HB

392

26-LS1528\S
Mischel
3/17/10

CS FOR HOUSE BILL NO. 392( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE HERRON

A BILL

FOR AN ACT ENTITLED

"An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 14.43 is amended by adding new sections to read:

Article 8A. Health Care Professions Loan Repayment.

Sec. 14.43.430. Loan repayment; purpose. (a) The commission shall repay a portion of education loans made to eligible tier I and tier II health care professionals under the health care professions loan repayment and employment incentive program established in AS 18.29.010 and the loan repayment procedures established under this section.

(b) The Department of Health and Social Services shall administer the health care professions loan repayment program under AS 18.29.010 - 18.29.099. The commission shall act as a disbursing agent in carrying out the provisions of

AS 14.43.430 - 14.43.449.

(c) Loan repayments under this section shall be made with funds appropriated by the legislature for that purpose. The loan repayments made under this section do not constitute a financial obligation of the corporation.

Sec. 14.43.435. Eligibility. To be eligible for loan repayment under AS 14.43.430, an individual must

(1) meet eligibility and priority criteria established under AS 18.29.030;

(2) have an unpaid balance on one or more education loans verified by the commission; and

(3) meet other criteria established by the commission.

Sec. 14.43.440. Conditions and limitations on loan payments. (a) A loan repayment under AS 14.43.430 - 14.43.449 shall be in an amount not to exceed 33.3 percent of the unpaid loan balance existing in the first year of program participation, multiplied by the percentage of full time equivalent employment for each of up to three years of qualified employment less a matching loan or incentive amount from an employer or other entity as determined under AS 18.29.020.

(b) The commission shall make a loan repayment under this section in quarterly installments payable to the lending institution. A loan repayment made under this section may not exceed the annual benefit amounts established under AS 18.29.020(b). The commission may not make a loan repayment installment for an employment period of less than one calendar quarter.

(c) A loan or interest on a loan is not eligible for repayment under this section if the loan or interest is eligible for repayment from another source, including another loan repayment or forgiveness program or an employer-sponsored repayment program.

Sec. 14.43.449. Definitions. In AS 14.43.430 - 14.43.449,

(1) "qualified employment" has the meaning given in AS 18.29.099;

(2) "tier I health care professional" means a dentist, pharmacist, or physician;

(3) "tier II health care professional" means a dental hygienist,

registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 29. Health Care Professions Loan Repayment and Incentive Program.

Sec. 18.29.010. Health care professions loan repayment and incentive program; purpose; advisory body. (a) The health care professions loan repayment and incentive program is established in the department for the purpose of addressing the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care.

(b) The program established under this section must include

(1) loan repayments made under AS 14.43.430 - 14.43.449;

(2) direct incentives paid under AS 18.29.020;

(3) procedures for the commissioner's designation and prioritization of sites eligible for participation in the program;

(4) an application process for participation in the program as

(A) an eligible site; or

(B) a tier I or tier II health care professional;

(5) the dissemination of public information and notices pertinent to the program;

(6) classification by the commissioner of each eligible site as having either regular or very hard-to-fill positions, or both;

(7) a lifetime maximum period of six years for participation in the loan repayment and direct incentive aspects of the program by a tier I or tier II health care professional; and

(8) annual program evaluations and reports.

(c) Except as provided under AS 14.43.430, the program shall be administered by the commissioner in consultation with an advisory body appointed by the commissioner. The advisory body is made up of members with health care expertise, including expertise in economic issues affecting the hiring and retention of health care

professionals in the state. Members of the advisory body serve at the pleasure of the commissioner to provide recommendations for and oversight and evaluation of all aspects of the program. The commissioner shall accept a recommendation of the advisory body on a matter pertaining to the identification and monitoring of areas of shortages, eligible sites, payment priorities, or evaluation of the program, unless the commissioner finds, in writing, that the recommendation cannot be financially or otherwise supported by the department.

Sec. 18.29.020. Direct incentives. (a) The department shall provide direct incentives in the form of quarterly cash payments to eligible tier I and tier II health care professionals engaged in qualified employment. The department may not make an incentive payment

(1) before the employment period begins;

(2) for a period of qualified employment of less than three months; or

(3) under a contract term that is less than one calendar quarter.

(b) Payments made under this section, when combined with a loan repayment amount paid under AS 14.43.440, if any, may not exceed

(1) $35,000 annually for a tier I health care professional employed in a regular position;

(2) $47,000 annually for a tier I health care professional employed in a very hard-to-fill position;

(3) $20,000 annually for a tier II health care professional employed in a regular position; or

(4) $27,000 annually for a tier II health care professional employed in a very hard-to-fill position.

(c) The commissioner shall calculate the annual incentive payment amount by multiplying the annual maximum payment under (b) of this section by the percentage of full time equivalent employment for each of not more than three years of qualified employment less a matching payment amount as determined under (d) of this section and loan repayment amount, if any, under AS 14.43.440.

(d) An employer or other entity that employs an eligible tier I or tier II health care professional at an eligible site shall make nonrefundable quarterly matching

payments to the department. The payments must be in an amount that is

(1) not more than half of the combined annual incentive payment made under (c) of this section and the loan repayment amount paid under AS 14.43.440(a), as determined by the commissioner; and

(2) based on the employer's or entity's ability to pay, as determined by the commissioner, in consultation with the program advisory body.

(e) A payment made under (d) of this section shall be combined with the payment made to the professional by the department.

Sec. 18.29.025. Number of participants. (a) The number of participants to whom the commissioner may provide a direct payment, loan repayment, or both under the program established under AS 18.29.010 may not exceed 90 participants annually as described in (b) of this section, regardless of whether the participant is a new or continuing participant.

(b) The commissioner shall provide direct incentive payments, loan repayments, or both, to not fewer than three participants employed in very hard-to-fill positions at an eligible site in each of the 10 tier I and tier II health care professions.

Sec. 18.29.030. Eligibility and priority. (a) To be eligible for a direct incentive payment under AS 18.29.020, an individual shall

(1) submit an application on a form approved by the commissioner;

(2) be engaged in qualified employment;

(3) be licensed as a tier I or tier II health care professional in the state within 90 days after the first day of employment;

(4) meet a priority for payment established under (b) of this section; and

(5) meet other criteria established by the commissioner.

(b) The commissioner shall establish priorities for payment of a loan and incentive under the program based on the recommendations of the program advisory body and the availability of funding. The commissioner shall prioritize eligible sites based on the percentage of patients treated at the site who

(1) are uninsured;

(2) have or are eligible for medical assistance or Medicare coverage; or

(3) have or are eligible for other federal health program benefits.

Sec. 18.29.099. Definitions. In AS 18.29.010 - 18.29.099,

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services;

(3) "eligible site" means a service area or health care facility that the commissioner has designated as located in a health care services shortage area based on a needs assessment and employment statistics for qualified tier I or tier II health care professionals;

(4) "program" means the health care professions loan repayment and incentive program;

(5) "qualified employment" means employment of a tier I or tier II health care professional at an eligible site at which the health care professional is hired and paid to work

(A) in a full-time or not less than half-time position;

(B) for a contract term that is not less than three years; and

(C) not less than 50 percent time on direct patient health care services;

(6) "tier I health care professional" means a dentist, pharmacist, or physician;

(7) "tier II health care professional" means a dental hygienist, registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

Talking Points HB 392: Loan Repayment and Direct Incentives for Certain Medical Providers

- Financial incentives of various types—loan repayment, moving costs, housing assistance and tax breaks—can influence a provider's decision to practice in Alaska.
- Research on support-for-service programs indicate that these programs bring health care providers to needy communities where they remain in practice for many years. Of all types of programs, loan repayment and direct financial incentives that target the practitioner after training show the broadest success.[1]
- HB 392 establishes in the Dept. of Health and Social Services a loan repayment and incentive program for medical providers who serve in health care shortage areas in Alaska.
- This bill will provide a combination of loan repayment or cash incentives for up to 90 applicants per year in 10 different health care occupations that fall into tier I or tier II categories.
- Tier-1 includes dentists, pharmacists, and physicians (MD and DO); and Tier-2 includes dental hygienists, nurse practitioners, nurses (RN), physical therapists, physician assistants, psychologists, and clinical social workers (LCSW).
- The amount of monetary incentive will vary with each slot, according to the category of healthcare provided and the location. The Commissioner, based on a needs assessment and employment statistics, designates sites as very hard-to-fill or regular.
- 30 slots each are reserved for very hard-to-fill sites and regular sites and 30 slots can be assigned to either category at the discretion of the Commissioner.
- Priority will be given to sites that treat patients who are uninsured and who have medical assistance or Medicare coverage.
- The combination of loan repayment and incentives cannot exceed $47,000 at a very hard-to-fill site and $35,000 at a regular site for a tier I medical provider.
- For a tier II provider the maximum is up to $27,000 per year for three years at a very hard-to-fill site and up to $20,000 per year for three years at a regular site.
- HB 392 will be one of the only programs that would allow incentives to mid-career professionals and thus will be a powerful recruitment tool. Forty-four states have "support-for-service programs" and Alaska cannot compete with these states when attempting to recruit health care professionals.
- Once HB 392 goes into effect, it will immediately begin to remedy the shortage of health care professionals within the state of Alaska. In combination with current programs aimed at students, e.g. WWAMI, we can greatly enhance the availability of medical services in our underserved areas, getting this important population the access to health care that they deserve.

[1] Donald E. Pathman, M.D., et al, *Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians*, Medical Care, Vo. 42, No. 6, Juneau 2004, p. 567

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

Alaska Commission on Aging

March 18, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska State Capitol, Room 411
Juneau, AK 99801-1182

Subject: Support for HB 392, Incentives for Certain Medical Providers

Dear Chair Keller and Chair Herron:

The Alaska Commission on Aging (ACoA) encourages support for HB 392 by the House HSS Committee, a bill to establish a loan repayment program to build Alaska's health care workforce by increasing the recruitment and retention of targeted health care professionals in urban and rural, underserved communities. This bill is authored by Representative Bob Herron.

Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment program for health care professions. As a result, our hospitals, clinics, and communities lose potential health care workers to other states that incentivize their workforce with loan repayment programs.

Access to quality health care is a priority for all Alaskans and a critical need for people age 65 years and older. Older Alaskans benefit from regular health care services which enhance their overall health and decrease the need for more expensive, intensive treatment and emergency visits.

Alaska continues to lead all states with the fastest growing senior population currently comprising about 12 percent of our state's population and is projected to increase by five to six percent each year until 2020. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors, as demand increases and providers are reaching retirement age. If older Alaskans are unable to find a health care provider, they may be forced to leave the state in search of access to health care professionals. As a result, Alaska could suffer from a loss of retirees, who contribute more than $1.7 billion to the state's economy in addition to their significant volunteer service, caregiving activities, and community leadership.

ACoA supports HB 392 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information about our position. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Representative Tammie Wilson, Vice-Chair
Representative Bob Lynn
Representative Paul Seaton

Cc: Representative Sharon Cissna
Representative Lindsey Holmes

From: donotreply@votervoice.net [mailto:donotreply@votervoice.net]
Sent: Thursday, March 18, 2010 11:40 AM
To: Ann Ehret
Subject: Confirmation of: HB 392 - Loan repayment

Please do not reply to this email--this confirmation simply lets you know that your message was sent.

Your message has been sent to the following recipients:

* Representative Paul Seaton
* Representative Sharon Cissna
* Representative Wes Keller
* Representative Bob Herron
* Representative Lindsey Holmes
* Representative Bob Lynn
* Representative Tammie Wilson

The content of your message is as follows:

Dear [The message(s) you sent had each recipient's name here]:

I am writing to urge you to support this legislation for the loan repayment and incentive program in Alaska. As a physician who works 75% time in the Aleutians I am not eligible for federal loan repayment toward my $150,000.00 medical school loans. After three years in our community health center at a average salary, I am no longer financially able to sustain the cost of living, monthly loan payments without loan repayment of some sort. I am seriously considering moving out of state to obtain more flexibility in the reimbursement options. If this legislation passes, I will stay in Alaska to provide rural primary care to under served populations.

Sincerely,

Dr. Ann Nora Ehret

Rob Earl

From: Marguerite Stetson [mstetso1@alaska.edu]
Sent: Thursday, March 18, 2010 11:29 AM
To: Rob Earl
Subject: Health Care Loans to providers

Representative Herron

As I understand it, this HB 392 would provide loans to providers in order to attract more providers to Alaska.

It is apparent that there is a problem now in accessing care when you are on Medicare.

I would support this bill to help ease the problem of care.

Sincerely,

Marguerite Stetson
1810 Ponds Cir
Anchorage, AK 99507

Rob Earl

From: Heather Goecke [hgoecke@scf.cc]
Sent: Thursday, March 18, 2010 10:55 AM
To: Rob Earl
Subject: HB 392

Representative Herron

Alaska needs to establish a Loan Repayment & Incentive Program so we can recruit and retain the providers we need and to help solve the shortage problem.

Average debt for occupations - especially tier 1: range 100,000 to 400,000 (like a mortgage!)

Cost of doing nothing? Economics of no action:
- Without action, ongoing recruitment costs and high locum tenens costs due to high turnover and length of vacancies will continue to increase health care costs in Alaska
- Without action, Alaska will continue to trend toward a public health crisis in pockets of the state
- Without action, Alaska can expect increased ER use, increased Medivac use, increased Medicaid travel costs, and increased costs associated with chronic disease

Sincerely,

Heather Goecke
4040 N Preston Ave
Wasilla, AK 99654

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182
Phone: (907) 465-4942 • Fax: (907) 465-4589

House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Akiachak
Akiak
Atmautluak
Bethel
Chefornak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingok
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Toksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

House Bill 392 – Loan Repayment and Incentives for Certain Medical Providers

Version 26-LS1528\R

SPONSOR STATEMENT

House Bill 392 establishes a loan repayment and direct incentive program in the Department of Health and Social Services (DHSS), for certain health care professionals employed in the state of Alaska. The goals of the program are to increase the quality and quantity of medical services in underserved regions using a combination of loan repayment and direct monetary incentives to recruit and retain experienced health care professionals.

Alaska has long faced a heath care provider shortage that is expected to worsen. The lack of health care providers is apparent not only in urban regions but also in rural communities where it is especially difficult to recruit health care practitioners. The intent of HB 392 is to create a competent and competitive workforce that has the experience necessary to serve our citizens.

