiotics. After rent, food, bills and household expenses we don't have that much left over. Two of my children have respiratory disorders (asthma and spasmodic croup) and my newest child was born premature and needed. Hospitalization. Since the advent of the Denali Kid Care System, my pregnancies have been covered and I have been able to sleep at night, knowing if my children need medical attention I can take them in without debating whether or not we can afford it.

[redacted] My husband and I provide a safe, healthy home for our children. It's just that we simply cannot afford health insurance. It is expensive to live in Alaska, but we love it here and it is our home. We are not asking for large handouts, only to feel secure that our children can go to the doctor when they need to.

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau AK 99801-1182

Dear Senator Green:

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Michael K. Garland

JANE WALSH

October 30, 2001

Senator Lyda Green,

By cutting funding to Medicaid programs, such as Denali Kid Care, you will be negatively affecting many, many people. Many of these people, through the voting process, have put you in the office you currently hold.

Not a good career move.

Please reevaluate your position on this issue. Thank you for your time.

Jane Walsh

Cc: John Coghill
119 N. Cushman #211
Fairbanks, AK 99701

1097 VICKI LANE, NORTH POLE, AK 99705

7209 Richardson Hwy.
Salcha, AK 99714

October 30, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Ms. Green,

I am writing to you to ask your support toward strengthening Medicaid funding.

My personal experience regarding the need to maintain a strong base of assistance to our states residents involves my 85-year-old mother. She has worked hard all of her life, supporting her family, sometimes working two or more minimum wage jobs. Her social security benefits are now based on those 60 years of minimum wage jobs. Without the benefit of Medicaid, she would not be able to afford her needed medications, let alone maintain a reasonably comfortable standard of living.

Sincerely,

JAN - OWEN-DENTON

Janet Owen-Denton

cc: John Coghill

ROBERT GOULD
4820 Drake St.
Fairbanks, AK 99709

October 29, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green:

It has come to my attention that you are seriously looking to reduce Medicaid spending. I could not disagree more! You should be looking at ways to increase spending and ways to make the current system more efficient.

At this point, Medicaid fails to pay their share of the cost of care. As a result, providers are forced to shift the cost to individuals who have insurance. Talk to any provider, physician or insurance company and they will tell you that the insured population has to cover for the shortcomings of the Medicaid program.

Let me offer the following suggestions. Please look for ways to increase spending on preventative care (breast cancer detection, low birth weight, mental health, programs that help people reduce their drinking or help them to stop smoking.)

Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Robert Gould

cc: Rep. John Coghill

JANA WALTERS
P.O. BOX 81293
FAIRBANKS, ALASKA 99708

October 31, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green,

Having worked for over 30 years in the healthcare industry I have witnessed the impact of providing Medicaid funds to people in need.

The most profound effect, I believe, is in providing these funds to women and children. As an example, a young teen finds herself giving birth to her own child without the resources, emotionally or financially, to adequately care for herself or her unborn child. Without Medicaid funding she most likely will forego pre-natal care, putting herself and her child at risk for costly medical complications.

These complications often result in life-long medical expenses which ultimately are reimbursed by State funds. Adequate pre-natal care can and does decrease this risk. To eliminate the Medicaid funds at this level results in more costly expenditures throughout the lives of mother and child.

Maintaining the funds to provide care to this population is essential in allowing these individuals to lead productive and health lives.

Sincerely,

Jana Walters

Jana Walters

cc: Representative John Coghill
119 N. Cushman St. Suite 211
Fairbanks, AK 99701

Jennifer House
1951 Gilmore Trail
Fairbanks, AK 99712

October 30, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99802-1182

Dear Senator Green,

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Jennifer House

Jennifer House

cc: John Coghill

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

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State Capitol, Room 125
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Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Michael R. Gorham

Post-it® Fax Note	7671	Date 11-8-01	# of pages ▶ 1
To Senator Lyda Green		From C.I.T.C.	
Co./Dept		Co.	
Phone #		Phone #	
Fax # 376-3157		Fax #	

COOK INLET
TRIBAL
COUNCIL, INC.

Date: November 7, 2001

Senator Lyda Green
600 Ease Railroad Avenue
Wasilla, AK 99654

Dear Senator Green:

Consider the working poor. Medicaid, Food Stamps, and Denali Kid Care are going to be essential pieces of the safety net for working families who reach the end of ATAP eligibility.

In order to help these struggling families maintain pride in being members of the work force, a solid safety net needs to be in place. Welfare reform and a healthy economy have combined to allow for a 50% reduction in cash benefit caseloads.

Currently we are facing the first wave of families who are at the end of their five years of eligibility and we are in a recession.

Now seems to be the appropriate time to assure Medicaid and Denali Kid Care continue to be available at the current level of services. This will go a long way in helping families break the dependency cycle and give their children the best chance to grow healthy and independent. This decision will be pivotal to the continued success of welfare reform.

Sincerely,

Gloria O'Neill, President and CEO

TRANSITIONAL SERVICES DEPARTMENT
670 W. FIREWEED LANE, ANCHORAGE, ALASKA 99503-2578
FAX: (907) 265-7942
PHONE: (907) 265-5900

Dear Honorable Committee Members, 11-5-2001

My name is Randal Esslinger. I have numerous urgent medical needs that I am unable to meet. I have contacted DHSS and I have been seen by several doctors and I qualify in all respects. I am however being denied Medicaid. I am being told that unless I am getting either SSI or SSD I can't have Medicaid benefits. This is contradictory to Alaska Statue 7.08.010&47.07.020. Some of the injuries that I am seeking care for and corrective surgery happened while I was incarcerated for DUI. The state violated facility safety regulations by allowing an inmate to flood his cell repeatedly and I fell in the water seriously injuring myself This was 3-17-2000 so I have been suffering since that time. I am at home now yet unable to work due in part to this injury. It is my belief that medicaid is illegally being withheld as retaliation for filing lawsuits against the state for damages. I request that this committee look into this matter for me.

Thank you

R Es

Randal L. Esslinger
PO19551
Thorne Bay,Alaska 99919
(907) 828-8880
DHSS Case No.05383414

IONE WRIGHT

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green:

It has come to my attention that certain funding reductions are being considered for Medicaid patients. I have been in nursing for 20 years, and have witnessed the significant impact of persons / patients who fall through the cracks when it comes to medical care.

We have ongoing Fetal Alcohol Syndrome and drug addicted infants that require extensive and ongoing medical care, placement, and support throughout their lives.

We have many psychiatric patients and substance abuse patients that require many repeated hospitalizations with the result of no employment or income to support their families and children. This is especially critical in single parent homes – the children suffer the most.

I would emphasize also the many elders in the community who, following an admission for a fractured hip or severe pneumonia, cannot return home to live alone again. They often have no one from their family in our state that they can turn to. Taking them from familiar surroundings into assisted living and / or long-term care is traumatic enough without forcing them to relocate to another state. The high cost of medications is another issue that causes severe strain to our senior citizens.

I realize these are very tough issues to address for the state of Alaska and would like to encourage you to not cut funding, but rather seek ways of increasing support for these hurting areas of our communities. I believe the "return to work" programs are very good and would like to see that continued.

I feel children are our most important assets in this state and should be afforded every opportunity for health wellness, education, and support, as they will someday become Alaska's leaders.

I believe strongly in wellness programs for all in the community because this helps to keep medical costs/hospitalization down for the entire state and keep our population healthy. I would ask that you please make every attempt to be supportive of the medicaid system and funding required maintaining these programs. Thank you.

Sincerely,

I. Wright

Ione Wright

Cc: John Coghill

P.O. BOX 82929, FAIRBANKS AK 99708

October 31, 2001

Senator Lyda Green
Alaska State Legislature
State Capitol
Juneau, Alaska 99801

Dear Senator Green,

I am writing as a concerned citizen to urge your not to pursue a decrease in the Medicaid budget. Funding for these services is crucial in the Fairbanks community. As a health care provider, I see numerous instances in which this funding has prevented disastrous consequences.

I recall a young mother of two suffering from breast cancer, which became well advanced. Their Christmas two years ago consisted of concern over heating their one bedroom apartment, having enough food for her small children and adequate clothing to endure a Fairbanks winter. This is exactly the type of instance which I would desire my tax dollars, state dollars and general concern be focused towards.

Granted, there are times that I am frustrated with people who abuse the system intended to do good; however, I do not believe the approach of cutting dollars is the best. I would suggest instead a focus towards efficiency, accountability of dollars spent, and demonstrated value of programs be the priority.

Thank you for your consideration.

Sincerely,

Karl H. Sanford

Karl Sanford
384 Snowy Owl Ln.
Fairbanks, Alaska 99712

cc: Rep. John Coghill

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green,

I have recently been advised of your position on Medicaid funding, and to be quite honest I am disappointed in our state government and in your decision making process. I have been a registered nurse for 16 years. For the past 13 years, I have been working with the Mentally Ill and Substance Abuse populations.

These populations are becoming more and more recognized and require greater types of services. Unfortunately these populations are affecting many children and adolescents.

I have had to serve as a nurse to many teenagers whose parents either had/have major Mental Health Illness and/or Alcohol or Substance abuse issues. These children are victims. Dysfunctional parents who are unable to be good role models or educate their children are raising these children.

Many of these children become severely depressed and turn to substance abuse themselves. Many develop major mental illness themselves. On the Mental Health unit we have used the Denali Kid Care services to help get some of these children into early treatment. Out of the many children we have sent to treatment, I have had the pleasure of seeing two return to our community and they are able to contribute to other teenagers in need. These adolescents could not have been so productive if they had not gone to treatment. They could not have had treatment without the aide of Denali Kid Care.

Another request I have in supporting the continued funding of Alaska's Medicaid Program is the importance of the pharmaceuticals to individuals who cannot afford it. Many of our Mental Health patients are not on Medicaid as they choose to be employed, yet their income could never cover the cost of the medications required to keep them productive, functioning individuals. Without the help of Medicaid funding these patients could not afford medications, and soon would not be able to be productive, and surely would cost the public more in the long run.

Senator Green, I implore you to reconsider your stand and continue supporting these inpatient programs. Thank you for understanding the general public's position.

Sincerely,

Lauri Ellis

Lauri Ellis
cc: John Coghill

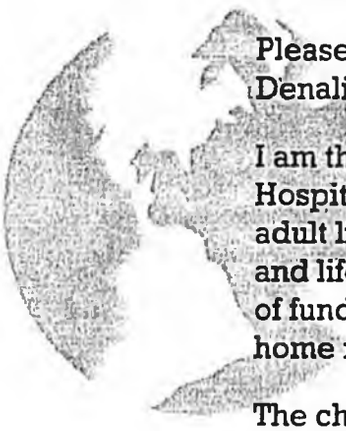
P.O. BOX 55521
NORTH POLE, AK 99705

Pat Connelly
4525 Woodriver Drive
Fairbanks, AK 99709

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green:



Please reconsider your position on Medicaid funding, especially for Denali Kid Care and Breast Cancer detection.

I am the manager of the surgical orthopedic unit at Fairbanks Memorial Hospital. We frequently see patients who have been healthy for their adult life and then they fall and break a hip. This can be a very expensive and life threatening injury in an elderly patient. They frequently run out of funds and need Medicaid funds for long-term care, home care, and home medical equipment.

The children, elderly, and poor people of Alaska need this program. Please reconsider your position.

Sincerely,

Pat Connelly

cc: John Coghill

Carol Barnett
1696 Dredgeview Dr.
Fairbanks, AK 99712

October 26, 2001

Alaska State Senator Lyda Green
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Green:

I am writing this letter today to implore that you not cut Alaska Medicaid funding. In my personal opinion, I am most concerned about what budget reductions will do to existing programs that support our children. Particularly programs such as Denali Kid Care and TEFRA benefit so many children who otherwise wouldn't get the care they need. As a mother of three children, it is one of my strongest desires that each and every child receive the medical attention and preventative care they need.

Furthermore, special needs babies relinquished by parents are helpless victims who deserve a safe and nurturing home. Without this financial assistance, finding adoptive homes will become much more difficult; leaving these children to grow up in a less than optimal environment as Wards of the State. Children who are not raised in a safe and nurturing environment eventually end up costing tne public system more dollars in the end, i.e. illness, accidents, crime, alcoholism, drug abuse.

Please continue supporting and funding these very important programs that protect our children and future adult population. It is a wise investment into Alaska's future.

Sincerely,

Carol Barnett

Carol Barnett

cc: Rep. John Coghill
119 N. Cushman
Suite 211
Fairbanks, AK 99701

CAROL MEYER

SENATOR LYDA GREEN
STATE CAPITOL
JUNEAU, AK 99801-1182

DEAR SENATOR,

AS A CONCERNED CITIZEN OF ALASKA, AND A NURSE IN THE EMERGENCY DEPARTMENT, I FEEL COMPELLED TO WRITE TO YOU REGARDING YOUR PROPOSED CUTS TO THE MEDICAID PROGRAM IN ALASKA.

MANY OF THE PATIENTS I HAVE SEEN IN THE EMERGENCY DEPARTMENT ARE MEDICAID BENEFICIARIES. WHILE CERTAINLY THERE ARE SOME THAT ARE ABUSIVE OF THIS PROGRAM, MANY MORE WOULD BE DESTITUTE WITHOUT IT, PRIMARILY THOSE WITH CHILDREN. HOW YOU COULD EVEN FATHOM CUTTING THE MEDICAID BUDGET TO THE DETRIMENT OF ALASKA'S CHILDREN AND THEIR HEALTH CARE NEEDS IS BEYOND ME. I FEEL THAT THE REPERCUSSIONS OF THIS ACTION WOULD HAVE VERY NEGATIVE CONSEQUENCES TO THE HEALTH AND WELFARE OF KIDS ACROSS THE STATE, PERHAPS WHICH WOULD EVENTUALLY COST THE STATE MORE THAN WHAT YOUR PROPOSED CUTS WOULD SAVE.

I URGE YOU TO RECONSIDER THIS PROPOSED ACTION AS I FEEL IT WOULD HAVE A MONUMENTAL NEGATIVE IMPACT STATEWIDE.

SINCERELY,

Carol Meyer

CAROL MEYER

CC: JOHN COGHILL
119 N. CUSHMAN #211
FAIRBANKS, AK 99701

4250 ASPENWOOD DRIVE
FAIRBANKS, AK 99709

715 John Cole Road
Fairbanks, AK 99712

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green:

As an administrator in early childhood programs in Fairbanks for the past 17 years, I am imploring you to strengthen Medicaid funding. I have personally seen the impact of Alaska's Medicaid program on Fairbanks families.

An employee of mine, who is a single parent, adopted three FAS/FAE children (siblings). She has provided them a loving, stable home and they have made tremendous progress over the past few years. She could never have done this without the continuation of the children's Medicaid after the adoption process was completed.

I have seen many families utilize Denali Kid care insurance for their children. What a wonderful program, and what a great way to invest in our future – by ensuring a health population by providing preventative care and early treatment for our children and teens.

Again, I encourage you to support continued funding of Alaska's Medicaid program.

Sincerely,

Patty Rich

Patty Rich
cc: John Coghill

ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
(907) 465-3805 Fax

SENATOR LYDA GREEN
SENATE DISTRICT N

PRESS RELEASE FOR THE HEALTH CARE AND WELFARE SUBCOMMITTEE

September 19, 2001

For Immediate Release —Lyda Green (R-Mat-Su), Chair of the Senate Health, Education and Social Services Committee announced the formation of a legislative subcommittee to explore the future of health care costs and welfare reform in Alaska.

After education, health care is Alaska's most expensive service, and it is continuing to grow every year. At the current rate of growth, approximately 10% annually, Medicaid costs could overtake education costs within five years and the state's total budget for Medicaid services will double in seven years. Alaska's Medicaid expenditures increased by approximately $75 million in the last budget cycle and are anticipated to exceed that in the next cycle unless cost containment measures are implemented. In addition to the rising costs of the total program, reductions by the new leaders in Congress of Alaska's Federal Match Percentage (FMAP), which go into effect October 1, 2001, will create an immediate shortfall of $10 million in the coming year. Cost containment measures must begin now to address that shortfall.

State provided welfare is another program that will be revisited during the coming legislative session, since the mandatory 60-month limit occurs for some recipients in 2002. Additionally, the federal government is reducing their funding of the state's welfare program by $7 million in the upcoming year. Consequently, it will be necessary for the Legislature to address the continuation of and changes to the welfare program.

In response to these issues, Senator Green has formed a legislative subcommittee to progressively address these important social and policy issues. "It has been years since the legislature has taken a comprehensive look at our state's growing health care costs. It is important that, as these costs increase, the legislature consider these programs and their costs and whether they are appropriate and reasonable," said Senator Green. "Furthermore, access to quality health care is a major concern to residents of both rural and urban areas of Alaska. I want to be sure that Alaskans who really need health care coverage are receiving it, and we need to explore how greater access to health care insurance can be provided for the people of Alaska," continued Green.

Senator Green will be joined by Senators Bettye Davis, Robin Taylor and Jerry Ward, as well as Representatives Fred Dyson (Chair of the House Health, Education and Social Services Committee), Sharon Cissna and John Coghill.

The subcommittee will hold a series of public meetings at the Mat-Su Legislative Information Office this fall. The meetings will focus on:

- Access to health insurance for Alaskans;
- Welfare reform and reauthorization and its effects on health care costs and access;
- The Certificate of Need Program for expanding health care facilities or building new health care facilities and its effects on health care costs;
- Review of Medicaid programs, including the Child Health Insurance Program (CHIP), costs associated with Medicaid, cost containment and proposed solutions; and
- Rural Health Care and the role of the state, the federal government, the Denali Commission and native non-profit health corporations.

The subcommittee will be inviting expert testimony from state and federal agencies and interested groups as well as public testimony. At the conclusion of the hearings, the subcommittee will submit a written report to the Legislature and may propose legislation to be introduced by the Senate or House Health Education and Social Services Committees.

The public is encouraged to contact Senator Green to provide the subcommittee with questions to explore with experts and written testimony concerning health care costs and access. Questions or comments can be submitted to Senator Green in writing at 600 East Railroad Avenue, Wasilla, AK 99654, by email at Senator_Lyda_Green@legis.state.ak.us, or by telephone at (907)376-3370 or (888)465-6601.

Denali Commission Update
November 2001

Note to Legislators and Staff: Please contact Krag Johnsen, Alaska State Legislature's Staff Representative at the Denali Commission for further information. (907) 271-1413, Kjohnsen@denali.gov.

Energy

Energy projects comprise nearly $65 million of Denali Commission funding. This is leveraging an additional $22 million from other funding sources. The two primary agents used to complete projects are **Alaska Industrial Development and Export Authority/Alaska Energy Authority (AIDEA/AEA)** with **$43.8 million, and Alaska Village Electric Cooperative (AVEC)** with $21.3 million presently funded.

All Federal FY01 financial awards incorporated sustainability criteria for their projects. This requires that a business plan be developed demonstrating how the community will operate and maintain the utility in a business-like manner, attain the full expected economic life of the utility, and build some equity for future replacement. Construction funds are not authorized for these projects until the business plan has been approved, and a potential backup operator is named for the event that a community is unable to adhere to the business plan. Funding for business plan development is currently available for 54 communities. Most Denali Commission Energy projects need a two-year cycle to complete planning design and construction. As the cycle has developed, questions continue to arise on how to fund projects equitably, and how to plan for future work. In September, the Denali Commission issued three draft policies regarding capacity, fuel pipelines and dispensers, and energy project prioritization.

BULK FUEL UPGRADES

Bulk Fuel Upgrades are the largest part of the Energy program at $39.3 million. By the end of 2001, new bulk fuel projects will be substantially complete and operational in nine communities: **Kotlik, Chignik Lagoon, Old Harbor, Noorvik, Port Graham, Manokotak, Kiana, Allakaket, and Napaskiak.** Three projects were put into operation last year.

RURAL POWER SYSTEMS UPGRADES

Rural Power Systems Upgrades represent $16.9 million of the Energy program. Twelve other energy projects (including power plant upgrades, electrical distribution upgrades, and fuel-line replacements) should be complete in **Kasigluk. Kiana, Huslia, Kivalina, Ambler, Quinhagak, Pilot Station, Shishmaref, Savoonga, Toksook Bay, Tuntutuliak and Kotlik.**

ENERGY COST REDUCTION RFP

Energy Cost Reduction RFP, with $4 million in Denali Commission funds, was issued by AEA on May 18, 2001. Preference in evaluation will be given to economically distressed rural communities, or those with extremely high-energy costs. It is anticipated this money will be allocated to projects in the January 2002 Quarterly meeting.

Contact Information:
AIDEA/AEA Contact Mike Harper, (907) 269-3000
AVEC Contact Meera Kohler, (907)561-1818
Denali Commission Program Manager Kathy Prentki, (907) 271-1414

Health

To date the Commission has obligated $22 Million for health care facilities leveraging an additional $20 Million in contributor funding. A total of 24 clinic construction projects have been funded and an additional 28 planning/design projects have been funded.

There is no one State or Federal agency tasked with provision of health care facilities throughout all of Alaska. Many agencies and health care organizations have overlapping interests, but there is no one agency to turn to. Accordingly, the Commission established a Health Care Steering Committee of agencies and organizations with interests in health care. The Steering Committee is chaired by the **Director, State of Alaska Division of Public Health** and has members from the following organizations: **Indian Health Service, Alaska Native Tribal Health Consortium (ANTHC), University of Alaska, Alaska Primary Care Association, Alaska Native Health Board, and the Alaska Mental Health Trust Authority.**

For carrying out its Health Care Program for the "Small Clinic" program (typically a clinic that serves one community with a year-round population less than 750) and the "Clinic Repair/Renovation" program, the Commission has turned to the State of Alaska as our "pre-award" partner and ANTHC as our "post-award" partner. The State manages the Commission's request for proposals process in conjunction with the Commission. Once projects have been identified, then ANTHC will manage the projects on our behalf. Communities have a choice of 6 management options through ANTHC:

- Community-managed force account
- Community-managed competitive contract with strong local hire component
- Regional Health Corporation - managed force account
- Regional Health Corporation - managed contracts with strong local hire requirement
- ANTHC-managed competitive contract with strong local hire requirement
- ANTHC Department of Environmental Health and Engineering - managed force account

For our "Large Clinic" program (typically a clinic that serves multiple communities or a community with a year-round population greater than 750) the State of Alaska is our "pre-award" partner. To date, all project applicants are our "post-award" partners and provide project management. However, in time the Commission may have to revisit this approach as the volume of "Large" clinic grantees grows beyond Commission staffing ability to respond to our Large Clinic partners needs.

Contact Information:
Denali Commission
Joel Neimeyer, Health Care Program Manager: (907) 271-1459
Al Ewing, Chief of Staff: (907) 271-1426

ANTHC
Rick Boyce, Facilities Program Manager: (907) 729-3601
Seth Yerrington, Clinic Construction Program Manager: (907) 729-3747, (907) 729-3600

State of Alaska
Karen Pearson, Director, Division of Public Health & Chair of the Steering Committee: (907) 465-3090
Pat Carr, Program Manager, Primary Care and Health Promotions: (907) 465-8618

Training

DENALI TRAINING FUND

The Denali Training Fund was established by the Denali Commission specifically to ensure that local residents have the skills to become employed on the construction, operation, and maintenance of Denali Commission and other state and federally funded public infrastructure projects. To date over three hundred people from rural Alaska communities have been trained for numerous construction, operations, and maintenance careers.

The **Department of Labor and Workforce Development** operates, selects, oversees, and administers the Denali Training Fund. On a quarterly basis applications of up to $25,000 for training are solicited from non-profit and for-profit organizations and governments.
Contact Information: Gerry McDonagh, (907) 269-4551

ALASKA NATIVE COALITION ON EMPLOYMENT AND TRAINING (ANCET)

ANCET consists of the **twelve regional Native Nonprofit Corporations** and **Metlakatla** as a unified organization to further employment and training issues statewide and nationally. The focus of ANCET for the Denali Commission has been to implement a **Regional Coordination Initiative** that handles much of the recruitment for various training courses that are funded by the Denali Training Fund.
Contact Information: Bonnie Jo Savland, (907) 644-8312

ASSOCIATED GENERAL CONTRACTORS OF ALASKA

With Denali Commission funds the **Associated General Contractors** administer the **Construction Career Pathways Initiative**, placing construction curriculum in rural schools through **Build Up!** for elementary grades. To date **Build Up!** has been introduced to 27 different schools in 13 rural school districts. AGC is looking for more for more rural schools to offer the curriculum.
Contact Information: Vicki Schneibel, (907) 561-5334

ALASKA WORKS PARTNERSHIP

Alaska Works Partnership (AWP) and the Denali Commission have partnered to deliver apprenticeship outreach services in rural Alaska. **AWP** provides information to students and adults about jobs in the construction industry and opportunities to learn construction skills through registered apprenticeship. To date thirty rural residents successfully entered specific craft apprenticeship programs, and over sixty are registered as **Building Maintenance Repair (BMR)** apprentices with **Alaska Works**.
Contact Information: Tom Brice, (907) 457-2597

ALASKA VOCATIONAL TECHNICAL CENTER

AVTEC has implemented two programs that provide advanced skills certification. The first is the **Building Maintenance Repairer Apprenticeship (BMR)**, which includes comprehensive training in the basics of carpentry, plumbing, heating, and electric. The second initiative developed the curriculum for the **Bulk Fuel Tank Farm Operator course**, which trains the individual in the statutes, regulations, and requirements of the operation and maintenance of bulk fuel storage facilities in Alaska.
Contact: Dick Harrell, (907) 224-4162

Contact Information:
Denali Commission
Krag Johnsen, Program Manager, (907) 271-1414

Other Infrastructure

MINI-GRANT PROGRAM
The Division of Community and Business Development (DCBD) administers the program, under the **Alaska Department of Community and Economic Development**. The program has one grant cycle, which began August 8, and will conclude with final awards on January 15. The Denali Commission contributed $500,000 and the **USDA Forest Service** contributed $144,755, for a total Mini-grant program of $644,755. *Contact Information: Nelda Warkentin, (907) 269-4568*

COMMUNITY PRIORITIES PROGRAM
The Denali Commission invested $4,500,000 in this program, which is administered by the **Division of Community and Business Development (DCBD)**, under the **Alaska Department of Community and Economic Development**. The program has quarterly grant cycles. The second grant cycle is under way. Pre-applications for the third and fourth grant cycles are due November 2, 2001, and February 18, 2002 respectively. *Contact Information: Nelda Warkentin, (907) 269-4568*

ALASKA GROWTH CAPITAL PROGRAM
The Denali Commission has invested $2,340,000 with **Alaska Growth Capital** to support viable businesses in rural Alaska, with emphasis on Alaska-owned businesses in economically distressed communities. The program does not have a funding cycle, but responds to requests for assistance on a year round basis. **Alaska Growth Capital** (AGC) has made $1,625,000 in loans this year to Alaska-owned businesses in economically distressed communities. An additional $600,000 in loans is in the closing process. The businesses that received loans have an annual payroll of $350,000. In addition, AGC has made 15 consulting engagements with clients or potential clients. *Contact Information: David Hoffman at (907) 349-4904*

Contact Information:
Denali Commission
Paul McIntosh, Program Manager, (907) 271-1640

First Alaskans Foundation

In late 2000, the Commission granted $1.2 million to the First Alaskans Foundation. The foundation, a non-profit organization affiliated with the Alaska Federation of Natives, is working to develop capacities of Alaska Native people and communities "to meet social, educational and economic challenges of the future." This capacity building program will be phased over a two-year period and will work on the development of local decision-making, and enhancement of management and governance skills necessary to plan and implement sustainable community development efforts. Funding has been made available through five separate RFP processes: community development, community economic development, statewide visioning, regional/sub-regional infrastructure planning, and community infrastructure construction.

Contact: Jason Metrokin, Director of Programs, (907) 263-9890

Denali Commission brings GrantStation.com to Rural Alaska

The Denali Commission, Alaska State Libraries, USDA Rural Development, and GrantStation.com Inc. recently announced a jointly funded project to bring state of the art grant seeking services to organizations and residents in rural Alaska.

GrantStation.com is an Alaskan owned and operated company provides an on-line comprehensive, fully interactive and searchable database of funding sources for organizations at www.grantstation.com. Members of GrantStation have access to worldwide funding sources (soon to include all state and federal sources) with the most up-to-date contact information, an accurate understanding of a funder's philosophies and rules, and valuable information on the most effective way to work with a particular funder.

Under the terms of the contract GrantStation.com membership will be provided to the following organizations for two years:

- All State Libraries (approximately 75 Rural Locations will have grantstation.com access for the public)
- All Tribal offices
- All City offices
- All Health Corporations
- All Regional Native Non-Profits
- All Rural School Districts
- All Rural Borough offices

Jeff Staser, Federal Co-Chair of the Denali Commission said, "The Denali Commission has already been successful in securing private foundation dollars with previous projects, we believe that GrantStation.com services will help expand on this success and bring more funding to rural Alaska and ultimately stretch the federal and state's investment into rural communities

Alaska
Rural Primary Care Facility Needs Assessment

Volume I • Overview



Final Report

ALASKA RURAL PRIMARY CARE FACILITY NEEDS ASSESSMENT

October 20, 2000

Dear Commissioners:

The Steering Committee for the Alaska Rural Primary Care Facility Needs Assessment Project has published the enclosed Final Report summarizing its work to:

- Build a statewide database of detailed information on rural primary care facilities and program services.
- Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide-unmet need related to primary care facilities.
- Establish a resource distribution methodology for rural primary care facility projects funded through the Commission.

This Final Report is the culmination of ten months of collaborative effort incorporating information from a community questionnaire, testimony received during statewide public meetings, and written comments submitted to the Steering Committee.

We appreciate the significant contribution made by the 218 communities that completed the questionnaire and the over 200 individuals who attended meetings and/or submitted written comments. While this project has launched a process that will improve Alaska's rural clinic infrastructure, the work has just begun. We encourage the on-going, active participation of those who are committed to strengthening and continually improving the recommendations and procedures outlined in this report. Our intent and hope is that this first effort will evolve into an on-going process that meets the primary care infrastructure needs of all Alaskans.

Sincerely,

Steering Committee Members

Joel Neimeyer, PE
Project Manager
Denali Comr ission

Rick Boyce, PE
Director, Division of Health Facilities
Alaska Native Tribal Health Consortium

Torie Heart, MS, RN
Director, CHAP/Rural Health
Indian Health Service

Patricia A. Carr, MPH
Unit Manager, Primary Care and Health
Promotion Unit
Division of Public Health, State of Alaska

3925 Tudor Centre Drive, Anchorage, Alaska 99508
Phone: (907) 729-3606 Facsimile: (907) 271-4735
Web: http://ruralhealthcare.geonorth.com

ALASKA RURAL PRIMARY CARE FACILITY NEEDS ASSESSMENT PROJECT

FINAL REPORT

VOLUME I

OVERVIEW

Prepared for:

DENALI COMMISSION

510 "L" Street
Suite 410 Peterson Tower
Anchorage, Alaska 99501
(907) 271-1414

Prepared by:

Alaska Native Tribal Health Consortium
Department of Health and Social Services
Indian Health Service

October 2000

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LIST OF ACRONYMS

ACRH ..... Alaska Center for Rural Health
ADA ..... Americans with Disabilities Act
ANHB ..... Alaska Native Health Board
ANMC ..... Alaska Native Medical Center
ANTHC ..... Alaska Native Tribal Health Consortium
APCA ..... Alaska Primary Care Association
APCD ..... Alaska Primary Care Database
APCDS ..... Alaska Primary Care Data System
ARC ..... Appalachian Regional Commission
ARPCFNA ..... Alaska Rural Primary Care Facility Needs Assessment
BTU ..... British Thermal Unit
CDBG ..... Community Development Block Grant
CHA ..... Community Health Aide
CHAP ..... Community Health Aide Program
CHA/P ..... Community Health Aide/Practitioner
CHC ..... Community Health Centers
CLIA ..... Clinical Laboratory Improvement Act
C/MHC ..... Community/Migrant Health Center
DCED ..... Alaska Department of Community and Economic Development
DHHS ..... U.S. Department of Health and Human Services
DHSS ..... Alaska Department of Health and Social Services
HUD ..... U.S. Department of Housing and Urban Development
EMS ..... Emergency Medical Service
EMT ..... Emergency Medical Technician
FNAQ ..... Facility Needs Assessment Questionnaire
FQHC ..... Federally Qualified Health Centers
FTE ..... Full Time Equivalent
GIS ..... Geographic Information System
GSF ..... Gross Square Feet
HRSA ..... Health Resources and Services Administration
HTML ..... Hyper Text Markup Language
HVAC ..... Heating, Ventilation, and Air Conditioning
ICDBG ..... Indian Community Development Block Grant
IHS ..... Indian Health Service
M&I ..... Maintenance and Improvement
MLP ..... Mid Level Provider
MRP ..... Multi-disciplinary Review Panel
NFPA ..... National Fire Protection Association
O&M ..... Operation and Maintenance
PITS ..... Project Information Tracking System
RDM ..... Resource Distribution Methodology
RFP ..... Request for Proposal
RHC ..... Rural Health Clinic
SOW ..... Scope of Work
UBC ..... Uniform Building Code

UFC ..... Uniform Fire Code
USDA ..... U.S. Department of Agriculture
WIC ..... Women, Infants, and Children
YKHC ..... Yukon-Kuskokwim Health Corporation

PREFACE

The Denali Commission Act of 1998 (Division C, Title III, P.L. 105-277) created the Denali Commission (Commission). The Commission is an innovative federal-state partnership established by Congress to provide critical utilities, infrastructure, and economic support throughout Alaska. Its mission is to lower the cost of living --- and raise the standard of living --- throughout rural Alaska in the most cost effective manner possible. The Commission receives an annual appropriation from Congress and then, through its Commissioners, allocates these funds for specific projects. Criteria for funding and an annual work plan are developed with public participation. Priority is given to comprehensive, community based and regionally supported, sustainable projects. The original enabling legislation identified three areas of focus for the Commission including job training, economic development, and infrastructure development.

The Commission has seven members who are listed below.

- Fran Ulmer — Lt. Governor, State of Alaska and State Co-Chair
- Jeffrey Staser — Federal Co-Chair
- Mark Hamilton — President, University of Alaska
- Julie Kitka — President, Alaska Federation of Natives
- Mano Frey — Executive President, Alaska State AFL-CIO
- Kevin Ritchie — Executive Director, Alaska Municipal League
- Henry Springer — Executive Director (Retired), Associated General Contractors of Alaska

In general, the Commission is based upon a format similar to the Appalachian Regional Commission (ARC), which was created in 1965 to fulfill a similar mission for 13 eastern seaboard states. Of interest to the Denali Commission and Alaskans is that one of ARC's primary goals was to insure that: "Appalachian residents will have access to affordable, quality health care." As further evidence that Congress intended for the Denali Commission to address health care issues, amendments to P.L. 105-277 were enacted at the end of 1999 authorizing demonstration projects between the Commission and the U.S. Department of Health and Human Services (DHHS) --- that can extend beyond primary care facilities, e.g., into hospitals, mental health facilities, elder care and child care facilities (see Appendix I for

full text of referenced amendment). Accordingly, the Denali Commissioners adopted Resolution 00-01 on January 28, 2000 identifying rural health care facilities and services as the second area of focus or theme for infrastructure related projects funded and supported by the Commission. Their first infrastructure focus was rural energy projects.