HB 392 is one of the only programs that would allow incentives to mid-career professionals and thus will be a powerful recruitment tool. Forty-four states have "support-for-service programs" and Alaska cannot compete with these states when attempting to recruit health care professionals. HB 392 is a much-needed solution to our shortage of health care professionals because the bill will allow for the employment of up to 90 participants in any given year.

DHSS would run the program and serve as the fiscal agent making quarterly loan payments directly to eligible lenders and incentive payments directly to practitioners from 10 different heath care occupations.

The amount of loan repayment and/or direct incentive payment would depend on the location of the position and the category of health care provided. There are currently two tiers of practitioners: Tier-1 includes dentists, pharmacists, physicians (MD and DO); and Tier-2 includes dental hygienists, nurse practitioners, nurses (RN), physical therapists, physician assistants, psychologists, and social workers (LCSW).

A provider in Tier-1 who serves in a designated "very-hard-to-fill" position could receive up to an extra $47,000 and in a "regular" position an extra $35,000 per year for up to three years. A provider in Tier-2 who serves in a designated "very-hard-to-fill" position could receive up to an extra $27,000 and in a "regular" position an extra $20,000 per year for up to three years.

Representative Bob Herron

Rep.Bob.Herron@legis.state.ak.us

State Capitol • Juneau, Alaska 99801-1182
Phone: (907) 465-4942 • Fax: (907) 465-4589

House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Akiachak
Akiak
Atmautluak
Bethel
Chefornak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingok
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Toksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

To address the shortage of health care providers in rural areas 30 of the 90 slots would be reserved for "very-hard-to-fill" positions, which are designated by the Commissioner of Health and Social Services based upon a needs assessment and employment statistics for Tier-1 and Tier-2 health care professionals.

Once HB 392 goes into effect, it will immediately begin to remedy the shortage of health care professionals within the state of Alaska. In combination with current programs aimed at students, e.g. WWAMI, we can greatly enhance the availability of medical services in our underserved areas, getting this important population the access to health care that they deserve.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 11, 2010

SUBJECT: Sectional Summary (HB 392; Work Order No. 26-LS1528\R)

TO: Representative Bob Herron
Attn: Nikoosh Carlo

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires the Alaska Commission on Postsecondary Education to repay education loans made to health care professionals, as defined, under eligibility criteria established in sec. 2. Specifies that the loan repayment obligation is not a financial obligation of the corporation. Provides for quarterly payments based on the fulfillment of qualified employment at eligible sites located in the state.

Section 2. Establishes the health care professions loan repayment and incentive program in the Department of Health and Social Services for the purpose of addressing a shortage of certain health care professionals in the state and for improving the distribution of those professionals. Requires the commissioner of health and social services to administer the program, to designate and prioritize eligible employment sites, and to monitor the program in consultation with an advisory body established under this section. Provides for maximum combined loan repayment and employment incentives based on the type of employment.

Section 3. Provides for an immediate effective date for the bill.

JMM:med
10-036.med

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB392
() Publish Date:

Identifier (file name): HB 392-DHSS-MAA-03-18-10
Dept. Affected: Health & Social Services

Title: Incentives for Certain Medical Providers
RDU: Health Care Services
Component: Medical Assistance Administration

Sponsor: Herron

Requester: House HSS
Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	89.3		89.3	89.3	89.3	89.3	89.3
Travel	6.0		6.0	6.0	6.0	6.0	6.0
Contractual	2,777.4		2,742.4	2,742.4	2,742.4	2,742.4	2,742.4
Supplies	2.0		2.0	2.0	2.0	2.0	2.0
Equipment	7.6						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**2,882.3**	**0.0**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	2,036.3		2,036.3	2,036.2	2,036.2	2,036.2	2,036.2
1004 GF	167.3		124.7	124.7	124.7	124.7	124.7
1005 GF/Program Receipts	678.7		678.7	678.8	678.8	678.8	678.8
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,882.3**	**0.0**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**	**2,839.7**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time	**1.0**		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 392 creates a loan repayment program for identified health professional occupations and provides for cash incentives for eligible health professionals engaged in qualified employment. The intent of the legislation is to "address the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care."

Division of Health Care Services estimates that it will need a total of 1 FTE to fully administer the loan repayment and employment incentive programs.

(continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Division: DHSS Health Care Services
Phone: (907) 269-7827
Date/Time: 3/15/10 8:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/18/2010

(Revised 11/6/2009 OMB)

ANALYSIS CONTINUATION

Health Care Professions Loan Repayment & Incentive Program

The Division assumes it will need $2,715.0 for practitioner payments in FY2011. This funding will be used for either practitioner payments as cash incentives, or payments to lender institutions for loan repayments, or there can be a combination of the two types of payments. Maximum payments established for any combination of loan repayment and cash incentive are: $35.0 annually for tier I health care professionals employed in "regular" positions; $47.0 annually for tier I health care professionals employed in "very hard-to-fill" positions; $20.0 annually for tier II health care professionals employed in "regular" positions; and $27.0 annually for tier II health care professionals employed in "very hard-to-fill" positions. The need for $2,715.0 in FY2011 assumes the following:

Tier I	27 Practitioners	$1,161.0	(assumes 9 participants from each of 3 types comprising tier I at $387.0 for each type)
Tier II	63 Practitioners	$1,554.0	(assumes 9 participants from each of 7 types comprising tier II at $222.0 for each type)
Total	90 Practitioners	$2,715.0	

The Division assumes the employing entities will provide 25% of the $2,715.0 as contributing match as specified in HB392. Therefore, the expected GF match is $2,036.3 The match for the employing entities is $678.7.

Incentive payments are available to professionals for up to 3 years of qualified employment with a lifetime maximum participation of six years in the loan repayment and direct incentives aspects of the program by a tier I or tier II health care professional. The total number of participants in the program may not exceed 90 participants annually, regardless of whether the participant is a new or continuing participant.

On the fiscal note, the payments for practitioners will be paid from the contractual line:

Item	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
Practitioner Payments	$2,715.0	$2,715.0	$2,715.0	$2,715.0	$2,715.0	$2,715.0
Evaluation Contract	$ 18.0	$ 18.0	$ 18.0	$ 18.0	$ 18.0	$ 18.0
Staff Contractual Costs	$ 9.4	$ 9.4	$ 9.4	$ 9.4	$ 9.4	$ 9.4
ACPE Software	$ 35.0	$	$	$	$	$
Total:	$2,777.4	$2,742.4	$2,742.4	$2,742.4	$2,742.4	$2,742.4

Administrative Costs
1 Health Program Manager II, $89.3 (includes fringe benefits). Assumes $9.4 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $2.0 per FTE annually for supplies; $6.0 per year for travel; $18.0 each year for a program evaluation contract.

Health Program Manager II.
This position will serve as lead program manager for the loan repayment and employment incentive program and will: establish procedures for the commissioner's designation and prioritization of sites eligible for participation in the program, develop the application process for participation in the program for sites and professionals, develop and disseminate public information and notices pertinent to the program, lead the development of the methodology and procedures for classifying each eligible site as having either regular or very hard-to-fill positions, prepare annual reports that document the successes and challenges of the program, facilitate the creation of and ongoing work of the advisory committee, and establish procedures and manage the employer contribution portion of the program.

Assumes one time costs of $35.0 for contractual services/software development for Alaska Commission on Postsecondary Education (ACPE).

ACPE will facilitate the disbursement of the loan repayment benefit. It will not be the budgetary agency for requesting and receiving the funds. After HCS selects program participants, ACPE will verify the existence of their qualifying education debt, and, on a periodic basis, transmit the appropriate benefit amount to the individual's lender.

Health Professional Shortage Area (HPSA) and Medically Underserved Areas and Populations (MUA/MUP) Listing 3/2009

(Listing does not include the automatic Primary Care HPSAs for Alaska Native Tribal Populations, which are available to meet designation requirements)

Census Area/Borough	Primary Care HPSA	Dental HPSA	Mental Health HPSA	MUA (Medically Underserved Area)	MUP (Medically Underserved Population per Governor's Request)
013 - Aleutians East Borough	yes	yes	yes	y	
016 - Aleutians West Census Area	yes	yes	yes	y	
020 - Anchorage Borough	CHC	CHC	CHC		y (North)
050 - Bethel Census Area	yes	CHC (applied for geographic DHPSA)	yes	y	
060 - Bristol Bay Borough	CHC	yes	applied/CHC	y	
068 - Denali Borough	yes	applied; CHC site	yes		y
070 - Dillingham Census Area	only AN; CHC shortly	yes	applied for geographic; CHC		y
090 - Fairbanks North Star Borough	Low income	CHC;applying for low income	CHC		y
100 - Haines Borough	CHC	–	yes		y
110 - Juneau Borough	–	–	–	–	–
122 - Kenai Peninsula Borough	CHC	CHC	CHC; Seward subarea is MHPSA		y
130 - Ketchikan Gateway Borough	–	–	–	–	–
150 - Kodiak Island Borough	CHC	CHC	CHC		y
164 - Lake and Peninsula Borough	yes	yes	yes	y	
170 - Matanuska-Susitna Borough	yes (north); 2 CHCs	yes (north); 2 CHCs	2 CHCs		y
180 - Nome Census Area	yes	yes	yes	y	
185 - North Slope Borough	yes	yes	yes	y	
188 - Northwest Arctic Borough	yes	yes	yes	y	
201 - Prince of Wales-Outer Ketchikan Census Area	CHC (lost geo)	CHC	CHC	y	
220 - Sitka Borough	–	–	–	–	–
232 - Skagway-Hoonah-Angoon Census Area	yes	yes	yes	y	
240 - Southeast Fairbanks Census Area	yes	–	–		y
261 - Valdez-Cordova Census Area	Cordova geo (and CHC); CHC Copper Valley	2 CHCs	2 CHCs	y part (Copper Valley)	y part (Cordova; Whittier)
270 - Wade Hampton Census Area	yes	yes	yes	y	
280 - Wrangell-Petersburg Census Area	CHC	CHC	yes		y
282 - Yakutat Borough	yes	yes	CHC	y	
290 - Yukon-Koyukuk Census Area	yes	yes	yes	y	

data from www.hrsa.gov March 3, 2009

http://www.hpsafind.hrsa.gov/HPSASearch.aspx

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

USDHHS HRSA: More about shortage areas

Alaska Primary Care Office information: http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_Home.htm

"Yes" in HPSA columns means there is a "geographic" HPSA designatuion approved by HRSA Office of Shortage Designation, for all or part of the census area or borough.

"CHC" indicates there is at least one Community Health Center with automatice HPSA designation. Where geographic HPSAs exist, the geographic area score is generally higher than the CHC score. Most of the areas with geographic designations also have CHCs in one or more sites within the census area or borough.

Prepared by Health Planning and Systems Development Section, Health Care Services, Alaska Department of Health and Social Services 3/19/2009

Alaska Center for Rural Health – Alaska's AHEC
UNIVERSITY of ALASKA ANCHORAGE
August 2007

2007 Alaska Health Workforce Vacancy Study Research Summary

Key Findings: *Alaska is confronted by severe shortages of professional health workers, primarily in high-level primary care occupations that include* ***Family Physician, General Internist, Critical Care Nurse, Nurse Case Manager, Family Nurse Practitioner, Physician Assistant, Pharmacist, Dentist, Physical/Occupational/Speech Therapist,*** *and* ***Behavioral Health*** *occupations. Shortages in* ***RNs*** *and* ***Allied Health*** *are much less acute. Most affected are rural areas and Tribal Health Organizations, though growth-driven high vacancy rates affect the Anchorage-Matsu region as well.*

BACKGROUND

Alaska is confronted by a "perfect storm" of health professional shortages. The state has long suffered from a deficient "supply side" characterized by insufficient numbers of key health workers whose recruitment, retention and training have been impeded by Alaska's remoteness, harsh climate, rural isolation, low population density and scarce training resources. Now exacerbating this already difficult situation is a burgeoning "demand side" for increased health services for a steadily growing and aging population. The health services industry is the fastest growing sector of Alaska's economy, employing over 7% of the state workforce.

METHODOLOGIES

The key questions this study sought to answer were: What health occupations were at this time most critically affected by shortages? Exactly how many budgeted positions existed and how many of these currently remained unfilled? Where were these vacancies regionally and in what types of organizations? What did employers perceive to be the major underlying causes of their vacancies? How many new trainees/graduates could the job market actually absorb annually and how many organizations could absorb them?

Four hundred seventy-six (476) purposively sampled Alaska health service organizations of all types responded to the study survey (Figure 1). Survey data was used to generate estimates of positions and vacancies for the entire state of Alaska.

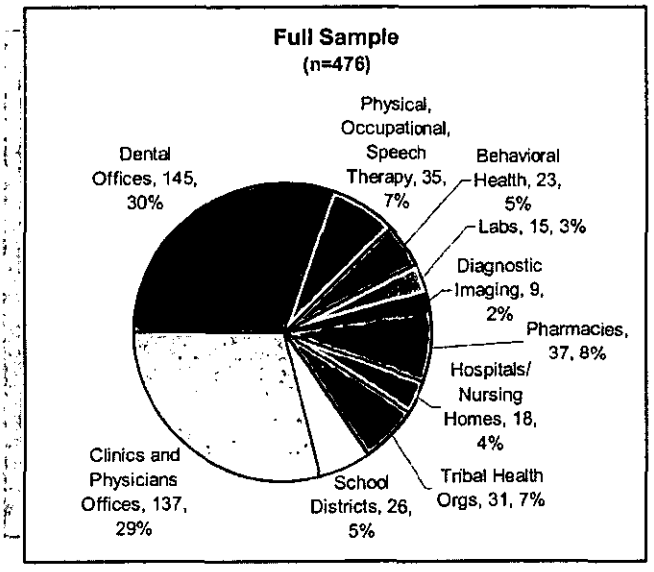


Figure 1

KEY FINDINGS

The findings confirm and quantify the trends cited in recent studies and accumulating anecdotal evidence: despite the recent progress in training and deploying health personnel, such as **Registered Nurses,** critical shortages persist (Tables 1,2).

The situation for key primary care occupations – **Family Physician, General Internist, Nurse Practitioner, and Physician Assistant** – was troubling, particularly in the rural areas, with numerous estimated vacancies and high estimated state vacancy rates between 15% and 20%.

Though vacancies for **Psychiatrists** were not numerous, they were particularly in demand (19.0% estimated vacancy rate) and difficult to recruit (mean vacancy length of 34.5 months).

This study was funded by the Office of Associate VP for Health, University of Alaska Anchorage, through Center for Disease Control and Prevention grant #5-H755-DP024673, and by the Alaska Mental Health Trust Authority.

The national **Pharmacist** shortage has hit Alaska hard and affects every region, with high estimated vacancy numbers (98), and an estimated vacancy rate of 23.7%.

Therapists of all kinds – **Physical, Occupational, Speech, and Speech-Language Pathologists** – were in short supply, with estimated vacancy rates ranging from 15.6% to 29.3%. No part of the state escaped the shortages; vacancy rates were most acute in rural areas, but numerically high in the Anchorage Mat-Su region.

High numbers of vacancies and high vacancy rates were reported for key specialized nursing occupations, particularly for **Nurse Case Manager, Family Nurse Practitioner,** and **Critical Care Nurse.** These appeared to be the current areas of most critical shortage in nursing.

The estimated **Registered Nurse** vacancy rate was moderate (8.0%), but this masked 10% rates in hospitals and tribal health organizations, and an estimated rural rate of 16.1%.

While the estimated vacancy rate for **Dentist** was 10.3%, this masked a 15.3% estimated rural rate and a very high 42.0% rate for tribal health organizations, which had 39% of estimated **Dentist** vacancies.

Table 1. Occupational Groups

Occupational Groups	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
All Occupations	18158	1866	10.3%	34738	3529	10.2%
Physicians	730	109	14.9%	1931	226	11.7%
Professional Nurses	4202	462	11.0%	7139	696	9.8%
Other Nursing Staff	1769	135	7.6%	1762	111	6.3%
Professions/ Therapists	1240	217	17.5%	2281	404	17.7%
Behavioral Health	2938	327	11.1%	7450	1033	13.9%
Allied Health	3209	291	9.1%	5523	434	7.9%
Public Health/ Nutrition	154	18	11.7%	189	ND	ND
Other Primary Care (PA & CHAP)	759	132	17.4%	1067	198	18.5%
Managers	1337	69	5.2%	2947	160	5.4%
Health Information/ Reimbursement	1816	106	5.8%	4451	253	5.7%

In the **Behavioral Health** occupational group, the most acute shortages – with both extremely high vacancy numbers and high vacancy rates – appeared to be among **Human Services Workers.** In addition, overall estimated **Behavioral Health** occupation vacancies were extremely numerous (1033), around 29% of all estimated vacancies – more than any other occupational group.

Among **Allied Health** occupations, high vacancy rates were affecting employers of **Physical Therapy Assistants** and **Respiratory Therapists. Sonographer** vacancies were difficult to fill, and **Surgical Technician** vacancies, though not numerous, were averaging 3 to 4 years in length.

One hundred (100) vacancies and a vacancy rate of 18.1% were reported for **Community Health Aide/Practitioners (CHA/Ps).**

Among "front office" and "back office" occupations, **Coding Specialist** and **Certified Coder** had 11% estimated vacancy rates and very long mean vacancy lengths.

The managerial occupations for which high vacancy rates were reported were healthcare related: **Behavioral Health Supervisor, Clinical Department Manager, Health Information Manager, Medical Director, Nurse Manager, and Practice Manager.** Behavioral health organizations had the most estimated managerial vacancies.

Table 2. Key occupations

Key Occupations (high numbers of vacancies, high vacancy rates)	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Family Physician	252	48	18.3%	675	107	15.8%
General Internist	71	15	21.1%	200	40	20.0%
Psychiatrist	36	10	27.8%	93	18	19.0%
Registered Nurse	3109	299	9.6%	5489	439	8.0%
Critical Care Nurse	497	43	8.7%	629	60	9.5%
Nurse Case Manager	136	42	30.9%	209	49	23.4%
Family Nurse Practitioner	155	36	23.2%	364	71	19.5%
Physician Assistant	207	32	15.5%	515	98	19.0%
Pharmacist	302	73	24.2%	413	98	23.7%
Physical Therapist	271	29	10.7%	510	84	16.5%
Dentist	319	47	14.7%	692	71	10.3%
Human Services Worker	1568	170	10.8%	4800	697	14.5%
Behavioral Health Clinician	297	35	11.8%	555	71	12.8%
Case Manager/Care Coordinator	505	52	10.3%	1163	164	14.1%
Physical Therapy Assistant	35	11	31.4%	62	18	28.6%
Medical Assistant	367	38	10.4%	1092	102	9.3%
CHA/P	552	100	18.1%	552	100	18.1%
Certified Coder	85	6	7.1%	209	22	10.6%
Medical Director	49	6	12.2%	120	18	14.8%
Behavioral Health Supervisor	82	13	15.9%	176	22	12.5%

Looking at respondent types, tribal health organizations reported the highest overall vacancy rate (16.5%). These organizations reported 87 **CHA/P** vacancies; approximately half of all estimated vacancies for **Nurse Case Manager, Pharmacist, Chemical Dependency Counselor, Dentist, Medical Lab Tech, Medical Technologist,** and **Health Educator**; and all the estimated vacancies for **Coding Specialist**. But every respondent type was a locus for acute shortages in key occupations, such as clinics/offices of physicians for **PAs**, hospitals/nursing homes for **RNs**, pharmacies for **Pharmacists**, behavioral health organizations for **Human Services Workers**, and school districts for **Speech-Language Pathologists**.

Higher vacancy rates were generally found in the rural respondents, particularly in the North/West and Southwest regions, which reported double digit vacancy rates for nearly all occupational groups, and overall vacancy rates of around 20% (Table 3, Figure 2). Occupations with much higher rural estimated vacancy rates included **RN** (6.9% urban, 16.1% rural), **Behavioral Health Clinician** (9.3% urban, 22.9% rural), **Dentist** (7.2% urban, 15.3% rural), **Physical Therapist** (13.5 urban, 31.6% rural), and **PA** (14.7% urban, 26.8% rural) (Table 4).

DISCUSSION

The "supply side" shortages apparently persist. "Inadequate Pool of Qualified Workers" was the top reason given for vacancies, cited by 54% of respondents, followed by "Transience/Moving Away" (28%), "Insufficient Compensation" (18%), and "Rural Isolation" (16%). Many tribal health organizations also reported "Insufficient/Expensive Housing" as a top reason for unfilled vacancies. The data also indicated a burgeoning "demand side," where shortages were exacerbated by population growth and an increased need and demand for health services, particularly in the high-growth Anchorage Mat-Su region.

Table 3. Regional vacancy rates

Occupational Group	Regions (Study Sample – n =476)						
	North/ West (n=10)	Southwest (n=17)	Interior (n=72)	Anchorage Mat-Su (n=232)	Gulf Coast (n=69)	Southeast (n=70)	Statewide/ Multiregional (n=6)
Physicians	26.7%	21.2%	21.6%	12.6%	10.4%	6.8%	30.3%
Professional Nurses	26.0%	21.6%	5.9%	11.1%	8.0%	5.9%	12.1%
Other Nursing Staff	18.6%	18.8%	5.8%	6.2%	4.6%	2.3%	8.8%
Dentists/Pharmacists/Therapists	32.4%	32.4%	20.7%	15.9%	16.5%	16.3%	12.4%
Behavioral Health	19.0%	22.7%	13.1%	8.3%	7.1%	11.1%	11.6%
Allied Health	17.0%	24.6%	7.3%	6.5%	8.4%	7.7%	8.6%
Public Health/ Nutrition	30.0%	6.3%	0.0%	4.0%	18.9%	0.0%	10.5%
Other Primary Care (PA & CHA/P)	19.7%	18.6%	24.5%	9.0%	9.1%	4.0%	0.0%
Managers	13.8%	2.4%	3.5%	3.2%	6.4%	11.7%	4.0%
Health Information/ Reimbursement	15.9%	16.9%	2.0%	5.3%	6.6%	2.8%	7.2%
All Occupations	20.1%	20.3%	9.0%	8.6%	8.1%	7.7%	10.2%

Table 4. Urban vs. Rural vacancies and vacancy rates

Occupation	Urban		Rural	
	Estimated Vacancies	Estimated Vacancy Rate	Estimated Vacancies	Estimated Vacancy Rate
Family Physician	68	14.9%	38	17.6%
General Internist	27	18.8%	13	23.1%
RN	339	6.9%	94	16.1%
Family Nurse Practitioner	36	13.3%	34	36.4%
Pharmacist	68	22.7%	30	25.9%
Behavioral Health Clinician	36	9.3%	34	22.9%
Human Services Worker	158	8.5%	209	10.1%
Dentist	32	7.2%	38	15.3%
Dental Hygienist	14	3.6%	17	10.0%
Dental Assistant	27	4.4%	64	14.9%
Physical Therapist	59	13.5%	26	31.6%
PA	50	14.7%	47	26.8%
All Occupations	1998	8.1%	1162	13.3%

Many respondents provided commentary with their surveys and noted positions that are particularly difficult to fill:

- *"We have been hiring travelers for Physical Therapy positions at $67/hr – we can't find therapists to employ. We have been looking for 2 years."* (Urban Medical Clinic).
- *"Without a state Physical Therapy program it is very difficult to get PT staff. Usually this area is staffed by PTs that leave competing PT clinics."* (Urban Physical Therapy Office)
- *We really need a pharmacy school in Alaska. It took two years to fill our last pharmacist position."* (Urban Pharmacy)
- *"Pharmacists are always the most difficult position to fill."* (Rural Pharmacy)

The availability of military spouses has apparently alleviated some of the workforce pressure, but has exacerbated the "transience" problem. Also affecting the shortages was the absence of local training resources (such as medical, dental, pharmacy, and therapy schools) to provide a local workforce pipeline. In the qualitative data, common refrains were, "we need a pharmacy school," "we need a dental school," "we need a physical therapy school."

The acuity of workforce shortages was also reflected by the high percentage of estimated vacancies the responding employers would consider filling with new grads (Table 5). Respondents indicated that they had the capacity to hire sizeable graduating cohorts of Family Physicians, PAs, Occupational and Physical Therapists, Pharmacists, and Dentists. These may be the occupations likely to yield optimal responses to substantial investments in preparation and training programs and/or targeted recruitment and retention campaigns.

Copies of the full study can be downloaded from the ACRH website at:

http://nursing.uaa.alaska.edu/acrh/

Table 5. New Grad Vacancies

Occupation	Study Sample (n=476)	Statewide Estimate
Human Services Worker – HS diploma	68	266
Registered Nurse	93	226
Human Services Worker – AA degree	47	195
Case Manager/Care Coordinator	37	120
Family Physician	25	89
CHA/P	88	88
Pharmacist	46	84
Medical Assistant	21	84
Physician Assistant	23	80
Occupational Therapist	21	75
Dental Assistant	26	75
Dentist	27	67
Physical Therapist	23	62
Speech-Language Pathologist	28	53
Behavioral Health Clinician	19	53

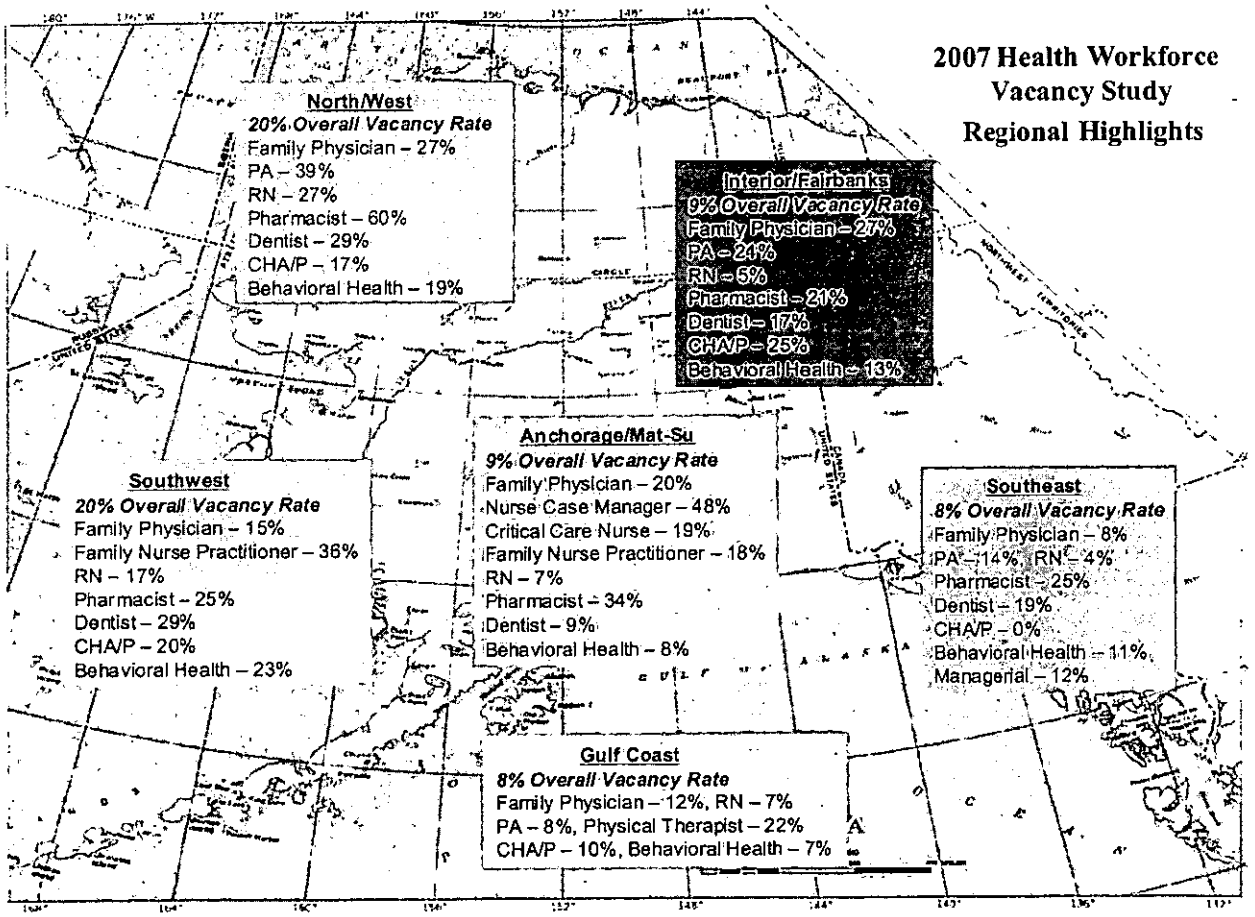


Figure 2. Regional Highlights

How Hard Is It for Alaska's Medicare Patients to Find Family Doctors?