The following report provides background on the goals and objectives of the Alaska Rural Primary Care Facility Needs Assessment (ARPCFNA) Project --- one of the first health care related initiatives undertaken by the Commission. It includes an initial estimate of the unmet need with respect to primary care facilities in rural Alaska, and describes the Alaska Primary Care Data System (APCDS) and Resource Distribution Methodology (RDM) developed as part of the project.

The following websites contain more specific information about the Denali Commission itself and the Rural Primary Care Facility Needs Assessment Project.

- *www.denali.gov*
- *www.apcds.org*

EXECUTIVE SUMMARY

A. EXECUTIVE SUMMARY

In October 1999, the Denali Commission approved funding for a project with the Alaska Native Tribal Health Consortium (ANTHC) to develop an assessment of rural primary care facilities related needs throughout Alaska. The Commission and ANTHC subsequently formed a partnership with the State of Alaska Department of Health and Social Services (DHSS) and the Indian Health Service (IHS) to:

1. Build a statewide database of detailed information on rural primary care facilities and program services.

2. Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide unmet need related to primary care facilities.

3. Establish a resource distribution methodology for rural primary care facility projects funded through the Commission.

The purpose of this final report is to document the results of the Alaska Rural Primary Care Facility Needs Assessment (ARPCFNA) Project. The report includes an initial estimate of the unmet facility related needs.

A relational database has been developed that includes detailed information on primary care facilities and program services for 288 communities throughout rural Alaska (all locations with year-round populations greater than 20 and no existing in-patient facility). The final database and associated applications are being referred to as the Alaska Primary Care Data System (APCDS) which has the following capabilities.

- Web Enabled
- Ad Hoc Queries
- Graphical Analysis via a Geographic Information System (GIS) Component

A set of primary care program goals and space guidelines have been established for rural Alaska. These goals and guidelines (reference Tables 8 and 9 on pages 24 and 25) were used as a benchmark for establishing unmet, rural primary care needs for the state. Table 1

summarizes the new statewide space requirements derived from these goals and guidelines. Also included in the table is an allowance for 12 - 14 new multi-community clinics around the state where it may be more appropriate to construct a single but somewhat larger facility to serve several small communities within a common service area. This multi-community or "sub-regional" concept is a proven model and is being successfully implemented by entities such as the Yukon-Kuskokwim Health Corporation (YKHC). The last entry in the table is an estimate of the funding required to correct the backlog of needed renovations and repairs at existing rural primary care clinics.

Table 1: Unmet Need Data

Unmet Need Category	Basis (GSF)	Amount (millions)[1]
New Space at Individual Locations	305,000	$99
New Multi-Community Clinics	130,000	$52
Backlog of Repairs	330,000	$102
Total		**$253**

1. In terms of May 2000 dollars

The dollar estimates summarized above include design, construction, and equipment. They do not include unmet program needs (staffing and other operational costs).

A resource distribution methodology has been developed for prioritizing funds made available through the Denali Commission for primary care design and construction projects. Significant public and stakeholder input was solicited during the development of this management tool. The three-part process is outlined below.

Part I: Community Prioritization

Comparison of all eligible communities based on data in the APCD and a prioritization formula that includes seven factors.

1. Facility Related Deficiencies
2. Overall Regional Health Status
3. Isolation
4. Dependency Ratio (Ratio of Young and Old to Working Age Residents)

5. Economic Status
6. Local Incidence Rates of Trauma Related Hospitalizations
7. Seasonal Population Increases

Part II: Proposal Review and Capability Measurement

Based on available funding, a short-list of communities from the top of the Part I prioritization list will be invited to submit detailed project proposals. Proposals will be evaluated by a multi-disciplinary review panel (MRP) with respect to the following criteria.

1. Local Support for Project
2. Site Availability and Control
3. Utility Extension Plan
4. Cost Sharing
5. Service Delivery Plan
6. Business Plan
7. Facility Related Deficiencies
8. Consistency With Overall Community Development Plan
9. Multi-use Components of Project
10. Project Management Plan

If proposals are determined to be inadequate with respect to any of these factors and/or specific data needs to be verified, the proposal will be referred back to the community for amendment. In these instances, recommendations may be provided on where to secure technical assistance to develop the appropriate amendments. Based on the Part II results, an annual approved project list will be published.

Part III: Funding

Funding agreements and transfers will be initiated once the Denali Commission's Program Manager has determined that all appropriate planning, design, permit and construction related documents are in place.

The recommended methodology is intended to be an equitable system for the distribution of federal funding to those communities with the greatest need, recognizing that the successful delivery of health services includes the ability of a community to operate and maintain the facility over the long term. More detail on the distribution methodology can be found beginning on page 31. Appendix XII contains the FY01, Part I Community Prioritization.

In September 2000, the Denali Commission selected ANTHC as the Program Manager for the APCDS and most of the rural primary care facilities related projects funded through the Commission. ANTHC is providing a database administrator who will maintain the APCDS. The four primary partners in the project will have full access to all data in the system. For data confidentiality reasons, other organizations and/or the general public will only have access to aggregate data summarized on a regional or service area basis.

B. BACKGROUND

In most parts of the country, the highest cost of delivering health care service is found in urban areas. This does not hold true in Alaska where rural residents generally face higher costs than those found in the state's major population centers. Rural residents are isolated from the regional hospitals and health centers by immense distances, climatic extremes, and geographic barriers.

Initial access to either the native or private health care system for most rural residents in Alaska is through a small, village-built clinic facility. Most are locally staffed with a Community Health Aide / Practitioner, funded in part by IHS. Services are generally limited to basic primary care and emergency medical treatment. Most clinics do not provide behavioral or dental health services. The IHS provides minimal lease funds (typically $20,000 annually to a community) for some 168 such facilities to cover basic utility and janitorial costs. IHS has no recurring capital improvement program for these facilities. A large number of these facilities are in need of repair, renovation or replacement. Many are not even connected to a water and wastewater system. Small, non-native communities scattered around the state have similar facility and program issues. In 1994, DHSS compiled basic information on most village health clinics in the state (reference *DHSS Village Health Clinic Survey*). Of the 174 facilities that were subjectively "rated" with respect to physical condition, approximately 33 percent were categorized as needing replacement or major renovation. Seventy-nine facilities (40 percent) were still using a honey bucket and/or pit privy system for sewage disposal. Currently no one federal or state agency is tasked with oversight or prioritization of improvements for these facilities. There are unmet needs both with respect to program and facility funding.

There has never been a comprehensive one time or recurring funding source to build or renovate primary care clinics for rural Alaska. Nor can small rural communities participate in the normal (and backlogged) IHS health facilities priority system, which is solely for building and replacing regional and referral facilities. The limited capital funding made available for rural clinic projects to date has come largely from the U.S. Department of Housing and Urban Development (HUD) - Community Development Block Grant (CDBG)

Program, Department of Agriculture (USDA) - Rural Development Loan Program, special state appropriations, and/or commercial loans. At best, communities are usually forced to patch a project together from several sources. More often, projects are either put on hold due to a lack of funding or significant compromises made with respect to space and/or construction standards.

C. NEEDS ASSESSMENT PROJECT

C.1.0 Authorization and Funding

In October 1999, the Commissioners approved funding for a project with ANTHC to produce an assessment of rural primary care facility related needs throughout the state. ANTHC offered to provide project management and a portion of their own funds for the effort. In light of its mission to provide federal services for all of Alaska, the Commission and ANTHC sought the participation of the Alaska DHSS. After DHSS agreed to collaborate on the project, the three parties then sought the participation of the IHS based upon their long history and in-depth knowledge of rural primary care programs and facilities. On February 24, 2000, the four partners finalized an agreement for carrying out the ARPCFNA Project.

C.2.0 Objectives and Schedule

The needs assessment project had three main goals.

1. Build a statewide database of detailed information on rural primary care facilities and program services.

2. Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide unmet need related to primary care facilities.

3. Establish a resource distribution methodology for rural primary care facility projects.

An overall schedule for the project appears below.

Table 2: Project Milestones
(Calendar Year 2000)

Task	Start	Finish
Scoping and Project Start-Up	January	February
Establish Criteria	January	May
Data Collection	March	August
Design and Develop Database	April	July
Interim Report	July	
Develop Methodologies	May	September
Design and Develop Computer Applications	March	September
Final Report	October	

Information from the needs assessment project will be used by the partners to seek funding for both improvements and/or new facilities and primary care service enhancements. In the event Congress looks favorably on the results of the assessment, the distribution methodology should guide federal, state, municipal, and tribal managers on which projects to fund and in what order.

C.3.0 Project Team

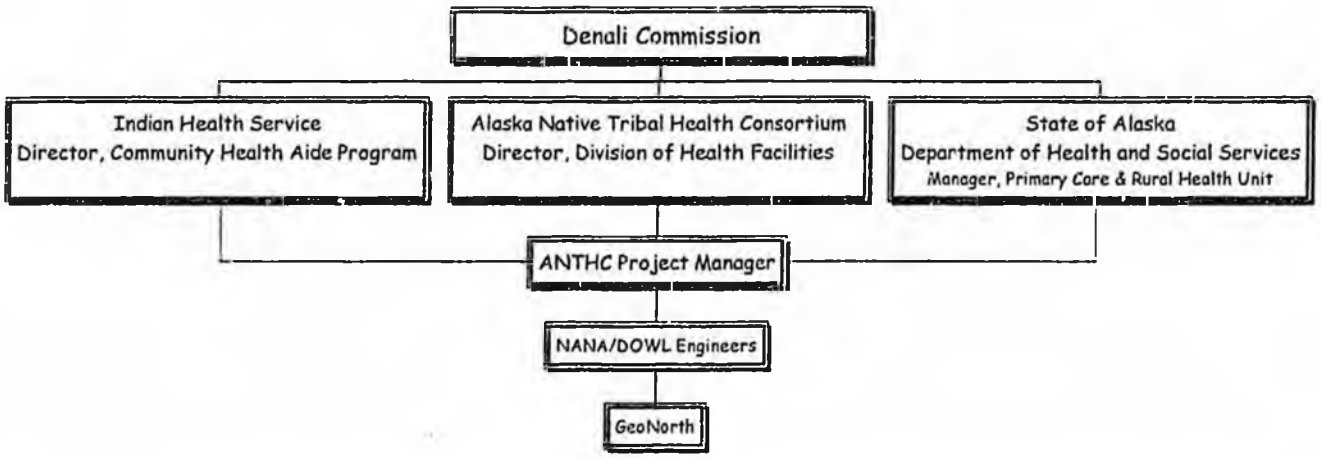
A project Steering Committee was formed that included representatives from the Denali Commission, ANTHC, IHS, and DHSS. A project organizational chart and primary contact list appears below.

Table 3: Primary Contacts

Name	Organization	Position	Phone	e-mail
Joel Neimeyer, PE	Denali Commission	SC	(907) 271-1414	jneimeyer@denali.gov
Pat Carr, MPH	DHSS	SC	(907) 465-8618	pat_carr@health.state.ak.us
Torie Heart, MS, RN	IHS	SC	(907) 729-3642	vheart@anmc.org
Rick Boyce, PE	ANTHC	SC	(907) 729-3601	rboyce@anthc.org
Gary Kuhn, PE	ANTHC	Project Manager	(907) 729-3604	gkuhn@anthc.org

SC = Steering Committee Member

Figure 1. Alaska Rural Primary Care Facility Needs Assessment Project Organizational Chart



ANTHC was tasked with the overall responsibility for developing a work plan and schedule to meet project goals. ANTHC and the Steering Committee received assistance from two primary consultants during the project: NANA/DOWL JV (health facility expertise) and GEONORTH, LLC (database design). These services were obtained through an existing indefinite delivery contract between ANTHC and NANA/DOWL. The Commission and ANTHC agreed to use this contract in order to expedite the project and meet the key milestone dates.

C.4.0 Basic Criteria

The project addressed needs in all native and non-native communities in the state that met the following basic criteria:

- Year-round community population of at least 20 individuals.
- No local in-patient health care facility.

In order to provide some practical limits to the assessment, the parties agreed to study only those communities without a local in-patient facility, i.e. a hospital. The assumption is that, in general, primary care services are available in these communities at a significantly higher level than most rural, "non-hospital" communities. A population threshold of 20 was used since the IHS has a program to lease clinic space from villages with 20 year-round residents or more. The parties accepted this existing federal program criterion as a reasonable lower community population limit for the needs assessment.

A list of the 288 communities meeting the above criteria appears in Appendix II. Both an alphabetical and ascending population sort are presented. The population figures are 1999 values as reported by the State Department of Community and Economic Development (DCED).

C.5.0 Website

A website was developed to facilitate communications during both the Needs Assessment Project and follow-on program implementation. The website has two levels; one for the general public and a more detailed one for use by the project / program management team. The current address is: *http://www.apcds.org*

C.6.0 Public and Stakeholder Input

The Steering Committee determined early on that developing public support through outreach to stakeholders and other interested parties would be essential to the success of the Needs Assessment Project. Accordingly, committee meetings were open to the public. The project team also conducted five regional workgroups during May. The primary purpose of these workgroups was to collect input and ideas on the factors used to develop a statewide resource distribution methodology for facilities related projects. Open workgroup meetings were held in Anchorage, Juneau, Fairbanks, Kotzebue, and Bethel. As well, there was a special statewide public meeting conducted on July 11 via both a teleconference with the twenty-two Legislative Information Office sites and a facilitated meeting at the Loussac Library in Anchorage. The partners also had on-going communications with interested organizations and individuals throughout the project by way of special mailings and presentations at related meetings (e.g., State MEGA meetings, Alaska Native Health Board [ANHB], Primary Care Partnership, and Community Health Aide Program [CHAP] Certification).

C.7.0 Phase II - Primary Care Program Development and Support

In September 2000, the Steering Committee presented a proposal to the Denali Commission for a Phase II Primary Care Program Development and Support project to build on the program data collected as part of the initial needs assessment described in this report ("Phase

1"). The Phase II scope of work focuses on working with communities to develop and support primary care programs. Public testimony received during Phase 1 emphasized the necessity for developing and supporting primary care programs as a complimentary component to the construction, renovation, and repair of primary care facilities.

C.8.0 Beyond Primary Care Facilities

It is anticipated that the work of the Denali Commission and their health care partners will be expanded to investigate other health related service delivery and infrastructure gaps in rural Alaska. There are unmet needs beyond those identified in this report and/or additional communities that should be evaluated. Undertaking this additional work would be consistent with the intent of federal legislation passed at the close of the 1999 Congressional calendar authorizing demonstration projects between the Commission and U.S. DHHS --- that can extend beyond primary care facilities (e.g. hospitals, mental health facilities, elder care, and child care facilities).

D. QUESTIONNAIRE

D.1.0 Overview

A Facility Needs Assessment Questionnaire (FNAQ) was developed and mailed to all 288 communities meeting the basic project criteria during the last week of March 2000. Copies of the questionnaire were also made available to Regional Health Corporations and Boroughs. All data received by September 1 was entered into the database and used to develop both the unmet need estimate and the FY 2001 community priority list. The Steering Committee encourages all 288 communities to submit responses; questionnaires are still being accepted. Communities submitting after the deadline will be eligible for subsequent fiscal year funding. Three mechanisms are available for submitting data: (1) Internet, (2) hard copy via mail, and (3) hard copy via FAX.

The FNAQ has an introductory section that requests information on the number of organizations/programs providing primary care services in the community and the total number of facilities being used to support these services. The body of the questionnaire is divided into two main sections that address current status and additional needs with respect to

facilities and services / programs. The Steering Committee agreed that a review of program needs must be a part of any facility condition and/or additional space needs evaluation. A summary of the Sections and Subsections in the main questionnaire appears below. A full copy of the questionnaire appears in Appendix III.

***Facilities*:**

- Basic Data
- Ownership / Lease Data
- Physical Deficiencies
- Space Related Deficiencies
- Medical Equipment Deficiencies
- Utility and Maintenance Data

Data from these sections were used to calculate the unmet need compared to the space guidelines developed as part of this project. Data were also used to estimate the backlog of repairs for existing space. The methodology to prioritize communities and distribute resources utilized some of this data.

Program:

- Services Provided and/or Needed
- Patient Transportation Data
- Program Administration Data
- Support Services Delivery Location and Mechanism
- Staffing Provided and/or Needed
- Clinical Caseload (Workload) Data
- Extended Patient Stay Data
- Living Quarters Information
- Telehealth Information

As discussed in Section C7.0, the program data collected via the FNAQ will become the basis for additional research and analysis under a Phase II assessment project. It is envisioned that this data will be instrumental in the development of program advocacy and

support strategies for numerous organizations and entities around the state involved with primary care issues.

D.2.0 Response Rate

The following is a summary of the responses received and entered into the database as of September 1, 2000.

Table 4: FNAQ Response Summary as of September 1, 2000[1]

Communities Responding To General Section	218
Total Program Section Responses	194
Total Facilities Section Responses	183

This represents a total response rate on the order of 76 percent. Numerous efforts were made (via phone, fax, and mail) to contact all locations that did not initially respond to the questionnaire. Documentation on the results of these efforts is on file at ANTHC. It should also be noted that some communities had multiple organizations, programs, and/or facilities.

E. ALASKA PRIMARY CARE DATA SYSTEM

The database and applications developed as part of the project are collectively referred to as the *Alaska Primary Care Data System* (APCDS). This is a web-enabled system comprised of the following core components.

- The Alaska Primary Care Database (APCD), containing all questionnaire responses and other relevant data from multiple external resources.
- An ad hoc query tool that facilitates data analysis and allows Primary End Users to create a variety of reports.
- A Geographic Information System (GIS) that provides for the graphical presentation of data.
- Applications for calculating unmet need and prioritizing communities.

The primary software used to develop the APCDS tools and applications are summarized in Table 5.

[1] As of October 20, the number of responses were 220, 196, and 185, respectively.

Table 5: APCDS Software

Name of Software	Purpose
SQL Server	Database platform
Cold Fusion	Web development language
QueryMill™	Ad hoc query tool
MapObjects Internet Mapping Server	Enables development of custom GIS applications
MapOptix™	Web-enables graphical and tabular information

E.1.0 Alaska Primary Care Database

Obtaining data from existing database resources was a key requirement for the development of the APCD. Various state and federal sources were reviewed and selected to provide additional data content for a variety of research and reporting needs. The following table summarizes the major data resources utilized for the APCD.

Table 6: APCD Data Resources

DATA CATEGORY	PRIMARY SOURCE	SECONDARY SOURCES	% of APCD
General Community Information	State DCED		85
Access	State EMS System	State DCED	
Existing Clinic Facility Information	FNAQ	IHS and 1994 State Survey	
Existing Health Program Information	FNAQ	State Public Health Nursing Survey	
Demographics	State DCED		15
Health Status Indicators	State DHSS		

The data content extracted from all external data resources is static, i.e. a one-time data download from each resource. The technology to create dynamic links to a variety of resources is available; however, this capability was not necessary since APCD updates will only be accomplished on an annual or semiannual basis.

A web-enabled application was developed for the APCD since the end users are geographically dispersed throughout the state. SQL Server was the underlying technology used to build the APCD. SQL Server is highly compatible with Access, Excel, GIS software and web applications, as well as many SQL compliant query tools. SQL Server was selected because it is a robust system and many of the external data resources and systems currently in place are already in SQL Server or Access. Also, the APCD had to be built in a manner that would support easy to learn solutions and require minimal help from support personnel at project turnover. Currently the APCD has 106 data tables and contains 1,447 data columns. In addition, it contains 32 views for querying with 747 data columns, and 12 QueryMill-specific tables with 88 data columns. The current size of the database is approximately 21.5 MB.

E.2.0 Queries and Reports

The APCDS provides both standard and ad hoc query and reporting capabilities. The various standard reports, such as the Unmet Need Report, are static reports in read-only format with limited access depending on the user's security level. Raw Data Reports are another example of standard reports. They contain all of the supporting data used to generate one of the summary reports, such as the Unmet Need or Part I Community Prioritization.

Ad hoc queries enable the Primary End Users to create a wide variety of unique reports depending on their specific area of interest. The query tool allows individual analyses to be saved and recalled at a later date. It also allows Primary End Users to share query results electronically. The primary categories for initiating queries are listed below.

- Census Area
- Borough
- Regional Health Organization
- Community
- State Election Districts, both House and Senate
- Data Dictionary

Each major category is further subdivided to refine the query. Ultimately, any query report can be produced in either MS Word, MS Excel or Hyper Text Markup Language (HTML)

format as specified by the Primary End User. Since this was a statewide project, Census Areas (see Appendix IV) have been designated as the primary method for organizing and summarizing data.

While analysis of the information collected during this Needs Assessment was beyond the scope of the project (except for unmet need estimates and an initial community prioritization). Appendix V contains a sample ad hoc query report. It is a summary by House Election District of all Emergency Medical Service (EMS) Level I and II communities with clinics that are not equipped to accommodate over night patients or have no existing clinic facility at all.

E.3.0 Geographic Information System

The APCDS includes a GIS component that provides for the graphical presentation of data using the following geographic boundaries:

- Census Areas
- State Election Districts, both House and Senate
- Boroughs

It can also display the following information for individual locations:

- Regional Health Organization Affiliation
- Unmet Need
- Communities With Hospitals
- Communities Without Any Primary Care Facilities

These layers are in addition to routine map elements such as major rivers and highways. The GIS application can be easily enhanced to meet future, additional requirements.

E.4.0 Access to Data

In September 2000, the Denali Commission selected ANTHC as the Program Manager for the APCDS and most of the rural primary care facilities related projects funded through the Commission. Accordingly, the APCDS was recently installed on a server at ANTHC. ANTHC is providing a database administrator who will maintain the system. The four

primary partners in the project will have full access to all data in the APCDS. For data confidentiality reasons, other organizations and/or the general public will only have access to aggregate data summarized on a regional or service area basis.

F. PUBLISHED PROGRAM GUIDELINES AND REGULATIONS

As with many issues related to the delivery of health care services, Alaska is unique. National recommendations, where they exist, do not adequately provide for the variables encountered in Alaska with respect to remoteness, weather, and lifestyle. Therefore, most national standards and guidelines that do exist must be adapted for use in Alaska or not used at all. The recommended program goals in this report were developed after a review of the following.

(1) Federal Section 330 Community Health Center Program

(2) DHSS "Community Levels-of-Care" system

(3) IHS Community Health Aide Program

(4) Alaska Assistance for Community Health Facilities Program

(5) Federal Rural Health Clinic Program

F.1.0 Federal Community Health Center Program

Community health centers (CHCs) are publicly funded organizations that provide primary health and related services to residents of a defined geographic area that is medically under served. Community health centers are authorized under Section 330 of the Public Health Service Act (42 USC, 254b.). Section 330 was revised in 1996 by the Consolidated Health Centers Act, which combined community health centers with migrant health centers, health care for the homeless, and public housing health care programs. The CHC program is administered by the U.S. DHHS, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care.

Community health centers are required by law to provide primary health services and additional health services as necessary to the residents of the area served by the center. Primary health services are defined as 1) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, 2) diagnostic laboratory and radiology services, 3) preventive health services, 4) EMS, and 5) pharmaceutical services. Additionally, primary health services include patient case management services, enabling services such as transportation and language translation, patient education, and referrals to providers of substance abuse and mental health services

The guidelines for health center structure, population served, service area, services provided, personnel, financial characteristics, organizational arrangements, governance, community participation, and referral systems are specified by the Bureau of Primary Health Care.

CHCs are recognized as federally qualified health centers (FQHCs). FQHCs meet statutory requirements for receiving federal community or migrant health center grant or health care for the homeless program funds. Certification as a FQHC reserves a health center's right to cost-based reimbursement for Medicaid services in states which have not received special waiver provisions. Health centers receiving federal Community/Migrant Health Center (C/MHC) funding are automatically eligible for certification as Medicaid and Medicare FQHCs.

The information included in the Consolidated Health Center Act of 1996 and the guidelines issued by HRSA, Bureau of Primary Health Care, were instrumental in defining the program related questions and establishing the program goals for this Rural Primary Care Needs Assessment Project.

F.2.0 State Emergency Medical Service Program

Alaska EMS Goals (February 1996) describes Community Levels-of-Care and makes recommendations for EMS services. It is based on a regional approach / organization as described in the 1984 *Alaska State Health Plan*. This approach identifies appropriate health resources and services for five community levels. These are:

Table 7: Community Levels

LEVEL	DESCRIPTION	POPULATION IN IMMEDIATE COMMUNITY
I	Village	50 – 1,000
II	Sub-Regional Center	500 – 3,000 +
III	Regional Center	2,000 – 10,000 +
IV	Urban Center	10,000 – 100,000
V	Metropolis	100,000 +

There is no counterpart to the EMS goals document, which makes a recommendation on the level of primary care services that should be provided in Alaska communities. A key discriminator in establishing EMS levels of service is how people get to and from a community, i.e. access. The *EMS Goals* document identifies communities as either "Isolated" or "Highway". Highway refers to those major roadways in the state, including:

- Alaska
- Copper River
- Dalton
- Denali
- Edgerton/McCarthy Road
- Elliott
- George Parks
- Glenn
- Haines
- Klondike
- Richardson
- Seward
- Steese
- Sterling
- Taylor/Klondike Loop
- Marine

The Marine Highway is Alaska's marine transportation system, which provides year-round ferry service to Alaska's coastal communities and to Washington and British Columbia. A map showing the major roadways in relation to organized boroughs within the State appears in Appendix VII.

F.3.0 IHS Community Health Aide Program

The IHS has the responsibility for providing health care services to Alaska Native and American Indian beneficiaries in Alaska. The total beneficiary population is 17 percent of

the state's population. Historically, the Alaska Native population lived mainly in the more isolated village communities.

The Community Health Aide Program (CHAP) was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968, the CHAP received formal recognition and congressional funding. The program was established under the authority of 25 U.S.C. §16161. The long history of cooperation and coordination between federal and state governments and the Native regional health corporations has facilitated improved health status in rural Alaska. The CHAP is considered a model for delivering primary health care services in a remote area. In addition to strong training and supervision components, there is an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center (ANMC). One hundred forty (140) villages with less than 500 population have a clinic facility staffed by Community Health Aides / Practitioners (CHA/P) providing primary care and emergency medical services. Another 38 communities with a population greater than 500 have a Community Health Aide (CHA) clinic. In the non-Native health care delivery system, there is no model. Communities vary in their level of organization, resource base, and ability to partner with other agencies to provide primary care and emergency services at the local level.

F.4.0 Alaska Assistance for Community Health Facilities Program

The Assistance for Community Health Facilities Program is outlined in Alaska Statute (AS 18.23.100 and 18.25.010 – 18.25.120) and Alaska Administrative Code (7 AAC 13.010 – 13.140 and 13.845 – 13.900).

The scope of authority is subject to legislative appropriation and the provisions of AS 18.25.070-18.25.110. The Alaska DHSS awards grants to assist in the operation of community health facilities when there are operational deficits. Statutes outline the requirements of facilities that are receiving monies such as the application procedure, an overview of service areas to be considered, government and advisory boards, collection of fees for services, self-sufficiency issues, coordination and non-duplication issues, capital expenditures, other monetary issues, and personnel.

The Assistance for Community Health Facilities Program through the Alaska DHSS currently supports grants to 12-15 communities to partially support primary clinics. Most of the funds are used to help cover salaries of mid-level practitioners. Primary care clinics follow state statutes, regulations, and program guidelines in the areas of administration and program reporting.

F.5.0 Federal Rural Health Clinic Program

In 1977, Public Law 95-210 was enacted by Congress and authorized Medicare and Medicaid reimbursement to non-physician primary care practitioners in rural health clinics. This program was created because many isolated rural communities are not able to attract or retain physicians. Congress recognized that many clinics were staffed by non-physician providers who were not covered by Medicare unless they were under the immediate supervision of a physician. There was concern was that these clinics would never become self-sufficient; they would continue to have financial difficulties and may be forced to close.

The Rural Health Clinic (RHC) Program is one of the few federal programs that is able to address under-service in small communities that do not have a traditional health care system in place. The RHC program is administered nationally by the Health Care Financing Administration.

In Alaska, the RHC certification process is administered by the DHSS, Division of Medical Assistance, Health Facilities Licensing and Certification.

Guidelines for the RHC Program and the Rural Health Clinic Survey Reports were considered in the development of the ARPCFNA program goals described in this needs assessment final report.

G. PUBLISHED SPACE STANDARDS AND GUIDELINES

Specific space planning information was collected from recent projects and existing institutional / organizational standards (e.g. prototype designs produced by the Yukon-Kuskokwim Health Corporation (YKHC), Maniilaq Association, North Slope Borough, DHSS Public Health Nursing Center Design Standards, etc.). That data is summarized in

Appendix VIII. It includes summary information for a full range of clinic sizes, from small up to and including multi-community (sub-regional) facilities.

H. ALASKA RURAL PRIMARY CARE GOALS

Based on a review of the existing program and space guidelines, standards, and regulations summarized above, the Steering Committee developed the general Rural Primary Care Program Goals and Space Guidelines outlined in Tables 8 and 9. These criteria are presented as a minimum benchmark. The detail provided should not be interpreted as a prescriptive design standard. These are general guidelines only. They were used for estimating unmet needs and establishing criteria for the funding of projects through the Denali Commission.

It should be noted that permanent staff quarters are not included in the recommendations based on the assumption that these facilities are more appropriately provided by private individuals and/or businesses in the community.

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Table 8: Minimum Program Goals

EMS CATEGORY			POPULATION		
			20 - 100	101 - 500	> 500[1]
Access		Community Level	Space Guideline Small = 1,535 GSF Medium = 1,990 GSF Large = 2,460 GSF		
Designation	Description				
Isolated	Limited air / water access and / or Road access > 60 miles; Daily air/water access	I & II	Small	Medium	Large
Highway	Considered a subregional center and < 60 minutes travel time to next care level	II		Medium	Large
Highway	< 60 minutes travel time to next care level	I	*EMS Only*	Designated Itinerant Space[2]	Medium

1. Some communities in this population range may be candidates for multi-community or sub-regional centers. While services, staffing & square footage will be unique for each individual subregional center, a general guideline of 10,000 GSF is recommended.
2. 500 GSF of designated space in community building, school, etc.

STAFFING	Dedicated Itinerant Space	Small Clinic	Medium Clinic	Large Clinic
Resident Providers	EMT	EMT CHA/P	EMT CHA/P	EMT CHA/P MLP
PHN	Itinerant	Itinerant	Itinerant	Itinerant
Dental	Itinerant	Itinerant	Itinerant	Itinerant

PROGRAMS AND SERVICES[3]	Dedicated Itinerant Space	Small Clinic	Medium Clinic	Large Clinic
Basic EMS	X	X	X	X
Preventive Health Screenings	X	X	X	X
Other Preventive Health Services		X	X	X
Basic Primary Care		X	X	X
Limited Laboratory & Pharmacy		X	X	X
Patient Case Management			X	X
Outreach, Transportation & Interpreter			X	X
Community Health			X	X
Advanced EMS			X	X
Limited Radiological				X
On-site Administration & Support				X

[3] *See Pages 14-17 and 20 of FNAQ (Appendix III) for more detail*

Table 9: Space Guidelines

	Designated Itinerant Space			Small Clinic			Medium Clinic			Large Clinic		
Purpose / Activity	Size	#	Net Area (SF)	Size	#	Net Area (SF)	Size	#	Net Area (SF)	Size	#	Net Area (SF)
Arctic Entries			0	50	1	50	50	2	100	50	2	100
Waiting / Reception / Closet	150	1	150	100	1	100	150	1	150	170	1	170
Trauma / Telemedicine / Exam	200	1	200	200	1	200	200	1	200	200	1	200
Office / Exam			0	150	1	150	150	1	150	150	2	300
Admin./Records			0			0	110	1	110	110	1	110
Pharmacy / Lab			0	80	1	80	80	1	80	80	1	80
Portable X-ray			0			0			0	40	1	40
Specialty Clinic / Health Education / Conference			0	150	1	150	150	1	150	150	1	150
Patient Holding / Itinerant Sleeping Room			0	80	1	80	80	1	80	150	1	150
Storage	150	1	150	80	1	80	100	1	100	120	1	120
HC Toilet	Access To			60	1	60	60	2	120	60	2	120
Janitor's Closet	Access To			30	1	30	30	1	30	30	1	30
Subtotal			500			980			1,270			1,570
Circulation & Net to Gross Conv. Factor @ 45%			n/a			441			572			707
Subtotal (GSF)						1,421			1,842			2,277
Mechanical Space @ 8%						114			147			182
Total Heated Space			500			1,535			1,989			2,459
Morgue (unheated enclosed space)			0	30	1	30	30	1	30	30	1	30
Exterior Ramps, Stairs, Loading Area	HC Accessible			As Required			As Required			As Required		

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I. UNMET NEED

I.1.0 Additional Space for Individual Locations

The unmet space need for individual locations was derived by subtracting the existing square footage at that location from the appropriate space standard in Table 9. The cost of this new space was calculated using the following algorithm.

$$C = S \times B \times Z \times LI$$

Where:

C = **Cost of Additional Space**

S = **Additional Space Need = Space Standard - E**

E = **Existing Square Footage**

B = **Unit Construction Cost** of new clinic space in Anchorage (construction only)
= $183.20 per gross square foot (May 2000 dollars)

Z = **Other Project Cost Factor** (accounts for design, movable equipment and furniture, construction inspection and contingencies), expressed as a decimal percentage of B
= 1.45

LI = **Location Index** (adjusts Anchorage base costs to specific locations)

The unit construction cost and location factors were developed by Estimations, Inc., a professional cost estimating firm with extensive rural Alaska experience. As a check on the base unit cost and the location indices, an algorithm estimate was compared to the actual bid costs for the new 2,430 gross square feet (GSF) clinic in Noorvik. This project is now complete and occupied. The May 1999 bid price reduces to $320.93 per GSF when adjusted to the spring of 2000 at an annual inflation rate of 2.5 percent. This compares very well with the algorithm estimate of $320.60 per GSF (construction only).

The total, statewide unmet need based on the algorithm is 305,000 GSF, which extends to $99M. These costs include and/or assume the following:

- Site Work
- Design Fees
- Permits
- Construction Inspection

- Construction Contingency
- Communications System
- Movable Medical Equipment and Furnishings
- Competitive Pricing on Construction
- Prevailing State Construction Wage Rates

They do not account for:

- Land Acquisition
- Off site Utility or Road Extensions
- Special Purpose Equipment (e.g. radiography, dental)
- Special Local Taxes

I.2.0 Multi - Community and/or Larger Facilities

A preliminary analysis indicates that there are probably 12 – 14 locations around the state where it may be more appropriate to construct a single but somewhat larger clinic, which in most cases would serve several small communities within the same service area (above and beyond these types of facilities that are already in place or currently under construction). This multi-community or "sub-regional" concept is a proven model and is being successfully implemented by entities such as the YKHC. Assuming a 10,000 GSF new facility and applying an average location factor of 1.5 yields a total multi-community facility unmet need of $52M.

I.3.0 Backlog of Repairs

The total cost to correct deficiencies (other than new space) at existing facilities was estimated based on the deficiency data for each facility in the APCD. The FNAQ had requested data on each of the following eight categories and an overall condition rating.

- Structural
- Mechanical
- Electrical
- Energy Management
- Handicap Access
- Site / Environmental
- Fire / Life Safety
- Floor Plan

The *1994 State Clinic Survey* also contained an overall "status" rating for most rural clinics in the state. Each facility was evaluated against the following three algorithms in the process of assigning an estimated backlog repair cost to it. If a facility did not fall into one of these categories or if insufficient data was available to run the algorithm, then it was assigned a backlog cost of zero.

1. If data in the APCD indicated that a facility needed "replacement" or was in "poor" condition, then the new space algorithm was applied to the existing space, i.e.

$$BRC = E \times B \times Z \times LI$$

2. If data in the APCD indicated that a facility had "deficiencies needing correction", needed "major renovation" or was in "fair condition", then the following algorithm was applied to the existing space.

$$BRC = E \times K \times Z \times LI$$

3. If actual cost estimate data was submitted in response to the FNAQ, and it exceeded either of the above, then BRC was set equal to that self reported value.

In these algorithms:

BRC = Backlog Repair Cost

K = Base Renovation Cost = $119.08 per gross square foot

The base renovation cost of $119.08 is 65 percent of the Anchorage based unit cost for new construction, i.e., 0.65 x (B). The IHS Health Facility Budget Estimating System uses this factor for renovations that involve the replacement of interior walls and finishes. This is the "middle" factor in the IHS system; they use 25 percent for projects that only involve the upgrade of finishes, but 85 percent where facilities are completely gutted on the interior and then rebuilt.

The total estimated cost to correct existing deficiencies based on this methodology is $102M for 330,000 square feet of evaluated space. This figure includes design, construction, equipment and contingencies.

As more accurate and site specific code and condition data is collected by ANTHC in support of the Denali Commission's primary care facilities program, it will be entered into the APCD. Through this process, the statewide unmet need estimate will be continuously refined and updated.

I.4.0 Routine Maintenance and Improvement

The IHS methodology for identifying the annual maintenance and improvement (M&I) funding requirement for health care facilities is based on the "Oklahoma Formula". This is a methodology developed at the University of Oklahoma specifically for health care facilities. It estimates the recurring annual cost for benchstock supplies and materials, service contracts, in-house repairs and minor renovations, routine replacement of fixed equipment, and maintenance training. It does not include wages for maintenance staff or the cost of utilities. The methodology is summarized below.

$$M\&I = S \times B_I \times CC \times UI \times LI$$

Where:

M&I = **Annual Maintenance & Improvement Funding**

S = **Additional Space Need = Space Standard - E**

E = **Square Footage of Facility**

B_I = **Unit Cost** of new clinic space in Anchorage (design and construction)
= $262.32 per gross square foot (March 2000 dollars)

CC = **Construction Classification**

UI = **Use Intensity**

LI = **Location Index** (adjusts Anchorage base costs to specific locations)

Applying this methodology to the total existing and total new space requirements using a construction classification factor of 0.0175 (wood frame), a use intensity of 1.00 (moderate), and an average location index of 1.5 results in a total annual M&I requirement of approximately $5M.

Apart from the work of the Denali Commission, there should be an evaluation of the IHS Village Built Clinic appropriation currently being used to lease clinics in support of the CHA

Program and its relationship to the M&I unmet needs reported here. There is some question about whether or not the lease funds being provided are sufficient to warrant these arrangements being classified as true full service leases. In communities without an IHS leased clinic, there is in all likelihood, even less chance that an adequate routine M&I funding stream is available. In the long term, this issue could represent a significant unmet need for all program providers and/or communities in rural Alaska.

I.5.0 Summary

Appendix IX contains an unmet need summary by census area. A statewide summary appears below.

Table 10: Unmet Need Data

Unmet Need Category	Basis (GSF)	Amount (millions)	Type
New Space at Individual Locations	305,000	S99	Capital
New Multi-Community Clinics	130,000	S52	Capital
Backlog of Repairs	330,000	S102	Capital
Subtotal		S253	Capital
Routine Maintenance and Improvement	765,000	S5	Recurring

J. RESOURCE DISTRIBUTION METHODOLOGY

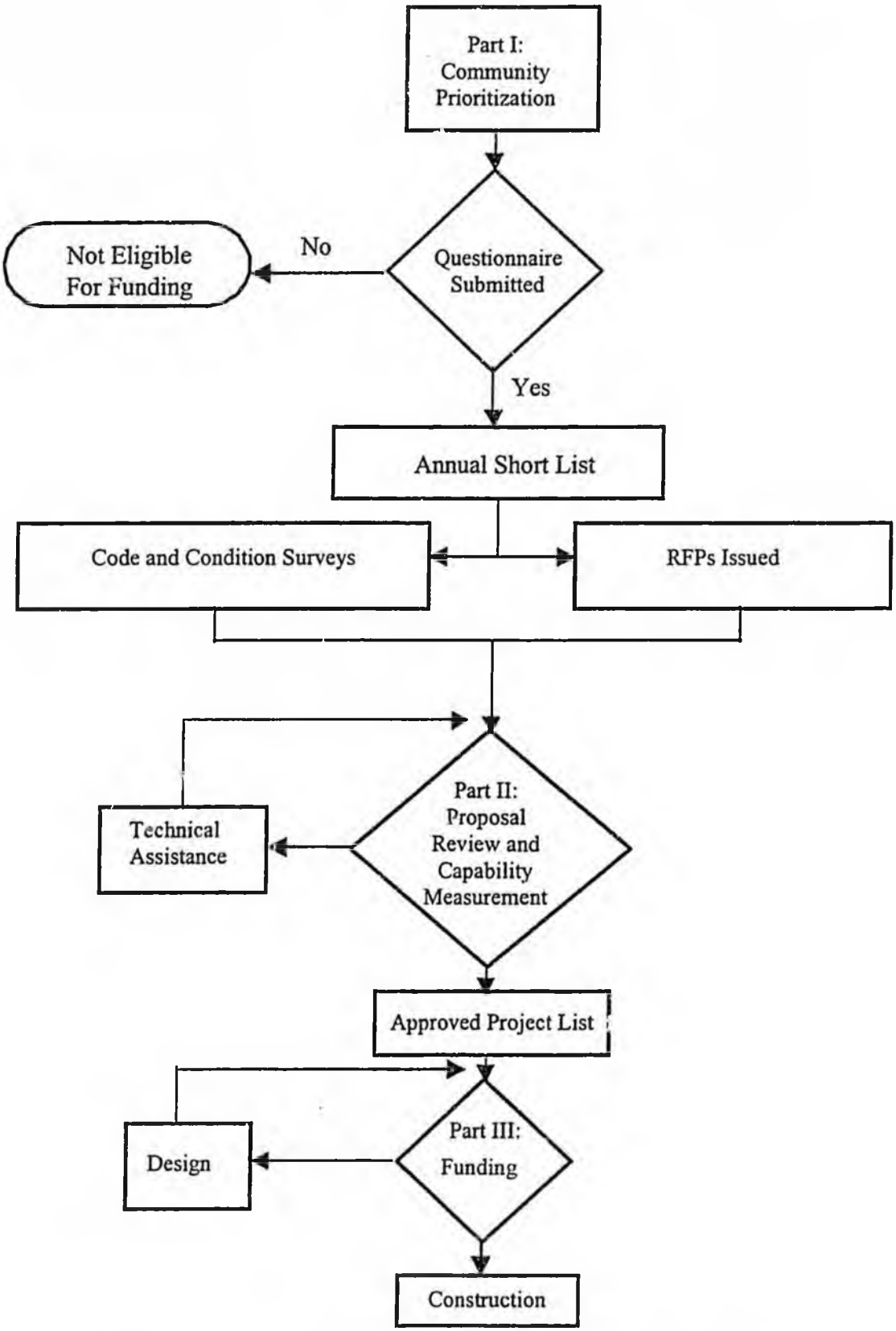
The Steering Committee has developed a three part process for funding "small", individual community primary care facilities projects through the Denali Commission[1]. Figure 2 is a simplified flowchart of the process. A preliminary multiple year schedule appears in Appendix X. Facilities constructed using Denali Commission funds must be operated by not-for-profit entities, and everyone in the service area must have access to the primary care services provided in the facility. Projects funded through this methodology may include the following, but are limited to a total of one million dollars.

- Planning and Pre-Design
- Design
- Repair of Existing Structures
- Renovation and/or Expansion of Existing Structures
- Construction of New Facilities
- Non-expendable Medical Equipment

This methodology will be reviewed annually by the Steering Committee and amended as appropriate.

[1] The Steering Committee has recommended that an additional funding methodology be developed for communities with populations greater than 800 (needing larger facilities) and/or those locations that may be logical candidates for a subregional or multi-community type facility. The committee will continue to work on an RFP type process for such communities. It is anticipated that this second methodology will follow a format similar to the resource distribution methodology described in this report for small individual communities. In addition, it is noted here that on 14 September 2000, the Commission approved design funding for two replacement health centers in St. Paul and Metlakatla. Extensive project justification documents have already been prepared for both projects and they have been on the IHS National Priority List since 1995. These are the only two outpatient facilities in Alaska currently on the national IHS list. Denali Commission funding for St. Paul and Metlakatla is for design only; it is assumed that IHS will construct and staff the facilities once the designs are complete. Accordingly, these two locations were excluded from the final FY 2001 Part I Prioritization analysis described in this report.

Figure 2: Denali Commission Resource Distribution Methodology for Rural Primary Care Facilities Projects



This model is based, to a large degree, on the comments and input received during the five regional workgroup meetings held in May, the public hearing held on July 11, and via feedback on the numerous draft methodologies distributed for comment in August and September. The outcome of this effort is intended to be an equitable system for distribution of federal funding to those communities with the greatest need, recognizing that the successful delivery of health services includes the ability of a community to operate and maintain the facility over the long-term.

J.1.0 Part I – Community Prioritization

The goal of Part I is to prioritize basic needs. Using responses to the FNAQ and other data, a rating score was developed for each community meeting the basic requirements described in Section C4.0. Points were assigned based on the following seven criteria. A more detailed summary of the Part I prioritization formula and the measurements developed for each criteria can be found in Appendix XI.

Criteria	Maximum Points
1. Facility Deficiency	45
2. Health Status	20
3. Isolation	10
4. Dependency Ratio	10
5. Economic Status	9
6. Trauma Rates	5
7. Seasonal Population	1
TOTAL	**100**

Results for the FY 2001 cycle are presented in Appendix XII. Using this information, the Steering Committee will develop a "short list" of communities based on anticipated FY 2001 funding and estimated unmet need for the communities at the top of the list. Short listed communities will then be invited to submit project proposals for consideration by a multi-disciplinary review panel (MRP) convened by the Steering Committee. The Denali Commission's Program Manager, ANTHC, will also conduct on-site code and condition

surveys at existing facilities in those short listed communities needing this type of information in order to prepare a complete proposal. ANTHC may also conduct on-site surveys to validate information used in the Part I analysis.

It should be noted that communities have been listed alphabetically within point ranges on the Part I Priority List. Individual points have not been reported, nor have individual ranks been assigned --- to emphasize that the Part I formula is only an initial screening tool.

Communities must have submitted a FNAQ by September 1, 2000 to be eligible for the FY2001 shortlist. While questionnaires are still being accepted, communities submitting after the deadline will only be eligible to compete for funding in subsequent fiscal years.

J.2.0 Part II – Proposal Review and Capability Measurement

Using a Request for Proposal (RFP) type format, ANTHC will assemble project proposals for review by a MRP made up of individuals from organizations that have both facilities and health program expertise. The review panel will evaluate proposals based on the following Part II criteria. A more detailed summary of the Part II capability scoring criteria appears in Appendix XIII.

Criteria	Maximum Points
1. Local Support for Project*	0
2. Site Availability and Control*	0
3. Utility Extension Plan*	0
4. Cost Sharing*	20
5. Service Delivery Plan*	10
6. Business Plan*	10
7. Facility Related Deficiencies	45
8. Consistency with Overall Community Development Plan	5
9. Multi-Use Components of Project	5
10. Project Management Plan	5
TOTAL	**100**

* *The proposal must meet minimum standards for these six elements. If the proposal does not meet these minimum standards, it will be set aside and a recommendation made to the community that they seek technical assistance to develop more capability.*

Communities will have two project funding cycles to establish capability, after which time they will be reprioritized in the current year Part I cycle.

The primary focus during Part II is to determine if the community has the capability to manage the proposed health programs and maintain the facility. The detailed data and information presented during this phase will also refine and validate the initial Part I prioritization. The final recommendations developed by the MRP will be submitted to the Steering Committee after considering the specific scores per the above criteria, and more general judgements related to capability based on professional experience.

Based on recommendations from the MRP, the Steering Committee will publish an annual list of approved projects. With appropriate justification, the MRP and/or the Steering Committee may recommend funding at an amount less than requested in any individual proposal.

The Steering Committee will have the authority to remove a community from further Part II consideration at any time, based on current assessments of need, facility deficiencies and other Part I or II criteria. However, the committee will also develop an appeals procedure for the proposal evaluation and capability measurement process.

J.3.0 Part III – Funding

The appropriate funding documents and agreements will be prepared for projects on the approved Part II list once ANTHC has determined that all of the following conditions have been met and the appropriate documents are in hand.

1. Verification of original planning assumptions
2. Community and/or regional resolutions
3. Stamped design documents
4. All applicable permits and regulatory approvals
5. Site control documentation
6. Utility extension plan and funding (by others)
7. Project budget and progress payment schedule
8. Construction Schedule
9. Construction quality control and inspection plan

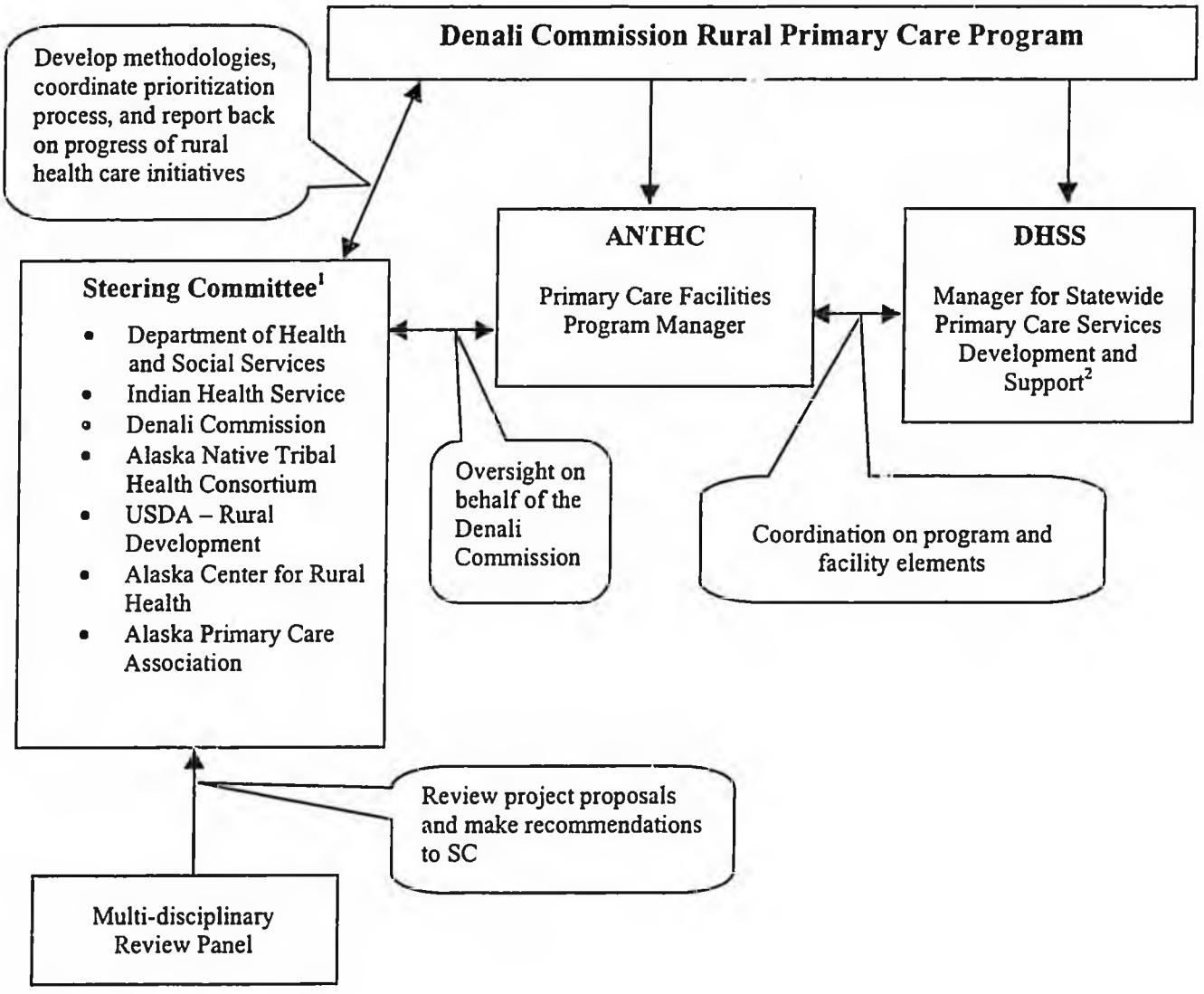
ANTHC will develop a menu of off-the-shelf design and construction management services to assist individual communities in completing these tasks.

Funding may be phased for design and/or construction. The number of projects funded in any given fiscal year will depend on actual appropriation levels. Once a community reaches Part III, the project will remain eligible for funding until all the above readiness elements are in place and sufficient funds become available. Projects approved in any given fiscal year will have priority over projects approved in subsequent years.

K. PROGRAM MANAGEMENT

As previously mentioned, in September 2000 the Denali Commission named ANTHC as the Program Manager for implementing its goals related to improving primary care facilities throughout rural Alaska. DHSS will also continue to partner with the Commission, both as the Steering Committee lead, and manager of an initiative to review and document current health care delivery issues in rural Alaska. Figure 3 is a model of how the Rural Primary Care Program will be administered. Note that the existing Steering Committee will be expanded to include the Alaska Center for Rural Health (ACRH), the Alaska Primary Care Association (APCA) and the USDA – Department of Rural Development. The expanded Steering Committee will provide oversight for the Denali Commission on all aspects of the program.

Figure 3: Rural Primary Care Facilities Program Model



[1] Lead = Director, Division of Public Health, DHSS
[2] Pending approval of scope of work by Commission Co-chairs

L. RECOMMENDATIONS

This Phase I final report focuses on the statewide unmet needs of rural primary care facilities in 288 communities without hospitals, and a methodology for distributing resources to address those needs. An expanded steering committee is being formed to assist with the implementation of Phase I, work on primary care program development and support (Phase II), and begin to address other health related service delivery and infrastructure gaps in rural Alaska. The Phase I Steering Committee's specific recommendations to the Denali Commission are:

Overall

- Maintain a statewide commitment and focus on the unmet needs of rural primary care facilities and programs in the 288 communities without hospitals identified under Phase I of the project.
- Maintain a public access website (www.apcds.org) for the Commission's Alaska Rural Primary Care Program.
- Support on-going public participation in an annual review of the resource distribution methodologies developed by the Steering Committee.

Phase I

- Implement Phase I by awarding FY 2001 funds for the repair, renovation, and construction of new rural primary care facilities.
- Develop a resource distribution methodology and request for proposals (RFP) process for multi-community and/or large (e.g. over $1 million) projects.
- Collaborate with complimentary funding sources (e.g. HUD and USDA) to maximize resources and streamline processes to fund the repair, renovation, and/or construction of new primary care facilities.

- Complete data collection for the 70 communities that did not submit a FNAQ prior to September 1, 2000.

- Provide leadership to locate funding for the delivery of technical support to those communities that are prioritized as having the greatest unmet need but fail to qualify for funding due to an inability to meet the capability criteria.

Phase II

- Initiate Phase II of the needs assessment project: Primary Care Program Development and Support.

- Provide leadership to locate funding for the development and support of primary care programs in small, rural communities.

Beyond Phase I and Phase II

- Assess and prioritize the unmet primary care facility needs of rural communities that were not included in Phase I.

- Define and authorize demonstration projects that extend beyond primary care facilities as defined in the enabling legislation found in Appendix I.

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APPENDIX I

DENALI COMMISSION LEGISLATION

Denali Commission

The conference agreement amends Section 307 of Title II -- Denali Commission of Division C -- Other Matters of P.L. 105-277 by adding a new subsection that authorizes the Secretary of HHS to make grants to the Denali Commission to plan, construct, and equip multi-county demonstration health, nutrition, and child care projects in accordance with the Work Plan referred to under section 304. The House and Senate bills contained no similar provision.

Conference Report for H.R. 3194 as printed in the Congressional Record of November 17, 1999

TITLE VII--DENALI COMMISSION

Sec. 701. Denali Commission, Section 307 of Title III -- Denali Commission of Division C - Other Matters of Public Law 105-277 is amended by adding a new subsection at the end thereof as follows:

(c) Demonstration Health Projects. In order to demonstrate the value of adequate health facilities and services to the economic development of the region, the Secretary of Health and Human Services is authorized to make grants to the Denali Commission to plan, construct, and equip demonstration health, nutrition, and child care projects, including hospitals, health care clinics, and mental health facilities (including drug and alcohol treatment centers) in accordance with the Work Plan referred to under section 304 of Title III -- Denali Commission of Division C -- Other Matters of Public Law 105-277. No grant for construction or equipment of a demonstration project shall exceed 50 percentum of such costs, unless the project is located in a severely economically distressed community, as identified in the Work Plan referred to under section 304 of Title III -- Denali Commission of Division C -- Other Matters of Public Law 105-277, in which case no grant shall exceed 80 percentum of such costs. To carry out this section, there is authorized to be appropriated such sums as may be necessary.

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APPENDIX II
COMMUNITY LIST

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
1	Adak	106	Wiseman	20
2	Akhiok	101	Gakona	22
3	Akiachak	560	Port Clarence	22
4	Akiak	338	Alcan	23
5	Akutan	408	Evansville	24
6	Alakanuk	659	Kupreanof	24
7	Alatna	34	Ivanof Bay	29
8	Alcan	23	Harding Lake	30
9	Aleknagik	244	Meyers Chuck	30
10	Alexander Creek	39	Paxson	30
11	Allakaket	204	Alatna	34
12	Ambler	286	Bettles	35
13	Anaktuvuk Pass	314	Birch Creek	35
14	Anchor Point	1227	Circle Hot Springs	35
15	Anderson	517	Stony River	35
16	Andreafsky	442	Pedro Bay	36
17	Angoon	576	McCarthy	37
18	Aniak	604	Lake Minchumina	38
19	Anvik	93	Alexander Creek	39
20	Arctic Village	138	Nikolski	39
21	Atka	105	Jakolof Bay	40
22	Atmautluak	296	Karluk	41
23	Atqasuk	274	Platinum	43
24	Beaver	126	Red Devil	44
25	Bettles	35	Prudhoe Bay	47
26	Big Delta	511	Tonsina	47
27	Big Lake	2162	Hobart Bay	48
28	Birch Creek	35	Kasaan	48
29	Brevig Mission	279	Takotna	48
30	Buckland	428	Elfin Cove	50
31	Butte	2699	Game Creek	50
32	Cantwell	166	Port Protection	50
33	Central	62	Point Baker	51
34	Chalkyitsik	102	Chistochina	52
35	Chase	55	Lutak	53
36	Chefornak	416	Chase	55
37	Chenega Bay	69	Edna Bay	55
38	Chevak	763	Slana	55

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
39	Chickaloon	212	Dot Lake	61
40	Chignik	103	Healy Lake	61
41	Chignik Lagoon	68	Central	62
42	Chignik Lake	136	Igiugig	62
43	Chiniak	75	Lime Village	62
44	Chistochina	52	Primrose	62
45	Chitina	94	Whale Pass	62
46	Chuathbaluk	105	Oscarville	64
47	Circle	89	Rampart	66
48	Circle Hot Springs	35	Covenant Life	67
49	Clam Gulch	113	Chignik Lagoon	68
50	Clark's Point	68	Clark's Point	68
51	Coffman Cove	228	False Pass	68
52	Cohoe	602	Chenega Bay	69
53	Cold Bay	97	Halibut Cove	71
54	College	12122	Skwentna	72
55	Cooper Landing	285	Ferry	74
56	Copper Center	553	Chiniak	75
57	Copperville	194	Twin Hills	76
58	Covenant Life	67	Hughes	80
59	Craig	2136	Mendeltna	80
60	Crooked Creek	137	Port Alexander	86
61	Crown Point	91	Tanacross	86
62	Cube Cove	139	Nelson Lagoon	87
63	Deering	148	Manley Hot Springs	88
64	Delta Junction	889	Port Alsworth	88
65	Dot Lake	61	Circle	89
66	Dry Creek	115	Tetlin	89
67	Eagle	152	Gulkana	90
68	Edna Bay	55	Crown Point	91
69	Eek	281	Pilot Point	92
70	Egegik	117	Stevens Village	92
71	Eklutna	434	Anvik	93
72	Ekwok	125	Iliamna	93
73	Elfin Cove	50	Tenakee Springs	93
74	Elim	306	Chitina	94
75	Emmonak	818	Kobuk	94
76	Ester	240	Mosquito Lake	9

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
77	Evansville	24	Cold Bay	97
78	Eyak	162	Akhiok	101
79	False Pass	68	Koyukuk	101
80	Ferry	74	Chalkyitsik	102
81	Fort Yukon	570	Perryville	102
82	Fox	332	Chignik	103
83	Fox River	439	Sleetmute	103
84	Fritz Creek	2097	Atka	105
85	Gakona	22	Chuathbaluk	105
86	Galena	563	Nikolai	105
87	Gambell	668	Tatitlek	105
88	Game Creek	50	Adak	106
89	Glennallen	494	Hollis	111
90	Golovin	141	Clam Gulch	113
91	Goodnews Bay	256	Northway	113
92	Grayling	184	Dry Creek	115
93	Gulkana	90	Northway Junction	116
94	Gustavus	377	Egegik	117
95	Haines	1775	Moose Pass	118
96	Halibut Cove	71	Whitestone Logging Camp	118
97	Happy Valley	401	Ekwok	125
98	Harding Lake	30	Mentasta Lake	125
99	Healy	646	Port Heiden	125
100	Healy Lake	61	Beaver	126
101	Hobart Bay	48	Hyder	126
102	Hollis	111	Hope	130
103	Holy Cross	247	Levelock	131
104	Hoonah	877	Lignite	131
105	Hooper Bay	1028	South Naknek	132
106	Hope	130	Chignik Lake	136
107	Houston	836	Klukwan	136
108	Hughes	80	Little Diomede	136
109	Huslia	272	Crooked Creek	137
110	Hydaburg	369	Larsen Bay	137
111	Hyder	126	Pelican	137
112	Igiugig	62	Arctic Village	138
113	Iliamna	93	Cube Cove	139
114	Ivanof Bay	29	Shageluk	140

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
115	Jakolof Bay	40	Golovin	141
116	Kachemak	419	Pitka's Point	146
117	Kake	745	Deering	148
118	Kaktovik	259	Eagle	152
119	Kalifonsky	338	Tyonek	160
120	Kaltag	254	Eyak	162
121	Karluk	41	Kokhanok	163
122	Kasaan	48	Naukati Bay	164
123	Kasigluk	528	Centwell	166
124	Kasilof	548	McKinley Park	169
125	Kenai	7005	Nanwalek	170
126	Kenny Lake	507	Wales	170
127	Kiana	398	Saint George	173
128	King Cove	691	Newhalen	178
129	King Salmon	499	Port Graham	178
130	Kipnuk	573	Sheldon Point	181
131	Kivalina	366	Grayling	184
132	Klawock	673	Ruby	184
133	Klukwan	136	Mekoryuk	193
134	Knik	483	Copperville	194
135	Kobuk	94	White Mountain	197
136	Kokhanok	163	Allakaket	204
137	Koliganek	205	Koliganek	205
138	Kongiganak	359	Chickaloon	212
139	Kotlik	579	Point Lay	217
140	Koyuk	280	Shaktoolik	218
141	Koyukuk	101	Nondalton	224
142	Kupreanof	24	Coffman Cove	228
143	Kwethluk	714	Nightmute	230
144	Kwigillingok	360	Venetie	232
145	Lake Minchumina	38	Ester	240
146	Larsen Bay	137	Port Lions	243
147	Lazy Mountain	1109	Aleknagik	244
148	Levelock	131	Holy Cross	247
149	Lignite	131	Minto	248
150	Lime Village	62	Kaltag	254
151	Little Diomede	136	Shungnak	255
152	Lower Kalskag	310	Goodnews Bay	256

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
77	Evansville	24	Cold Bay	97
78	Eyak	162	Akhiok	101
79	False Pass	68	Koyukuk	101
80	Ferry	74	Chalkyitsik	102
81	Fort Yukon	570	Perryville	102
82	Fox	332	Chignik	103
83	Fox River	439	Sleetmute	103
84	Fritz Creek	2097	Atka	105
85	Gakona	22	Chuathbaluk	105
86	Galena	563	Nikolai	105
87	Gambell	668	Tatitlek	105
88	Game Creek	50	Adak	106
89	Glennallen	494	Hollis	111
90	Golovin	141	Clam Gulch	113
91	Goodnews Bay	256	Northway	113
92	Grayling	184	Dry Creek	115
93	Gulkana	90	Northway Junction	116
94	Gustavus	377	Egegik	117
95	Haines	1775	Moose Pass	118
96	Halibut Cove	71	Whitestone Logging Camp	118
97	Happy Valley	401	Ekwok	125
98	Harding Lake	30	Mentasta Lake	125
99	Healy	646	Port Heiden	125
100	Healy Lake	61	Beaver	126
101	Hobart Bay	48	Hyder	126
102	Hollis	111	Hope	130
103	Holy Cross	247	Levelock	131
104	Hoonah	877	Lignite	131
105	Hooper Bay	1028	South Naknek	132
106	Hope	130	Chignik Lake	136
107	Houston	836	Klukwan	136
108	Hughes	80	Little Diomede	136
109	Huslia	272	Crooked Creek	137
110	Hydaburg	369	Larsen Bay	137
111	Hyder	126	Pelican	137
112	Igiugig	62	Arctic Village	138
113	Iliamna	93	Cube Cove	139
114	Ivanof Bay	29	Shageluk	140

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
153	Lutak	53	Ouzinkie	256
154	Manley Hot Springs	88	Kaktovik	259
155	Manokotak	399	Upper Kalskag	261
156	Marshall	318	Teller	266
157	McCarthy	37	Huslia	272
158	McGrath	423	Atqasuk	274
159	McKinley Park	169	Old Harbor	276
160	Meadow Lakes	5232	Brevig Mission	279
161	Mekoryuk	193	Koyuk	280
162	Mendeltna	80	Whittier	280
163	Mentasta Lake	125	Eek	281
164	Metlakatla	1537	Newtok	284
165	Meyers Chuck	30	Seldovia	284
166	Minto	248	Cooper Landing	285
167	Moose Creek	677	Ambler	286
168	Moose Pass	118	Tazlina	294
169	Mosquito Lake	94	Atmautluak	296
170	Mountain Village	766	Tanana	301
171	Naknek	624	Elim	306
172	Nanwalek	170	Lower Kalskag	310
173	Napakiak	363	Russian Mission	311
174	Napaskiak	406	Anaktuvuk Pass	314
175	Naukati Bay	164	Marshall	318
176	Nelson Lagoon	87	Tununak	331
177	Nenana	435	Fox	332
178	New Stuyahok	475	Akiak	338
179	Newhalen	178	Kalifonsky	338
180	Newtok	284	Trapper Creek	344
181	Nightmute	230	Tuntutuliak	350
182	Nikiski	3038	Kongiganak	359
183	Nikolaevsk	488	Kwigillingok	360
184	Nikolai	105	Napakiak	363
185	Nikolski	39	Talkeetna	363
186	Ninilchik	687	Kivalina	366
187	Noatak	423	Hydaburg	369
188	Nondalton	224	Saxman	371
189	Noorvik	632	Gustavus	377
190	North Pole	1616	Nulato	381

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
191	Northway	113	Saint Michael	381
192	Northway Junction	116	Salcha	387
193	Nuiqsut	486	Kiana	398
194	Nulato	381	Manokotak	399
195	Nunapitchuk	471	Happy Valley	401
196	Old Harbor	276	Napaskiak	406
197	Oscarville	64	Akutan	408
198	Ouzinkie	256	Chefornak	416
199	Paxson	30	Kachemak	419
200	Pedro Bay	36	McGrath	423
201	Pelican	137	Noatak	423
202	Perryville	102	Buckland	428
203	Pilot Point	92	Eklutna	434
204	Pilot Station	544	Nenana	435
205	Pitka's Point	146	Fox River	439
206	Platinum	43	Andreafsky	442
207	Pleasant Valley	584	Tuluksak	443
208	Point Baker	51	Sutton	470
209	Point Hope	794	Nunapitchuk	471
210	Point Lay	217	New Stuyahok	475
211	Port Alexander	86	Saint Mary's	475
212	Port Alsworth	88	Knik	483
213	Port Clarence	22	Scammon Bay	484
214	Port Graham	178	Nuiqsut	486
215	Port Heiden	125	Nikolaevsk	488
216	Port Lions	243	Glennallen	494
217	Port Protection	50	King Salmon	499
218	Primrose	62	Kenny Lake	507
219	Prudhoe Bay	47	Willow	507
220	Quinhagak	595	Big Delta	511
221	Rampart	66	Toksook Bay	513
222	Red Devil	44	Anderson	517
223	Ridgeway	2382	Stebbins	521
224	Ruby	184	Kasigluk	528
225	Russian Mission	311	Pilot Station	544
226	Saint George	173	Wainwright	545
227	Saint Mary's	475	Kasilof	548
228	Saint Michael	381	Copper Center	553

	Communities by Alpha Sort		Communities by Population	
	Community	Population	Community	Population
229	Saint Paul Island	673	Shishmaref	556
230	Salamatof	1122	Akiachak	560
231	Salcha	387	Galena	563
232	Sand Point	842	Fort Yukon	570
233	Savoonga	653	Kipnuk	573
234	Saxman	371	Angoon	576
235	Scammon Bay	484	Kotlik	579
236	Selawik	767	Thorne Bay	582
237	Seldovia	284	Pleasant Valley	584
238	Shageluk	140	Quinhagak	595
239	Shaktoolik	218	Cohoe	602
240	Sheldon Point	181	Aniak	604
241	Shishmaref	556	Naknek	624
242	Shungnak	255	Noorvik	632
243	Skagway	825	Healy	646
244	Skwentna	72	Savoonga	653
245	Slana	55	Alakanuk	659
246	Sleetmute	103	Two Rivers	660
247	South Naknek	132	Gambell	668
248	Stebbins	524	Klawock	673
249	Sterling	6138	Saint Paul Island	673
250	Stevens Village	92	Womens Bay	675
251	Stony River	35	Moose Creek	677
252	Sutton	470	Ninilchik	687
253	Takotna	48	King Cove	691
254	Talkeetna	363	Kwethluk	714
255	Tanacross	86	Yakutat	729
256	Tanana	301	Kake	745
257	Tatitlek	105	Chevak	763
258	Tazlina	294	Mountain Village	766
259	Teller	266	Selawik	767
260	Tenakee Springs	93	Point Hope	794
261	Tetlin	89	Unalakleet	805
262	Thorne Bay	582	Emmonak	818
263	Togiak	841	Skagway	825
264	Tok	1235	Houston	836
265	Toksook Bay	513	Togiak	841
266	Tonsina	47	Sand Point	842

	Communities by Alpha Sort		Communities by Population	
	Community	**Population**	**Community**	**Population**
267	Trapper Creek	344	Hoonah	877
268	Tuluksak	443	Delta Junction	889
269	Tuntutuliak	350	Hooper Bay	1028
270	Tununak	331	Lazy Mountain	1109
271	Twin Hills	76	Salamatof	1122
272	Two Rivers	660	Anchor Point	1227
273	Tyonek	160	Tok	1235
274	Unalakleet	805	Metlakatla	1537
275	Unalaska	4178	North Pole	1616
276	Upper Kalskag	261	Haines	1775
277	Venetie	232	Fritz Creek	2097
278	Wainwright	545	Craig	2136
279	Wales	170	Big Lake	2162
280	Wasilla	5213	Ridgeway	2382
281	Whale Pass	62	Butte	2699
282	White Mountain	197	Nikiski	3038
283	Whitestone Logging Camp	118	Unalaska	4178
284	Whittier	280	Wasilla	5213
285	Willow	507	Meadow Lakes	5232
286	Wiseman	20	Sterling	6138
287	Womens Bay	675	Kenai	7005
288	Yakutat	729	College	12122

APPENDIX III
QUESTIONNAIRE

Alaska Rural Primary Care Facility Needs Assessment

Denali Commission

Dated Material – Please Read Immediately

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PROJECT OVERVIEW

Denali Commission and Health Care Facilities

The Denali Commission Act of 1998 (see *www.denali.gov*) created the Denali Commission (Commission). Three general areas of focus were identified for the Commission including job training, economic development and rural infrastructure development. The Commission is based upon a format similar to the Appalachian Regional Commission (ARC), which was created in 1965. Of interest to the Denali Commission and Alaskans is that the ARC (in partnership with the 13 eastern-seaboard states it serves) arrived at five broad goals including: "Appalachian residents will have access to affordable, quality health care." Correspondingly, the seven Denali Commissioners recently identified rural health care facilities and services as the second area of focus or theme for infrastructure related projects funded and supported by the Commission. The first infrastructure focus for the Commission was rural energy projects.