By Rosyland Frazier and Mark Foster

UA Research Summary No. 14 • March 2009
Institute of Social and Economic Research • University of Alaska Anchorage

In the past few years, Alaskans have been hearing reports that some primary-care doctors won't see new Medicare patients. Medicare pays these doctors only about two-thirds of what private insurance pays—and that's after a sizable increase in 2009. But most Americans 65 or older have to use Medicare as their main insurance, even if they also have private insurance. Just how widespread is the problem of Alaska's primary-care doctors turning away Medicare patients? ISER surveyed hundreds of doctors to find out—and learned that so far there's a major problem in Anchorage, a noticeable problem in the Mat-Su Borough and Fairbanks, and almost no problem in other areas.

Medicare is the federal health insurance program for older Americans and for some younger people with disabilities. At issue is what Medicare pays primary-care doctors for their services—not what it pays for other medical costs. Alaska's 50,000 Medicare enrollees are almost all in the "fee for service" plan, which pays doctors standard fees for their services.*

Why is it so worrisome if primary-care doctors won't see Medicare patients? These are the doctors who provide broad care, track patients' overall health, and coordinate care with specialists. That's very important for older people, who often have various medical problems and chronic conditions. And the number of Alaskans over 65 is growing fast—it's expected to double in the next 15 years.

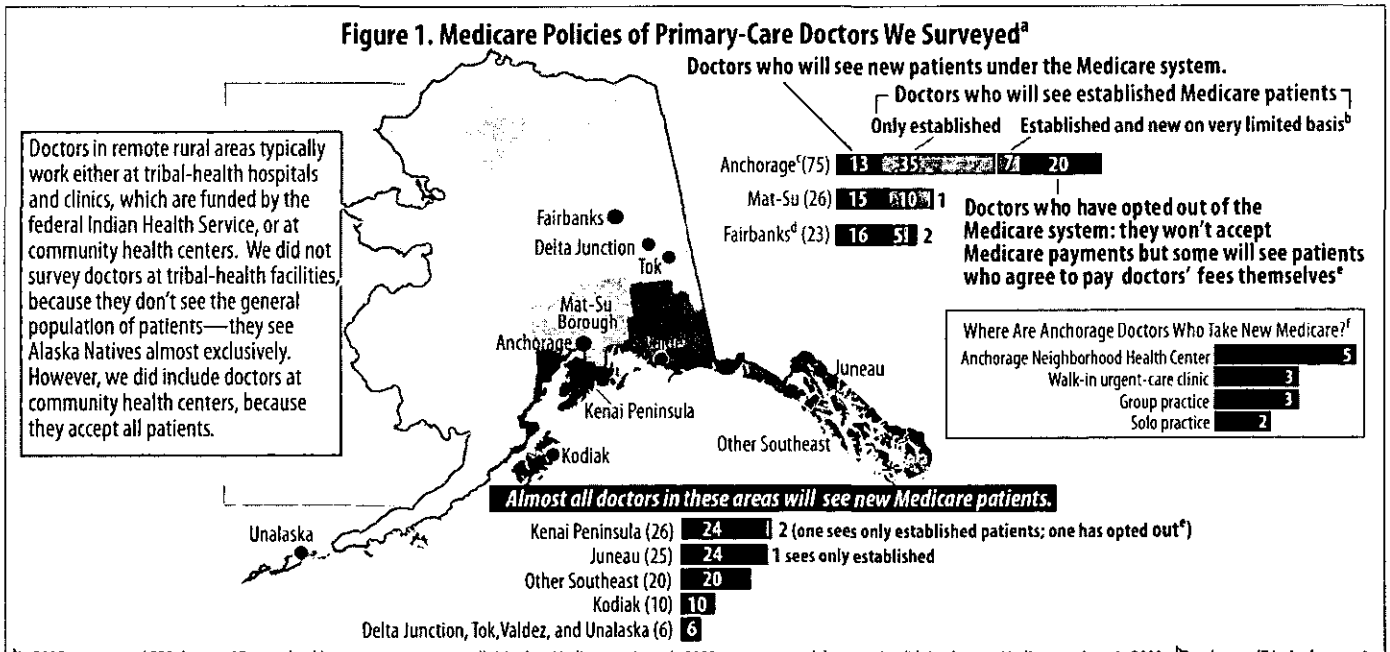
To learn how hard it is for older Alaskans to find primary-care doctors, in 2008 we tried to survey all those who could see the general population of Medicare patients. We were able to interview 229 doctors or their staffs—about 85% of those we tried to reach.

But Medicare payments for Alaska doctors increased in 2009, thanks to efforts of Alaska's U.S. senators. So we recently called back the doctors who had told us they weren't taking new Medicare patients. None of them had opened their doors to significant numbers of new Medicare patients. Four said they now see a very limited number of new Medicare patients, under special circumstances. Two doctors in a joint practice who still didn't see new Medicare patients had hired a nurse practitioner who did.

It's certainly also possible that without the 2009 increase, even more doctors would have decided not to see Medicare patients. Figure 1 shows what our 2008 and 2009 surveys found.

- *It's mainly doctors in Alaska's larger urban areas who are declining to see new Medicare patients.* But that's where the majority of older Alaskans live. Most doctors (even in Anchorage) will still see established patients—that is, patients they've seen in the past.
- *Almost all doctors in smaller communities take new Medicare patients.* Rural places have few doctors—so doctors probably feel more of an obligation to see all patients. For patients (Medicare or otherwise) in rural Alaska, the challenge is more likely to be recruiting and keeping doctors.
- *One in ten doctors we surveyed has opted out of the Medicare system.* Most are in Anchorage. They will not accept Medicare payments, but some will see patients who agree to pay the entire doctor's bill themselves.
- *The Anchorage Neighborhood Health Center,* which accepts all patients, saw twice as many Medicare patients in 2007 as in 2001. It has become the only choice for many of Anchorage's Medicare patients.
- *Medicare patients are not relying more on emergency rooms,* if figures for Providence Hospital's emergency room in Anchorage are typical. Numbers of Medicare patients there haven't changed much in the past several years.

Figure 1. Medicare Policies of Primary-Care Doctors We Surveyed[a]



[a]In 2008 we surveyed 229 doctors; 15 weren't taking any new patients at all; 3 had no Medicare patients. In 2009 we re-surveyed doctors who didn't take new Medicare patients in 2008. [b]Ten doctors (7 in Anchorage, 2 in Fairbanks, 1 in Mat-Su) accept a few new Medicare patients under special circumstances, but don't typically see new Medicare patients. [c]Includes Eagle River/Chugiak. [d]Includes North Pole. [e]See Figure 9. [f]See page 3.

*Nationwide, 21% of beneficiaries have enrolled in Medicare Advantage programs—which means they become members of private health plans, and Medicare then pays the plans a set monthly amount for each Medicare enrollee.

Survey of Primary-Care Doctors

We surveyed only primary-care doctors. So far there hasn't been any sign that specialists are declining to see Alaska's Medicare patients—not surprising, since Medicare tends to pay them closer to private-insurance rates.

We first had to determine how many doctors fit our survey criteria: those who currently practice general, family, or internal medicine at least 20 hours a week and who could see the average Medicare patient, if they chose to.

About 700 primary-care doctors are licensed in Alaska, but most aren't available to see the general population of Medicare patients. Hundreds work for government agencies, are in public health, or see only specific groups (Figure 2).

Among those who didn't fit our criteria are doctors working for tribal-health facilities that provide Indian Health Service programs for Alaska Natives. These doctors do see Alaska Native Medicare patients.

We estimated that 264 doctors were left, after we took out those who didn't fit our criteria. In 2008 we tried to reach all 264. We were able to talk with about 85%—229 doctors or their staffs. We asked them to tell us their policies for seeing Medicare patients and to rank reasons why they might be limiting or turning them away. The top reason they cited was "inadequate reimbursement"—that is, Medicare payments aren't enough to cover the costs of seeing patients.

We also followed up, in 2009, with doctors who had told us in 2008 that they weren't taking new Medicare patients. We reached all but two.

Figure 2. How Many Primary-Care Doctors Are Available to See Medicare Patients?
(Among Alaska Doctors Practicing General, Family, or Internal Medicine at Least 20 Hours per Week)

709	Total licensed primary-care doctors in 2006. Includes pediatricians and and ob-gyns. Often cited as number of Alaska primary-care doctors.
608	Listed in 2008 Alaska State Medical Directory as practicing general, family, or internal medicine. Excludes pediatricians and ob-gyns.[a]
459	Excludes doctors who are federal, state, or municipal employees or public-health doctors.
394	Excludes doctors who are retired or working less than 20 hours per week.
352	Excludes doctors with no current work addresses or phone numbers.[b]
264	**Estimated number who could see Medicare patients.** Excludes doctors working for tribal or other organizations not serving the general population.[c]
229	**Number we interviewed[d]** Excludes 8 doctors unavailable during survey and 27 who declined interview.

[a]We excluded pediatricians and obstetrician-gynecologists, who are often included in definitions of primary-care doctors, because they don't routinely see older patients. [b]About 42 doctors were not at the addresses and phone numbers in the medical directory. We tried but weren't able to find them, and we assume they have left the state or are not practicing [c]We excluded doctors working for tribal-health organizations, the military, the Veterans' Administration, and Planned Parenthood, because they don't see the general population of Medicare patients. Doctors who work for tribal-health facilities do see Alaska Native Medicare patients. [d]We interviewed either doctors or members of their staffs.

Medicare Versus Private Insurance

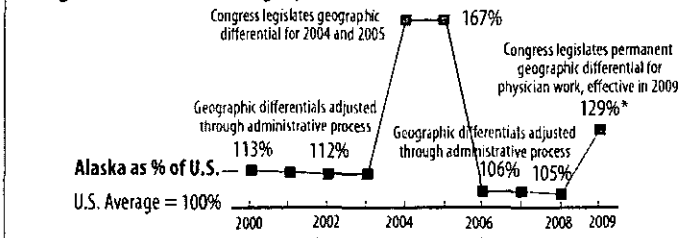
The federal Center for Medicare and Medicaid Services (CMS) calculates Medicare payments for doctors under a complex formula that takes into account geographic differences in costs around the country. Alaska's doctors have historically been paid more than the U.S. average for seeing Medicare patients.

The CMS formula actually includes three geographic differentials: one for "physician work" itself, one for doctors' costs of operating practices, and one for doctors' costs of carrying liability insurance.

In 2008, Congress set the Alaska geographic differential for "physician work" at 50% above the U.S. average, effective in 2009. Alaska's U.S. senators Lisa Murkowski and Ted Stevens were instrumental in gaining that increase for Alaska doctors. But combined with the other differentials—set by CMS—the overall Medicare geographic differential for Alaska doctors in 2009 is 29% above the U.S. average. Figure 3 shows the differential since 2000.

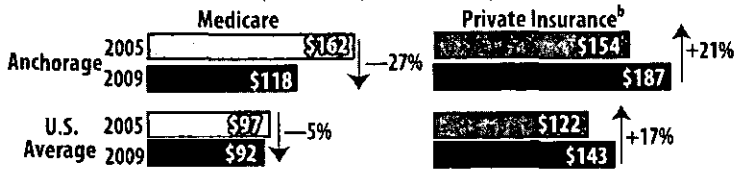
- *From 2000 to 2003, the geographic differential for Alaska doctors was about 12% above the U.S. average.* That differential was set entirely under CMS's administrative process.
- *In 2004 and 2005, the differential for Alaska doctors jumped to 67% above the U.S. average.* Ted Stevens, at that time Alaska's senior U.S. senator, spearheaded the legislation that led to the substantial but temporary increase. In those two years, Medicare paid Alaska doctors as much as private health insurance (Figure 4).
- *After that legislation expired, the Medicare differential dropped sharply,* to about 5% above the U.S. average from 2006 to 2008.
- *In 2009, the cost differential for Alaska doctors climbed to 29% above the U.S. average,* due to new federal legislation—as we just discussed. But Medicare still pays doctors less now than it did in 2005 (Figure 4).
- *Medicare pays about two-thirds of what private insurance pays, in Alaska and on average nationwide.* (But in the adjacent markets of Washington state, Medicare pays 68% to 75% of what private insurance pays.)
- *That nationwide gap helps explain why more Medicare patients are having trouble finding doctors.* Recent national surveys sponsored by the Medicare Payment Advisory Commission found that 17% of Medicare patients in the U.S. had "a big problem" finding family doctors in 2007, up from 13% in 2005. Alaska may be the harbinger of a national trend.

Figure 3. Medicare Geographic Cost Differential* for Alaska Doctors



*This is a weighted average of three geographic cost differentials the Center for Medicare and Medicaid Services uses in a complex formula that determines what doctors are paid. One of those is the differential for "physician work," and Congress set that at 150% of the U.S. average for Alaska doctors, effective in 2009. But the other differentials—for physicians' costs of operating their practices and for carrying liability insurance—are set by CMS and can vary from year to year.
Source: Center for Medicare and Medicaid Services; Medicare Payment Advisory Committee

Figure 4. Medicare and Private Insurance Payments[a] To Primary-Care Doctors, Anchorage and U.S. Average, 2005 and 2009
(New Patient, 30-Minute Visit)



[a]Figures include the amount Medicare or private insurance pays and the amount the patient pays. [b]Median payments
Source: Ingenix National Fee Analyzer

Where Are the Medicare Patients?

- *Nearly 70% of non-Natives over 65 live in Anchorage, the Mat-Su Borough, and the Fairbanks area.* Figure 5 shows only where older non-Natives live, because older Alaska Native patients have access to doctors through tribal-health care facilities. For them, the issue is not that doctors won't see them but that there may not be enough doctors, especially in rural areas.

Who Accepts Medicare Patients?

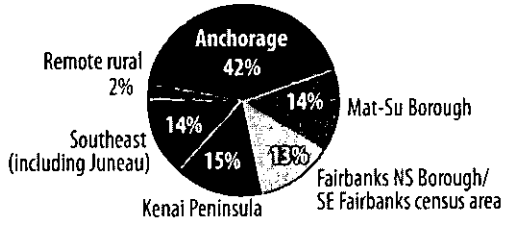
Besides the doctors who will see new or established patients, some doctors have made another choice: they've opted out of the Medicare system. They don't accept any Medicare payments (see Figure 9), but some will see Medicare patients who agree to pay the doctor's fee themselves. Patients who can do that have more choices. But for those who need Medicare to help pay the bill, the access problem is the worst in Anchorage.

- *We found only 13 primary-care doctors seeing the general population of new Medicare patients in Anchorage.* Of those, 3 were at walk-in, urgent-care clinics, which mostly just treat minor injuries and illnesses (Figure 1).
- *Five of the 13 Anchorage doctors seeing new Medicare patients in 2008 were at the Anchorage Neighborhood Health Center.* That's one of dozens of federally funded community health centers in Alaska. There are hundreds more across the U.S. These centers are open to everyone, but they are mainly for medically "under-served" groups of people—poor and uninsured, for instance—or areas of the country without adequate local medical care, like many of Alaska's rural communities.
- *The Anchorage Neighborhood Health Center is the main choice for growing numbers of Medicare patients.* Both the number of Medicare patients coming to the clinic and the percentage they make up of all patients doubled between 2001 and 2007 (Figure 6). That growth did flatten out in 2004 and 2005, when Medicare paid doctors at a level comparable to private insurance. But after that, the numbers climbed. (In Fairbanks, the community health center saw a similar percentage increase. In the Mat-Su Borough, a health center just opened in 2005, so data are limited.)
- *Until recently there was another choice for Anchorage's Medicare patients—the Alaska Family Medicine Residency Program*, where some family doctors get their final phase of training. These resident doctors see patients, and they had been accepting growing numbers of Medicare patients. But to make sure the residents see a variety of patients, the program has now capped the number of Medicare patients it accepts.
- *Anchorage's Medicare patients don't seem to be turning more to emergency rooms.* Data from Providence Hospital's emergency room show that visits by older patients have stayed mostly steady, with seasonal variations, since 2004 (Figure 7). But some health-care providers think that Medicare patients may be postponing care they need and coming in only when medical problems get much worse.

Medicare Payments to Doctors and to Health Centers

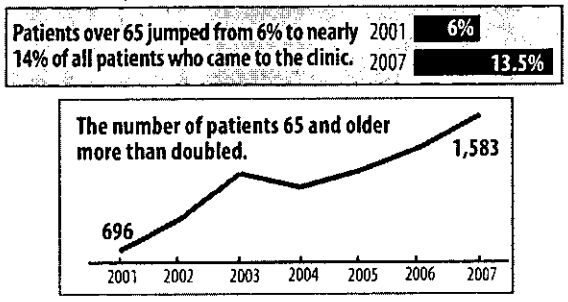
- *Medicare pays doctors and community health centers differently.* Some people believe that Medicare uniformly pays health centers more than it pays private doctors, making it more feasible for health centers to see Medicare patients. But the reality is more complex.
- *Medicare pays health centers the same fee for seeing Medicare patients for any visit, but private doctors more for longer, more complex visits.* Figure 8 compares payments for 30- and 60-minute visits with new patients, at doctors' offices and the Anchorage Neighborhood Health Center (ANHC). For a 30-minute visit, Medicare pays ANHC $119 and doctors about $95. But for a 60-minute visit, it still pays ANHC $119, but the doctors $189.

Figure 5. Where Do Non-Native Alaskans Over 65 Live?
(2006 Estimate: 38,227)



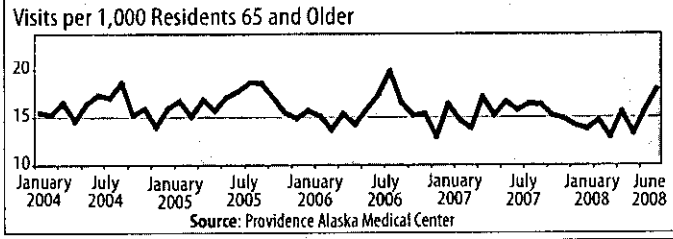
Source: Alaska Department of Labor, Research and Analysis section, 2006 bridge estimates

Figure 6. Growth in Number of Patients 65 and Older at Anchorage Neighborhood Health Center, 2001-2007



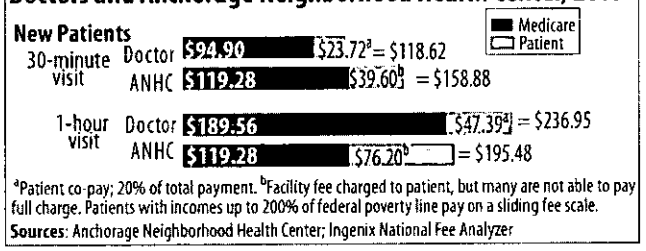
Source: Uniform Data System Reports, U.S. Department of Health and Human Services, Health Resources and Services Administration

Figure 7. Visits to Providence Hospital's Emergency Room in Anchorage, Patients 65 and Older, 2004 to 2008



Source: Providence Alaska Medical Center

Figure 8. Medicare and Patient Payments to Private Doctors and Anchorage Neighborhood Health Center, 2009



[a]Patient co-pay; 20% of total payment. [b]Facility fee charged to patient, but many are not able to pay full charge. Patients with incomes up to 200% of federal poverty line pay on a sliding fee scale.

Sources: Anchorage Neighborhood Health Center; Ingenix National Fee Analyzer

- *What Medicare patients pay at health centers and at doctors' offices is also determined in different ways.* Essentially, Medicare allows the health centers to take their own fees into account when determining what patients are charged. But Medicare doesn't allow doctors to use their own fees; instead, Medicare sets a maximum allowable charge for specific kinds of visits, and patients pay a portion of that (see Figure 9).
- *Neither ANHC nor the doctors' offices necessarily collect the amounts shown in Figure 8 as payments from patients.* At ANHC, patients with incomes up to 200% of the federal poverty line are charged on a sliding fee scale. Likewise, private doctors may not always be able to collect the patient's share. And both private doctors and ANHC report losing money when they see Medicare patients.

Doctors and the System

Primary-care doctors who see Medicare patients have three choices for getting paid. Figure 9 describes those choices among doctors we surveyed.

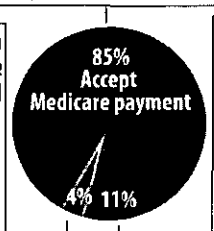
About 85% choose the standard Medicare process ("participating"). Another 4% still work with the Medicare system but charge patients somewhat more ("non-participating"). The final 11% have opted out of the Medicare system, but will still see patients who agree to foot the bill.

Patients also pay different amounts, depending on their doctors' policies. For a service with an allowable Medicare fee of $100, patients seeing doctors who accept that fee would pay $20—but only after Medicare paid the other $80. Patients seeing "non-participating" doctors would pay the doctors $109.25; Medicare would later reimburse the patients $76, so their final cost would be $33.25. Patients seeing doctors who have opted out of the Medicare system would pay a fee determined by the doctor—perhaps a negotiated fee, but still typically more than Medicare pays.

Figure 9. How Do Alaska Primary-Care Doctors Who See Medicare Patients Deal with the System?
(Among 211 Surveyed Who See New or Established Patients)

Most doctors accept standard Medicare fees and bill Medicare. They are called "participating." Medicare sets maximum allowable charges for various services. Participating doctors agree not to charge more than the allowable rate, and Medicare pays them 80% of that. The patients (and their secondary insurance, if they have any) pay the other 20%.

A few doctors (called non-participating) can charge up to 9% more than the allowable Medicare charge. But Medicare pays less and patients pay more. Here's how it works. The patient pays the entire bill, but the doctor submits a statement to Medicare so the patient is paid for the Medicare share. But instead of paying 80% of the charge, Medicare pays only 76%. The patients (and their secondary insurance, if they have any) pay the rest of the bill.



Some doctors don't accept Medicare payments for their fees. They are said to have "opted out." They will still see Medicare patients, but patients must agree to pay a fee the doctor sets. Medicare doesn't pay either doctors or patients, and patients can't bill any secondary health insurance they may have. Remember that patients pay only the fee for the doctor. They still use Medicare to help pay hospital and other medical costs. Doctors who opt out have to re-confirm their decision with Medicare every two years. They can also apply to come back into the system after two years.

Example: How Much Would Patients Pay for a Service with an Allowable Medicare Charge of $100?

	Participating Doctors Charge $100	Non-Participating Doctors Can Charge $109.25	Doctors Who Have Opted Out Can Set Their Own Fees
Medicare pays	$80	$76	$0
Patient pays	$20[a]	$33.25[a]	Entire doctor's fee[b]

[a]Patients can bill secondary insurance to help pay their share. [b]Patients can't bill secondary insurance to pay any amount.

Sources: American Academy of Family Physicians; Government Accountability Office

Conclusion

With few exceptions, Americans 65 or older who are retired have to use Medicare as their primary insurance—even if they also carry private health insurance or have retirement benefits that include health-care coverage. Any other insurance they have can *only* be used to help pay *their share of the allowable Medicare charge*. They can't use private insurance to pay doctors more than Medicare allows.

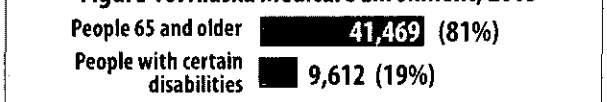
As more Alaskans turn 65, the access problem will get worse, unless something changes. Growing numbers of Medicare patients around the country are also reporting access problems. And the American College of Physicians has reported that a nationwide shortage of primary-care doctors is looming—which would make the problem even worse.

This summary talks about just a very narrow slice of the multitude of issues facing Medicare. It's one of the largest and fastest-growing federal programs, and President Obama has said reforming it will be part of his plan to improve the U.S. health-care system. How potential reforms might affect Medicare patients' access to family doctors isn't clear today.

Because Medicare is a federal program, the state's options for helping improve access are limited. But Alaskans are talking about various possibilities—like recruiting more doctors and offering them bonuses to see Medicare patients, and either establishing an Anchorage clinic for Medicare patients or expanding the Anchorage Neighborhood Health Center.

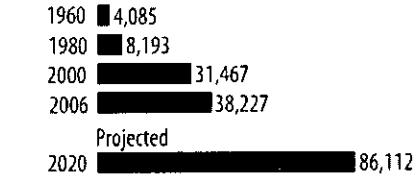
In a publication later this year, we'll look at the implications of various ways of trying to improve access for Medicare patients. We'll also report what family doctors themselves told us—how they make decisions about seeing Medicare patients and what might make them willing to see more.

Figure 10. Alaska Medicare Enrollment, 2005



Source: Alaska Department of Health and Social Services, Alaska Health Care Data Book 2007

Figure 11. Non-Native Alaskans 65 and Older



Sources: U.S. Bureau of the Census; ISER estimates based on census data; Alaska Department of Labor, Research Analysis, 2006 estimates and mid-range 2020 projections

Back-up materials for figures in this summary are available from ISER. Call the authors at 907-786-7710 with questions. We've also developed a basic model that doctors—or anyone else—can use to estimate how changing the balance between patients paying with Medicare and with private insurance could affect doctors' revenues. To try that model, go to ISER's Web site:

www.iser.uaa.alaska.edu

The authors thank the doctors and others in health care who took the time to help us. We especially thank doctors Leslie Bryant, Richard Neubauer, and Thomas Nighswander; Joan Fisher of the Anchorage Neighborhood Health Center; James Jordan of the Alaska State Medical Association; and Providence Alaska Medical Center, Providence Health and Services - Alaska.

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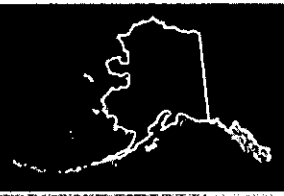
Editor: Linda Leask Graphics: Clemencia Merrill

Summary of SB 139 / HB 392 Proposal for Alaska: Health Care Professions Loan Repayment & Incentive Program



The following organizations support the loan repayment and incentive solution in SB 139 / HB 392 Incentives for Certain Medical Providers:

Alaska State Medical Association • Alaska Dental Society • Alaska Primary Care Association • Alaska Osteopathic Medical Association • Alaska State Hospital and Nursing Home Association • Alaska Mental Health Trust Authority • Alaska Native Health Board • Alaska Pharmacists Association • Alaska Physical Therapy Association • AARP-Alaska • Advisory Board on Alcoholism and Drug Abuse • Alaska Behavioral Health Association • Alaska Mental Health Board • Alaska Mental Health Trust Authority • Alaska Public Health Association • Alaska Hygienists Association • Commonwealth North • Iliuliuk Family and Health Services, Inc. • Maniilaq Association • Municipality of Anchorage Senior Citizens Advisory Board • Mary Willard, DDS, Clinical Site Director, Alaska Native Tribal Health Consortium • Alaska Chapter National Association of Social Workers • Nome Eskimo Community • SEARHC • School of Social Work-UA • Dental Hygiene Program-UA • Sunshine Community Health Center

Problem:

Having a sustainable and competent practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, "support-for-service programs" (SFSPs) have shown substantial and long-standing success as a cost-effective public strategy to address workforce shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 44 other states have one or more SFSPs.

Solution:

The Health Care Professions Loan Repayment and Incentive Program (HCPLRIP), as outlined in Senator Olson's SB 139 and in Representative Herron's HB 392 will make Alaskan health care employment competitive and attractive enough for practitioners to want to work in Alaska, particularly in hard-to-fill localities. State funds will be used to insure that Alaskans with the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description:

1) **Oversight Entity**
   - Health Planning and Systems Development, Department of Health & Social Services will serve as the Oversight Entity.
   - DHSS Commissioner will appoint a HCPLRIP Council to make recommendations regarding program administration & this Council will serve as primary communication between providers and program administrators.

2) **Fiscal Agent**
   - Alaska DHSS will serve as Fiscal Agent. DHSS will make loan payments directly to eligible lenders and incentive payments directly to practitioners.

3) **Practitioner Eligibility**
   - DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
     - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
     - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
   - A practitioner's clinical duties must constitute at least 50% of duties to be eligible.
   - A part-time practitioner may participate and be eligible for pro-rated payments.
   - Practitioners are not eligible while fulfilling other service obligations (NHSC or IHS loan repayment, WWAMI obligations, service-option scholarships, etc.) but may subsequently participate in the program.
   - Preference may be given to current Alaskan residents.

4) **Site Eligibility:**
   - DHSS Commissioner will rank eligibility of sites annually and determine any area and/or population in Alaska as a "shortage priority." These may include, but are not limited to, federally defined Health Professional Shortage Areas.
   - Preference will be given to sites that provide care to individuals regardless of their ability to pay, including persons who are uninsured or have Medicare and/or Medicaid.