Agreement for the Needs Assessment

In October 1999, the Commissioners approved funding for a project with the Alaska Native Tribal Health Consortium (ANTHC) for a needs assessment of rural primary care facilities. ANTHC offered to provide project management and a portion of their own funds for a needs assessment project. In light of the mission to provide federal services for all of Alaska, the Commission and ANTHC sought the participation of the Alaska Department of Health and Social Services (DHSS) to obtain representation for all rural communities. After DHSS agreed to participate in the needs assessment project, the three parties then sought the participation of the Indian Health Service (IHS), based upon their long history and in-depth knowledge of rural primary care programs and facilities. On February 24, 2000, the four partners entered into an agreement for carrying out the Alaska Rural Primary Care Facility Needs Assessment project. The project will address needs in all Native and non-Native communities in the state that meet the following basic criteria:

- Year-round community population of at least 20 individuals
- No direct access to an in-patient health care facility

Goals of the Needs Assessment Project

The needs assessment project will accomplish three main tasks. First, a database will be created that provides detailed information on health care facilities and program services. Data will be obtained via a statewide questionnaire. Additional information from existing databases maintained by other agencies will also be gathered to complement information obtained from the questionnaire. Second, a report with a statewide cost estimate will be generated that summarizes the magnitude of primary care facility needs in Alaska. The goal is to provide this report to the Alaska Congressional delegation by July 1, 2000. Third, the needs assessment project will develop a resource distribution methodology for rural primary care facilities by October 1, 2000. The partners will strive to obtain maximum public participation in developing this methodology. The outcome of this effort is intended to be an equitable system for distribution of federal funding to those communities with the greatest need, recognizing that cost effective delivery of service includes the ability of a community to operate and maintain the facility over the long-term.

Information from the needs assessment project will be used by the partners to seek funding for both facilities and primary care services. In the event Congress looks favorably on the July 2000 report, the methodology should guide Federal, State and Tribal managers on which projects should be funded.

Project Team

A project Steering Committee has been formed that includes representatives from the Denali Commission, ANTHC, IHS and DHSS. The committee and all four parent organizations will be collaborating with stakeholders throughout the project.

ANTHC has been tasked with the overall responsibility for developing a work plan and schedule to meet project goals. ANTHC and the Steering Committee will receive assistance from two primary consultants during the project; NANA/DOWL JV (health facility expertise) and GEONORTH, Inc. (computer expertise). These services were obtained through an existing indefinite delivery contract between ANTHC and NANA/DOWL. The Commission and ANTHC agreed to use this contract in order to expedite the project and meet the July 1 report milestone.

Future Efforts

The four partners have accepted that this needs assessment project is only the beginning. They are in the process of developing a follow on scope of work to address more specific program needs and "deep look" surveys (to document code and other deficiencies at existing facilities).

At the close of last year's Congressional calendar, legislation was passed that authorized demonstration health projects between the Commission and U.S. Department of Health and Human Services. Demonstration projects can extend beyond primary care facilities, for example, into hospitals, mental health facilities and child care facilities. Although no funding was appropriated, one avenue is now in place for future federal support. Hopefully, the efforts of the Alaska Rural Primary Care Facility Needs Assessment project will help convince Congress to address unmet primary care needs in rural Alaska.

Communications

A web site has been established to facilitate communications during the project. Please refer to *http://ruralhealthcare.geonorth.com* for additional information on this initiative and e-mail links to the ANTHC project office. You can also contact the project office toll free by calling 800-560-8637 ext. 3606.

QUESTIONNAIRE

Alaska Rural Primary Care Facility Needs Assessment

Developed by:

Alaska Native Tribal Health Consortium
Indian Health Service
State of Alaska, Department of Health and Social Services

Prepared for:

Denali Commission

Return by April 25, 2000

to

Alaska Native Tribal Health Consortium
3925 Tudor Centre Drive
Anchorage, Alaska 99508

Phone: (800) 560-8637 ext. 3606 • Fax: (907) 271-4735
Website: http://ruralhealthcare.geonorth.com

INSTRUCTIONS

Questionnaire Design

The questionnaire is divided into two main sections that address the status and additional needs with respect to primary health care facilities and services/programs. All subsections and questions in the main questionnaire are identified with either an F (facilities) or P (program) prefix. The partners in the project have agreed that an assessment of program needs is essential and must be included in any evaluation of facility condition and/or additional space needs. Please be aware that the data you submit now may be enhanced in subsequent phases of the project.

Getting Started

1. Locate your 3-digit unique identifying number on the mailing label on the back of this packet.
2. Determine how many "**Facilities**" and "**Program**" sections of the questionnaire should be completed for your community. You will be able to make this determination after completing the "**General**" section of the questionnaire. Make the appropriate number of copies of the Facilities section and the Program section.
3. Review the major headings in each section of the questionnaire and then identify the appropriate people to assist with data collection for your community. You may need to talk with several people with facilities and health care expertise to provide the most accurate responses.
4. Determine if your site will submit data electronically (via the Internet), by mail or by fax. If you are submitting by mail or fax, please remember to fill in all the identifying information (Organization, Facility Name and Unique Identifying Number) at the top of each section that will be submitted.
5. Complete the questionnaire. *Note: even if you intend to submit the final data via the Internet, it is recommended that you first complete a "working paper copy" of the questionnaire.*
6. Submit your data.

Complete Questionnaires and Submit Data by April 25, 2000

THREE WAYS TO SUBMIT YOUR DATA

1



INTERNET

Access the project web site:
http://ruralhealthcare.geonorth.com

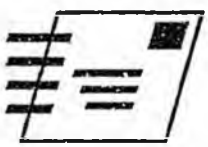
Then click on the questionnaire icon and follow the on-line instructions

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2

Mail completed questionnaire to:

Alaska Native Tribal Health Consortium
Alaska Rural Primary Care Facility Needs Assessment
Project Office
3925 Tudor Centre Drive
Anchorage, Alaska 99508



MAIL

3



FAX

You may also submit your data by faxing a completed questionnaire to:

(907) 271-4735

Have a question? See the Help Desk on the project web site:

(http://ruralhealthcare.geonorth.com)

or call...



General & Facility Related Questions

Alaska Rural Primary Care Facility Needs
Assessment Project Office
Alaska Native Tribal Health Consortium
800-560-8637 extension 3606

Gary Kuhn, P.E., Project Manager
e-mail: *gkdenali@anthc.org*

Rebecca Woodall, Project Assistant
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Program Related Questions

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Other Information

Other existing data sources will be used to enhance the information that each community is able to provide via this questionnaire. At this time, the project team envisions using the following existing data sources to round out the database:

- State of Alaska, Department of Community and Economic Development, community profile database Web site: *http://www.dced.state.ak.us/mra/CF_COMDB.htm*
- Alaska EMS Goals, (Fourth Edition)
- Indian Health Service Data System, (Health System Workload Data)
- Indian Health Service Facilities Database
- State Public Health Nursing Database
- ADOT&PF Airport Runway Inventory

Estimated Time to Complete

It is anticipated that if support people and data are readily available, the questionnaire will take at least 90 minutes to complete. If there are multiple facilities and/or primary care organizations in your community, it may take longer.

Confidentiality

Although the general public can access the project web site, all electronic responses are confidential. All responses received by mail and fax are also confidential.

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GENERAL

Community_____ **Unique ID #**_____

G1.1 **Is there an existing primary care facility (or facilities) in your community? Check the box that best describes the situation in your community** (see subsection P1 in the Program section of the Questionnaire for more detail on the categories of primary care services being used in this survey).

☐ (a) NO – but there is a facility in an adjacent community that provides primary care services for us; we do not need a stand-alone facility of our own.

If you answered NO to (a), enter the name of the adjacent community below, sign the certification on page 2 and then stop. You do not need to complete any other sections of this questionnaire.

Adjacent Community: _____

☐ (b) NO – and our community needs one.

If you answered NO to (b), complete the entire Program section and subsection F4.0 of the Questionnaire.

☐ (c) YES – one central facility that houses all health related services is currently available.

If you answered YES to (c), complete one Facilities and one Program section of the Questionnaire.

☐ (d) YES – one organization / program, but somewhat decentralized. One or more primary care services are housed in stand-alone building(s) remote from the main facility.

If you answered YES to (d), list all the different facilities (major stand-alone buildings, separate leased space in larger buildings and/or donated space) that are used to deliver primary care services in the community, then complete a Facilities section of the Questionnaire for each major facility. Please also complete the Program section. For example, if the organization / program providing services utilizes two different major buildings, you would complete one Program section and two Facilities sections of the Questionnaire.

	Facility Name	***Services Provided***
1.	_____	_____
2.	_____	_____
3.	_____	_____

☐ (e) YES - and there are two or more different organizations that provide primary care services in the community.

If you answered YES to (e), list all the different organizations and facilities (major stand-alone buildings, separate leased space in larger buildings and/or donated space) that are used to deliver primary care services in the community, then complete one or more Program sections of the Questionnaire. Complete an entire Program section for each separate organization that provides primary care. The total number of Program sections to be submitted will depend on your assessment of how many it takes to adequately paint a complete primary care picture for the community. You should also complete a Facilities section for each major facility used to deliver services, regardless of the organization that delivers the service. For example, if there are two organizations in the community that provide various primary care services, one utilizing three different major buildings and one that only operates out of one building, you would complete two Program sections and four Facilities sections of the Questionnaire.

	Organization	***Facility Name***	***Services Provided***
A.	_____	_____	_____
			_____
		_____	_____
			_____
B.	_____	_____	_____
			_____
		_____	_____
			_____
C.	_____	_____	_____
			_____
		_____	_____
			_____

Note: *If you answered YES to either (d) or (e) please do not fill out a separate Facilities section for small ancillary structures (i.e., unheated storage buildings, etc.). Instead, associate them with an appropriate major building and then provide an overall response to the questions for that "facility". If you are not sure how many sections of the questionnaire to complete, due to a unique multiple building, program and/or mixed use situation, please call the HELP DESK for guidance (800-560-8637 extension 3606).*

This section of the Questionnaire was completed by:

_____ _____ _____

Signature *Date*

_____ _____

Printed Name *Position*

FACILITIES

Community_____ **Unique ID #**_____

Organization_____

Name of Facility_____

F1.0 Basic Data

F1.1 Is this facility included in a written facilities master plan for the organization / program?

- ☐ NO
- ☐ YES
- ☐ Master plan is under development

If yes, has the plan been coordinated with any of the following? Check all that apply.

- ☐ Main referral facility (next level of care)
- ☐ Regional Native Health Corporation
- ☐ Parent Organization
- ☐ Other *(list)* _____

F1.2 Is the facility included in the Indian Health Service (IHS) Facilities Database?

- ☐ NO
- ☐ YES

If yes, please provide the unique identifying number(s) from the IHS database so we can match the data provided in this questionnaire with the correct building in their database.

Facility No. _____

Building No. _____

F1.3 Does the health program share the facility with other non-medical tenants?

- ☐ NO
- ☐ YES

If yes, total non-medical space in the building = _____ *Gross Square Feet (GSF)*

- ☐ Don't Know

F1.4 Is a detailed floor plan available for the space occupied by the health program?

- ☐ NO
- ☐ YES

F1.5 How much space does your health program use in the facility?

Direct services & support: _____ *GSF*

Staff quarters: _____ *GSF*

Other (list) _____: _____ *GSF*

☐ Don't Know

☐ Use values in IHS Facilities Database

☐ Use value in 1994 State DHSS Village Clinic Survey

F1.6 Check the box below that most closely describes the construction of the facility.

☐ Wood Frame – single story

☐ Wood Frame – multi-story

☐ Steel Frame (commercial type building) – single story

☐ Steel Frame (commercial type building) – multi story

☐ Other

F1.7 Is the facility protected with an automatic sprinkler system?

☐ NO

☐ YES

F1.8 Does the facility have a central fire alarm system?

☐ NO

☐ YES

F1.9 Does the facility have a standby generator?

☐ NO

☐ YES

F1.10 Is the facility insured against loss by fire and other perils through a commercial premium-based policy?

☐ NO

☐ YES

Comments:

F2.0 Ownership / Lease Data

F2.1 Who owns the facility?

- ☐ City
- ☐ State
- ☐ U.S. Public Health Service
- ☐ IRA
- ☐ Regional Native Health Corporation
- ☐ Village Corporation
- ☐ Private Individual
- ☐ Other *(list)* _____

F2.2 Is the facility leased from another party?

- ☐ (a) NO *If no, go to question F2.3.*
- ☐ (b) YES

If yes, check the box that best describes the type of lease.

- ☐ Full service (owner provides all repairs, utilities and maintenance)
- ☐ Triple Net (tenant provides all repairs, utilities and maintenance)
- ☐ Other *(list)* _____

Are there adequate funds to cover the entire lease and/or your share of the ownership, repair, utility and maintenance costs?

- ☐ (c) NO
- ☐ (d) YES

F2.3 If the facility is owned by a local or regional organization, and another entity pays lease money to operate the clinic, are the funds adequate to cover the cost of ownership, repairs, utilities and maintenance?

- ☐ NO
- ☐ YES
- ☐ N/A

F2.4 If your organization owns the facility and is self supporting, are there adequate funds to cover the cost of ownership, repairs, utilities and maintenance?

- ☐ NO
- ☐ YES
- ☐ N/A

F2.5 If you answered "NO" to F2.2(c), F2.3 or F2.4, check the box that most accurately describes the annual funding shortfall at the facility with respect to ownership, repair, utility and maintenance costs.

- ☐ $1 - $10,000
- ☐ $10,001 - $25,000
- ☐ $25,001 - $50,000
- ☐ Greater than $50,000

Comments:

F3.0 Physical Deficiencies

Rate the condition of the facility with respect to the following categories. Use the good, fair, and poor guidelines summarized below.

Structural:	*Related to structure or fabric of the building, including foundation, roof, framing, windows and interior finishes*
Mechanical:	*Plumbing, heating, ventilation and other special systems (e.g., medical gas)*
Electrical:	*Electrical distribution and emergency/standby power systems. Also includes low voltage wiring and control systems for telephone, paging, alarm systems, etc.*
Energy Management:	*Energy efficiency of building envelope and mechanical and electrical systems*
Handicap Access:	*Compliance with the Americans with Disabilities Act (ADA)*
Site / Environmental:	*Flood hazard, inadequate water and sewer connections, setback problems and known spills of hazardous materials on the immediate property, etc.*
Fire / Life Safety:	*Construction requirements related to fire protection contained in the Uniform Fire Code (UFC), Uniform Building Code (UBC) and the National Fire Protection Association Life Safety Code (NFPA 101)*
Floor Plan:	*Overall workflow issues related to staff and patient circulation patterns, room proximities, etc. This category is not meant to cover additional space needs, only the layout of existing spaces.*

****

Good = *System(s) less than 10 years old and/or no documented major problems. Only routine maintenance required to keep building completely functional.*

Fair = *System(s) more than 10 years old and/or some components need replacement. Documented problems could be corrected with a renovation project and useful life of building extended for at least another 10 years.*

Poor = *System(s) of any age which are approaching or are beyond the end of their useful life. Complete replacement necessary to maintain a proper environment for patients and staff.*

		Good	Fair	Poor	Don't Know
F3.1	Structural				
F3.2	Mechanical				
F3.3	Electrical				
F3.4	Energy Management				
F3.5	Handicap Access				
F3.6	Site / Environmental				
F3.7	Fire / Life Safety				
F3.8	Floor Plan				

Comments:

Structural:_____

Mechanical: _____

Electrical:_____

Energy Management:_____

Handicap Access:_____

Site / Environmental:_____

Fire / Life Safety:_____

Floor Plan:_____

F3.9 Check the box below that best describes the overall condition of the facility.

☐ Good

☐ Fair

☐ Poor

F3.10 Check the box below that best describes what your organization and the community as a whole think should be done with the facility.

- ☐ Correct deficiencies, renovate and/or add space and remain in service
- ☐ Replace with new facility
- ☐ Don't know or no consensus

F3.11 Is there a system for documenting deficiencies in the facility?

- ☐ NO
- ☐ YES

If yes, please describe _____

F3.12 Is there a cost estimate to correct some or all of the physical deficiencies summarized above?

- ☐ NO *If no, go to subsection F4.0.*
- ☐ YES - All
- ☐ YES - Some

If yes, estimate = $ _____

Date of estimate: _____

Check the boxes that apply to the estimate.

- ☐ Prepared by an Engineer or Contractor
- ☐ Includes design and project management fees
- ☐ Includes a construction contingency

F3.13 Has your organization and/or the community received a commitment from a funding source to correct the above deficiencies?

- ☐ NO
- ☐ YES
- ☐ PARTIAL

If yes or partial, please list

1. Source: _____ *Amount: $* _____

2. Source: _____ *Amount: $* _____

3. Source: _____ *Amount: $* _____

Comments:

F4.0 Space Related Deficiencies

F4.1 Do you need a facility where none exists now, or more space in an existing facility? Check all that apply.

- ☐ NO *If no, go to subsection F5.0.*
- ☐ YES – and a planning document has been prepared for either an addition, replacement or new first time facility
- ☐ Addition = _____ *GSF*
- ☐ New facility = _____ *GSF*
- ☐ YES – but don't know how much

F4.2 Is there a business plan that details how additional services and space will be financially supported?

- ☐ NO
- ☐ YES

If yes, please check the box below that best describes what the total ownership, repair, utility and maintenance budget would be for the new facility (do not include program costs).

- ☐ $1 - $50,000
- ☐ $50,001 - $100,000
- ☐ $100,001 - $200,000
- ☐ $200,001 - $300,000
- ☐ $300,001 - $400,000
- ☐ $400,001 - $500,000
- ☐ Greater than $500,000
- ☐ Don't Know

F4.3 Is there a cost estimate to construct the new space?

- ☐ NO *If no, go to question F4.4.*
- ☐ YES

If yes, estimate = $ _____
Date of estimate: _____

Check the boxes that apply to the estimate.

- ☐ Prepared by an Engineer or Contractor
- ☐ Includes design and project management fees
- ☐ Includes a construction contingency
- ☐ Includes cost of new medical equipment

F4.4 Has your organization and/or the community received a commitment from a funding source to correct the space related deficiencies?

☐ NO

☐ YES

☐ Partial

If yes or partial, please list

1. Source: _____ *Amount: $* _____

2. Source: _____ *Amount: $* _____

3. Source: _____ *Amount: $* _____

F4.5 Has the community made a commitment to provide in-kind contributions for the project?

☐ NO

☐ YES

F4.6 Are matching funds available for the project? Check all that apply.

☐ Regional Native Health Corporation

☐ State

☐ Federal Government

☐ Other *(list)* _____

F4.7 Is a design complete for the project?

☐ NO

☐ YES

☐ Under development

F4.8 Has a site been identified for the project?

☐ NO *If no, go to question F4.11.*

☐ YES

F4.9 Have all site control issues been resolved?

☐ NO

☐ YES

F4.10 Is the site close to existing infrastructure and primary community services, including water/sewer lines, power, local roads, airstrip, EMS office, school(s), etc. Check the box that best describes the site in this regard.

- ☐ Good – no major off site work required and in a convenient location to other primary community services
- ☐ Fair – some off site work required to connect utilities and/or location is inconvenient with respect to one or two other primary community services
- ☐ Poor – significant off site work required to connect to utilities and/or location is remote from most other primary community services

F4.11 Are there other funding sources or potential resource enhancement opportunities that would be more accessible if a new facility was constructed in the community?

- ☐ NO
- ☐ YES

If yes, please list

1. _____

2. _____

3. _____

- ☐ Don't Know

F4.12 Is there a new clinic or major clinic renovation project for the community that is approved and awaiting funding by a government entity or other outside source?

- ☐ NO
- ☐ YES

If yes, check the box that most closely describes the status of your project.

- ☐ Funding anticipated within 2 years
- ☐ Funding anticipated between 2 and 5 years
- ☐ Funding year uncertain

Comments:

F5.0 Medical Equipment Deficiencies

F5.1 Is the existing facility in need of new or replacement capitalized medical equipment? *Note: capitalized medical equipment is fixed or movable medical equipment greater than $500 in value.*

☐ NO

☐ YES

If yes, is there a cost estimate for the needed equipment?

☐ NO

☐ YES *Estimate = $* _____

F5.2 Does the facility have access to funds from any of the following sources for capitalized medical equipment?

☐ IHS

☐ State

☐ Regional Native Health Corporation Medical Equipment Fund

☐ Medical Equipment Fund at your parent organization

☐ Other *(list)* _____

If you checked any of the above five boxes, what is your estimate of the remaining funds necessary to meet your current medical equipment needs?

Estimate = $ _____

Comments:

F6.0 Utility and Maintenance Data

F6.1 Please provide the following energy data for calendar year 1998.

Total electrical usage at facility = _____ Kilowatt-hours

Total fuel oil usage at facility = _____ Gallons

Total natural gas usage at facility = _____ Cubic Feet

Total other energy sources (e.g. waste heat, coal etc.) = _____ Million BTU's

Other *(list)* _____

F6.2 On average, what are the annual costs for utilities and routine maintenance activities at the facility? Include costs for all utilities, building service contracts, maintenance benchstock and supplies, maintenance training, and small (less than $10,000) in-house repair / remodel projects. Do not include wages for maintenance staff.

$ _____ *per year*

F6.3 What funds are used to pay for ownership, repair, utility and maintenance costs at the facility? Check all the boxes that apply.

- ☐ IHS Village Built Clinic lease funds
- ☐ IHS / ANTHC Maintenance and Improvement funds
- ☐ Regional Native Health Corporation Funds
- ☐ Clinic Operating Funds
- ☐ City Funds
- ☐ State Funds
- ☐ Private Funds (e.g. contributions by building owner)
- ☐ Other *(list)* _____

F6.4 Is there a regional or other non-local support system for facilities management issues that your facility / staff can access?

- ☐ NO
- ☐ YES

If yes, indicate the lead organization for this support _____

F6.5 Does the owner of the facility have a building replacement and depreciation fund?

- ☐ NO
- ☐ YES
- ☐ Don't Know

Comments:

Certification: *The above information is true and accurate to the best of my knowledge.*

_____ _____
Signature *Date*

_____ _____
Printed Name *Position*

The following additional individuals participated in the completion of this section of the questionnaire.

_____ _____
Printed Name & Position *Printed Name & Position*

_____ _____
Printed Name & Position *Printed Name & Position*

The facilities section is now complete.

PROGRAM

Community _____ **Unique ID #** _____

Organization _____

P1.0 Services

The services listed in questions P1.1 – P1.41 and P4.1 – P4.7 may be considered components of comprehensive primary care. These services may be provided by a variety of health care providers, including Community Health Aides / Practitioners, Nurse Practitioners, Physician Assistants, Physicians, etc. Please indicate whether your program provides these services and functions. A "YES" answer implies that these services are provided on a regular basis by full or part time local staff. If you answered "NO" or "Itinerant Basis Only" please indicate why by checking one or more boxes to the right, and then indicate if any of the services should be provided on a regular basis to meet local program and/or community goals.

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Basic Primary Care Services Related to:													
P1.1	Family Health												
P1.2	Emergency Medical Treatment												
P1.3	Substance Abuse Diagnosis												
P1.4	Substance Abuse Treatment												
P1.5	Mental Health Diagnosis												
P1.6	Mental Health Treatment												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
P1.7	Prenatal and Perinatal Services												
P1.8	Breast and Cervical Cancer Screening												
P1.9	Well-Child Services												
P1.10	Immunizations												
P1.11	Supplemental Nutrition Program (WIC)												
P1.12	Family Planning Services												
P1.13	Preventive Dental Services												
P1.14	Dental Treatment Services												
P1.15	Patient Education												
P1.16	Other (list) _____												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract
CLIA = Clinical Laboratory Improvement Act

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
P1.17	CLIA Waived Tests												
P1.18	Specimen Collection for Shipment to Referral Lab												
P1.19	Provider Performed Microscopy												
P1.20	Moderate Complexity Lab												
P1.21	Ultrasound												
P1.22	X-Ray												
P1.23	Mammography												
P1.24	Pharmacy Services												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

	Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
	Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Patient Assistance Services												
P1.25 Referral of Patients to Providers												
P1.26 Counseling and Follow-Up Services to Assist Patients to Become Eligible for Health Care Coverage												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

	Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
	Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
Services That Help Patients to Use Site												
P1.27 Outreach												
P1.28 Home to Clinic Transportation												
P1.29 Language Interpretation												
P1.30 Sliding Fee Scale / Reduced Rates												
P1.31 Alternate / Extended Hours												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
P1.32	Education on Availability and Appropriate Use of Services												
P1.33	Off Site Services (e.g., school, senior center)												
P1.34	Home Health Visits												
P1.35	Personal Care Services												
P1.36	Community Health Education & Health Promotion												

Comments:

Key:
Avail. = Available
Comm. = Community
Inadeq. = Inadequate
Itin. = Itinerant / Contract

		Currently Provided?			*If Not, Why? (check all that apply)*							*Should Be Provided?*	
		Yes	Itin. Basis Only	No	Not Needed In This Size Comm.	Not Wanted By Comm.	Inadeq. Funding	Inadeq. Space	Inadeq. Equip.	Inadeq. Staff Avail.	Other	Yes	No
P1.37	First Responder Services												
P1.38	Ambulance Services												
P1.39	Ability to Provide Advanced Cardiac Life Support in Clinic												
P1.40	Dedicated Area for Dealing with Emergency Patients												
P1.41	Radio Communications Between Clinic & Emergency Medical Personnel												

Comments:

P2.0 Transportation

P2.1 Do you arrange for transport to other communities for care?

- ☐ NO
- ☐ YES

P2.2 What is the primary mode of travel to the next level of care?

- ☐ Motor Vehicle
- ☐ Airplane
- ☐ Boat
- ☐ Other *(list)* _____

P2.3 For routine referrals, what is the average travel time to the next level of care (door-to-door)?

- ☐ Less than 1 hour
- ☐ 1 – 2 hours
- ☐ 2 – 6 hours
- ☐ more than 6 hours

P2.4 In emergencies, what is the average travel time to the next level of care (door-to-door)?

- ☐ Less than 1 hour
- ☐ 1 – 2 hours
- ☐ 2 – 6 hours
- ☐ more than 6 hours

P2.5 What were your total travel costs for patient and accompanying staff to the next level of care in calendar year 1998?

$ _____

☐ Don't Know

Comments:

P3.0 Administration

P3.1 What term best defines the organization that provides administration of your program?

- ☐ Private, for profit
- ☐ Private, not for profit
- ☐ City/Borough
- ☐ PL 93-638 Contract / Compact
- ☐ Other *(explain)* _____
- ☐ N/A *If n/a go to question P3.3*

P3.2 Does the facility have a governing board / body?

- ☐ NO
- ☐ YES

P3.3 Check the box in each column that most accurately describes the budget situation for your health services delivery program. *Note: this question relates only to "program" budget, i.e., excludes facility ownership, repair, utility and maintenance costs, which are addressed separately in the Facilities section of the questionnaire.*

Annual Amounts	*Current Operating Budget*	*Current Deficits*	*Total Projected Operating Budget if all Needed Services Were Provided*
$0			
$1 - $50,000			
$50,001 - $100,000			
$100,001 - $150,000			
$150,001 - $200,000			
$200,001 - $250,000			
$250,001 - $300,000			
$300,001 - $350,000			
$350,001 - $400,000			
$400,001 - $450,000			
$450,001 - $500,000			
Greater Than $500,000			

P3.4 **Check all the funding sources that apply, or would apply, to your health services program. Checking a box is the same as answering yes. Blank boxes will be interpreted as either a NO or Don't Know response.** *Note: this question relates only to "program" budget, i.e., excludes facility ownership, repair, utility and maintenance costs, which are addressed separately in the Facilities section of the questionnaire.*

		Using Now	*Would Use if all Needed Services Were Provided*
	Funding Sources		
P3.4.1	Medicaid		
P3.4.2	Denali KidCare		
P3.4.3	Medicare		
P3.4.4	Other Health Insurance		
P3.4.5	Federal Grants		
P3.4.6	State Grants		
P3.4.7	Other Grants		
P3.4.8	Private Pay		
P3.4.9	P.L. 93-638		
P3.4.10	Community Subsidy		
P3.4.11	Other *(list)* _____		

Comments:

P4.0 Support Services

The following is a list of support services. Please check all the boxes that apply.

		Done On-Site by Local Staff?	*Done On-Site by Itinerant/Contract Staff?*	*Done Off Site?*	*Not Done*
	Support Services				
P4.1	Medical Records				
P4.2	Accounting / Budget				
P4.3	Billing / Collections				
P4.4	Computer Information Support				
P4.5	Facilities Management				
P4.6	Janitorial Services				
P4.7	Staff Development / In-Service				

Comments:

P5.0 Staffing

The following is a list of staff. For each type of staff, please indicate the number of funded positions you have, the number of positions filled and the number needed. Also indicate if you use Itinerant or Contract staff. Please report positions in terms of "Full-time equivalents (FTE's)".

Key:	
Full-time employee	1.0 FTE
4 days/week	.8
3 days/week	.6
Half-time	.5
2 days/week	.4
1 day/week	.2
0 days/week	0

		Number of Funded Positions	*Number of Filled Positions*	*Additional Number of Positions Needed*	*Itinerants or Contract Staff*	
					Current	*Additional Needed*
P5.1	Director / Clinical Manager					
P5.2	Business Manager					
P5.3	Billing / Collections Staff					
P5.4	Computer Information Staff					
P5.5	Clerical / Reception/Travel					
P5.6	Medical Records Staff					
P5.7	Maintenance / Janitorial Staff					
P5.8	Community Health Aide / Practitioner					
P5.9	Community Health Representative					
P5.10	Rural Human Services Worker					
P5.11	WIC Staff					
P5.12	Emergency Medical Technician					
P5.13	Nurse					
P5.14	State/Contract Public Health Nurse					
P5.15	Nurse Practitioner					
P5.16	Physician Assistant					
P5.17	Physician					
P5.18	Dental Hygienist					
P5.19	Dentist					
P5.20	Other (list) _____					

Comments:

P6.0 Clinical Caseload (Workload) Data

P6.1 Is caseload data available for your program?

☐ NO *If no, go to question P6.5.*

☐ YES

☐ N/A *If n/a, answer question P6.5 and then skip to section 8.0.*

P6.2 How many total patient encounters / visits were reported in your program in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.3 How many total dental encounters / visits were reported in your program in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.4 How many emergency medical patients were seen in your facility in calendar year 1998?

_____ *(write in number)*

☐ Don't Know

P6.5 Is there a significant seasonal or itinerant population in your community that requires health services?

☐ NO *If no, go to subsection P7.0.*

☐ YES

If yes, is the population high risk? Check all that apply below.

☐ Fishing

☐ Logging

☐ Tourism

☐ Other *(list)* _____

If yes, do many of these individuals experience a language barrier at your facility?

☐ NO

☐ YES

Comments:

P7.0 Extended Patient Stays *(greater than 4 hours)*

P7.1 Does your primary care facility ever treat patients for extended stays including overnight?

- ☐ NO *If no, go to subsection P8.0.*
- ☐ YES

P7.2 If you answered "YES" to question P7.1, how often were patients treated for extended stays in calendar year 1998?

- ☐ 1-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times

P7.3 Why did these patients require extended stays in your facility? Check all that apply.

- ☐ Lack of adequate transportation
- ☐ Could not transport patient(s) out of community due to weather
- ☐ Condition of patients(s) required extended observation or treatment, but not out of community
- ☐ Other circumstances *(please explain below)*

_____

P7.4 Is your facility equipped to accommodate patients overnight?

- ☐ NO
- ☐ YES

Comments:

P8.0 Living Quarters

P8.1 Do you have living quarters available for Itinerant / Contract staff? Select one response that best describes the situation.

- ☐ NO
- ☐ YES – in clinic
- ☐ YES – in community

P8.2 Do you have living quarters available for permanent staff? Select one response that best describes the situation.

- ☐ NO
- ☐ YES – in clinic
- ☐ YES – in community

P8.3 If you answered "NO" to question P8.1 or P8.2, do you believe that dedicated living quarters for clinic staff are needed? Check all responses that apply.

- ☐ NO
- ☐ YES – in the clinic
- ☐ YES – in the community but not in the clinic
- ☐ YES – this affects our ability to provide certain health care services

Comments:

P9.0 Telehealth

P9.1 Does your main referral facility have an advanced medical communication system in place that takes advantage of new telemedicine technology?

- ☐ NO
- ☐ YES
- ☐ Under Development
- ☐ Don't Know

P9.2 If you currently have, or plan to have telemedicine equipment available in your facility, do you have adequate space for it?

- ☐ NO
- ☐ YES
- ☐ Don't Know

Comments:

Certification: *The above information is true and accurate to the best of my knowledge.*

_____	_____
Signature	*Date*
_____	_____
Printed Name	*Position*

The following additional individuals participated in the completion of this section of the questionnaire.

_____	_____
Printed Name & Position	*Printed Name & Position*
_____	_____
Printed Name & Position	*Printed Name & Position*

ADDITIONAL COMMENTS

Community _____ Unique ID # _____

Organization _____

Name of Facility _____

Question Number [ ] _____

Question Number [ ] _____

Question Number [ ] _____

Question Number [ ] _____

Question Number [ ] _____

ADDITIONAL COMMENTS

Community _____ **Unique ID #**_____

Organization_____

Name of Facility _____

Question Number [ ] _____

_____

_____

_____

Question Number [ ] _____

_____

_____

_____

Question Number [ ] _____

_____

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_____

Question Number [ ] _____

_____

_____

_____

Question Number [ ] _____

_____

_____

_____

DID YOU REMEMBER TO

For Hard Copy Submissions

☑ Enter the community, facility and program identification information at the beginning of the General, Facilities, and Program Sections of the questionnaire.

☑ Sign the certification at the end of all applicable sections of the questionnaire.

☑ Return the General Section of the questionnaire.

☑ Return the appropriate number of Facilities and Program Sections of the questionnaire.

☑ Keep copies of all sections for your records.

For Electronic Submissions via the Project Web Site

☑ Complete the appropriate number of Facilities and Program Sections of the questionnaire.

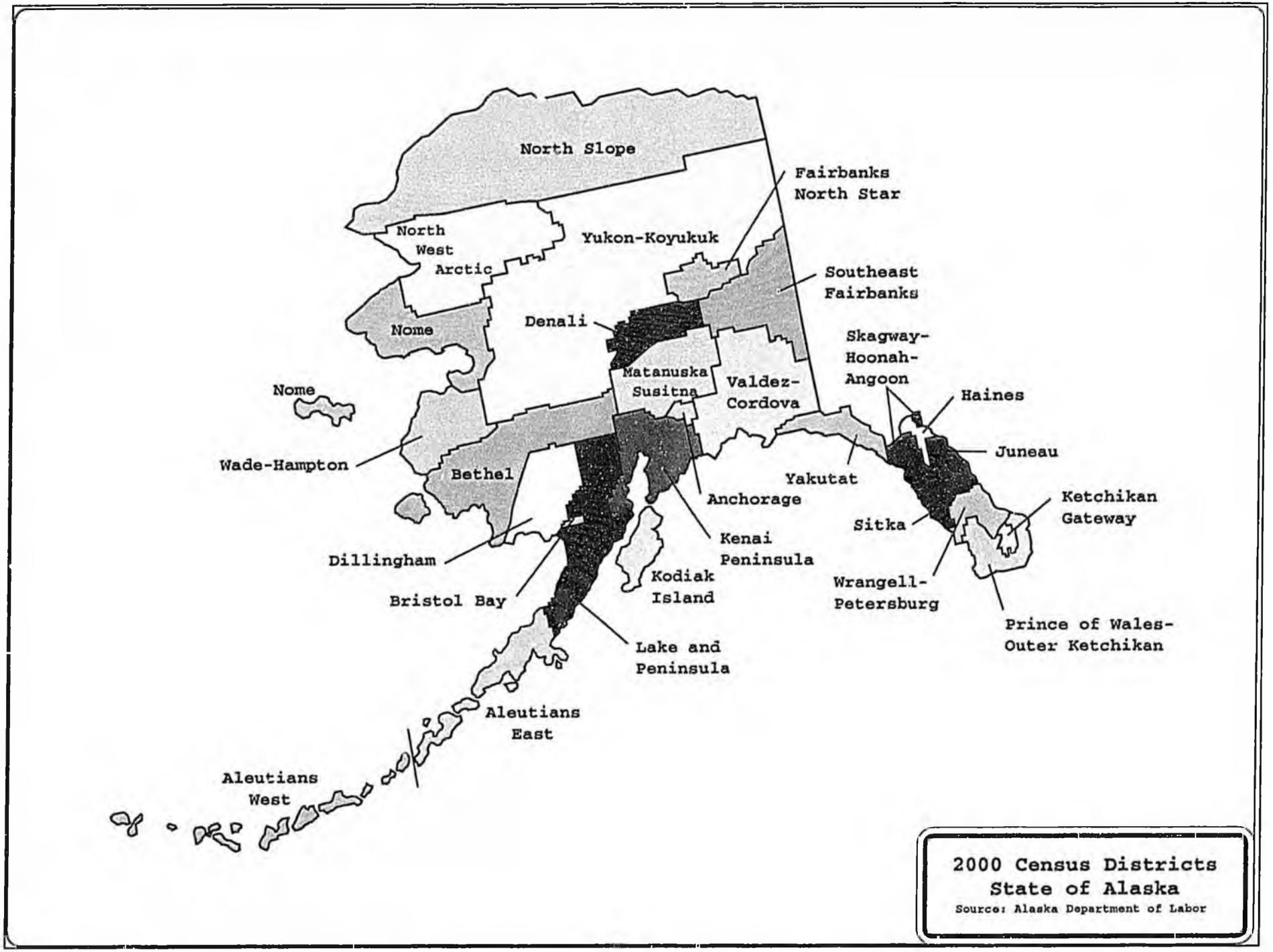
☑ Print a copy of all sections for your records.

Complete Questionnaires and Submit Data by April 25, 2000



APPENDIX IV

2000 CENSUS DISTRICTS


North Slope
Fairbanks North Star
North West Arctic
Yukon-Koyukuk
Southeast Fairbanks
Nome
Denali
Skagway-Hoonah-Angoon
Matanuska Susitna
Valdez-Cordova
Nome
Haines
Juneau
Wade-Hampton
Bethel
Yakutat
Anchorage
Ketchikan Gateway
Sitka
Kenai Peninsula
Dillingham
Kodiak Island
Wrangell-Petersburg
Bristol Bay
Prince of Wales-Outer Ketchikan
Lake and Peninsula
Aleutians East
Aleutians West
2000 Census Districts
State of Alaska
Source: Alaska Department of Labor

APPENDIX V
SAMPLE AD HOC QUERRY

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

The following information is sensitive and restricted from public release

	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
1	1	Hyder	1-Isolated	Y	0	0	300	N
2	1	Saxman	1-Highway	Y	0	0	288	N
3	2	Kupreanof	1-Isolated	N	0	0	0	N
4	5	Angoon	1-Isolated	Y	1950	0	1950	N
5	5	Coffman Cove	1-Isolated	N	0	0	0	N
6	5	Covenant Life	1-Isolated	N	0	0	0	N
7	5	Craig	2-Isolated	Y	2800	0	3730	N
8	5	Cube Cove	1-Isolated	N	0	0	0	N
9	5	Edna Bay	1-Isolated	N	0	0	0	N
10	5	Elfin Cove	1-Isolated	N	0	0	0	N
11	5	Game Creek	1-Isolated	Y	108	0	0	N
12	5	Gustavus	2-Isolated	Y	800	0	0	N
13	5	Haines	2-Isolated	Y	6000	1561	0	N
14	5	Hobart Bay	1-Isolated	N	0	0	0	N
15	5	Hollis	1-Isolated	N	0	0	0	N
16	5	Hoonah	2-Isolated	Y	0	0	2740	N
17	5	Kake	1-Isolated	Y	3300	3295	3134	N
18	5	Kasaan	1-Isolated	N	0	0	0	N
19	5	Klawock	2-Isolated	Y	6772	6769	1176	N
20	5	Klukwan	1-Isolated	N	0	0	0	N
21	5	Lutak	1-Highway	N	0	0	0	N
22	5	Metlakatla	2-Isolated	Y	8255	8273	0	N
23	5	Meyers Chuck	1-Isolated	N	0	0	0	N
24	5	Mosquito Lake	1-Isolated	N	0	0	0	N
25	5	Naukati Bay	1-Isolated	N	0	0	0	N
26	5	Pelican	2-Isolated	Y	1600	0	0	N
27	5	Point Baker	1-Isolated	N	0	0	0	N
28	5	Port Alexander	1-Isolated	N	0	0	0	N
29	5	Port Protection	1-Isolated	N	0	0	0	N
30	5	Skagway	2-Isolated	Y	0	0	720	N
31	5	Tenakee Springs	1-Isolated	N	0	0	0	N
32	5	Thorne Bay	2-Isolated	Y	1102	0	0	N
33	5	Whale Pass	1-Isolated	N	0	0	0	N
34	5	Whitestone Logging Camp	1-Isolated	N	0	0	0	N
35	6	Chiniak	1-Isolated	N	0	0	0	N
36	6	Karluk	1-Isolated	Y	0	0	392	N
37	6	Larsen Bay	1-Isolated	Y	615	0	615	N
38	6	Old Harbor	1-Isolated	Y	784	0	784	N
39	6	Ouzinkie	1-Isolated	Y	1056	0	960	N
40	6	Port Lions	1-Isolated	Y	1655	0	1465	N
41	6	Womens Bay	1-Highway	N	0	0	0	N
42	7	Anchor Point	2-Highway	N	0	0	0	N
43	7	Clam Gulch	1-Highway	N	0	0	0	N

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

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	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
44	7	Cohoe	1-Highway	N	0	0	0	N
45	7	Fox River	1-Highway	N	0	0	0	N
46	7	Fritz Creek	1-Highway	N	0	0	0	N
47	7	Halibut Cove	1-Isolated	N	0	0	0	N
48	7	Happy Valley	1-Highway	N	0	0	0	N
49	7	Jakolof Bay	1-Isolated	N	0	0	0	N
50	7	Kachemak	1-Highway	N	0	0	0	N
51	7	Kalifonsky	1-Highway	N	0	0	0	N
52	7	Kasilof	1-Highway	N	0	0	0	N
53	7	Nikolaevsk	1-Highway	N	0	0	0	N
54	7	Ninilchik	1-Highway	Y	3202	0	0	N
55	7	Port Graham	1-Isolated	Y	0	0	530	N
56	8	Cooper Landing	1-Highway	N	0	0	0	N
57	8	Crown Point	1-Highway	N	0	0	0	N
58	8	Hope	1-Highway	N	0	0	0	N
59	8	Moose Pass	1-Highway	N	0	0	0	N
60	8	Primrose	1-Highway	N	0	0	0	N
61	8	Ridgeway	2-Highway	N	0	0	0	N
62	8	Sterling	2-Highway	N	0	0	0	N
63	9	Kenai	2-Highway	Y	0	3600	0	N
64	9	Nikiski	2-Highway	N	0	0	0	N
65	9	Salamatof	1-Highway	N	0	0	0	N
66	26	Wasilla	2-Highway	N	0	0	0	N
67	27	Butte	1-Highway	N	0	0	0	N
68	27	Chickaloon	1-Highway	N	0	0	0	N
69	27	Lazy Mountain	1-Highway	N	0	0	0	N
70	27	Sutton	1-Highway	N	0	0	0	N
71	28	Alexander Creek	1-Isolated	N	0	0	0	N
72	28	Big Lake	2-Highway	N	0	0	0	N
73	28	Chase	1-Isolated	N	0	0	0	N
74	28	Houston	1-Highway	N	0	0	0	N
75	28	Knik	1-Highway	N	0	0	0	N
76	28	Meadow Lakes	2-Highway	N	0	0	0	N
77	28	Skwentna	1-Isolated	N	0	0	0	N
78	28	Talkeetna	2-Highway	Y	3000	0	0	N
79	28	Trapper Creek	1-Highway	N	0	0	0	N
80	28	Willow	1-Highway	N	0	0	0	N
81	29	Ester	1-Highway	N	0	0	0	N
82	33	Fox	1-Highway	N	0	0	0	N
83	33	Pleasant Valley	1-Highway	N	0	0	0	N
84	33	Two Rivers	1-Highway	N	0	0	0	N
85	34	Anderson	1-Isolated	N	0	0	0	N
86	34	Cantwell	1-Isolated	Y	0	0	589	N

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

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	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
87	34	Ferry	1-Isolated	N	0	0	0	N
88	34	Harding Lake	1-Isolated	N	0	0	0	N
89	34	Healy	2-Isolated	N	0	0	0	N
90	34	Lignite	1-Isolated	N	0	0	0	N
91	34	McKinley Park	1-Isolated	N	0	0	0	N
92	34	Moose Creek	1-Highway	N	0	0	0	N
93	34	North Pole	2-Highway	N	0	0	0	N
94	34	Salcha	1-Highway	N	0	0	0	N
95	35	Big Delta	2-Isolated	N	0	0	0	N
96	35	Chenega Bay	1-Isolated	Y	0	0	545	N
97	35	Delta Junction	2-Isolated	N	0	0	0	N
98	35	Eyak	1-Highway	N	0	0	0	N
99	35	Gakona	1-Isolated	N	0	0	0	N
100	35	Glennallen	2-Isolated	N	0	0	0	N
101	35	Kenny Lake	1-Isolated	N	0	0	0	N
102	35	Mendeltna	1-Isolated	N	0	0	0	N
103	35	Paxson	1-Isolated	N	0	0	0	N
104	35	Tazlina	1-Isolated	N	0	0	0	N
105	35	Tonsina	1-Isolated	N	0	0	0	N
106	35	Whittier	2-Isolated	Y	900	0	0	N
107	36	Alatna	1-Isolated	N	0	0	0	N
108	36	Alcan	1-Isolated	N	0	0	0	N
109	36	Allakaket	1-Isolated	Y	0	0	437	N
110	36	Aniak	2-Isolated	Y	6300	7538	841	N
111	36	Anvik	1-Isolated	Y	944	1055	765	N
112	36	Arctic Village	1-Isolated	Y	0	0	1240	N
113	36	Beaver	1-Isolated	Y	0	0	480	N
114	36	Bettles	1-Isolated	N	0	0	0	N
115	36	Birch Creek	1-Isolated	Y	500	0	0	N
116	36	Central	1-Isolated	N	0	0	0	N
117	36	Chalkyitsik	1-Isolated	Y	0	0	480	N
118	36	Chistochina	1-Isolated	Y	0	0	768	N
119	36	Chitina	1-Isolated	Y	540	0	980	N
120	36	Chuathbaluk	1-Isolated	Y	840	720	720	N
121	36	Circle	1-Isolated	Y	0	0	480	N
122	36	Circle Hot Springs	1-Isolated	N	0	0	0	N
123	36	Copper Center	1-Isolated	Y	140	2977	980	N
124	36	Copperville	1-Isolated	N	0	0	0	N
125	36	Crooked Creek	1-Isolated	Y	680	680	680	N
126	36	Dot Lake	1-Isolated	Y	384	0	363	N
127	36	Eagle	1-Isolated	Y	0	0	448	N
128	36	Evansville	1-Isolated	Y	720	0	0	N
129	36	Fort Yukon	2-Isolated	Y	0	5920	0	N

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

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	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
130	36	Galena	2-Isolated	Y	2307	0	3702	N
131	36	Grayling	1-Isolated	Y	899	898	768	N
132	36	Gulkana	1-Isolated	Y	50	0	816	N
133	36	Healy Lake	1-Isolated	N	0	0	0	N
134	36	Holy Cross	1-Isolated	Y	768	1125	768	N
135	36	Hughes	1-Isolated	Y	896	0	265	N
136	36	Huslia	1-Isolated	Y	0	0	832	N
137	36	Kaltag	1-Isolated	Y	117	0	713	N
138	36	Koyukuk	1-Isolated	Y	0	0	805	N
139	36	Lake Minchumina	1-Isolated	N	0	0	0	N
140	36	Lime Village	1-Isolated	Y	0	480	480	N
141	36	Lower Kalskag	1-Isolated	Y	768	768	768	N
142	36	Manley Hot Springs	1-Isolated	Y	0	0	488	N
143	36	Marshall	1-Isolated	Y	1632	1632	696	N
144	36	McCarthy	1-Highway	N	0	0	0	N
145	36	McGrath	2-Isolated	Y	0	0	1600	N
146	36	Mentasta Lake	1-Highway	Y	400	0	980	N
147	36	Minto	1-Isolated	Y	636	0	792	N
148	36	Nenana	2-Highway	Y	0	0	513	N
149	36	Nikolai	1-Isolated	Y	576	0	520	N
150	36	Northway	1-Isolated	Y	0	0	673	N
151	36	Northway Junction	1-Isolated	Y	0	0	673	N
152	36	Nulato	1-Isolated	Y	864	910	757	N
153	36	Pilot Station	1-Isolated	Y	1200	768	768	N
154	36	Rampart	1-Isolated	Y	0	0	320	N
155	36	Red Devil	1-Isolated	Y	0	0	336	N
156	36	Ruby	1-Isolated	Y	0	0	653	N
157	36	Russian Mission	1-Isolated	Y	1280	1000	1000	N
158	36	Shageluk	1-Isolated	Y	538	288	810	N
159	36	Slana	1-Isolated	N	0	0	0	N
160	36	Sleetmute	1-Isolated	Y	840	840	1408	N
161	36	Stevens Village	1-Isolated	Y	396	0	443	N
162	36	Stony River	1-Isolated	Y	956	437	437	N
163	36	Takotna	1-Isolated	Y	376	0	575	N
164	36	Tanacross	1-Isolated	Y	710	0	495	N
165	36	Tanana	2-Isolated	Y	0	55772	0	N
166	36	Tetlin	1-Isolated	Y	0	0	480	N
167	36	Tok	2-Isolated	Y	7780	0	1338	N
168	36	Tuluksak	1-Isolated	Y	1008	1000	837	N
169	36	Tyonek	1-Isolated	Y	800	0	900	N
170	36	Upper Kalskag	1-Isolated	Y	960	960	504	N
171	36	Venetie	1-Isolated	Y	0	0	1200	N
172	36	Wiseman	1-Isolated	N	0	0	0	N

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

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	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
173	37	Ambler	1-Isolated	Y	870	0	870	N
174	37	Anaktuvuk Pass	1-Isolated	Y	2623	0	4400	N
175	37	Atqasuk	1-Isolated	Y	2623	0	4400	N
176	37	Buckland	1-Isolated	Y	805	0	805	N
177	37	Deering	1-Isolated	Y	725	0	725	N
178	37	Kaktovik	1-Isolated	Y	0	0	4400	N
179	37	Kiana	1-Isolated	Y	780	0	1083	N
180	37	Kivalina	1-Isolated	Y	930	0	867	N
181	37	Kobuk	1-Isolated	Y	805	0	805	N
182	37	Noatak	1-Isolated	Y	800	0	800	N
183	37	Noorvik	1-Isolated	Y	2500	3284	0	N
184	37	Nuiqsut	1-Isolated	Y	0	0	4400	N
185	37	Point Hope	1-Isolated	Y	4000	0	870	N
186	37	Point Lay	1-Isolated	Y	5246	0	4400	N
187	37	Prudhoe Bay	2-Isolated	N	0	0	0	N
188	37	Selawik	1-Isolated	Y	2100	884	768	N
189	37	Shungnak	1-Isolated	Y	1620	0	0	N
190	37	Wainwright	1-Isolated	Y	0	0	4400	N
191	38	Alakanuk	1-Isolated	Y	1344	1344	1344	N
192	38	Andreafsky	2-Isolated	N	0	0	0	N
193	38	Brevig Mission	1-Isolated	Y	0	0	1260	N
194	38	Chevak	1-Isolated	Y	2816	2836	1977	N
195	38	Elim	1-Isolated	Y	737	0	954	N
196	38	Emmonak	1-Isolated	Y	1792	13473	869	N
197	38	Gambell	1-Isolated	Y	2587	1048	1260	N
198	38	Golovin	1-Isolated	Y	1267	0	992	N
199	38	Hooper Bay	1-Isolated	Y	1790	2838	1790	N
200	38	Kotlik	1-Isolated	Y	2400	960	960	N
201	38	Koyuk	1-Isolated	Y	1110	0	1120	N
202	38	Mekoryuk	1-Isolated	Y	966	800	768	N
203	38	Mountain Village	1-Isolated	Y	1656	1899	1900	N
204	38	Newtok	1-Isolated	Y	442	442	442	N
205	38	Nightmute	1-Isolated	Y	910	910	417	N
206	38	Nunam Iqua (Sheldon Point)	1-Isolated	Y	768	768	840	N
207	38	Pitka's Point	1-Isolated	Y	1000	999	374	N
208	38	Port Clarence	1-Isolated	N	0	0	0	N
209	38	Saint Mary's	1-Isolated	Y	720	720	0	N
210	38	Saint Michael	1-Isolated	Y	1800	0	0	N
211	38	Scammon Bay	1-Isolated	Y	1020	1019	880	N
212	38	Stebbins	1-Isolated	Y	722	0	1833	N
213	38	Teller	1-Isolated	Y	1472	0	910	N
214	38	Toksook Bay	1-Isolated	Y	1440	1440	1200	N
215	38	Tununak	1-Isolated	Y	768	768	768	N

Alaska Primary Care Data System

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	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
216	38	Unalakleet	2-Isolated	Y	3202	1400	1440	N
217	38	White Mountain	1-Isolated	Y	0	0	768	N
218	39	Akiachak	1-Isolated	Y	0	1791	768	N
219	39	Akiak	1-Isolated	Y	1628	831	1628	N
220	39	Aleknagik	1-Highway	Y	0	0	623	N
221	39	Atmautluak	1-Isolated	Y	768	4425	768	N
222	39	Chefornak	1-Isolated	Y	960	936	609	N
223	39	Clark's Point	1-Isolated	Y	0	0	240	N
224	39	Eek	1-Isolated	Y	729	1399	768	N
225	39	Ekwok	1-Isolated	Y	0	0	439	N
226	39	Kasigluk	1-Isolated	Y	768	768	768	N
227	39	Kipnuk	1-Isolated	Y	1536	1536	960	N
228	39	Kongiganak	1-Isolated	Y	960	960	768	N
229	39	Kwethluk	1-Isolated	Y	1792	1791	792	N
230	39	Kwigillingok	1-Isolated	Y	946	1039	946	N
231	39	Napakiak	1-Isolated	Y	1008	1000	768	N
232	39	Napaskiak	1-Isolated	Y	960	1959	0	N
233	39	New Stuyahok	1-Isolated	Y	800	0	1000	N
234	39	Nunapitchuk	1-Isolated	Y	1679	1678	775	N
235	39	Oscarville	1-Isolated	Y	320	320	320	N
236	39	Platinum	1-Isolated	Y	0	0	427	N
237	39	Quinhagak	1-Isolated	Y	1161	1139	1139	N
238	39	Togiak	2-Isolated	Y	0	0	784	N
239	39	Tuntutuliak	1-Isolated	Y	1440	1439	1440	N
240	39	Twin Hills	1-Isolated	Y	0	0	725	N
241	40	Adak	2-Isolated	N	0	0	0	N
242	40	Akutan	2-Isolated	Y	960	0	720	N
243	40	Atka	1-Isolated	Y	960	0	960	N
244	40	Chignik	2-Isolated	Y	1200	0	0	N
245	40	Egegik	1-Isolated	Y	400	0	432	N
246	40	False Pass	1-Isolated	Y	0	0	530	N
247	40	Igiugig	1-Isolated	Y	854	0	640	N
248	40	Iliamna	1-Isolated	Y	0	0	750	N
249	40	Ivanof Bay	1-Isolated	Y	0	0	576	N
250	40	King Cove	2-Isolated	Y	790	0	2000	N
251	40	King Salmon	1-Isolated	Y	0	0	528	N
252	40	Levelock	1-Isolated	Y	0	0	912	N
253	40	Naknek	2-Isolated	Y	0	0	672	N
254	40	Nelson Lagoon	1-Isolated	Y	0	0	670	N
255	40	Newhalen	1-Isolated	Y	0	0	440	N
256	40	Nikolski	1-Isolated	Y	820	0	382	N
257	40	Nondalton	1-Isolated	Y	100	0	660	N
258	40	Pedro Bay	1-Isolated	Y	800	0	400	N

Alaska Primary Care Data System

EMS Level 1 or 2 Communities Without A Clinic, or Not Equipped for Overnight Stays

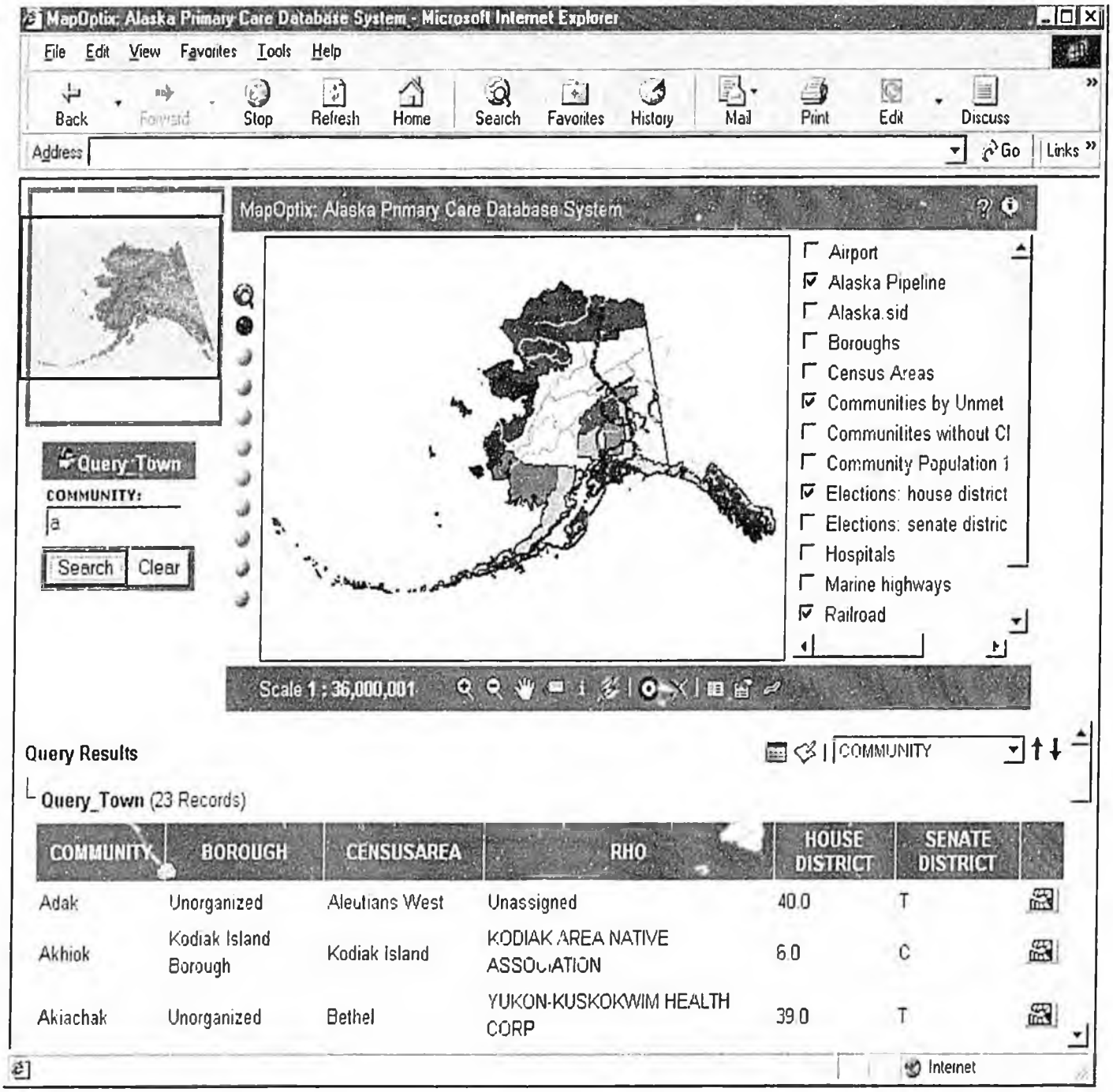
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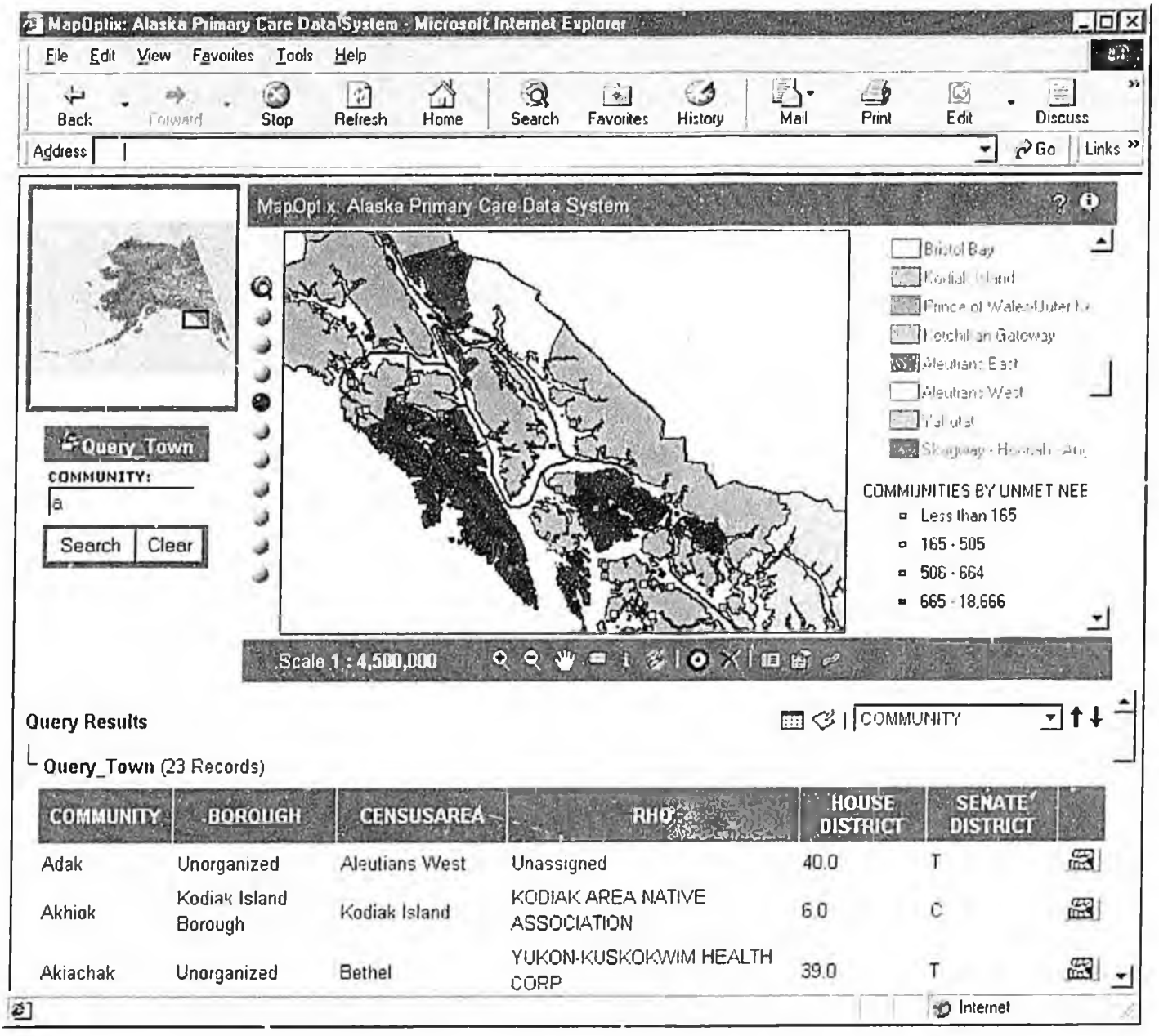
	House Election District	Community	EMS Level	Has Clinic	FNAQ GSF	IHS GSF	1994 Clinic Survey GSF	Equipped for Overnight
259	40	Perryville	1-Isolated	Y	600	0	760	N
260	40	Port Alsworth	1-Isolated	N	0	0	0	N
261	40	Port Heiden	1-Isolated	Y	0	0	710	N
262	40	Saint George	2-Isolated	Y	2100	0	2100	N
263	40	South Naknek	1-Isolated	Y	0	0	1045	N
264	40	Unalaska	2-Isolated	Y	1796	0	3100	N

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APPENDIX VI

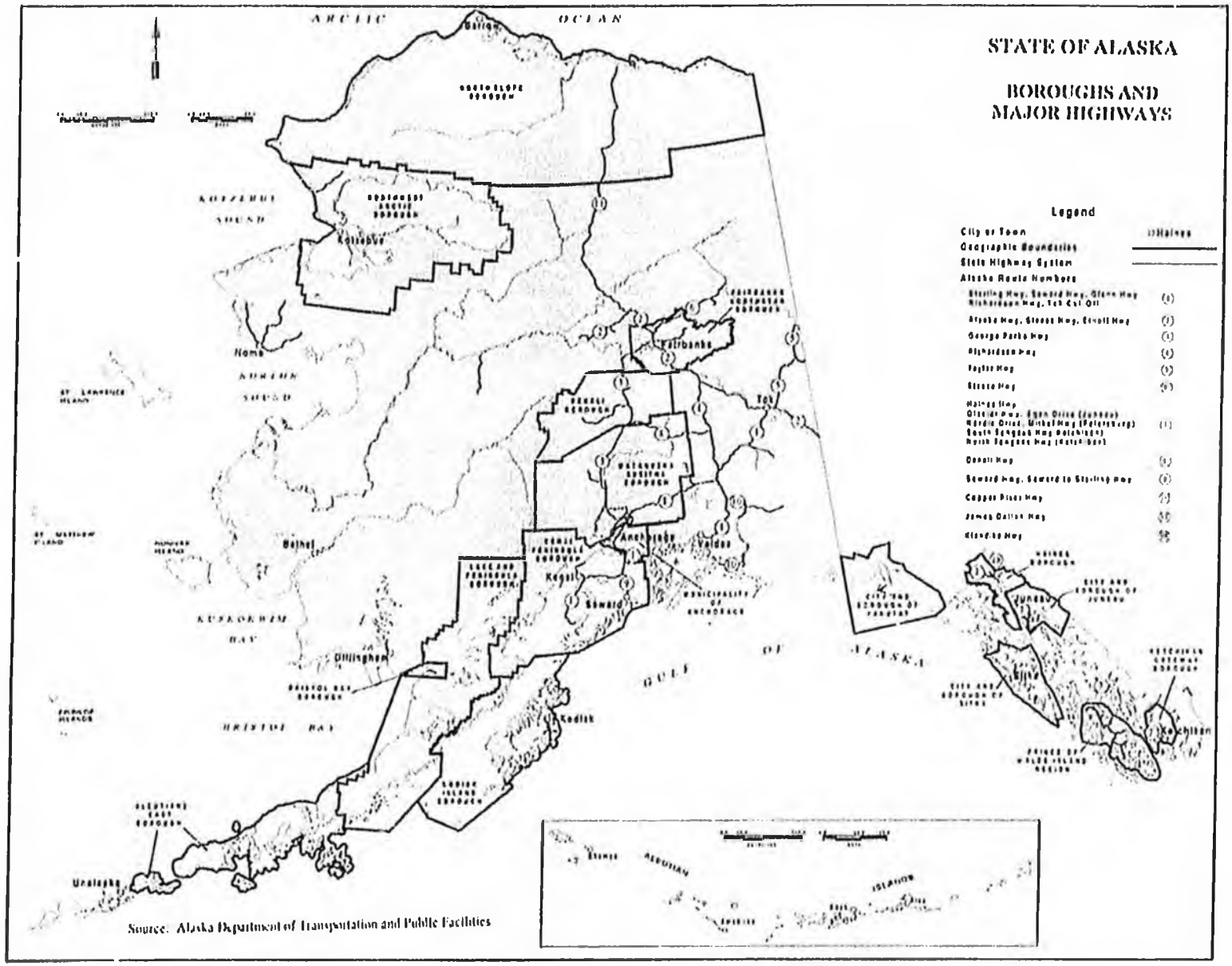
SAMPLE GEOGRAPHIC INFORMATION SYSTEM DISPLAY


MapOptix: Alaska Primary Care Database System - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail Print Edit Discuss
Address
Go Links
MapOptix: Alaska Primary Care Database System
Airport
Alaska Pipeline
Alaska.sid
Boroughs
Census Areas
Communities by Unmet
Communitites without CI
Community Population 1
Elections: house district
Elections: senate distric
Hospitals
Marine highways
Railroad
Query_Town
COMMUNITY:
a
Search Clear
Scale 1 : 36,000,001
Query Results
COMMUNITY
Query_Town (23 Records)
COMMUNITY BOROUGH CENSUSAREA RHO HOUSE DISTRICT SENATE DISTRICT
Adak Unorganized Aleutians West Unassigned 40.0 T
Akhiok Kodiak Island Borough Kodiak Island KODIAK AREA NATIVE ASSOCIATION 6.0 C
Akiachak Unorganized Bethel YUKON-KUSKOKWIM HEALTH CORP 39.0 T
Internet