5) **Payment Detail:**
   - Placement Type — Regular — Hard-to-Fill
     - Tier 1: up to $35,000/year — up to $47,000/year
     - Tier 2: up to $20,000/year — up to $27,000/year
   - Payment details are same for two component types: loan repayment and incentives.
   - Duration of award is for a 3-year period of service.
   - Payments will be made every quarter following a completed full quarter of service.
   - A program practitioner in good standing may re-apply for a 2nd period of service.
   - Lifetime participation cap is six years regardless of component type.

6) **Program Evaluation:**
   - The Oversight Entity will conduct annual survey of program practitioners, exit interviews, and tracking of alumni.
   - The Oversight Entity will develop measures to make workforce projections, according to practitioner type category and may assess sustainability, cost-benefit issues, and rural and remote benefits of program.
   - The Oversight Entity will develop evaluation policy and procedures.
   - The HCPLRIP Council will adopt an evaluation plan within 12 months of initial program funding and amend annually.
   - HCPLRIP will assess adequacy and distribution of the Alaska health care workforce for all program eligible-practitioner types annually.
   - The Commissioner will report to the Legislature every three years whether payments are adequate to meet program goals. The Oversight Entity will have specified discretion based on HCPLRIP Council's review of report to adjust payment rates.

7) **Funding:**
   - An in-cash "employer match" is required and is paid annually by eligible sites to DHSS. The level of required match will be adjusted according to the ability of the eligible site to contribute and may be set between 0% and 100%
   - Program funds will not be used to offset current or expected provider supports.
   - Funding will be provided to allow DHSS to (1) conduct program management; (2) monitor placements & practice environments; (3) resolve placement issues; and (4) assess the statewide health care workforce regarding the program practitioner types.
   - Proposed total funding for FY11 is $2.7 million. A total of $7.1 million, expensed across 3 years, will fund at least 90 participants for 3-year contracts; that is, approximately 9 practitioners (at least) in each of 10 occupational categories.

For more information re: HCPLRIP and SB 139 / HB 392, please contact Shelley Hughes/Alaska Primary Care Association at Shelley@alaskapca.org or 907-841-1634

Health Care Professions Loan Repayment Program

Concept Proposal

Submitted by
Pat Carr, Chief
Health Planning & Systems Development
Department of Health & Human Services
State of Alaska

on
September 11th, 2007

via
PCC Workforce Subcommittee

to
Alaska Primary Care Council

Health Care Professions Loan Repayment Program

Summary

Problem

Alaska is competing with other states and nations for the finite pool of available healthcare professionals. This competition will only intensify since the growth of supply is continuing to fall behind that of demand.

A common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSP's). Good outcomes have been achieved with these. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and residency support programs. All SFSP's have the same public goal: To improve healthcare staffing in shortage areas. National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention (see: *HCPLRP: Issue Paper*, 2007)

A key problem is that Alaska does not have a robust support-for-service program while most other states do, many have several, and further, some of those are growing. In sum, Alaska is at a substantive disadvantage as it necessarily competes in the national healthcare labor market.

Discussion

Alaskan health care provider agencies use many approaches to recruit and retain staff. This has proved difficult, however, and particularly so where (1) federal loan repayment programs do not apply, or, (2) there is insufficient resource available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most all other states have state-sponsored programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have had a greater likelihood of success than have programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs typically are a fundamental part of those strategies.

Support-for-Service Programs

It is well-established that many healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, in 2004, young physicians' educational debt averages stood at over $109,000 and this cost was increasing at the rate of more than $4,000 per annum.

There are several types of support-for-service programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans

they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Overall, 81 state-level programs were identified. There were 44 states with at least one program (88% of states). Fully 21 states had two or more programs (47%), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 states had nearly two programs (1.8) each.

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain health care professionals. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples include: (a) high position-fill rates, (b) high service-completion rates, and (c) high retention rates.

These programs are successful because the benefit of loan repayment is clear to potential applicants, and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties.

In 2006, the Alaska Physician Supply Task Force recommended a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need. One of the PSTF findings was that loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs.

Conclusion

Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages.

Recommendation

It is recommended that Alaska create a "Health Care Professions Loan Repayment Program".

To do this, a planning process should be established. This process should define and prepare for adoption at least the following program elements: (a.) organizational support, (b.) oversight, (c.) fiduciary agent, (d.) practitioner eligibility, (e.) site eligibility, (f) repayment details, (g.) program design & management, and (g) program evaluation.

Resource

Health Care Professions Loan Repayment Program: Issue Paper (2007). Health Planning & Systems Development, Alaska Department of Health & Social Services.

Health Care Professions Loan Repayment Program
Issue Paper

Abstract

This paper: (1.) illustrates the current and expected healthcare workforce needs of Alaska; (2.) indicates the widespread use elsewhere of support-for-service programs, and in particular loan repayment; and (3.) recommends that Alaskans should now explore creation of a Health Care Professions Loan Repayment Program (HCPLRP).

Main Issue

Alaska is increasingly vulnerable to the competitive challenges posed by other states and nations for the finite pool of available healthcare graduates. This vulnerability will increase during coming years because of two factors. (1.) The need for health care professionals in Alaska is steadily rising, and, shortages are now evident in some categories. (2.) Further, these trends are national. These workers are part of, and often respond to, nationwide labor markets. Further, these trends are expected to accelerate. This is particularly true in those states that do not produce adequate numbers of their own health workers in the given disciplines. This puts such states at a marked disadvantage. Financial incentive programs are particularly important for those states, and Alaska is one of these. As a result, several other states have become robust competitors in recruitment of the healthcare workforce, and some are planning new and expanded loan repayment programs (Pathman, 2007).

A fundamental, and common, state-level response to these pressures is the use of financial inducements, these collectively known as support-for-service programs (SFSP's). Excellent outcomes are readily achievable from these efforts. There are five types: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. All support-for-service programs have the same key public goal: To improve healthcare staffing in shortage area communities.

National studies have determined loan repayment programs to be one of the most effective of the several support-for-service strategies - in terms of both recruitment and retention. As compared to the other SFSP options, here loan repayment participants sign support-for-service contracts after they complete their training, when they are older and better informed as to their career options. These professionals make commitments at the time they are ready to begin their service-obligations. They are more likely to know their own needs and those of their families at this later juncture. They know where they will serve and have a sense as to how well their chosen worksites will "fit" their needs.

Problem

This section presents evidence which indicates that:

- A healthcare workforce shortage currently exists in several occupations.
- Under current conditions these shortages will continue into the foreseeable future.
- In several occupations, these shortages will escalate.

Trends in National Workforce

Numerous, prominent sources indicate that there is a growing national shortage in the rural health care workforce. Two examples follow.

GAO Position (2001): In 2001, the General Accounting Office's (GAO's) director of health care-public health issues testified before Congress regarding growing concerns about the adequacy of the health care work force and lessons learned from the experience of the National Health Service Corps (NHSC) in addressing the maldistribution of health care professionals (Heinrich, 2001). Selected key points were:

- Recruitment and retention of adequate numbers of qualified health care workers are major concerns for many health care providers today.
- Available evidence suggests emerging shortages in some fields (e.g. nurses).
- Vacancy rates for HC workers in rural areas and inner cities are especially high.
- Although demand for most health workers will continue to grow, the increasing age of Americans, and their workforce may limit supply.
- The National Health Services Corp (NHSC) illustrates the challenges in addressing shortages of health professionals in certain locations.
- Better placement coordination with waivers for J-1 visa physicians is needed.
- Loan repayment is a better approach than service-requiring scholarships, to which individuals commit when they are still students.

NOSORH Position (2006): A representative and recent understanding can be gained from the National Organization of State Offices of Rural Health (NOSORH). In September 2006 NOSORH issued a Statement of National Priorities. Presented below are selected summaries of that document, without further comment. Interested readers should see: http://www.nosorh.org/pdf/Rural_Impact_Study_States_IT.pdf

- While most rural communities in the U.S. already experience health care workforce shortages, the demand for health care workers nationwide is projected to grow faster than the supply. This shortage of health care workers can impact health care in a variety of ways, including: decreasing quality of care, decreasing access to care, increasing stress in the workplace, increasing medical errors, increasing workforce turnover/decreasing retention rates, and increasing health care costs.

- Most rural areas ... are classified by the federal government as Health Professional Shortage Areas (HPSAs) for primary medical care. A HPSA designation is made using a formula that includes a ratio of physician to population that is greater than 1:3,500. A population is considered "adequately served" when the ratio is 1:2,000. In 1997, more than 2,200 additional physicians would have been needed in non-metropolitan areas to eliminate HPSA designations. SORH directors consider the workforce shortage to be one of the greatest issues facing rural health, in particular shortages related to physicians and nurses.

- Certain national health workforce trends that will have a profound impact on rural populations and exacerbate the current rural health workforce shortages. Examples follow:

    - If health care consumption patterns and physician productivity remain constant over time, the aging population will increase the demand for physicians per thousand population from 2.8 in 2000 to 3.1 in 2020. Demand for fulltime-equivalent RNs per thousand population would increase from 7 to 7.5 during this same period.

    - Minority and female physicians have a greater propensity than do non-minority and male physicians to practice in urban communities. Meanwhile the percentage of physicians that are minorities and women is increasing.

    - The Bureau of Health Professions projects that there will be a 33-44% increase in demand for physicians, 41 percent for RNs, and 46 percent for LPNs from 2000 to 2020.

    - According to the Bureau of Health Professions, there is an acute shortage of pharmacists in the U.S. In February 1998, there were 2,670 unfilled full and part-time positions in the U.S. as compared to 6,920 in February 2000. Adding to this, enrollment rates in U.S. schools of pharmacy declined during this period.

    - In 1970, women accounted for 13 percent of the nation's pharmacists as compared to 2000 when they were 46 percent of the nation's pharmacists. Women tend to elect part-time work as pharmacists.

    - From 1990 to 1999, there was a 46 percent increase in the number of prescriptions dispensed from hospitals.

- *NOSORH concluded the following in its 2006 statement of national priorities:* ...SORH directors around the U.S. determined that they are most concerned with issues related to rural health workforce, health care services, and the needs of special populations. Research suggests that this concern is warranted as: demand for health care workers is increasing while the supply is decreasing; rural health care facilities continue to be fragile, there are gaps in these services, and all of these rural health services are critical to the health and well-being of the U.S.; and the needs of rural populations are changing, however, the programs serving them are unable to meet their needs. While SORHs respond to a variety of rural health needs and issues, new health care policies and additional rural health programs and funding will be needed if states are to address these increasingly important rural health issues and concerns.

Growth in Alaskan Jobs

Healthcare Workforce Overall: In 2004 there were 301,300 jobs in Alaska, with 32,700 (10.9 percent) of these in health care and social assistance (HCSA). By 2014, the overall job count is projected to be 349,550, with the HCSA workforce at 43,650 (12.5 percent). Thus by 2014, the number of HCSA jobs is projected to grow by 10,950 (34 percent), accounting for 22.7 percent of overall statewide job growth for the period. By 2014, health care and social assistance is projected to be the largest single industry workforce category in Alaska with 43,650 workers. (AHCDB, 2007, Table 3.300).

Social Service Occupations: For 2004, employment in community & social service (CSS) occupations was estimated to be 6,025 jobs. By 2014, this category of jobs is forecasted to be at 7,487, a rise of 1,462 (24 percent). The highest projected growth rates from 2000-2014 are projected to include mental health & substance abuse social workers (36.2 percent), social & human service assistants (34.6 percent) and mental health counselors (32 percent). (AHCDB, 2007, Table 3.310).

Selected Occupations: Review of 42 particular healthcare occupations indicates that these held 14,083 jobs in 2000, and that these are forecasted to reach 25,009 by 2010, an overall rise of 10,026 jobs (78 percent). Registered nursing positions are expected to grow the most, from 4,439 in 2000 to 8,556 in 2010, a gain of 4,117 jobs or (93 percent). All but one of the examined occupations is expected to have more jobs available by 2010. Further, of the 42 occupations presented, employment in 8 of these will more than double (e.g. AHCDB, 2007, Table 3.330).

Shortage in Alaskan Workforce

Health Professional Shortage Areas: Alaska has a large number of federally designated "Health Professional Shortage Areas" (HPSAs), the point of these designations being to aid in health care planning and finance. Typically these are determined by the existence of: (1.) a relative lack of desired personnel, and (2.) the existence of particular socio-economic conditions. A second route to HPSA designation, which is automatic, is via the existence of a federally funded community health center (CHC). HPSAs are of three types. Statewide in 2007 the following HPSAs existed: 28 in Primary Care (with 16 scored, and 12 via CHCs), 27 in Mental Health (with 14 scored, and 13 via CHCs), and 24 in Dental Health (with 7 scored, & 17 via CHCs). (Alaska Health Care Databook, 2007, Table 3.360). However, an important caveat is that many observers feel that the federal HPSA designation process underestimates the extant need for more healthcare professionals (e.g. US GAO, 1995). Thus, these designations should be considered as a conservative method for establishing need for the healthcare workforce.

Medically Underserved Areas: Alaska also has numerous federally designated "Medically Underserved Areas" (MUA) and "Medically Underserved Populations" (MUP). These designations identify shortages of primary medical care, dental health or mental health providers. Designations may be either geographic (MUA, i.e. a county or service area), or demographic (MUP, i.e. low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services). Each designation is assigned an Index of Medical Underservice (IMU) score, which is used to determine the eligibility of an area or population for MUA/MUP status. For 2007, there were 17 area designations and 11 population designations. (Alaska Health Care Databook, 2007, Table 3.350).

Resident Workers with Age: Two aspects of worker demographics further suggest the likelihood of a workforce shortage in the health care and social assistance (HCSA). The first of these regards "resident workers with age". In 2005 total employment in all HCSA occupations stood at 28,356. Of resident workers in all HCSA occupations statewide, 40 percent were age 45 and older; 27 percent were age 50 and older. Of resident workers who were in health care practitioner occupations per se, 47 percent were age 45 and older; and 31 percent were age 50 and older. Therefore, succession planning will be of concern over the next two decades as today's mature health care professionals retire (Alaska Health Care Databook, 2007, Table 3.320).

Non-Resident Workers: A second workforce demographic issue regards the sizeable number of "non-resident" workers. Overall, 10 percent of the workforce was non-residents in 2005, with a

high of (13 percent) among non-resident health care practitioner and technologist occupations. Expect additional pressure to build on the health care system if non-resident (itinerate) workers are not available to fill Alaska health care workforce gaps (e.g. AHCDB, 2007, Table 3.320).