MapOptix: Alaska Primary Care Data System - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail Print Edit Discuss
Address
Go Links
MapOptix: Alaska Primary Care Data System
Query_Town
COMMUNITY:
a
Search Clear
Bristol Bay
Kodiak Island
Prince of Wales/Outer Ketchikan
Ketchikan Gateway
Aleutians East
Aleutians West
Valdez
Skagway - Hoonah - Angoon
COMMUNITIES BY UNMET NEE
Less than 165
165 - 505
506 - 664
665 - 18,666
Scale 1 : 4,500,000
Query Results
COMMUNITY
Query_Town (23 Records)
COMMUNITY
BOROUGH
CENSUSAREA
RHO
HOUSE DISTRICT
SENATE DISTRICT
Adak
Unorganized
Aleutians West
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YUKON-KUSKOKWIM HEALTH CORP
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Internet

APPENDIX VII

BOROUGHS AND MAJOR HIGHWAYS


STATE OF ALASKA
BOROUGHS AND
MAJOR HIGHWAYS
Legend
City or Town
Miles
Geographic Boundaries
State Highway System
Alaska Route Numbers
Barrow
Kotzebue
Nome
Fairbanks
Bethel
Anchorage
Valdez
Kenai
Seward
Dillingham
Kodiak
Juneau
Ketchikan
Unalaska
ARCTIC OCEAN
KOTZEBUE SOUND
NORTON SOUND
KUSKOKWIM BAY
BRISTOL BAY
GULF OF ALASKA
Source: Alaska Department of Transportation and Public Facilities

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APPENDIX VIII

SPACE STANDARDS COMPARISON

Space Standards Comparison

line	STANDARD or PROJECT	Size (Sq. Ft.)	Design Pop.	Code Criteria: UBC Type V-N	Bus. Occupancy	ADA	Other	Designer or Standard	Year Planned or Designed
column		a	b	c	d	e	f	g	h
1	**YKHC PROTOTYPES**								
2	Small	1,078	20 - 300	X	X	X		Winchester AK	1999
3	Medium	1,470	300 - 600	X	X	X			
4	Large	1,870	> 600	X	X	X			
5	Sub-Regional	10,607**	varies	X	X	X			
6	**MANILAQ PROTOTYPE**								
7	One Size Fits All	5,150	100 - 800	X	X	X		Bettisworth and Co.	2000
8	**NORTH SLOPE BOROUGH STANDARDS**								
9	Original Prototype	4,400	150 - 500	X	X			McCool - McDonald	1982
10	Upgrade Standard - Level 1	4,400	< 300	X	X	X		ECI - Hyer	1995
11	Upgrade Standard - Level 2	5,020	> 300	X	X	X		ECI - Hyer	
12	Upgrade Standard - Level 3	6,060		X	X	X		ECI - Hyer	
13	**IHS PLANNING STANDARDS**								
14	Small Leased Facilities	3,022 - 8,250	> 500	X	X			IHFM Addendum	1991
15	St. Paul PJD	18,697	1011*	X	X	X	NFPA	IHFM (1986 Ed.)	1994
16	Metlakatla PJD	28,632	1576	X	X	X			1995
17	**AANHS VBC STANDARDS**								
18	Small	400	20 - 200	No reference to UBC or ADA in Circulars			NFPA NEC UPC	AANHS Circulars 93-74 & 91-75	1986
19	Medium	800	200-450						
20	Large	1,000 - 2,500	>450						
21	**DHSS PUBLIC HEALTH CENTER STANDARDS**								
22	Small	2,162	n/a					Livingston - Slone & Dept. of Admin.	1988
23	Intermediate	3,798							
24	Large	7,345							
25	**SPECIFIC RECENT PROJECTS**		**Current Pop.**						
26	Crooked Creek	1,078	137					YKHC	1999
27	Holy Cross	1,078	247					YKHC	1999
28	Lower Kalskag	1,470	310					YKHC	1999
29	Kwigillingok	1,470	360					YKHC	1999
30	St. Marys Sub-Regional	10,607	3012					YKHC	1999
31	Aniak Sub-Regional	6,250	2636					Livingston Slone	1993
32	Noorvik	2,432	632					NANA/DOWL	1999
33	Alakanuk	1,870	659					YKHC	1999
34	King Cove	9,541	691					Planning For Health	1999
35	Selawik	1,707	767					Whitmore Johnson	1996
36	Unalakleet Sub-Regional	14,500	2157					Architects Alaska	2000
37	Emmonak Sub-Regional	10,607	3749					YKHC	1999
38	Craig	11,000	1,136					Livingston Slone	1996
39	Unalaska	16,000***	4,178					ECI - Hyer	1993

Space Standards Comparison

	STANDARD or PROJECT	Services									Annual Outpatient Workload			Staffing				COMMENTS
		Ambulatory	Admin. / Support	Community Health	Behavioral Health	Diagnostic	Dental	EMS	Quarters	Other	CHA Patient Encounters	PCPV's	Total Recorded OPV's *	CHA / CHR	PCP	Other	Total	
line	column	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	
1	YKHC PROTOTYPES																	
2	Small	X	X											X				3 exam rooms + ofc.
3	Medium	X	X											X				4 exam rooms + ofc.
4	Large	X	X											X				5 exam rooms + ofc.
5	Sub-Regional	X	X	X		X	X			X				X	X	X		
6	MANILAQ PROTOTYPE																	
7	One Size Fits All	X	X				X		X	X				X		X		
8	NORTH SLOPE BOROUGH STANDARDS																	
9	Original Prototype	X	X			X		X	X									EMS = ambulance garage
10	Upgrade Standard - Level 1	X	X			X		X	X				< 2000					
11	Upgrade Standard - Level 2	X	X			X		X					2000 - 3000					distinction between level 2 and 3 based
12	Upgrade Standard - Level 3	X	X		X	X		X					> 3000					primarily on demographics & workload
13	IHS PLANNING STANDARDS																	
14	Small Leased Facilities	X	X	X			X					1,115 - 4,400		X	X	X	40	
15	St. Paul PJD	X	X	X	X	X	X			X	n/a	5,237	10,458	X	X	X	30	proj. not yet designed
16	Metlakatla PJD	X	X	X	X	X	X	X		X		9,477		X	X	X	60	proj. not yet designed
17	AANHS VHC STANDARDS																	
18	Small	X	X								No Specific Standards			X			1	1 exam room + ofc.
19	Medium	X	X											X			1	2 exam room + ofc.
20	Large	X	X											X			2	2 exam room + ofc.
21	DHSS PUBLIC HEALTH CENTER STANDARDS																	
22	Small										No Specific Standards				X	X	3	
23	Intermediate														X	X	6	
24	Large													X	X	X	16	
25	SPECIFIC RECENT PROJECTS										FY 98 IHS DATA							
26	Crooked Creek	X	X								877			X			4	
27	Holy Cross	X	X								1,083			X			3	
28	Lower Kalskag	X	X								2,091			X			3	
29	Kwigillingok	X	X								2,696			X			5	
30	St. Marys Sub-Regional	X	X	X		X	X			X	3,160			X	X			under construction
31	Aniak Sub-Regional	X	X	X		X	X			X	6,966	7,898	11,549	X	X			original YKHC subregional design
32	Noorvik	X	X							X	3,836			X				
33	Alakanuk	X	X								3,894			X			6	
34	King Cove										2,154	1,921	3,811	X				in planning stage
35	Selawik		X	X					X		5,414			X				
36	Unalakleet Sub-regional										2,989			X				in planning stage
37	Emmonak Sub-Regional		X	X		X	X			X	4,725			X	X			under construction
38	Craig													X	X			
39	Unalaska	X	X	X	X	X	X			X								

Notes:

* Total OPV may not = CHAP + PCPV's since CHAP encounters are not "adjusted" values, and not all CHAP data finds its way into the official OPV reporting system.
** There is an additional 3,430 sf of open storage space on the mezanine storage level.
*** City clinic (Iliuk) only, i.e., excludes second floor space leased by APIA for their health programs: total building = 19,130 sf
Blank cells indicate either N/A or no data available.

APPENDIX IX

UNMET NEED BY CENSUS AREA

UNMET NEED BY CENSUS AREA

Census Area	Additional Space Need (sf)	Cost of Additional Space	Cost to Repair	Total Unmet Need
ALEUTIANS EAST	4,941	$2,011,941	$2,954,950	$4,966,892
ALEUTIANS WEST	3,436	$1,166,404	$6,740,817	$7,907,221
ANCHORAGE	0	$0	$124,320	$124,320
BETHEL	33,331	$14,648,422	$11,845,943	$26,494,365
BRISTOL BAY	4,192	$1,363,262	$406,897	$1,770,159
DENALI	11,831	$3,897,847	$121,023	$4,018,871
DILLINGHAM	8,897	$3,483,922	$2,375,556	$5,859,477
FAIRBANKS NSB	9,961	$2,522,281	$0	$2,522,281
HAINES BOROUGH	3,070	$1,072,402	$1,880,731	$2,953,133
JUNEAU	0	$0	$0	$0
KENAI PENINSULA	23,725	$8,111,283	$3,696,759	$11,808,042
KETCHIKAN	0	$0	$0	$0
KODIAK ISLAND	10,187	$2,305,513	$1,657,692	$3,963,205
LAKE-PENINSULA	17,648	$6,205,531	$3,885,523	$10,091,054
MATANUSKA-SUSITNA	19,938	$790,383	$1,020,058	$1,810,440
NOME	13,423	$5,511,953	$7,524,901	$13,036,854
NORTH SLOPE	1,535	$505,619	$8,846,655	$9,352,274
NORTHWEST ARCTIC	8,482	$3,626,833	$3,432,803	$7,059,636
PRINCE OF WALES	18,523	$4,674,042	$6,428,289	$11,102,331
SE FAIRBANKS	16,989	$4,332,912	$3,196,540	$7,529,452
SITKA	0	$0	$0	$0
SKAGWAY-HOONAH-ANGOON	15,825	$5,489,334	$1,779,964	$7,269,298
VALDEZ-CORDOVA	23,746	$7,941,851	$1,554,079	$9,495,930
WADE HAMPTON	12,075	$4,513,803	$6,098,352	$10,612,154
WRANGELL-PETERSBURG	3,070	$1,060,169	$585,000	$1,645,169
YAKUTAT	1,259	$394,640	$0	$394,640
YUKON-KOYUKUK	39,232	$13,415,306	$26,339,773	$39,755,079
TOTALS	**305,316**	**$99,045,654**	**$102,496,623**	**$201,542,277**

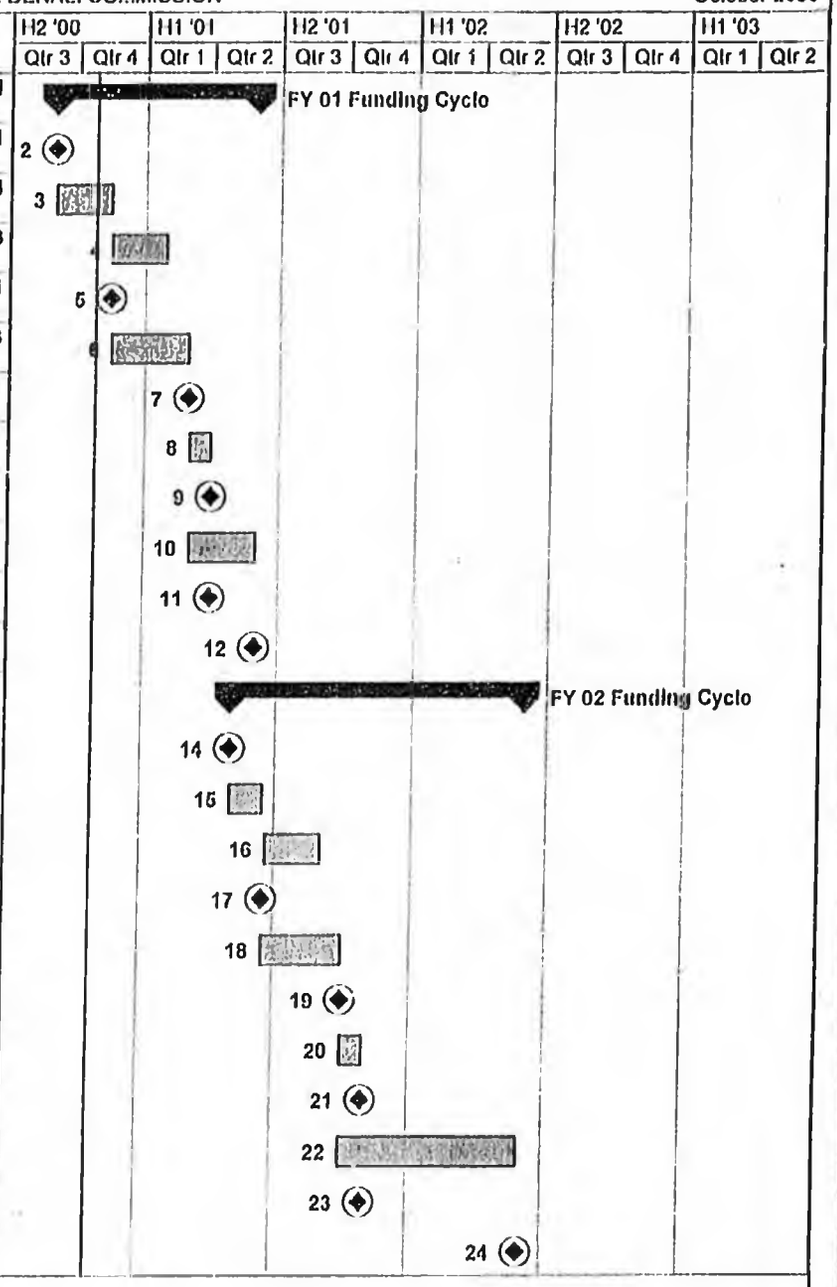
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APPENDIX X

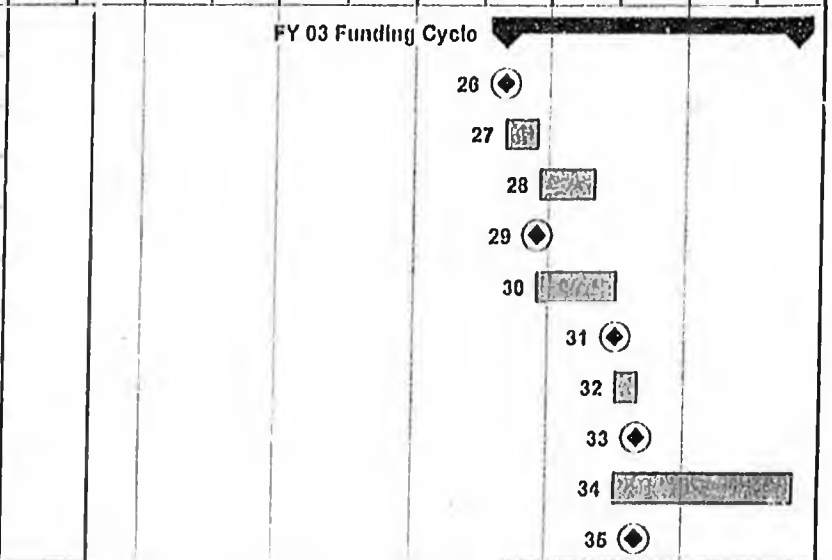
MULTIPLE YEAR SCHEDULE

DRAFT MULTI-YEAR SCHEDULE
PRIMARY CARE FACILITIES PROJECTS FUNDED THROUGH THE DENALI COMMISSION

ID	Task Name	Duration	Start	Finish
1	FY 01 Funding Cycle	272 days	Fri Sep 01	Thu May 31
2	FNAQ Due	0 days	Fri Sep 01	Fri Sep 01
3	Develop Community Short List	75 days	Fri Sep 01	Tue Nov 14
4	Code & Condition Surveys	75 days	Wed Nov 15	Sun Jan 28
5	RFP's Issued	0 days	Tue Nov 14	Tue Nov 14
6	Proposal Preparation Period	106 days	Wed Nov 15	Wed Feb 28
7	Proposals Due	0 days	Thu Mar 01	Thu Mar 01
8	MRP Evaluates Proposals	30 days	Thu Mar 01	Sat Mar 31
9	Publish FY 01 Approved Project List	0 days	Sun Apr 01	Sun Apr 01
10	TA Window For Projects Lacking Capability	90 days	Thu Mar 01	Wed May 30
11	Initiate Funding For Approved Projects	0 days	Sun Apr 01	Sun Apr 01
12	Updated Proposals Due For Projects Needing TA	0 days	Thu May 31	Thu May 31
13	FY 02 Funding Cycle	396 days	Tue May 01	Fri May 31
14	FNAQ Due	0 days	Tue May 01	Tue May 01
15	Develop Community Short List	45 days	Tue May 01	Thu Jun 14
16	Code & Condition Surveys	75 days	Sun Jun 17	Fri Aug 31
17	RFP's Issued	0 days	Fri Jun 15	Fri Jun 15
18	Proposal Preparation Period	108 days	Fri Jun 16	Sun Sep 30
19	Proposals Due	0 days	Mon Oct 01	Mon Oct 01
20	MRP Evaluates Proposals & Completed Design Projects	30 days	Mon Oct 01	Tue Oct 30
21	Publish FY 02 Approved Project List	0 days	Tue Oct 30	Tue Oct 30
22	TA Window For Projects Lacking Capability	240 days	Mon Oct 01	Tue May 28
23	Initiate Funding For Approved Projects	0 days	Wed Oct 31	Wed Oct 31
24	Updated Proposals Due For Projects Needing TA	0 days	Fri May 31	Fri May 31



ID	Task Name	Duration	Start	Finish
25	FY 03 Funding Cycle	393 days	Wed May 01	Wed May 28
26	FNAQ Due	0 days	Wed May 01	Wed May 01
27	Develop Community Short List	45 days	Wed May 01	Fri Jun 14
28	Code & Condition Surveys	75 days	Mon Jun 17	Sat Aug 31
29	RFP's Issued	0 days	Fri Jun 14	Fri Jun 14
30	Proposal Preparation Period	108 days	Sat Jun 15	Mon Sep 30
31	Proposals Due	0 days	Tue Oct 01	Tue Oct 01
32	MRP Evaluates Proposals & Completed Design Projects	30 days	Tue Oct 01	Wed Oct 30
33	Publish FY 03 Approved Project List	0 days	Wed Oct 30	Wed Oct 30
34	TA Window For Projects Lacking Capability	240 days	Tue Oct 01	Wed May 28
35	Initiate Funding For Approved Projects	0 days	Wed Oct 30	Wed Oct 30



APPENDIX XI

PART I - COMMUNITY PRIORITIZATION FORMULA

PART I - COMMUNITY PRIORITIZATION FORMULA

Total Point Score For Each Community = Sum of the Following:

	Maximum Points
1. Facility Deficiency Score (FDS)	45
2. Health Status Score (HSS)	20
3. Isolation Score (IS)	10
4. Dependency Ratio Score (DRS)	10
5. Economic Status Score (ESS)	9
6. Trauma Registry Score (TRS)	5
7. Seasonal Population Score (SPS)	1
TOTAL	**100**

FACILITY DEFICIENCY

This factor characterizes the physical condition of existing clinic facilities as well as the need for additional and/or new space. The basic assumption is that the ability to deliver quality health care services is affected by the quality of the facility or facilities that house the program. Physical condition was judged to be a function of the following:

- Available space compared to a recommended guideline
- Age of existing facilities
- Condition of basic building systems at existing facilities

FACILITY DEFICIENCY SCORE

$$\text{Facility Deficiency Score (FDS)} = \frac{G - (E \times AF \times CF)}{G} \times (45)$$

G = Space Guideline from Table 8 in ARPCFNA Final Report

1. For EMS Level I-IS or II-IS and Population = 20 – 100: **$G_1 = 1535$**
2. For EMS Level I-IS or II-IS and Population = 101 – 500: **$G_2 = 1989$**
3. For EMS Level I-IS or II-IS and Population > 500: **$G_3 = 2459$**

****

4. For EMS Level I-HI and Population = 20 – 100: **G4 = 0**
5. For EMS Level I-HI and Population = 101 – 500: **G5 = 500**
6. For EMS Level I-HI and Population > 500: **G6 = 1989**

****

7. For EMS Level II - HI and Population = 101 – 500: **G7 = 1989**
8. For EMS Level II - HI and Population > 500: **G8 = 2459**

****

9. For EMS Levels III and higher: **$G_6 = 2459$**

E = Existing Square Footage

Existing space data is taken from one of the following sources.

a. Response to F1 5 in the FNAQ
b. IHS Facilities Database
c. 1994 State Clinic Survey Database

If no data was available from any of these sources then E is set equal to G.
If a community indicated in the FNAQ that they do not have a clinic and they need one, then E is set equal to 0.

AF = Age Adjustment Factor per the attached Age Factor Table

Age data is obtained from one of the following sources.

a. DCED Database
b. IHS Facilities Database
c. 1994 State Clinic Survey Database

If no data is available, then AF is set equal to 1.0

FACILITY

AGE FACTOR TABLE

Age (yrs)	Age Factor
< 10 yrs.	1.0
10 – 14	0.95
15 – 19	0.90
20 – 24	0.85
25 – 29	0.80
≥ 30	0.75

CF = Condition Factor

= Sum of points from attached Condition Factor Table divided by 26.

Total points derived based on responses to F3.1 through 3.8 in the FNAQ.
If no response to any of the above or if response = "Don't Know", then the response to F3.9 in the FNAQ is used. If there is no response to any of the above, then a default response of "Good" is used.

FACILITY CONDITION FACTOR TABLE

CATEGORY	GOOD	FAIR	POOR
Structural	4	2	1
Mechanical	4	2	1
Electrical	4	2	1
Fire & Life Safety	4	2	1
Floor Plan	4	2	1
Energy Management	2	1	0.5
Handicap Access	2	1	0.5
Site / Environmental	2	1	0.5
Totals	26	13	6.5

HEALTH STATUS

This factor characterizes a community's health status based on the census area where the community is located. The overall factor is a combination of nine separate health status indicators that were selected to reflect differential conditions between the census areas. The indicators and the resultant overall factor reflect health status of the population as a whole, and the more specific requirements of various age groups. The nine health status indicators that have been included are:

- Fertility rate
- Percent of births to teens
- Post-neonatal mortality rate
- Age adjusted mortality rate
- Suicide death rate
- Unintentional injury death rate
- Homicide death rate
- Heart disease death rate
- Cancer death rates

This is a robust measure of health status due to the quantity and quality of vital statistics data. Differences within a given census area will be revealed with other community level measures (see Economic Distress, Dependency Ratio, Trauma Registry).

HEALTH STATUS SCORE

The nine health status indicators are being provided by DHSS on a statewide average and census area basis for incorporation into the APCD. For each indicator, DHSS compares the rate for the census area to the state average, creating a "rate ratio" for each indicator. The "rate ratios" for each of the nine indicators are then summed up for each of the census areas. Once imported into the APCD, an overall score is generated for each community as follows.

1. Divide 20.00 by the census area with the highest aggregate rate ratio sum to determine the Health Status Scaling Factor (HSSF).

2. The sum of the rate ratios for each of the other census areas is then multiplied by the scaling factor to generate the Health Status Score (HSS) for that particular census area.

3. The score for each individual census area is assigned to each community within that census area.

ISOLATION

The isolation factor is a measure of the inherent complications related to providing primary care services and managing a health program in an isolated setting. The assumption is that geographic isolation has a negative impact on both routine service delivery and emergent care.

ISOLATION SCORE

The isolation score is based on each community's EMS category, and the FNAQ responses, which characterize the mode of travel to and from a given community. The distance from the community to the nearest hospital is also considered. Based on these variables, a community is assigned a score from 0 to 10. Points are assigned according to the table below.

1. Primary mode of travel is determined based on the response to P2.2 in the FNAQ. If the P2.2 response = "Other" then the mode is set equal to *"Air or Water"*. If there is no response to P2.2, then the mode is assigned based on a review of the Economy and Transportation Section of the *Community Information Summary* in the DCED database.

2. Distance to nearest hospital is determined based on the following:

   - List of hospitals per the June 1998 Alaska Rural Health Plan.
   - Straight-line air miles to the nearest community with a hospital as calculated by a subroutine within the GIS application of the APCD.

3. All communities with an EMS level of III or higher are assigned an isolation score of 0, regardless of travel mode or distance to the nearest hospital.

ISOLATION SCORING TABLE

Distance To Nearest Hospital (miles)	EMS CATEGORY					
	ISOLATED I		ISOLATED II		HIGHWAY I	HIGHWAY II
	Primary Mode Of Travel To Next Level of Care					
	Air or Water	Motor Vehicle	Air or Water	Motor Vehicle	Motor Vehicle	Motor Vehicle
0 -100	7		4		1	0
101 - 200	8	2	5	2		
201 - 600	9	3	6	3		
> 600	10	4	7	4		

DEPENDENCY RATIO

The Dependency Ratio (DR) was selected as the best indicator of demographic differences between communities with respect to health care needs. The DR is the sum of the elderly and youth population divided by the working age population. Elderly = people 65 or over, youth = people under 18, and working age population = people ages 18 - 64. This ratio is the most reliable measure available of the different levels of "need" in communities related to the age structure of the population. It also suggests possible economic stress on a community if there is a very small population of working age adults supporting a large population of youth and elderly people.

The data used to determine this ratio is taken from the 1990 census information. This factor can be updated in 2001 with 2000 Census information. Census area, population estimates of age groups indicate that the dependency ratios have shifted slightly in some of the census areas and boroughs but not a great deal over the last decade. Those that were very high have moderated somewhat.

Like the health status indicators, the DR in one community can be compared with a state or project average to get the relationship to the state norm and the new ratio can be used as an index or score.

DEPENDENCY RATIO SCORE

DR data is being provided by DHSS on a community specific basis. Once imported into the APCD, a score is generated for each community as follows.

1. A statewide average DR or "ADR" is calculated using only the data for those communities meeting the baseline ARPCFNA Project criteria, i.e. only for those communities that received a FNAQ.

$$ADR = \frac{\sum \text{Youth} + \sum \text{Elderly}}{\sum \text{Working}}$$

2. A Dependency Ratio Index (DRI) is calculated for each community.

3. $DRI = \frac{\text{Community DR}}{\text{ADR}}$

4. Divide 10.00 by the highest individual DRI to determine the Dependency Ratio Scaling Factor (DRSF).

5. Multiply each individual DR Index by the DSF to determine the Dependency Ratio Score (DRS) for each community.

ECONOMIC STATUS

The most readily available measure of economic status at the community level based on the research conducted under this project is the per capita income of the community at the time of the last census (1990). An update with the 2000 census data will be possible in 2001. Other economic measures were considered such as subsistence income but they did not significantly change the ranking of communities in relation to each other. Therefore, per capita income alone is being used to define the economic status factor.

ECONOMIC STATUS SCORE

The State of Alaska, Division of Health and Social Services is providing per capita income (PCI) and population data for all communities in the state (based on 1990 census data). Once imported into the APCD, a score is generated for each community as follows.

1. A statewide average PCI or "APCI" is calculated using only the data for those communities meeting the baseline ARPCFNA Project criteria, i.e. only for those 288 communities that received a FNAQ.

$$APCI = \frac{\sum (PCI \times Pop)}{\sum Pop}$$

2. The following ratio is calculated for each community.

$$PCI\ Ratio = \frac{APCI}{Community\ PCI}$$

3. Divide 9.00 by the highest individual Income Ratio to determine the Economic Scaling Factor (ESF).

4. Multiply each individual community income ratio by the ESF to determine the Economic Status Score (ESS) for each community.

TRAUMA REGISTRY

The Trauma Registry factor offers an additional dimension of community level information related to demands on the local health care system. Trauma Registry data reports hospitalizations due to injuries (starting in 1993, poisonings were also included) by closest community of occurrence. Data is available beginning in 1991. Hospitalized injuries are assumed to be a proxy for the overall burden of injury occurrences in communities. The method of comparison for the community level data is similar to the vital statistics data on health status. Although in this case, the "rate" for a community is based on the occurrences which may be to nonresident workers, tourists or part-year residents or visitors, in relation to the resident population of the nearest community. Vital statistics data, in contrast, relate to the place of residence of the individual who is born or who dies, rather than the place of birth or death. Small communities in terms of resident population can have very high numbers of occurrences of serious injuries related to fishing, fish processing, extreme sports, etc. Thus, it is expected that places with a high frequency for the base population have a greater need for health service facilities than places of similar size that do not experience such high levels of serious injury.

TRAUMA REGISTRY SCORE

Predicted and Trauma Registry data on hospitalizations for injuries by closest community of occurrence are being provided by DHSS on a community specific basis. The predicted values are calculated based on state averages in terms of per 100,000 resident population. The actual values are corrected Trauma Registry data. DHSS is also providing a trauma rate ratio (TRR) for each community that compares each community's actual value to the state average. Once imported into the APCD, a Trauma Registry Score (TRS) score is generated for each community based on the following table.

TRAUMA REGISTRY SCORING TABLE

POINTS	TRAUMA RATE RATIO (TRR)
1	TRR < 1
2	1 ≤ TRR < 2
3	2 ≤ TRR < 3
4	3 ≤ TRR < 4
5	TRR ≥ 4

SEASONAL POPULATION FLUCTUATION

This factor is a measure of the demands on the local health care system as a result of an increase in a particular community's population --- due to seasonal or transient influences. The assumption is that seasonal increases in population related to industries such as tourism (high percentage of elderly clients) or fishing and logging (high accident rates) have a negative impact on both routine service delivery and emergent care.

SEASONAL POPULATION SCORE

If the first response to P6.5 of the FNAQ = YES, then the Seasonal Population Score (SPP) = 1; otherwise, SPP = 0.

APPENDIX XII

PART I - PRIORITIZATION SUMMARY

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
75.00 - 85.00 Points							
Alatna	YUKON-KOYUKUK	Y	B	0	34	1-Isolated	1
Arctic Village	YUKON-KOYUKUK	Y	D	1240	138	1-Isolated	1
Birch Creek	YUKON-KOYUKUK	Y	C	500	35	1-Isolated	1
Grayling	YUKON-KOYUKUK	Y	C	899	184	1-Isolated	1
Holy Cross	YUKON-KOYUKUK	Y	C	768	247	1-Isolated	1
Kaltag	YUKON-KOYUKUK	Y	E	117	254	1-Isolated	1
Kobuk	NORTHWEST ARCTIC	Y	C	805	94	1-Isolated	1
Lake Minchumina	YUKON-KOYUKUK	Y	B	0	38	1-Isolated	1
Minto	YUKON-KOYUKUK	Y	C	636	248	1-Isolated	1
Nikolai	YUKON-KOYUKUK	Y	C	576	105	1-Isolated	1
Nondalton	LAKE-PENINSULA	Y	D	100	224	1-Isolated	1
Nulato	YUKON-KOYUKUK	Y	C	[illegible]	381	1-Isolated	1
Ruby	YUKON-KOYUKUK	N		623	184	1-Isolated	1
Scammon Bay	WADE HAMPTON	Y	C	1020	484	1-Isolated	1
Shageluk	YUKON-KOYUKUK	Y	C	538	140	1-Isolated	1
Stevens Village	YUKON-KOYUKUK	Y	C	396	92	1-Isolated	1
Wiseman	YUKON-KOYUKUK	Y	B	0	20	1-Isolated	1
70.00 - 74.99 Points							
Alakanuk	WADE HAMPTON	Y	C	1344	659	1-Isolated	2
Allakaket	YUKON-KOYUKUK	N		437	204	1-Isolated	2
Ambler	NORTHWEST ARCTIC	Y	C	870	286	1-Isolated	2
Beaver	YUKON-KOYUKUK	N		480	126	1-Isolated	2
Buckland	NORTHWEST ARCTIC	Y	C	805	428	1-Isolated	2
Chalkyitsik	YUKON-KOYUKUK	Y	C	480	102	1-Isolated	2
Chignik Lake	LAKE-PENINSULA	Y	C	441	136	1-Isolated	2
Clark's Point	DILLINGHAM	Y	C	240	68	1-Isolated	2
Crooked Creek	BETHEL	Y	C	680	137	1-Isolated	2
Deering	NORTHWEST ARCTIC	Y	C	725	148	1-Isolated	2
Egegik	LAKE-PENINSULA	Y	C	400	117	1-Isolated	2
Elim	NOME	Y	C	737	306	1-Isolated	2
Evansville	YUKON-KOYUKUK	Y	D	720	24	1-Isolated	2
Game Creek	SKAGWAY-HOONAH-ANG	Y	E	108	50	1-Isolated	2
Hooper Bay	WADE HAMPTON	Y	C	1790	1028	1-Isolated	2
Hughes	YUKON-KOYUKUK	Y	C	896	80	1-Isolated	2
Huslia	YUKON-KOYUKUK	Y	C	832	272	1-Isolated	2
Kasigluk	BETHEL	Y	C	768	528	1-Isolated	2
Kiana	NORTHWEST ARCTIC	Y	C	780	398	1-Isolated	2
Kivalina	NORTHWEST ARCTIC	Y	C	930	366	1-Isolated	2
Lower Kalskag	BETHEL	Y	C	768	310	1-Isolated	2
Newtok	BETHEL	Y	C	442	284	1-Isolated	2
Noatak	NORTHWEST ARCTIC	Y	C	800	423	1-Isolated	2
Nunam Iqua (Sheldon Point)	WADE HAMPTON	Y	C	768	181	1-Isolated	2
Perryville	LAKE-PENINSULA	Y	C	600	102	1-Isolated	2
Pilot Station	WADE HAMPTON	Y	C	1200	544	1-Isolated	2
Port Alexander	WRANGELL-PETERSBG	Y	B	0	80	1-Isolated	2
Port Alsworth	LAKE-PENINSULA	Y	B	0	88	1-Isolated	2
Rampart	YUKON-KOYUKUK	Y	C	320	66	1-Isolated	2

*See Appendix III, Page 1

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Red Devil	BETHEL	Y	C	0	44	1-Isolated	2
Russian Mission	WADE HAMPTON	Y	C	1280	311	1-Isolated	2
Savoonga	NOME	Y	C	940	653	1-Isolated	2
Shungnak	NORTHWEST ARCTIC	Y	C	810	255	1-Isolated	2
Stebbins	NOME	Y	C	722	524	1-Isolated	2
Takotna	YUKON-KOYUKUK	Y	C	376	48	1-Isolated	2
Wales	NOME	Y	C	864	170	1-Isolated	2
65.00 - 69.99 Points							
Akhiok	KODIAK ISLAND	Y	D	315	101	1-Isolated	3
Chefornak	BETHEL	Y	C	960	416	1-Isolated	3
Chuathbaluk	BETHEL	Y	C	840	105	1-Isolated	3
Circle	YUKON-KOYUKUK	Y	C	480	89	1-Isolated	3
Covenant Life	HAINES BOROUGH	Y	B	0	67	1-Isolated	3
Eek	BETHEL	Y	C	729	281	1-Isolated	3
Elfin Cove	SKAGWAY-HOONAH-ANG	Y	B	0	50	1-Isolated	3
False Pass	ALEUTIANS EAST	Y	C	530	68	1-Isolated	3
Galena	YUKON-KOYUKUK	Y	D	2307	563	2-Isolated	3
Golovin	NOME	Y	D	1267	141	1-Isolated	3
Goodnews Bay	BETHEL	Y	C	600	256	1-Isolated	3
Igiugig	LAKE-PENINSULA	Y	C	854	62	1-Isolated	3
Iliamna	LAKE-PENINSULA	Y	C	750	93	1-Isolated	3
Karluk	KODIAK ISLAND	Y	C	392	41	1-Isolated	3
Kipnuk	BETHEL	Y	C	1536	573	1-Isolated	3
Kokhanok	LAKE-PENINSULA	Y	C	480	163	1-Isolated	3
Koyuk	NOME	Y	C	1110	280	1-Isolated	3
Koyukuk	YUKON-KOYUKUK	N		805	101	1-Isolated	3
Kwigillingok	BETHEL	Y	C	946	360	1-Isolated	3
Levelock	LAKE-PENINSULA	Y	C	912	131	1-Isolated	3
Lime Village	BETHEL	Y	C	480	62	1-Isolated	3
Mekoryuk	BETHEL	Y	C	966	193	1-Isolated	3
Meyers Chuck	PRINCE OF WALES	Y	B	0	30	1-Isolated	3
Mountain Village	WADE HAMPTON	Y	C	1656	766	1-Isolated	3
Newhalen	LAKE-PENINSULA	Y	C	440	178	1-Isolated	3
Nightmute	BETHEL	Y	C	910	230	1-Isolated	3
Nikolaevsk	KENAI PENINSULA	Y	B	0	488	Highway	3
Oscarville	BETHEL	Y	C	320	64	1-Isolated	3
Port Protection	PRINCE OF WALES	Y	B	0	50	1-Isolated	3
Shishmaref	NOME	Y	C	1879	556	1-Isolated	3
Sleetmute	BETHEL	Y	C	840	103	1-Isolated	3
Tazlina	VALDEZ-CORDOVA	Y	B	0	294	1-Isolated	3
Tetlin	SE FAIRBANKS	Y	C	480	89	1-Isolated	3
Tununak	BETHEL	Y	C	768	331	1-Isolated	3
Tyonek	KENAI PENINSULA	Y	D	800	160	1-Isolated	3
Venetie	YUKON-KOYUKUK	Y	C	1200	232	1-Isolated	3
White Mountain	NOME	Y	C	768	197	1-Isolated	3
60.00 - 64.99 Points							
Akiak	BETHEL	Y	C	1628	338	1-Isolated	4
Anchor Point	KENAI PENINSULA	Y	B	0	1227	Highway	4

*See Appendix III, Page 1

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Angoon	SKAGWAY-HOONAH-ANG	Y	C	1950	576	1-Isolated	4
Atka	ALEUTIANS WEST	Y	C	960	105	1-Isolated	4
Atmautluak	BETHEL	Y	C	768	296	1-Isolated	4
Chenega Bay	VALDEZ-CORDOVA	Y	C	545	69	1-Isolated	4
Chickaloon	MATANUSKA-SUSITNA	Y	B	0	212	Highway	4
Chignik	LAKE-PENINSULA	Y	D	1200	103	2-Isolated	4
Chitina	VALDEZ-CORDOVA	Y	C	540	94	1-Isolated	4
Cooper Landing	KENAI PENINSULA	Y	B	0	285	Highway	4
Copper Center	VALDEZ-CORDOVA	Y	C	139.5	553	1-Isolated	4
Dot Lake	SE FAIRBANKS	Y	C	384	61	1-Isolated	4
Ekwok	DILLINGHAM	N		439	125	1-Isolated	4
Emmonak	WADE HAMPTON	Y	C	1792	818	1-Isolated	4
Gambell	NOME	Y	C	2587	668	1-Isolated	4
Gulkana	VALDEZ-CORDOVA	Y	D	50	90	1-Isolated	4
Hope	KENAI PENINSULA	Y	B	0	130	Highway	4
Ivanof Bay	LAKE-PENINSULA	N		576	29	1-Isolated	4
Knik	MATANUSKA-SUSITNA	Y	B	0	483	Highway	4
Koliganek	DILLINGHAM	Y	C	480	205	1-Isolated	4
Larsen Bay	KODIAK ISLAND	Y	C	615	137	1-Isolated	4
Little Diomede	NOME	Y	C	768	136	1-Isolated	4
Manokotak	DILLINGHAM	Y	C	1120	399	1-Isolated	4
Marshall	WADE HAMPTON	Y	C	1632	318	1-Isolated	4
McGrath	YUKON-KOYUKUK	Y	C	1600	423	2-Isolated	4
Napaskiak	BETHEL	Y	C	960	406	1-Isolated	4
Nenana	YUKON-KOYUKUK	Y	C	513	435	Highway	4
Nikolski	ALEUTIANS WEST	Y	C	820	39	1-Isolated	4
Platinum	BETHEL	Y	C	427	43	1-Isolated	4
Port Graham	KENAI PENINSULA	Y	C	530	178	1-Isolated	4
Saint Mary's	WADE HAMPTON	Y	C	720	475	1-Isolated	4
Shaktoolik	NOME	Y	C	1792	218	1-Isolated	4
Stony River	BETHEL	Y	C	956	35	1-Isolated	4
Teller	NOME	Y	C	1472	266	1-Isolated	4
Tuntutuliak	BETHEL	Y	C	1440	350	1-Isolated	4
Twin Hills	DILLINGHAM	Y	C	725	76	1-Isolated	4
Wasilla	MATANUSKA-SUSITNA	Y	B	0	5213	Highway	4
55.00 - 59.99 Points							
Akutan	ALEUTIANS EAST	Y	C	960	408	2-Isolated	5
Anvik	YUKON-KOYUKUK	Y	C	944	93	1-Isolated	5
Cold Bay	ALEUTIANS EAST	Y	C	1200	97	1-Isolated	5
Dry Creek	SE FAIRBANKS	Y	C	192	115	1-Isolated	5
Eagle	SE FAIRBANKS	Y	A	448	152	1-Isolated	5
Eklutna	ANCHORAGE	Y	D	360	434	5	5
Hyder	PRINCE OF WALES	Y	B	300	126	1-Isolated	5
Kotlik	WADE HAMPTON	Y	C	2400	579	1-Isolated	5
Kwethluk	BETHEL	Y	C	1792	714	1-Isolated	5
Manley Hot Springs	YUKON-KOYUKUK	N		488	88	1-Isolated	5
Napakiak	BETHEL	Y	C	1008	363	1-Isolated	5
New Stuyahok	DILLINGHAM	Y	C	800	475	1-Isolated	5

*See Appendix III, Page 1

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Nunapitchuk	BETHEL	Y	C	1679	471	1-Isolated	5
Pitka's Point	WADE HAMPTON	Y	C	1000	146	1-Isolated	5
Port Heiden	LAKE-PENINSULA	Y	C	710	125	1-Isolated	5
Saint Michael	NOME	Y	C	1800	381	1-Isolated	5
Skagway	SKAGWAY-HOONAH-ANG	Y	C	720	825	2-Isolated	5
Tanacross	SE FAIRBANKS	Y	C	710	86	1-Isolated	5
Tanana	YUKON-KOYUKUK	Y	C	4388	301	2-Isolated	5
Thorne Bay	PRINCE OF WALES	Y	C	1102	582	2-Isolated	5
Togiak	DILLINGHAM	Y	D	784	841	2-Isolated	5
Tuluksak	BETHEL	Y	C	1008	443	1-Isolated	5
50.00 - 54.99 Points							
Brevig Mission	NOME	Y	A	1260	279	1-Isolated	6
Cantwell	DENALI	Y	C	589	166	1-Isolated	6
Kake	WRANGELL-PETERSBG	Y	E	3300	745	1-Isolated	6
King Cove	ALEUTIANS EAST	Y	C	790	691	2-Isolated	6
King Salmon	BRISTOL BAY	Y	C	528	499	1-Isolated	6
Kongiganak	BETHEL	Y	C	960	359	1-Isolated	6
Naknek	BRISTOL BAY	Y	C	672	624	2-Isolated	6
Nelson Lagoon	ALEUTIANS EAST	Y	C	670	87	1-Isolated	6
Northway	SE FAIRBANKS	N		673	113	1-Isolated	6
Northway Junction	SE FAIRBANKS	N		673	116	1-Isolated	6
Old Harbor	KODIAK ISLAND	Y	C	784	276	1-Isolated	6
Pedro Bay	LAKE-PENINSULA	Y	C	800	36	1-Isolated	6
Port Lions	KODIAK ISLAND	Y	C	1655	243	1-Isolated	6
Quinhagak	BETHEL	Y	C	1160.55	595	1-Isolated	6
Saint George	ALEUTIANS WEST	Y	C	2100	173	2-Isolated	6
Unalakleet	NOME	Y	D	3202	805	2-Isolated	6
Upper Kalskag	BETHEL	Y	C	960	261	1-Isolated	6
Whittier	VALDEZ-CORDOVA	Y	C	900	280	2-Isolated	6
45.00 - 49.99 Points							
Atqasuk	NORTH SLOPE	Y	E	2623	274	1-Isolated	7
Chevak	WADE HAMPTON	Y	C	2816	763	1-Isolated	7
Chignik Lagoon	LAKE-PENINSULA	Y	C	1200	68	1-Isolated	7
Chistochina	VALDEZ-CORDOVA	Y	C	768	52	1-Isolated	7
Gustavus	SKAGWAY-HOONAH-ANG	Y	C	800	377	2-Isolated	7
Point Lay	NORTH SLOPE	Y	E	2623	217	1-Isolated	7
Sand Point	ALEUTIANS EAST	Y	D	2421	842	2-Isolated	7
Selawik	NORTHWEST ARCTIC	Y	C	2100	767	1-Isolated	7
South Naknek	BRISTOL BAY	Y	C	1045	132	1-Isolated	7
Tatitlek	VALDEZ-CORDOVA	Y	C	2532	105	1-Isolated	7
Toksook Bay	BETHEL	Y	C	1440	513	1-Isolated	7
Yakutat	YAKUTAT	Y	C	1200	729	2-Isolated	7
40.00 - 44.99 Points							
Akiachak	BETHEL	N		1791	560	1-Isolated	8
Aleknagik	DILLINGHAM	Y	D	400	244	Highway	8
Ouzinkie	KODIAK ISLAND	Y	C	1056	256	1-Isolated	8
Pilot Point	LAKE-PENINSULA	Y	C	5213	92	1-Isolated	8
Saxman	KETCHIKAN	Y	A	288	371	Highway	8

*See Appendix III, Page 1

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Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Seldovia	KENAI PENINSULA	Y	E	2376	284	2-Isolated	8
35.00 - 39.99 Points							
Craig	PRINCE OF WALES	Y	E	2800	2136	2-Isolated	9
Haines	HAINES BOROUGH	Y	E	6000	1775	2-Isolated	9
30.00 - 34.99 Points							
Anaktuvuk Pass	NORTH SLOPE	Y	E	4400	314	1-Isolated	10
Bettles	YUKON-KOYUKUK	N		0	35	1-Isolated	10
Fort Yukon	YUKON-KOYUKUK	Y	D	9620	570	2-Isolated	10
Kaktovik	NORTH SLOPE	Y	E	4400	259	1-Isolated	10
Mentasta Lake	VALDEZ-CORDOVA	Y	C	400	125	Highway	10
Noorvik	NORTHWEST ARCTIC	Y	C	2500	632	1-Isolated	10
Nuiqsut	NORTH SLOPE	N		4400	486	1-Isolated	10
Pelican	SKAGWAY-HOONAH-ANG	Y	C	1600	137	2-Isolated	1
Point Hope	NORTH SLOPE	Y	C	4000	794	1-Isolated	10
Talkeetna	MATANUSKA-SUSITNA	Y	E	3000	363	Highway	10
Tenakee Springs	SKAGWAY-HOONAH-ANG	Y	C	0	93	1-Isolated	10
Unalaska	ALEUTIANS WEST	Y	C	1796	4178	2-Isolated	10
25.00 - 29.99 Points							
Andreafsky	WADE HAMPTON	N		0	442	2-Isolated	11
Central	YUKON-KOYUKUK	Y		0	62	1-Isolated	11
Circle Hot Springs	YUKON-KOYUKUK	N		0	35	1-Isolated	11
Healy Lake	SE FAIRBANKS	N		0	61	1-Isolated	11
Nanwalek (English Bay)	KENAI PENINSULA	Y	D	1774	170	1-Isolated	11
Wainwright	NORTH SLOPE	N		4400	545	1-Isolated	11
20.00 - 24.99 Points							
Anderson	DENALI	Y	E	0	517	1-Isolated	12
Aniak	BETHEL	Y	C	6300	604	2-Isolated	12
Cube Cove	SKAGWAY-HOONAH-ANG	N		0	139	1-Isolated	12
Delta Junction	SE FAIRBANKS	Y	A	0	889	2-Isolated	12
Edna Bay	PRINCE OF WALES	Y	A	0	55	1-Isolated	12
Fox River	KENAI PENINSULA	N		0	439	Highway	12
Gakona	VALDEZ-CORDOVA	N		0	22	1-Isolated	12
Klawock	PRINCE OF WALES	Y	E	6772	673	2-Isolated	12
Klukwan	SKAGWAY-HOONAH-ANG	N		0	136	1-Isolated	12
Mosquito Lake	HAINES BOROUGH	N		0	94	1-Isolated	12
Point Baker	PRINCE OF WALES	N		0	51	1-Isolated	12
Port Clarence	NOME	N		0	22	1-Isolated	12
Prudhoe Bay	NORTH SLOPE	N		0	47	2-Isolated	12
Skwentna	MATANUSKA-SUSITNA	Y	A	0	72	1-Isolated	12
Tok	SE FAIRBANKS	Y	C	7780	1235	2-Isolated	12
Tonsina	VALDEZ-CORDOVA	N		0	47	1-Isolated	12
Willow	MATANUSKA-SUSITNA	Y	A	0	507	Highway	12
15.00 - 19.99 Points							
Adak	ALEUTIANS WEST	N		0	106	2-Isolated	13
Alcan	SE FAIRBANKS	N		0	23	1-Isolated	13
Big Delta	SE FAIRBANKS	N		0	511	2-Isolated	13
Big Lake	MATANUSKA-SUSITNA	Y	A	0	2162	Highway	13
Butte	MATANUSKA-SUSITNA	Y	A	0	2699	Highway	13

*See Appendix III, Page 1

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Chase	MATANUSKA-SUSITNA	Y	A	0	55	1-Isolated	13
Chiniak	KODIAK ISLAND	Y	A	0	75	1-Isolated	13
Clam Gulch	KENAI PENINSULA	N		0	113	Highway	13
Coffman Cove	PRINCE OF WALES	Y	A	0	228	1-Isolated	13
Cohoe	KENAI PENINSULA	N		0	602	Highway	13
Copperville	VALDEZ-CORDOVA	N		0	194	1-Isolated	13
Eyak	VALDEZ-CORDOVA	Y	C	0	162	Highway	13
Fritz Creek	KENAI PENINSULA	N		0	2097	Highway	13
Glennallen	VALDEZ-CORDOVA	N		0	494	2-Isolated	13
Halibut Cove	KENAI PENINSULA	N		0	71	1-Isolated	13
Happy Valley	KENAI PENINSULA	N		0	401	Highway	13
Healy	DENALI	Y	E	0	646	2-Isolated	13
Hobart Bay	SKAGWAY-HOONAH-ANG	N		0	48	1-Isolated	13
Hollis	PRINCE OF WALES	N		0	111	1-Isolated	13
Hoonah	SKAGWAY-HOONAH-ANG	N		2740	877	2-Isolated	13
Houston	MATANUSKA-SUSITNA	Y	A	0	836	Highway	13
Hydaburg	PRINCE OF WALES	Y	C	2967	369	1-Isolated	13
Jakolof Bay	KENAI PENINSULA	N		0	40	1-Isolated	13
Kasaan	PRINCE OF WALES	Y	C	0	48	1-Isolated	13
Kasilof	KENAI PENINSULA	N		0	548	Highway	13
Kenai	KENAI PENINSULA	N		3600	7005	Highway	13
Kenny Lake	VALDEZ-CORDOVA	N		0	507	1-Isolated	13
Kupreanof	WRANGELL-PETERSBG	N		0	24	1-Isolated	13
Lazy Mountain	MATANUSKA-SUSITNA	Y	A	0	1109	Highway	13
Lutak	HAINES BOROUGH	N		0	53	Highway	13
McCarthy	VALDEZ-CORDOVA	Y	A	0	37	Highway	13
Mendeltna	VALDEZ-CORDOVA	N		0	80	1-Isolated	13
Moose Pass	KENAI PENINSULA	Y	A	0	118	Highway	13
Nikiski	KENAI PENINSULA	N		0	3038	Highway	13
Ninilchik	KENAI PENINSULA	Y	C	3202	687	Highway	13
North Pole	FAIRBANKS NSB	Y	A	0	1616	Highway	13
Paxson	VALDEZ-CORDOVA	N		0	30	1-Isolated	13
Primrose	KENAI PENINSULA	N		0	62	Highway	13
Salcha	FAIRBANKS NSB	N		0	387	Highway	13
Slana	VALDEZ-CORDOVA	N		0	55	1-Isolated	13
Sutton	MATANUSKA-SUSITNA	N		0	470	Highway	13
Trapper Creek	MATANUSKA-SUSITNA	N		0	344	Highway	13
Whale Pass	PRINCE OF WALES	Y	A	0	62	1-Isolated	13
Whitestone Logging Camp	SKAGWAY-HOONAH-ANG	N		0	118	1-Isolated	13
0.00 - 14.99							
Alexander Creek	not a census designated place	Y	A	0	59	1-Isolated	14
College	FAIRBANKS NSB	N		0	12122	3	14
Crown Point	KENAI PENINSULA	N		0	91	Highway	14
Ester	FAIRBANKS NSB	N		0	240	Highway	14
Ferry	DENALI	N		0	74	1-Isolated	14
Fox	FAIRBANKS NSB	N		0	332	Highway	14
Harding Lake	FAIRBANKS NSB	N		0	30	1-Isolated	14
Kachemak	KENAI PENINSULA	N		0	419	Highway	14

*See Appendix III, Page 1

PART I - FY 01 PRIORITIZATION SUMMARY

Community (in alphabetical order)	Census Area	FNAQ Submitted by Sept. 1, 2000	FNAQ G1.1*	Existing Space (sf)	Pop.	EMS Level	Group
Kalifonsky	KENAI PENINSULA	N		0	338	Highway	14
Lignite	DENALI	N		0	131	1-Isolated	14
McKinley Park	DENALI	N		0	169	1-Isolated	14
Meadow Lakes	MATANUSKA-SUSITNA	Y	A	0	5232	Highway	14
Moose Creek	FAIRBANKS NSB	N		0	677	Highway	14
Naukati Bay	PRINCE OF WALES	N		0	164	1-Isolated	14
Pleasant Valley	FAIRBANKS NSB	N		0	584	Highway	14
Ridgeway	KENAI PENINSULA	N		0	2382	Highway	14
Salamatof	KENAI PENINSULA	N		0	1122	Highway	14
Sterling	KENAI PENINSULA	N		0	6138	Highway	14
Two Rivers	FAIRBANKS NSB	N		0	660	Highway	14
Womens Bay	KODIAK ISLAND	Y	A	0	675	Highway	14

*See Appendix III, Page 1

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APPENDIX XIII

PART II - CAPABILITY MEASUREMENT

PART II - CAPABILITY MEASUREMENT

Total Point Score = Sum of the Following:

		Maximum Points
1.	Local Support For Project *	0
2.	Site Availability and Control *	0
3.	Utility Extension Plan *	0
4.	Cost Share Score *	20
5.	Service Delivery Plan Score *	10
6.	Business Plan Score *	10
7.	Existing Facility Deficiency Score	45
8.	Comprehensive Facility Development Plan Score	5
9.	Multi-use Facility Score	5
10.	Project Management Plan Score	5
	TOTAL	**100**

* Proposals must meet minimum standards with respect to items 1 – 6 in order to be considered for funding. Proposals that do not meet the minimum standards for these elements will be set aside and a recommendation made to the community that they seek technical assistance to develop more capability. If a proposal does meet the minimum standards for all six elements, then it will be further evaluated and points awarded based upon the quality of the submitted documentation.

LOCAL SUPPORT FOR PROJECT

Have all the necessary resolutions of support from local and regional organizations been passed? YES or NO

SITE AVAILABILITY AND CONTROL

Is there legal control of the proposed project site? YES or NO

UTILITY EXTENSION PLAN

If utility and transportation extensions of greater than 150 feet are required to develop the proposed site, has funding been identified for this additional infrastructure? YES or NO

COST SHARE

Description: In accordance with the authorizing language for the Denali Commission, minimum project cost shares are required based upon the economic conditions in a community. Communities categorized as economically distressed have a required cost share of 50 percent and communities that are severely economically distressed have a required cost share of 20 percent. The Denali Commission will prepare a list of what the cost share requirement will be for each community eligible for rural primary care facility funding. If an applicant does not have the minimum cost share available, then the project will not be funded.

Evaluation: Proposals should identify the amount of community and other non-Denali Commission contributions that will be applied to the project. For cash contributions or other grants, specify whether funds are immediately available or whether they represent a future anticipated commitment (e.g. HUD CDBG). If a future commitment, indicate whether the project would be viable if those funds do not become available.

Proposals meeting the minimum criteria will be scored based on the extent of non-Denali Commission resources available for the project according to the following table. In-kind contributions other then land will not be considered as a part of the cost share.

Community Cost Share		Points
Economically Distressed Community (%)	Severely Distressed Community (%)	
50.00*	20.00*	0
51.25	22.00	1
52.50.	24.00	2
53.75	26.00	3
55.00	28.00	4
56.25	30.00	5
57.50	32.00	6
58.75	34.00	7
60.00	36.00	8
61.25	38.00	9
62.50	40.00	10
63.75	42.00	11
65.00	44.00	12
66.25	46.00	13
67.50	48.00	14
68.75	50.00	15
70.00	52.00	16
71.25	54.00	17
72.50	56.00	18
73.75	58.00	19
75.00	60.00	20

*minimum requirements

SERVICE DELIVERY PLAN

Description: It is essential that new or expanded primary care facilities provide services that match the needs of the community, and meet the health program goals as recommended in the Final Report. Proposals must include documentation showing that the completed facilities will have an open door policy and score at least 6 overall points on this criteria. Proposals that do not meet these requirements will not be funded.

Evaluation: Proposals should contain a comprehensive, written service delivery plan that addresses population served, services, staffing and operational policies. State whether the completed facility will fully meet accreditation requirements. The applicants' ARPCFNA questionnaire will be reviewed as background information in evaluating the service delivery plan. Points will be awarded based on the criteria summarized in the following table.

SERVICE DELIVERY PLAN ELEMENTS	POINTS
Population Served • Identification of numbers of people served currently • Increases or changes in services anticipated with new / renovated facility • Population to be served in comparison to program and space guidelines presented in Final Report	**0 - 3**
Services • Services provided currently • Services to be provided with new/renovated facility • Services provided according to Final Report guidelines per facility size and population size • Level of service(s)	**0 - 3**
Staffing • Staff providing services currently • Staff anticipated in new/renovated facility • Staff employed compared to Final Report program guidelines	**0 - 2**
Service Delivery Policies and Agreements • Open door policy on seeing patients* • Referral agreements established	**0 - 2**

*minimum requirement

BUSINESS PLAN

Description: The capability to sustain a primary care clinic is dependent upon adequate funding and strong financial management practices. Proposals that do not score at least 6 points on this criteria will not be funded.

Evaluation: Proposals should contain a comprehensive, written business plan that addresses funding, operations, administration, and community support. The applicants' ARPCFNA questionnaire will be reviewed as background information in evaluating the proposed business plan. Points will be awarded based on the criteria summarized in the following table.

BUSINESS PLAN ELEMENTS	POINTS
Funding Status • Cost share for new facility • Current financial status • Sources of revenue, funding / income for the clinic • Projection of sources of funds to operate the facility after it is built • Plans for long term financial sustainability • Billing for Medicaid, Medicare, Tricare, private insurance and other sources	**0 - 3**
Clinic Administration • The organization that will administer the funding for the new / renovated clinic • Projected administrative staff for new/renovated clinic • Policies and procedures manuals • Quality of care, quality assurance procedures • History of providing care efficiently and effectively • Board of directors or other oversight body	**0 - 3**
Facility Operations • Budget for operating the current facility • Projected budget for operating new / renovated facility	**0 - 2**
Community Support • Resolutions and other documents that indicate community support • No adverse competition is created with private practices in the community • Evidence of community support through participation on boards • Description of the sources and commitment of funding for the cost share	**0 - 2**

EXISTING FACILITY DEFICIENCY

Description: The condition of building systems (structural, mechanical, electrical), energy management issues, handicap access, site / environmental conditions, compliance with fire / life safety codes, and space / floor plan issues all impact the ability to provide quality care in any facility.

Evaluation: Existing facilities will be evaluated via an in depth, on-site code and condition survey. The resultant information will be used to update the Part I Facility Deficiency score. These surveys will be performed by architects and engineers (A&Es), licensed in the State of Alaska, who are fully knowledgeable about life/safety/building codes and compliance issues associated with rural primary care facilities. The Denali Commission, or its agent(s), will hire the A&Es to perform these surveys. With Commission approval, individual communities, and/or their representatives, may directly contract with A&E firms to collect the necessary information. On-site surveys completed by individual communities must follow guidelines developed by the Commission and the results submitted for review by the Commission or its agent.

If it is determined that the facility is in much better condition than indicated in the FNAQ, the Commission reserves the right to revise the community's Part I score. This could lead to the community and the proposal being eliminated from any further consideration for funding.

While the specific Part II scoring criteria have not yet been developed, it is anticipated that they will be very similar to the criteria used in Part I.

COMPREHENSIVE FACILITY DEVELOPMENT PLAN

Description: The Denali Commission encourages community wide planning efforts. Since health clinics are an essential part of a community's overall infrastructure and services it is expected that proposed health facility projects would be addressed in existing community wide development plans.

Evaluation: Comprehensive community development plans that are submitted with a proposal will be reviewed to determine if the proposed project is consistent with the overall plan. A maximum of 5 points may be awarded based on this review.

MULTI-USE FACILITY

Description: Combining appropriate, but separate, services and programs in one building can result in operation and maintenance efficiencies. For example, a structure that houses both a community washeteria and a clinic can save heating costs, as well as reducing the capital cost of water and sewer connections to the clinic space. Head Start and other health care related services are also good examples of services that might be co-located in the same building. Of course, joint occupancies must make operational sense and not create significant conflicts for any of the programs or uses.

Evaluation: If there is a joint use aspect of the project, the proposal should include a written description of the multi-use facility / campus concept and summarize how the combined use enhances the performance of the structure and the delivery of primary care services. Only the clinic portion of the multi-use structure is eligible for Commission primary care facility funding; the balance of the building must be paid for from other sources. Up to 5 points may be awarded for this element based on the following table. Points are not additive, i.e., proposals will be assigned to one of the following categories.

PROJECT DESCRIPTION	POINTS
No significant multi-use aspect to the project.	0
The clinic facility is located in a central campus area to take advantage of improved and/or lower cost utility service, and/or to generally improve community access to primary care services.	2
25 to 50 percent of the structure (square footage basis) is occupied by other than the primary care clinic in an appropriate manner.	3
Over 50 percent of the structure is occupied by other than the primary care clinic in an appropriate manner.	5

PROJECT MANAGEMENT PLAN

Description: Having a well organized management plan that addresses both design and construction phase activities is essential for the successful completion of a project. The Commission encourages the development of such written plans.

Evaluation: Proposals should include a project summary document with a scope of work (new facility, replacement facility, expansion of an existing facility, or modernization / renovation of an existing facility), overall budget, schedule, design drawings (if available), summary of proposed contracting procedures, and an outline of the management team that will coordinate the project. Also describe the standards used in developing the plans (e.g. the IHS Health Facilities Planning Manual, the AIA Guidelines for Construction and Equipment of Hospitals and Medical Facilities, etc.) and other construction standards that will be followed (e.g. Uniform Building Code). Provide environmental review documentation and approvals, permits, etc. if available. Project Management plans that are submitted with a proposal will be reviewed to determine how well organized the project is and the status of all relevant project documentation. A maximum of 5 points may be awarded based on this review.

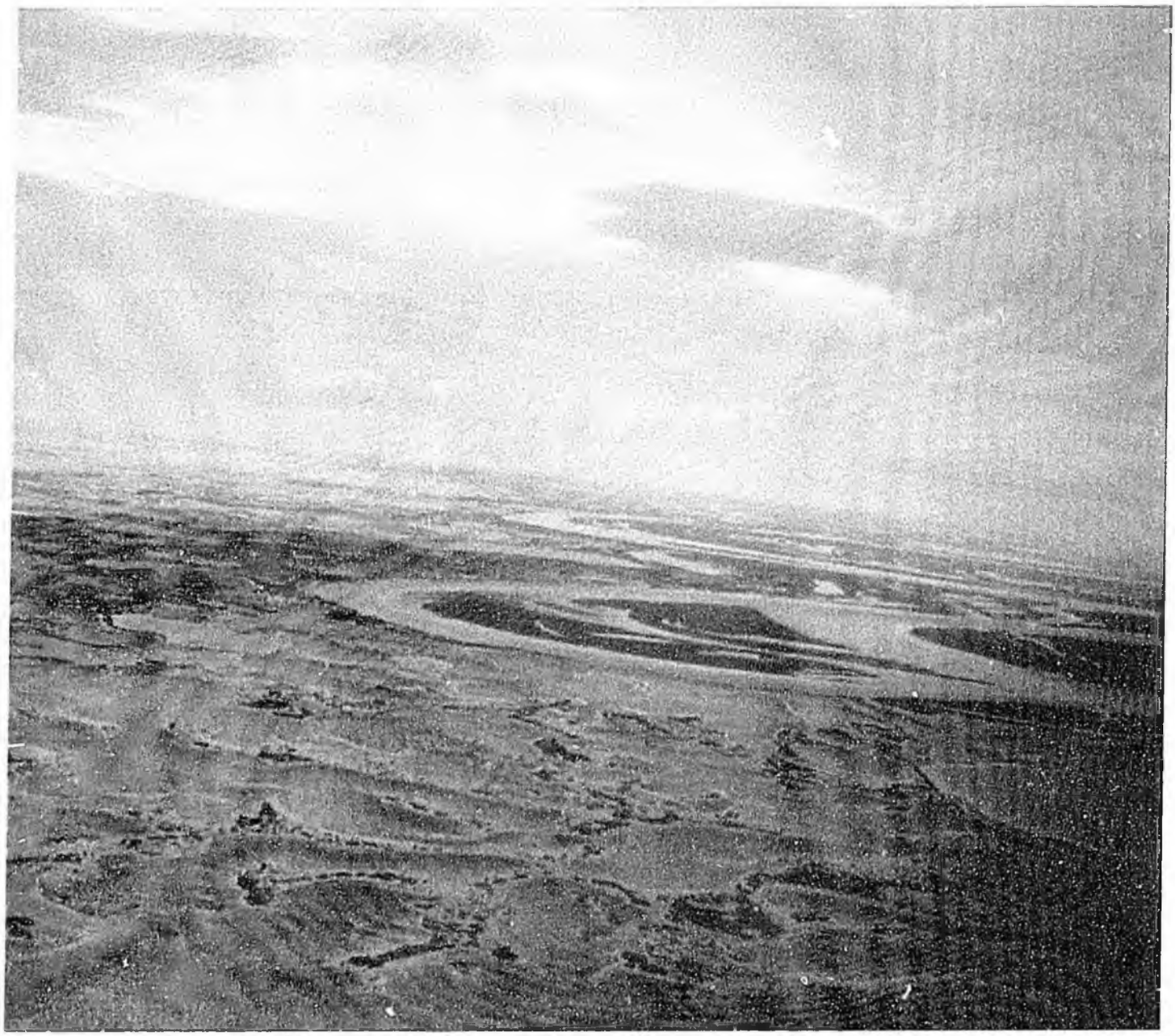
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Delivery Order 00-D-0297







Impacts of Health Care BRU Reallocations In Bush Alaska

Report to the Alaska State Legislature

Yukon-Kuskokwim Health Corporation

April 4, 2001

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Yukon-Kuskokwim Health Corporation

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SENATE FINANCE SUBCOMMITTEE PROPOSAL GRANT TRANSFERS & REDUCTIONS

The current Senate Finance Budget Subcommittee proposal (3/28/01) would eliminate the following grants:

• Human Services Community Matching Grants:	NOT ELIMINATED
• Maniilaq Designated Grants:	-$3,045.3 (all GF)
• Norton Sound Designated Grants	-$2,357.2 (all GF)
• SEARHC Designated Grants:	-$ 565.7 (all GF)
• Kawerak Social Services:	-$ 372.7 (all GF)
• Tanana Chiefs Conference Grants:	-$1,255.1 (all GF)
• Tlingit-Haida Designated Grants:	-$ 198.5 (all GF)
• Yukon Kuskokwim Health Corporation Grants:	-$2,742.2 (all GF)
TOTAL	-$10,536.7

All of these grants are for direct public health, substance abuse, mental health, social services or child protection services in their respective regions. These grant programs have existed in the state budget for almost 20 years and were established because of special circumstances or because of the lack of competition in these regions.

The budget proposal would transfer all of these grants to competitive grant programs such as Alcohol & Drug Abuse Grants or General Community Mental Health Grants. However, the transfer is not a net zero! The "transfer out" in elimination of these grants totals $10.5 million in state general funds and the "transfer in" to competitive grants totals $9.7 million in state general funds or a total cut of $800 thousand (see attached). This is a CUT of 8% of the transferred amount.

What does this mean for competitive grant programs? If these reductions are maintained and all of the designated grantees compete against existing grantees for fewer funds it means the following:

- Family Preservation grants will have to be cut by $148.4 a cut of 4%. These grants provide supports for safe and stable families to promote family reunification and provide such services as parenting classes.
- Community Health Grants would have to be cut by $359.4 a cut of 8%. Normally these grants support health clinics, provide training and support local programs aimed at reducing youth smoking.
- Alcohol & Drug Abuse grants would have to be cut by $326.0 a cut of 2%. These grants provide alcohol treatm and prevention funds statewide to a variety of non-profits.
- Community Mental Health grants would have to be cut by $5.0 a cut of less than 1%. General Community Mental Health grants assist many mental health grantees in serving those that do not qualify for Medicaid or other insurance.

PREFACE

Why the Budget Request Unit makes sense

Chris Bragg, Community Services Finance Administrator, Yukon-Kuskokwim Health Corporation.