Selected Occupations: Physicians

Physician Shortage – 1997: A decade ago Johnson and Norris (1997) conducted a comprehensive study to describe Alaska's geographic distribution of generalist physicians relative to population. These investigators queried all 443 generalist care physicians (family, general, general internal medicine, and pediatric) or their offices as to their specialties, employers, populations served, hours spent per week offering direct patient care, and locations. The results indicated a 30% overall shortage of generalist physicians for the state, representing roughly 141 full-time-equivalent generalists relative to national practice patterns and trends of health maintenance organizations. Of 17 primary health care areas, including the Anchorage area, 15 showed a need for additional generalist physicians. Most areas had a 20 to 40% shortage.

Physician Shortage – 2004: In 2004, a survey by the American Medical Association showed that, nationally, there were 2.38 practicing physicians per 1,000 people. Alaska's rate of practicing physicians was 2.05 per 1,000 people. Based on Alaska's 2004 population estimate of 656,834 and the national average of 2.38 physicians per 1,000 people, Alaska should have had 1,565 practicing physicians to be on par with national averages. The actual number of physicians practicing in Alaska was 1,347, indicating a shortage of 14 percent or 218 physicians. In areas outside of Anchorage, the rate of physician deficiency was 16 percent. (Alaska Health Care Databook, 2007, Table 3.370).

Physician Shortage – 2006: In 2006, the AK DHSS and the University of Alaska jointly assembled the "Alaska Physician Supply Task Force" (PSTF). This group then conducted a large inter-agency study, issuing the authoritative report, "*Securing an Adequate Number of Physicians for Alaska's Needs*". It found that Alaska had a shortage of physicians. Although not at crisis levels, the shortage was affecting access to care throughout the state, and, increasing cost to hospitals and other health care organizations. Up to 16% of rural physician positions in Alaska were vacant in 2004. Patients with Medicare were having difficulty finding a primary care physician. Several important specialties were in serious shortage in Alaska. It concluded that:

- The shortage is very likely to worsen over the next 20 years as the state's population increases and ages. Physician supply nationwide is entering a period of shortage, according to the best current predictions. Physicians in Alaska are aging and one-third may be retiring in the next 10-15 years. The new generation of physicians wants a more balanced life, meaning fewer hours on duty and more predictable schedules. These trends mean that more physicians will be required to serve the same population. Technology and scientific advances have increased the amount of medical care available, also adding to the need for physicians, as the patients expect more care than previously.

- As the supply of physicians shrinks, recruitment will become more competitive. Alaska's traditional system of recruiting physicians from federal assignment in the military and Indian Health Service is much less effective with changes in these systems. Alaska is far behind the other states in production capacity. (1-2) Long-range planning, even if it includes a four-year medical school in Alaska, will not address current physician needs in a timely fashion, so interim measures are needed. (59)

Selected Occupations: Nurses

Nursing Shortage – 2003: The nursing shortage is particularly acute, both in Alaska and nationwide. It is estimated that during this decade the need for RN's will increase by 4,117 (in 2000: 4,439; in 2010: 8,556) (Fried, N. & Keith, B. (2003). National shortages will make recruitment yet more difficult. As a result, Alaska will have a great need to recruit and retain registered nurses. Addressing the need of rural and remote areas will be yet more difficult and expensive than to do so for urban areas.

Impact on CHC's

Rosenblatt, et al. (2006) examined the status of provider workforce shortages such as these may limit CHC expansion. They noted that the federal government has continued to expand the capacity of community health centers (CHCs) to provide care to underserved populations. The researchers therefore conducted a survey of all 846 federally funded US CHCs that directly provide clinical services and are within the 50 states and the District of Columbia (May-Sept, 2004). Questionnaires were completed by the chief executive officer of each grantee. Overall response rate was 79.3%. Information was supplemented by data from the 2003 Bureau of Primary Health Care Uniform Data System and weighted to be nationally representative.

Rosenblatt, et al (2006) found that primary care physicians made up 89.4% of physicians working in the CHCs, the majority of whom are family physicians. In rural CHCs, 46% of the direct clinical providers of care were non-physician clinicians compared with 38.9% in urban CHCs. There were 428 vacant funded full-time equivalents (FTEs) for family physicians and 376 vacant FTEs for registered nurses. There were vacancies for 13.3% of family physician positions, 20.8% of obstetrician/gynecologist positions, and 22.6% of psychiatrist positions. Rural CHCs had a higher proportion of vacancies and longer-term vacancies and reported greater difficulty filling positions compared with urban CHCs. Physician recruitment in CHCs was heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers. The study concluded that CHCs face substantial challenges in recruitment of clinical staff, particularly in rural areas. The largest numbers of unfilled positions were for family physicians at a time of declining interest in family medicine among graduating US medical students. They stated that success of the current US national policy to expand CHCs may be challenged by these workforce issues.

Strategy

It is essential to enhance the capacity of Alaskan health care provider agencies to recruit and retain staff where: (1.) federal loan repayment programs either do not apply, or, (2.) there are insufficient resources available to meet need. More tools are needed to confront the problem of steadily growing vacancies in the Alaskan healthcare workforce.

Most other states have programs that influence health professionals' geographic and specialty distributions. Programs that integrate a number of strategies for attracting and retaining health professionals have a greater likelihood of success than do programs which rely on a single strategy. Substantial evidence indicates that state-level support-for-service programs should be, and typically are, a fundamental part of those strategies.

Debt from Health Care Training

What follows are brief summaries of recent, representative studies which suggest that:

- Health care student debt affects subsequent practitioner career choices;
- Loan repayment options support recruitment goals; and
- These programs directly help to correct practitioner maldistributions.

Factors in Recruitment & Retention: Daniels, et al. (2007) sought to identify factors associated with rural recruitment and retention of graduates from a variety of health professional programs in the southwestern United States. They conducted a longitudinal study by mailing a survey to graduates from 12 health professional programs in New Mexico. The main outcomes examined were: (1.) first rural employment, and, (2.) aspects of any rural employment, since graduation. Daniels, et al. (2007) concluded that rural background and preference for smaller sized communities are associated with both recruitment and retention. In addition, however, they stated that loan forgiveness and rural training programs appear to support recruitment. Retention efforts must focus on financial incentives, professional opportunity, and desirability of rural locations

Medical Student Debt & Career Choice: Rosenblatt & Andrilla (2005) examined the notion that medical students' rising total educational debt is one of the factors that explains the recent decline in students' interest in family medicine and primary care. They analyzed the results from questions on the Association of American Medical Colleges' 2002 Medical School Graduation Questionnaire that focused on students' debt and career choices. Students reported that higher levels of debt influenced their future career choices. An inverse relationship was observed between the level of total educational debt and the intention to enter primary care, with the most marked effect noted for students owing more than $150,000 at graduation.

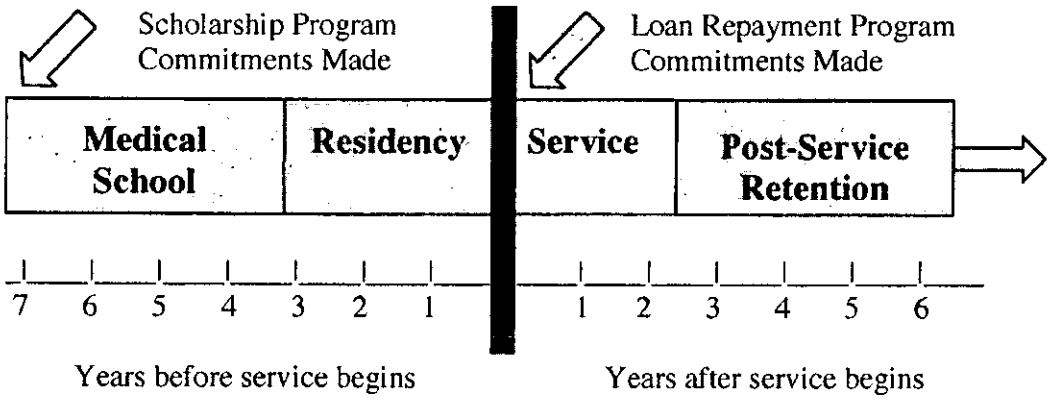
Medical Training Debt & Service Commitments: Pathman, et al (2000) assessed how student loan debt and scholarships, loan repayment and related programs with service requirements influence the incomes young physicians seek and attain, influence whether they choose to work in rural practice settings and affect the number of Medicaid-covered and uninsured patients they see. Data are from a 1999 mail survey of a national probability sample of 468 practicing family physicians, general internists and pediatricians who graduated from U.S. medical schools in 1988 and 1992. A majority of these generalist physicians recalled "moderate" or "great" concern for their financial situations before, during and after their training. Eighty percent financed all or part of their training with loans, and one-quarter received support from federal, state or community-sponsored scholarship, loan repayment and similar programs with service obligations. In their first job after residency, family physicians and pediatricians with greater debt reported caring for more patients insured under Medicaid and uninsured than did those with less debt. For no "specialty" was debt associated with physicians' income or likelihood of working in a rural area. Physicians serving commitments in exchange for training cost support, compared to those without obligations, were more likely to work in rural areas (33 vs. 7 percent, respectively, $p < 0.001$) and to provide care to more Medicaid-covered and uninsured patients (53 vs. 29 percent, $p < 0.001$), but did not differ in their incomes ($99,600 vs. $93,800, $p = 0.11$). Thus, among physicians who train as generalists, the high costs of medical education appear to promote, not harm, national physician work force goals by prompting participation in service-requiring financial support programs and perhaps through increasing student borrowing.

Support-for-Service Programs

It is well-established that a sizeable number of healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away. For instance, training to become a physician is expensive, as 80 percent of medical students who graduate in debt will attest (e.g. Jolly, 2005). In 2004, young physicians' educational debt averages stood at over $109,000 and was this cost was increasing at the rate of more than $4,000 per annum (e.g. AAMC, 2004). Nonetheless, educational costs and students' fears of acquiring six-figure debts have created a market for government programs that link support for healthcare training costs to a period of obligated clinical work in shortage areas.

There are several types of financial "support-for-service programs" (SFSP's). These include: scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs. One of the two most common types of such programs is the service-requiring scholarship program. These pay tuition and other costs for healthcare students while obligating them to a period of service that begins when they complete residency (or similar post-graduate training) years later. The other common program type is loan repayment. Loan repayment programs recruit healthcare practitioners as they complete their training and are ready to begin service in exchange for paying off the traditional education loans they acquired years earlier. Programs of both types typically require one year of service for each year of training cost support they provide.

Figure 1 - Timeline of physicians' training years, signing of commitments with service-requiring scholarship and loan repayment programs, service periods (typically two-to-four years) and post service retention.



(After: Pathman, D.E. (2006). What Outcomes Should We Expect From Programs That Pay Physicians' Training Expenses in Exchange For Service? NCMEDJ, 67(1), pg. 77)

Support-for-service programs appear to be a natural solution to both the students' and the public's needs. They have grown in popularity over the past 25 years in tandem with rising tuition costs, with both federal and state agencies using them. In one well-known federal example, in 2005 the Bureau of Health Professions reported that the National Health Service Corps (NHSC) was providing an obligated physician workforce of about 1,700 scholars and loan re-payers. As a result of NHSC shifting most of its funding to loan repayment, more workers were immediately brought into the fold, and that census has now roughly doubled. In addition, most states also

sponsor their own support-for-service programs. In 1996 there were a total of 69 state programs with an estimated workforce of 1,300 practicing physicians. These state programs doubled in number from 1990 to 1996 and very likely have grown further since (Pathman, et al. 2000).

State Scholarship, Loan Forgiveness, and Related Programs: Pathman, Taylor, et al (2000) noted that in the mid-1980s, states expanded their initiatives of scholarships, loan repayment programs, and similar incentives to recruit primary care practitioners into underserved areas. These programs have since grown substantially during the ensuing two decades. The authors thus sought to identify and describe state programs that provide financial support to physicians and midlevel practitioners in exchange for a period of service in underserved areas, and to begin to assess the magnitude of the contributions of these programs to the US health care safety net. This cross-sectional, descriptive study established the number and types of state support-for-service programs in 1996; trends in program types and numbers since 1990; distribution of programs across states; numbers of participating physicians and other practitioners in 1996; numbers in state programs relative to federal programs; and basic features of the state programs.

The study found that in 1996 there were 82 eligible programs operating in 41 states, including 29 loan repayment programs, 29 scholarship programs, 11 loan programs, 8 direct financial incentive programs, and 5 resident support programs. Programs more than doubled in number between 1990 (n = 39) and 1996 (n = 82). In 1996, an estimated 1306 physicians and 370 midlevel practitioners were serving obligations to these state programs, a number comparable with those in federal programs. Common features of state programs were a mission to influence the distribution of the health care workforce within their states' borders, an emphasis on primary care, and reliance on annual state appropriations and other public-funding mechanisms.

The authors concluded that as of 1996 the several states had fielded an obligated primary care workforce comparable in size to the better-known federal programs. Thus, these state programs constitute a major portion of the US health care safety net. The study emphasized that such state programs should be considered in plans to further improve health care access.

Experience of Other States

State-Level Support-for-Service Programs (2007): Considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel. Tables 1, 2 & 3 here-present listings of those state-level support-for-service programs that were web-posted by the Association of American Medical Colleges (as of 8/10/07). These provide a selective look at state and federal loan repayment, forgiveness and scholarship programs available to allopathic medicine and other health professions students. This compilation is not exhaustive, and at present, our office is not aware of one that is. The here-derived tables shows that, overall, there were 81 programs. There were 44 listed states with at least one program (88% of US states). Fully, 21 of these states had two or more programs (47% of listing), with highs found in New Mexico (at 5) and Minnesota (at 7). On average, the 44 listed states had nearly 2 programs (1.8) each. Table 1 presents 43 listings that were designated as "state programs". Table 2 presents another 20 listings that were designated as "federal/state programs". Finally, Table 3 presents another 18 programs were not otherwise classified, though quick inspection of titles suggests that many can be readily classified. Those programs that were categorized as (strictly) "federal" (e.g. NIH, military) are not further considered. Click on any program title for more programmatic detail.