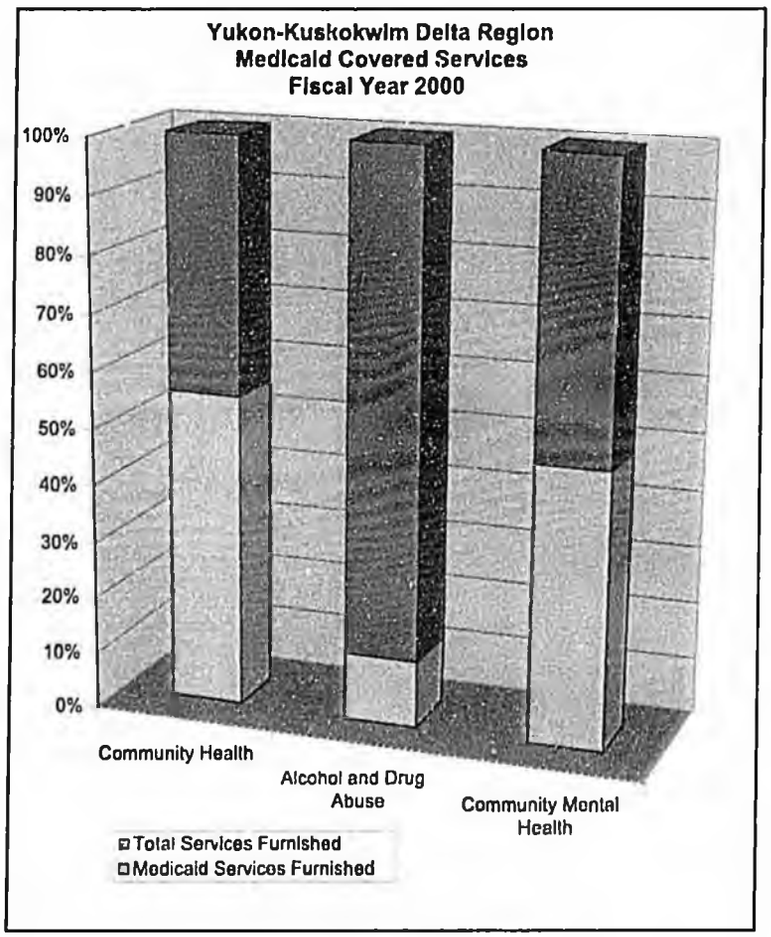
This health corporation provides almost 100 percent of the primary care, hospital, home care, mental health, and substance abuse services for the 25,000 people in an area of 80,000 square miles with no road access at all.

We enjoy the challenges of life here and have spent the last several years moving services from the hub community of Bethel to outlying villages for residents of the region to be able to access services as close to home as possible.

The state of Alaska has been a partner in this venture by providing resources through the BRU and other grant programs and helping to increase access to **Medicaid coverage.**

Medicaid now pays for 55 percent of community health visits, 12 percent of alcohol and drug abuse visits, and 48 percent of community mental health visits.

BRU funds are key to providing service for the visits Medicaid doesn't cover:
45 percent of community health visits, 88 percent of alcohol and drug abuse visits, and 52 percent of community mental health visits.



The BRU at the Yukon-Kuskokwim Health Corporation funds portions of many important services

- **80 percent of our Health Aide supervisor/instructors**
- **80 percent of the EMS instructors for the region**
- **50 percent of the region's Injury Prevention specialists**
- **14 village based counselors (to serve 35 villages)**
- **2 of 6 mental health clinicians**
- **Three days a week of Bethel Alcohol Safety Action Program services**
- **Residential crisis respite services**
- **Substance abuse treatment services.**

At this point, our service area still does not have reasonable access to all necessary health services, and lacks sufficient funds to provide a complete package of basic services. The Yukon-Kuskokwim Health Corporation works diligently to obtain funds to supplement the BRU and increase the level of service available.

It should be noted that BRU recipients must meet the same requirements and standards as grantees who participate in the competitive process elsewhere. Legislative allocations to rural areas assure that citizens of these areas receive the services the state is required to provide. *It simply makes sense to eliminate the incredible administrative effort and cost associated with the competitive process in areas served by only one health provider.*

At least 30 percent of the patients now receiving treatment will not be able to participate in treatment farther away from home. Untreated mental illness and alcoholism, as we all know, have huge costs to the people involved and cost the state huge sums in law enforcement, corrections facilities, child protection, and medical expenses.

Eliminating BRU funds will have several undesirable results.

Grant reductions stemming from the elimination of BRUs and reallocation of only a portion of those BRU funds into the competitive grant process are bringing the state precariously close to non-compliance with maintenance of effort requirements for federal substance abuse block grant funds. The state is at risk of losing federal funds for substance abuse, which will further reduce substance abuse funds available to all residents of the state.

Health corporations that receive BRUs also actively seek other funds, and the lack of BRU funds will directly and negatively impact their ability to receive additional federal funds for which they might otherwise qualify.

Thus, the state will lose funds, all residents of the state will experience a reduction of services as state funds are lost, and residents of remote regions will lose services again as the health corporations' ability to obtain federal funding on their own is reduced due to the BRU elimination.

Reducing counseling services and bed days available, or closing residential facilities due to reduced funding, will require individuals experiencing mental health crisis to travel from this region to Alaska Psychiatric Institute (API), four hundred miles away. Individuals requiring residential substance abuse treatment will need to go to treatment facilities in Dillingham and Anchorage. These communities now accept the occasional referral, as all treatment facilities do: they are by no means prepared to take on the patient load related to closing an entire facility.

Our Crisis Respite Center and Community Support Program between them divert 1,400 Alaska Psychiatric Institute patient days per year. At a cost of $1,000 per day, this is equivalent to $1,400,000 in hospital costs, and additional expense for transportation. Our residential substance abuse treatment program provides between 3,000 and 4,000 treatment days per year, and village based counselors provide treatment equivalent to many additional days. Eliminating funding for the facility and rural counselors will require care in Anchorage, which we estimate to cost $1,125,000, plus transportation (if bed space is even available!)

We would be able to offer only minimal Community Health Aide supervision outside of hospital based physicians. Replacing Health Aide Supervisor/Instructors with physicians at triple the salary cost is not an effective solution to budget woes. Injury Prevention and Emergency Medical Services both save lives each year. Loss of these services will obviously decrease over time the number of children and adults who can swim enough to get to safety after a boat capsizes and decrease the number of people in villages who can make a difference in a life threatening emergency.

You can't put a dollar value on loss of life, but you can put a dollar value on air ambulance costs, critical care unit days that result from serious injuries and delay in treatment due to lack of trained response personnel, and the cost of state custody of children without capable parents.

BRU cuts will cost the State more, not less

Sandra Mironov, Behavioral Health Administrator, YKHC

To cut services in under-funded programs working to meet the needs of under-served communities doesn't add up.

To move the funding of the Budget Request Units to the competitive grant cycles in the State Divisions of Mental Health and Alcohol and Drug Abuse puts Rural communities at an unfair disadvantage. Funding for grant writers is not available and if it were available the expertise writing competitive grants just isn't there for the Bush providers. Currently, grants that are written have to be done by direct service providers. When providers have to write and submit grant proposals valuable time is lost to services. Again, the capacity to develop competitive grants is not available.

When dealing with large caseloads in under-funded programs it is nearly impossible to further burden service providers with another responsibility such as grant writing.

Any loss of services to Bush communities will mean a direct shift of clients to urban areas of the State where services are available. Costs of transportation to get clients to services will increase dramatically. Services will revert to being provided on a crisis basis which makes them more costly than locally provided early intervention services. Thus, increased costs are shifted to the State to fund transportation and urban agencies providing services.

Finally, people will not seek treatment until they reach an emergency state because they do not want to leave their communities, families and culture. Forcing individuals into a foreign environment to obtain necessary care will significantly increase their risk for poor outcomes.

In an era when access to healthcare services are the hallmark of the provision of good care, any cuts to Budget Request Unit funding and any shift to move this funding from Budget Request Units to competitive grant cycles will deny some rural Alaskans access to essential care.

BRUs were established 20 years ago to meet the needs of under-served Alaskans. While some services are now available in the Bush communities, current BRU funding levels address only about one third of the level of the need.

The BRUs were designed to provide some funds for providers in largely rural areas where services would not be available without additional support.



Concerned citizens gather at the Bethel Legislative Information Office to testify in opposition to BRU cuts.

BEHAVIORAL HEALTH SERVICES

Regional Alcohol and Drug Abuse Services

Current BRU request $293,383

Community Support Program

Current BRU request $402,086

These portions of the YKHC BRU partially fund the Village Services component of the Behavioral Health Services.

Impacts of Proposed Cuts –

- **Only 22 of the more than 50 villages in the Y-K Delta have at least one counselor.**

  Any funding cuts to this program result in villages no longer having counseling services available.
- **Increased transportation costs to get people to Bethel or Anchorage for services.**
- **Increased out of village crisis calls due to no counselors available to assist village residents in times of life crisis.**
- **Loss of culturally competent services.**

Master's level Village Clinicians provide required supervision to village-based counselors.
YKHC now employs 5 FTEs for Village Clinicians. Our BRU Community Support Program (CSP) funds pay for two thirds of one FTE for a Village Clinician.

Village Wellness Counselors provide immediate response to those in need.
Interventions include crisis intervention, assessments, outpatient counseling and aftercare. Wellness counselors serve people close to home, eliminating the disruption and cost of frequent trips to Bethel. Populations served include all adults and children in the region who are displaying symptoms or behaviors which may be life-threatening to themselves or others, or creating disruption in their daily functioning.

Our BRU CSP funds pay for six Village Wellness Counselors. BRU Regional Alcohol and Drug Abuse funds pay for seven counselors.

Elder Counselors and Traditional Counselors work in coordination with Village Wellness Counselors to provide traditional counseling services and consultation to clients and their families.
Elder and traditional counselors receive this designation through recognition in their community and the State of Alaska for their life-long participation in helping their communities practice healthy lifestyles.

Our Budget Request Unit pays for three Elder Counselors.



Testimony:

Oscar Active, Village Services Field Supervisor

I just got word that the legislature is thinking of cutting some money from the substance abuse fund. If that happens it will hurt the programs that are trying to help the people. That's like telling me to go and save a hundred people that are drowning with a little boat or skiff. We can only do so much with what little we have. What do I tell the people that I can't save right now; Hold on I'll make another trip? How many do you think will drown before I can come back? Or it's just like teaching someone how to fly and half way through his program I tell him I have no more money, you need to learn the rest your self. How far do you think he'll get before he crashes?

Testimony: Sandra Kleven
Rural Human Services Coordinator, YKHC


Sandra Kleven.

Over the course of the last 20 years, the Yukon-Kuskokwim Health Corporation has carefully nurtured the growth of village-based counselors. At present, 30 counselors serve the 54 villages of the Yukon-Kuskokwim Delta. Out in the Bering Sea on the Island of Mekoryuk, Sam Smith has worked for all of those 20 years meeting the needs of his people.

In Emmonak, Virginia Moore has been working for more than six years. In Alakanuk, Priscilla Edmund has just begun her career in human services. In Akiak, Andrew Jasper serves the people with many years experience and hard won expertise. These counselors and others like them intervene when there is threat of suicide. They assist when those with mental illnesses experience episodes of acuity. They help families and individuals hurt by alcohol abuse. They help with healing and they help to promote the self-determination of Alaska's Native people.

With the BRU cut, positions will be eliminated. The impacts are many:

- *Village residents will fly to Bethel to see counselors at great expense and inconvenience.*
- *We will lose trained village response to suicide threats.*
- *When the jobs are cut, village economies will be affected.*
- *Careers in human services will be interrupted.*
- *Academic progress will be halted as most village counselors are also students of the University of Alaska Fairbanks, College of Rural Alaska, Rural Human Services program and Human Services Technology.*
- *Village development will be affected because village counselors are "community" helpers, educating and organizing.*

The village-based counselor program developed to replace the dependency on outside professionals. A constant stream of individuals hired from outside Alaska passed through our region. The average stay was usually two years. Some were excellent professionals, some were not, but eventually most were gone, taking with them skills honed in the region.

When we began to train local people the result was permanence. Locally recruited and trained counselors stay in the regions where they have homes and families. They make a permanent contribution to the well-being of the people. This "rooted in place" quality amplifies the impact when jobs are lost. When the counselor's job is taken away, the "counselor" is lost to the field. They are left struggling to find work among the small number of village jobs, perhaps as a school cook, janitor, or secretary. There are no alternative counseling jobs in villages.

Cutting the BRU moves us backwards and, worse, takes away something valuable and hard won. For 20 years, we have moved toward self-determination and culturally appropriate helping services, in a region that tops all statistical charts in measures of pain and suffering. Now we risk a major loss to a program that has demonstrated effectiveness. With this proposed cut the village counselors are undermined and the villages are left, once again, to silent struggles with trauma, hurt and loss—and the effort, 20 years in the making, to build a village based support system is decimated. When I think of the dedicated counselors who, by and large, work alone in their villages, I can't help but ask, who is going to tell them they have lost their jobs?

Phillips Ayagnirvik

Current BRU request $604,937

Impact of Proposed Cuts

- **Immediate decrease in treatment days available.**
- **Increased transportation costs to access services in Anchorage or beyond.**
- **Increased wait times for the reduced treatment days available.**
- **Decreased motivation to enter treatment due to increased waits.**
- **Increased incidence in domestic violence and child abuse due to persons not entering treatment.**
- **Loss of culturally competent programming**



Phillips Ayagnirvik currently offers 4032 treatment days annually to the people of the Y-K Delta.

Phillips Ayagnirvik is a residential treatment and recovery program for adults suffering from the disease of substance abuse.
Treatment services involve individual, group and family dynamics education. The program strives to develop culturally responsive individual treatment plans and activities that are proactive and emphasize relapse prevention.

90 percent of the Phillips Ayagnirvik operations money is funded by the Budget Request Unit.

Bethel Alcohol Safety Action Program

Current BRU request $ 35,000

Impact of Proposed Cuts

- **Decreased days ASAP assessments or case management are available.**
- **Increased burden on courts to case manage clients.**
- **Increased risk of repeat offenses while awaiting treatment services.**

This program screens court referred clients and monitors treatment programs for compliance for clients who have current misdemeanor charges against them within the State of Alaska.

Our Budget Request unit currently funds one position for th. :e days per week.

Youth Substance Abuse

Current BRU request $ 25,980

Impact of Proposed Cuts –

- **Decrease in counselor services to provide assessment and aftercare.**
- **Longer waits to get into treatment due to lack of counselors to do assessments and assist with processing treatment applications.**
- **Increased risk of relapse due to no aftercare services.**

Youth may receive an assessment of their treatment needs in a village by a Village Wellness Counselor or in Bethel by either a Complex Care Manager or Assessor. If they are referred out of the region for treatment services, upon return home they will receive follow-up services from a Village Wellness Counselor or an Aftercare Counselor in Bethel.

Our Budget Request Unit funds 50 percent of one part-time counselor position.

There are no residential treatment centers for YOUTH in need of substance abuse treatment in the Y-K Delta.

Community Mental Health

Crisis Respite Center

Current BRU request $339,652

Impact of Proposed Cuts

- **Decrease in days Crisis Respite Center could be operated.**
- **Hospital admission at API for five clients per day during all days of shut down.**
- **Loss of culturally competent programming.**

Crisis Respite Center (CRC) is a program that provides emergency support services for individuals experiencing a life crisis so disruptive it cannot be managed in an outpatient setting.

CRC provides evaluation, treatment, and referral in a voluntary setting for those individuals needing to be monitored and protected. The program also works closely with the Alaska Psychiatric Institute (State Hospital) for treatment that is not available locally. *The alternative setting provided by the Crisis Respite Center, while ensuring the client's needs are met closer to their home community, can also ensure the client's needs are met in a culturally sensitive manner.*

Our Budget Request Unit funds 90 percent of the operating budget of the CRC.



The current Crisis Respite Center opened in 1998 (YKHC file photo).

Populations served by CRC include all adults in the region who are displaying symptoms or behaviors which may be life threatening to themselves or others, or creating such disruption in their daily functioning that intensive interventions, including out of region or out of state placement, is imminent.

Testimony: Harry Nicholai

When I was in oppression and didn't know where to turn to. There was the CRC waiting for me after I had spent two to three days in the ER at the hospital. There was lots and lots of peace and quiet and there were people there for me. People just being there helped me to regain confidence in myself. During the time that I spent at the Crisis Respite Center.

The Bethel Mental Health was there when I needed somewhere to live and when I had needed to get Teeth. They helped me and now with these new Teeth I have a more positive attitude for myself. I can now go forth with these positive helps that have happened for me through their influence in my life.

So, in my response to the question at hand: Should the Mental Health/recovery program working together to restore the lives of those that have been held in oppression by the addiction of Alcohol should be kept here in Bethel, because of its vicinity to those of the nearby villages.

Harry Nicholai



Harry Nicholai

Emergency Services

Current BRU request $127,635

Impact of Proposed Cuts

- **Decreased capacity to respond adequately to crisis calls.**
- **Complex Case Management availability would be lost.**
- **Increased risk of completed suicides due to response times increasing.**

Emergency On-Call Responders. Emergency Services Clinicians (3) and Complex Care Managers (3) are available 24 hours a day to respond to behavioral health crises.

The Clinicians are Master's level prepared in Human Services with both experience and specialized training in the fields of Mental Health and Substance Abuse Treatment. The Complex Care Managers are experienced counselors whose specialty area is working in the field of Substance Abuse treatment. The Emergency On-Call Response Team is available 24 hours a day.

Our Budget Request Unit funds 1.2 Clinicians for Emergency Services.

Testimony: Steven Jumbo

My name is Steven Jumbo and I want to say a few things about API. Maybe lots of things. I was there the first time and I didn't like it. I missed my parents; my parents took me over, both of them. One thing I dislike about API is that they batter people around there. Many times I was locked up in the quiet room, completely out of harm's way because I was trying to hurt myself. I don't know how it is now-a-days. I haven't been there in ten years. I haven't been there in ten years because I have been getting support from YKHC program. Doctors in Bethel are significant, smart and reliable. In Bethel, I am in the big world. I can get my services in a place that is homey. I am not locked up. I am close to my home village. I can come and go as I please. Patients in API don't know what they're doing, they're locked up in there. They don't have any choices, they're stuck in a small world there. Please don't cut money for programs out here. People out here need them and benefit from them.

Sincerely,

Steven Jumbo



Steven Jumbo.



People gather to offer testimony in Bethel in regards to proposed funding cuts.

General Mental Health Services

Current BRU request $ 38,027

Impact of Proposed Cuts

- **Fewer service eligibility determinations due to decrease in provider hours.**
- **Increased risk of crisis development due to lack of any early intervention services.**

Psychiatric Services

The Yukon Kuskokwim Health Corporation employs three **psychiatrists** on a part-time basis. They provide regional psychiatric services by holding specialty clinics in Bethel, as well as traveling to villages as often as 90 times per year to see clients closer to home. Further, YKHC employs a **full time Mid-Level Practitioner** located in Bethel to perform psychiatric interventions and medication management for clients region-wide.

Psychological Services

YKHC employs a **Licensed Clinical Psychologist** who provides psychometrics and interpretive reports to assist in the provision of comprehensive diagnostics to specific clients in the region.

Children's Specialty Diagnostic Services

Clinicians work directly with children to ensure appropriate diagnosis, particularly when multiple contributing factors (including abuse issues, FAS/FAE) must be considered.

Outpatient Counseling Services

are available in the regional clinic as well to supplement services especially to Bethel residents.

Our Budget Request Unit for General Mental Health Services currently funds 1/3 of a Mental Health Professional Clinician position.

Testimony: Sarren Fred Weston

Dear Sirs:

I would appreciate it if mental health services would be conducted here in Bethel than in Anchorage. I prefer to speak to doctors in person than having to call them on the telephone or something. Having services here in Bethel keeps my medications up to date and current.

Sarren Fred Weston



Sarren Fred Weston.

Testimony: Rose Ashepak

Hello,

My name is Rose Ashepak. We need more mental health counseling in Bethel. I think they need more anger management counseling. I am consumer of services. How would I get my medicine if they move it to Anchorage? It would be hard.

It is better to have a program here than in Anchorage. Other patients from villages might have a hard time.

Rose Ashepak



Rose Ashepak.

VILLAGE OPERATIONS

Health Aide Training & Supervision

Current BRU request: $615,500

Supervision is an essential component of the Community Health Aide Program. Supervisor Instructors (SIs) help to assure the quality of village-level health care, monitor job performance, and provide guidance and support. This is critical due to the innate isolation of this rural program.

The Health Aide's overall job performance is monitored by the field SI. The SI ensures that corporate policies are implemented and maintained, and that safety and compliance issues are met.

There are three critical components to field supervision:

- **Administrative:** Recruit and train health aides, evaluations, schedules, policies, regulatory compliance with CLIA, OSHA, JCAHO.
- **Clinical:** Post session learning needs, evaluations, quality assurance, medico-legal issues.
- **Psychosocial Support:** Critical incidence stress debriefing.



Health Aides meet with their Supervisor/ Instructor in Mountain Village.

Since 1991, the need for field supervision has dramatically increased. There has been an increase in the number of people requiring supervision while the number of SIs has remained virtually the same.

Presently, the ratio of villages and health aides to field SIs is so high that none of the essential components of supervision is being well attended. SIs report that they are doing too many things, causing the quality of each to suffer. It is difficult to prioritize the choice between meeting mandatory federal regulatory standards, keeping up with the health aides' medical training and providing emotional support to a health aide who has just responded to an emergency. If there are not enough health aides to staff the clinic, the supervisor must go to work in the clinic, or the clinic is forced to close, leaving the village with only emergency response medical care.

The BRU currently funds eight SI positions. Each SI supervises 5 - 6 villages and 22 village-based health aides. A 25 percent reduction in funding would mean an increase of two villages and 10 or more persons to supervise.

A cut in funding would be a devastating blow to the Community Health Aide Program's infrastructure. There are no variables to eliminate the distance and isolation that these health care providers practice under. Funding resources must be adequate so that those living in rural Bush Alaska may have safe, consistent health care.

An optimal number of Supervisor/Instructor visits to each clinic would be four per year. If each SI had four villages, this schedule would require a minimum of 16 weeks of travel per year. In 1991 the CHAP In Crisis document stated that no SI should supervise more than 12 health aides. Presently, each SI supervises 22 - 26 health aides.

Testimony: Balassa Larson
Supervisor / Instructor


Balassa Larson.

My name is Balassa Larson, I am one of the Supervisor/Instructors (SI's) for the village Health Aide Program on the Yukon-Kuskokwim Delta. Before I became a supervisor I was a Community Health Practitioner in the village of Oscarville for nine years. I have been an SI for five years now.

Community Health Aides provide primary care to whoever seeks their assistance, be it an emergency, acute or chronic illness. Health aides are the first responders the community looks up to when in need of health care. When the health aides need assistance they call their SI.

My role as a Supervisor/Instructor is to provide immediate supervision to village based CHA/P. Supervision is a crucial component of the Community Health Aide Program. The YKHC Supervisor/Instructors supervise 47 villages with an approximate total of 200 health aides. We travel to our assigned villages at least twice a year to provide on-site observation. Without on-site observation we would not be able to assess the competency of health aides and evaluate their performance. Without knowing the competency of our health aides we would not be able to assure that quality health care is being delivered at the village level.

At present I am assigned to six villages and have direct responsibility for the clinical and managerial practice of 24 health aides. If there was a reduction in the BRU grant, our department would lose funding for two of our eight funded SI positions. I would be left to supervise eight or more village clinics and from 33 - 40 health aides. There are not enough hours in the day to perform all of the essential tasks it would take to do this.

Emergency Medical Services (EMS)

Current BRU request: $231,114

Impact of Proposed Cuts

The BRU grant accounts for 80 percent of funds for the EMS Regional Training Center, which provides training for all the health aides in the Yukon-Kuskokwim Delta, as well as...

- **CPR training for construction crews and fish processors**
- **44-hour-long First Responder training for high school students**
- **Advanced courses for the fire departments in the region.**

We are very careful with expenditures because we know that each person we can get training to will most likely need that training in the trauma-plagued life of rural village Alaska. The EMS system statewide is no different. We all work together to share our knowledge and equipment.


Students learn how to perform the abdominal thrust choking prevention technique with EMS instructor Bill O'Brien.

The proposed change to the funding of the BRU will impact us in two major ways.

1. We will be less sure of our funding and our funding amounts will be lower; we will not be able to establish the programs that require multi-year efforts.

Training is an activity that pays off very well in the long run, but is hard to demonstrate in the short run.

Many of our state dollars are magnified by a match to Federal dollars at a 3 to 1 ratio. A $100,000 cut is actually a $400,000 cut to the program.

If we suffered a 25% reduction in the BRU for EMS training in Bethel in this last year alone we would have 291 fewer people knowing CPR and Medic First Aid. We would have a dozen fewer advanced trained medical technicians.

2. Making the grant process competitive will undermine the statewide sharing among the EMS regions.

For instance, it is nearly impossible to compare the relative importance of a particular communication tool between Interior Alaska and Coastal Alaska. They use repeaters on mountains, we use VHF radios on snow machines.



EMS trains all the health aides in the YK Delta in emergency response.

A reduction in funding would mean we will have to divert funds from active programs to additional administrative overhead.

Testimony: John Dickens

I am an EMS Instructor with YKHC, a volunteer state certified Structural Firefighter, and an EMT2 with the Bethel Fire Dept. I am also a member of Bethel Search and Rescue and a sworn member of the Bethel Public Safety and Transportation Commission. I first became an EMT when I was 18. I went on to many years of active and reserve service in the US Coast Guard in Alaskan waters.



Bethel Firefighters benefit from YKHC's EMS training.

I must respectfully ask you to reconsider your attempt to cut the BRU Grant, to do so will literally be measured in large amounts of blood and tears. In my 30 years in Alaska I have never seen a greater need to support Emergency Medical Services and Injury Prevention, and all the other vital life or death activities that is the BRU than right now.



John Dickens.

So far this month I have responded to over 30 ambulance runs here in Bethel, everything from assaults involving deadly weapons, attempted suicides, to motor vehicle crashes. This month I helped teach over 130 7th and 8th graders CPR. I taught 11 Village Health Aides and one volunteer firefighter a 160-hour EMT course. Every one of my EMT students told me tales of trauma and sorrow that would freeze your blood! The people my partners and I train use the skills to save lives. Our office used to have six people, now we have four. By cutting the BRU Grant we will have only three instructors to serve over 25,000 people!

Try to imagine what it feels like to be a young woman treating a gunshot wound victim in the

bottom of an aluminum fishing boat, or a young mother doing CPR on her best friend's father while praying for the medevac aircraft to arrive. Please try and visualize yourself as a Village Health Aide doing an emergency childbirth at a clinic 100 miles from the nearest hospital. Or what it's like to have someone die in you arms because you lack the training to help him or her!

Please ask yourself, how your constituents would react if you told them that no EMS training is available. How would you feel if you or your loved ones suffered or perished because there were no trained responders in your area?

Times are hard and are going to get a whole lot harder. All Alaskans must realize that the days of easy money and spending are over! But the saving of human life and all the other actions that are funded by the BRU grant program must remain our highest priority.

As a boy raised in Alaska, I was imbued with a sense of duty to Alaska and her people. I remember the old Alaska. I am asking you to go back to your roots, and to the reasons you stay in this great land of ours. Please do not make our tough situation even worse by cutting the BRU grant. All Alaskans benefit from the work funded by the BRU Grant The lives saved may be yours! Cut this grant and people will die, and the blood will be on your hands!

Injury Prevention

Current BRU request: $60,786

Impact of Proposed Cuts

Injuries are the leading cause of death for Alaska Natives between the ages of 1 and 44, and the third leading cause of death overall in the State. In the YK Delta, injuries are the second leading cause of death.

Because injuries are such a serious public health problem in the YK Delta, injury prevention is a top priority for the Yukon Kuskokwim Health Corporation.

The Corporation Injury Prevention Program is in charge of reducing the incidence of injuries and continues to focus its efforts on the leading causes of injury death and hospitalization.

The main focus of our program is to develop intervention strategies and build Tribal capacity to reduce the incidence of injuries. *The Injury Prevention Program, in cooperation with other statewide programs, has witnessed a significant injury reduction.*

- **The drowning rate to Alaska Natives has been reduced by 42%.**
- **Motor vehicle related deaths have declined by 20% in Alaska during 1990 and 1996.**
- **Unintentional injuries have declined by 27% overall.**

The continued success of the Injury Prevention Program is very dependent on the continued availability of BRU funding.
The money from the BRU has allowed us to make these significant strides in the reduction of injury death and hospitalizations for our Alaskan Native communities and has allowed YKHC the resource to develop necessary infrastructure to maintain existing programs. Reducing the funding now will jeopardize the reduction of injury death that we have made to date.



Through programs that promote bicycle safety and other prevention efforts, YKHC's Injury Prevention Dept. has had an impact in reducing serious injuries in the region. Cuts in funds would jeopardize that progress.

If the rate of death for our Native Alaskan children could be the same as that for all US children, we would have...

- **59 Native Alaskan children still alive who died from drowning.**
- **82 Native Alaskan children still alive who died from firearms.**
- **29 Native Alaskan children still alive who died from fire.**
- **73 Native Alaskan children still alive who died from suicide.**

[CDC "State Injury Profile for Alaska," which is death data compiled by David Wallace for the years from 1985-1996]

To quote the former Surgeon General and Chairman, National SAFE KIDS Campaign, C. Everett Koop:

"If a disease were killing our children in the proportions that injuries are, people would be outraged and demand that this killer be stopped."

Testimony: Tom Fazzini

I am a Registered Environmental Health Specialist and the Injury Prevention Coordinator for YKHC. I am a LCDR in the Public Health Service. I have lived and worked in Bethel for five years and have lived in Alaska for seven. I am here to ask you to reconsider your proposal to cut the BRU Grant.

Our program has been a huge success in reducing injuries. The credit going to our field staff who travel to the villages and teach prevention based classes, and keep villages supplied with safety equipment such as float coats, snow machine helmets and the installation of smoke detectors.



A testament to ATV safety education: Elders wear their helmets.

It's imperative that the funding continue to keep our program functioning. Since funded with the BRU monies, our drowning has been reduced by 42 percent. Previously we averaged four snowmachine deaths per winter, in the past two seasons we have had one snow machine injury death. There have been 27 in the State this season.

With funding cuts our staff will be reduced by 50 percent, leaving one Injury Specialist to serve all 50 villages. I can guarantee, with reduced services there will be an increase in our injury deaths.

I urge you to reconsider. We must continue working towards building the necessary infrastructure to develop sustainable programs that will continue to reduce and eliminate injuries.



U.S. Surgeon General Dr. David Satcher, left, visited the YK Delta March 2. Clinical Director Dr. Jane McClure, Human Resources Director Susan Chief, Native Hire Coordinator Ruth Richardson, and President/CEO Gene Peltola presented a souvenir gift of his visit to the region.

U.S. Surgeon General Dr. David Satcher took a half-day tour March 2 of the Yukon Kuskokwim Delta Regional Hospital and a village clinic. Though the trip was short, the doctor liked what he saw.

"I've been the Surgeon General for three years and this is the first time that I have visited this region. I was determined to see how the Indian Health Service provided care to the people in the region.

"I was impressed with how the tribes have come together to bring health care to the Alaska Native people. I was also impressed with the challenges that patients have to endure to receive healthcare services and what the providers have to do to provide that care.

"I was also impressed with the community health aides who are trained to deliver health care. It is a very good model. In this country, one of our major weaknesses is dealing with community health. In what I have seen here and how the system has been adapted to the challenges in providing healthcare, we can come up with strategies for the whole system across the country.

"This trip was important because I saw first-hand how the patients and the providers get around in the area. It is an innovative model."

—Dr. David Satcher, U.S. Surgeon General

Acknowledgements.

Health Aide Supervision Impacts by Carol Odinzoff, RN, Director of Field Supervision for the Community Health Aide Program, Chair of the CHAP Directors statewide organization.

EMS Impacts by Curt Madison., Supervisor, Emergency Medical Services Regional Training Center (Bethel)

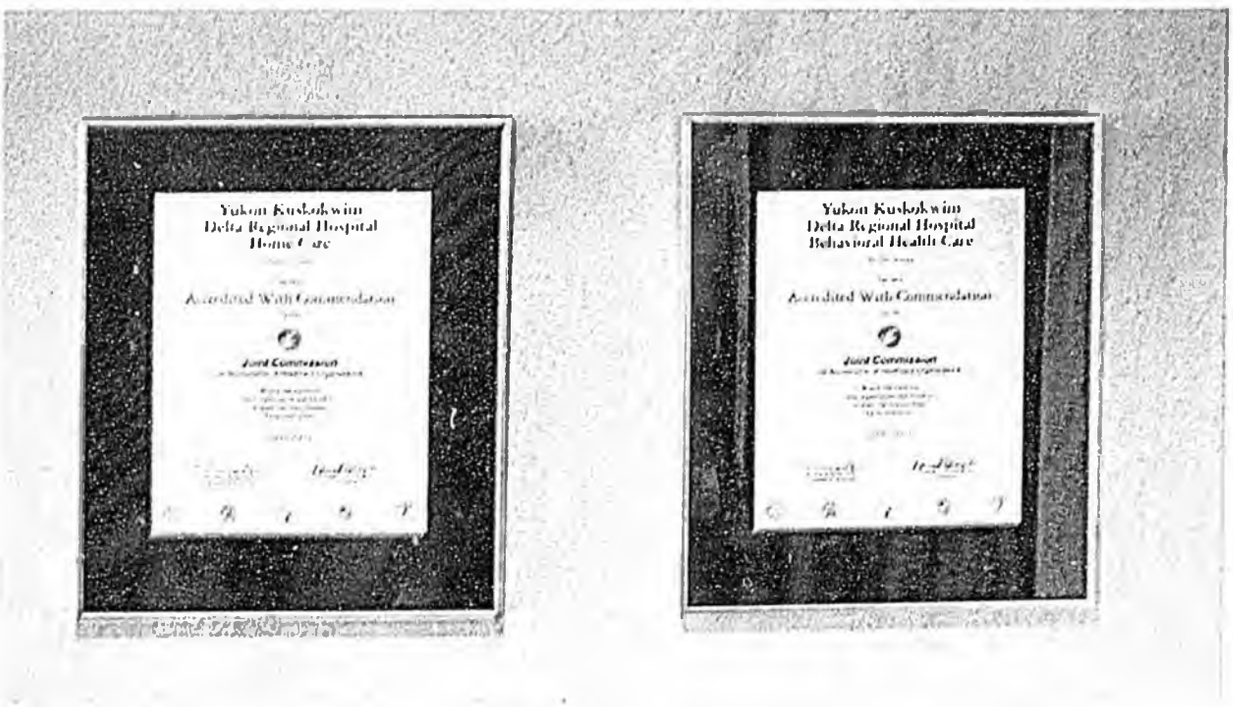
Injury Prevention Impacts by Dana Lee Hall, Registered Pharmacist, Director of Community Health & Wellness at YKHC, currently serving on Active Duty with the Public Health Service.

Layout by Michael Faubion, YKHC Media Services.

Thank you to Ted Horner, Delta Discovery. Also to Sandra Kleven, Dana Hall, John Dickens, and Rose Henderson for photos.

YKHC's Hospital, Behavioral Health and Home Care programs were surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in September.

We received full accreditation with commendation through 2003.



This was the first JCAHO survey for Behavioral Health and Home Care. Home Care passed after their first survey, which rarely occurs, and Behavioral Health performed exceptionally well, receiving a score of 96.

ALBERT B. CHANZON
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