State-Level Offices: Service-for-Support Programs

Table 1: Designation as: "State Program"

State	Program
Arizona	Arizona Medical Student Loan Program
Arkansas	Community Match Physician Recruitment Program
Arkansas	Physician Grant Recruitment and Retention Program
Colorado	Colorado Health Professions Loan Repayment Program
Georgia	State Medical Education Board of Georgia Scholarship Program
Indiana	Indiana Primary Care Scholarship Program (IPCSP)
Iowa	Osteopathic Physician Recruitment Program (O.P.R.P.)
Kansas	Kansas Bridging Plan
Maine (2)	Maine Health Professions Loan Program
Maryland	Loan Assistance Repayment Program for Primary Care Physicians
Minnesota	Minnesota Dentist Loan Forgiveness Program
Minnesota	Minnesota Nurse Loan Forgiveness Program
Minnesota	Minnesota Rural Mid-level Practitioner Loan Forgiveness Program
Minnesota	Minnesota Rural Physician Loan Forgiveness Program
Minnesota	Urban Physician Loan Forgiveness Program
Mississippi (2)	Family Medical Education Loan/Scholarship Program
Mississippi	State Medical Education Loan/Scholarship Program
Missouri	Primary Care Resource Initiative for Missouri (PRIMO)
Montana (3)	Montana Rural Physician Incentive Program (MRPIP)
Montana	WICHE Professional Student Exchange Program
Montana	WWAMI Medical Exchange Program
Nebraska	Nebraska Student Loan Program
Nevada	Nevada Health Service Corps
New Mexico (5)	Allied Health Loan-for-Service Program
New Mexico	New Mexico Health Professions Student Loan-for-Service Program
New Mexico	Nursing Loan-for-Service Program
New Mexico	Osteopathic Medical Student Loan for Service Program
New York	Regents Physician Loan Forgiveness Award Program
North Carolina (4)	Community Practitioner Program
North Carolina	NC Student Loan Program for Health, Science and Mathematics
North Carolina	North Carolina State Loan Repayment Program
Ohio	Ohio Physician Loan Repayment Program

Table 1: "State Program" (continued)

Oklahoma (3)	Family Practice Resident Rural Scholarship Loan Program
Oklahoma	Oklahoma Rural Medical Education Scholarship Loan Program
Oklahoma	Oklahoma State Loan Repayment Program
Oregon	Oregon Rural Health Services (RHS) Loan Repayment Program
South Dakota	South Dakota Midlevel Tuition Reimbursement Program
Tennessee (2)	Health Access Incentive Program: Incentive Grant: Mid-Levels
Tennessee	Health Access Incentive Program: Incentive Grant: Physicians
Virginia	Virginia Loan Repayment Program
Washington (2)	WA State Health Professional Loan Repayment Program
West Virginia	Medical Student Loan Program
Wyoming	Wyoming WWAMI Medical Education Program

State-Level Offices: Service-for-Support Programs

Table 2: Designations as: "Federal/State Program"

Connecticut	Connecticut State Loan Repayment Program
Delaware	Delaware State Loan Repayment Program
Illinois	Illinois/National Health Service Corps Loan Repayment Program
Iowa (2)	Iowa PRIMECARRE Loan Repayment Program
Louisiana	Louisiana State Loan Repayment Program
Maine	Maine State Loan Repayment Program
Massachusetts	Massachusetts State Loan Repayment Program
Minnesota	Minnesota State Loan Repayment Program
Missouri (2)	Physician Loan Repayment
New Hampshire	NH Primary Loan Care Repayment Provider Plans
New Jersey	Primary Care Loan Redemption Program of New Jersey
New Mexico	Health Professional Loan Repayment Program (HPLPP)
Ohio	NHSC / BHPr Ohio Loan Repayment Program
Pennsylvania	Pennsylvania's Primary Health Care Practitioners Loan Repayment Program
Texas	Physician Education Loan Repayment Program of Texas
Utah	Utah Health Care Workforce Financial Assistance Program
Virginia (2)	National Health Service Corp-VA Loan Repayment Program
Washington	WA State Health Professional Scholarship Program
Wisconsin (2)	Wisconsin Health Professions Loan Assistance Program
Wisconsin	Wisconsin Physician Loan Assistance Program

(number in parentheses indicates total state-office programs for that state that are not "federal" per se)

State-Level Offices: Service-for-Support Programs

Table 3: Programs – "Not Otherwise Designated"

Arizona (3)	Arizona Loan Repayment Program
Arizona	NHSC/Arizona Department of Health Services
Arkansas (3)	Arkansas Rural Medical Practice Student Loan/Scholarship Program (ARMPSLSP)
California (2)	Dr. James L. Hutchinson & Evelyn Ribbs Hutchinson Medical School Scholarship
California	NHSC/CA State Loan Repayment Program
Georgia (2)	Georgia Physician Loan Repayment Program
Kentucky	Rural Kentucky Medical Scholarship Fund (RKMSF) Grant Program
Michigan	Michigan Essential Health Provider Program/SLRP
Minnesota (7)	Federal National Health Service Corps (NHSC) Loan Repayment Program
Nebraska (2)	Nebraska Loan Repayment Program
North Carolina	Loan Repayment Program
North Dakota (2)	The Medical Personnel Loan Repayment Program
North Dakota	The State Community Matching Physician Loan Repayment Program
Rhode Island	Rhode Island Health Professional Loan Repayment Program
South Dakota (3)	NHSC/Loan Repayment and Scholarship Program
South Dakota	South Dakota Physician Tuition Reimbursement Program
Vermont (2)	Freeman Educational Loan Repayment for Physicians Program
Vermont	Vermont State Loan Repayment Program

(number in parentheses indicates total state-office programs for that state that are not "federal" per se)

Loan Repayment Programs

In national studies, loan repayment has been found to be a successful strategy to recruit and retain physicians and nurses. Twenty-five years of program evaluations have clarified many of the outcomes possible from healthcare training support-for-service programs. Furthermore, studies have demonstrated that loan repayment programs, as a whole, have better outcomes than scholarship programs. Results of these comparisons have proved compelling. For example, studies demonstrating the strengths of loan repayment programs prompted Congress recently to allow the NHSC to make more loan repayment and fewer scholarship awards (e.g. Bureau of Health Professions, 2005) and led some states to expand their loan repayment programs (Pathman, et al. 2000).

Studies have shown that there are several benefits which can accrue from loan repayment programs. Selected examples follow:

> *High Position Fill-Rates:* Some programs, including the NHSC, have many more applicants than their funds can support and regularly fill all funded positions; other programs have many unfilled positions for lack of applicants.
>
> *High Service Completion Rates*: Very few loan repayment programs, accordingly, have found a need to set any buy-out penalties; as a group, their service completion rates average 93% without them (Pathman, et al, 2004). It is the physician-program-community fit and the financial attractiveness of the program that prompts physicians to complete their obligations with service (the "carrot"), not financial and legal threats (the "stick").
>
> *High Retention Rates:* Beyond merely completing obligations with service, there has long been the hope that obligated physicians will remain in their service communities for years afterwards ... In fact, data show that physicians participating in state-run support-for-service programs remain in their service sites as long on average as other young physicians remain in practices of all types nationwide. Physicians obligated to state-run loan repayment programs remain substantially *longer* than other young physicians (e.g. Pathman, 2004).

Effectiveness of Support-for-Service: Sempowski, I.P. (2004) attempted to evaluate the effectiveness of programs that provide financial incentives to physicians in exchange for a rural or underserviced area return-of-service (ROS) commitment. This was done via a systematic literature review using Medline and Ovid HealthSTAR databases were searched from 1966 to 2002. The initial search yielded 516 results. Bibliography review yielded additional references. Ten publications were selected as the highest level of evidence available. The main outcome measures were: (a.) initial recruitment of physicians, (b.) buyout rates, and (c.) long-term retention.

The majority of studies reported effective recruitment despite high buyout rates in some US-based programs. The one prospective cohort study on retention showed that physicians who chose voluntarily to go to a rural area were far more likely to stay long term than those who located there as an ROS commitment. Multidimensional programs appeared to be more successful than those relying on financial incentives alone. Sempowski, I.P. (2004) concluded that ROS programs to rural and underserviced areas have achieved their primary goal of short-term recruitment but have had less success with long-term retention. However, this study combined different types of support-for-service programs within its analysis thus somewhat preventing conclusions as to loan repayment programs, per se.

Loan Repayment vs. Payback Programs: Miller & Crittenden (2001) sought to determine and contrast the possible impact that two different types of support-for-service programs might have on medical school choice, and, students' intentions to return to their home states. The authors examined difference in preferences for: (a.) payback programs regarding state-subsidized medical education which are designed to increase the rate of graduates returning to those states to practice; and (b.) loan repayment programs that are designed to entice medical school graduates from rural states to return to their home states.

Miller & Crittenden (2001) surveyed 229 medical students (response rate 80 percent). The questionnaire collected background information on the students and addressed the possible

impact of payback and loan repayment policy proposals on student plans. Forty-seven percent of students reported that they would attend a different medical school if a required payback program were in place. Students who were more competitive at the time of admission to medical school were significantly more likely to say they would attend another medical school than were less competitive students. In contrast, 48 percent of students reported that they would be more likely to return to their home states if expanded loan repayment programs were available for service in areas of need. The findings suggest that payback programs may dissuade more competitive students from entering medical schools with such requirements, compromising the pool of students most likely to return to rural areas. Conversely, medical students appear willing to consider loan repayment programs upon completion of their training.

Why Do Loan Repayment Programs Work? Expert opinion was sought for insights into why loan repayment programs work. Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

> "As a whole, state-run (loan repayment) programs are successful but not because they are run well---- most are under-funded, under-staffed and can't offer individualized assistance to the health care practitioners they support. They are successful because the benefit of loan repayment is clear to potential applicants and programs typically only provide payments to participants after they complete each 3 or 6 months of work; therefore, if a participant leaves or otherwise fails to work in the agreed upon area or practice, payments simply stop and there is no need to enforce penalties." (Pathman, 2007)

Does a Loan Repayment Program Make Sense for Alaska? Expert opinion was sought for perceptions as to whether a loan repayment program makes sense for Alaska. Again, Donald Pathman, MD, MPH, (Univ. of North Carolina) was queried as to his view. Dr. Pathman stated:

> "I am glad to hear that Alaska is thinking of expanding loan repayment opportunities. I visited Alaska for the first time this past spring for the National Rural Health Association meeting, in Anchorage, with a side trip to Minto and Fairbanks. What an amazing place! I spoke with several folks working with the Native American health corporation in the state, and realize the physician shortages for the populations they serve. I was impressed that they knew little about how to attract and keep a physician. Lots of opportunities there for improvement in programs." (Pathman, personal communication, 2007)

Position of the Alaska Physician Supply Task Force (2006): The PSRF recommended a number of specific strategies and action steps to achieve four main goals related to assuring an adequate supply of physicians to meet Alaska's need. One of the PSRF findings was that Alaska's clinics and hospitals receive inquiries from physicians about the availability of loan forgiveness often. Loan repayment is a proven strategy for recruiting physicians, and the federal loan repayment programs currently available to Alaska physicians need to be stabilized financially and supplemented with Alaska-based programs. For detail, see: *"Securing an Adequate Number of Physicians for Alaska's Need"* (2006).

Precedents in Alaska: There are, and have been, other circumspect loan repayment programs for health professionals here in Alaska. These have typically been via categorical federal funding. Examples include Indian Health Service supports, and use of the National Health Service Corp. There have also been selected opportunities via the regional health corporations, and certain hospitals. Further, the Alaska Mental Health Trust has recently considered some loan repayment supports in the behavioral health field. While promising, these will collectively still fall far short of garnering the needed workforce to face projected need.

Recommendation

Recommended: Alaska should establish a Health Care Professionals Loan Repayment Program (HCPLRP). Decisions as to particular program elements must await further public process. Questions should be addressed regarding at least the following program elements:

- *Organizational Support*: What are the best ways to build legislative and public understanding and support on this issue? For instance, members of the Alaska Physician Supply Task Force supported a loan payback provision for physicians.

- Oversight: What is that governance entity most suited to provide leadership and oversight of this program? Similarly, which entity is most suited to administer the program? There is evidence that no single entity has the expertise to properly oversee and administer such a program. This might argue for a blended or interagency oversight structure. One agency might provide programmatic administration, while the other might serve as fiduciary agent.

- *Fiduciary Agent*: It may prove both workable and preferred that fiduciary mechanics and other administrative aspects be organizationally separated. If so, which agency is most to assume this fiduciary role? One approach might be to have the program work in tandem with the Alaska Commission on Postsecondary Education (ACPE). It is possible that the functions of the Alaska Commission on Postsecondary Education could be amended as these relate to repayment provisions healthcare degree program participants. It appears likely that no substantive change would be necessary for ACPE to act strictly as fiscal agent for participant payments. Further, this would not be a recommendation to change the scope of the ACPE mission to include direct workforce development. This later function would likely be accomplished by another state agency via interagency partnership.

- *Provider Eligibility*: Which healthcare occupations are to be deemed as eligible for the HCPLRP? Are all eligible occupations to benefit equally from the HCPLRP, or, will the occupations differ in terms of: (a.) maximum financial benefit, (b.) length of service required, (c.) specificity of service location, and, (d.) penalty for early-quit? There is evidence that for a loan repayment program, marked penalties are not needed, and, are actually likely harm outcomes.

- *Repayment Details*: Several policy and procedural decisions must be concluded. Examples follow. What is an adequate period of service-payback? What is the proportionality of payback when scheduled over years? What are the most useful policies with which to govern service payoff?

- *Work Processes*: Several work-process details will need to be established as regards management client relationships. Programmatically, what ways do we want to work, one-on-one, with program applicants to help them find suitable communities/positions? What types of assistance do we most want to provide to applicants, practices and communities?

- *Program Evaluation*: An ongoing evaluation should be installed and maintained as an expected part of any proposed support-for-service program (e.g. Henderson & Fox-Grage, 1997). It is in everyone's interest, and particularly in those of Alaska's medically underserved communities, that such programs: (a.) have explicit outcome objectives, (b.)

are regularly monitor as to those outcomes, (c.) openly acknowledge weaknesses, and (d.) embrace change as needed. Many different types of outcomes might be monitored. Reasonable measures might include:

- Practice in specific needy communities (e.g. HPSAs)
- Serve high-priority patient groups (e.g. Medicaid)
- Service completion of participants
- Retention rate of participants
- Satisfaction of participants
- Indictors as to the content of practice/work of program participants (e.g., proportion that provide inpatient care, that provide obstetrical care, or whatever specific services are deemed to have critical workforce shortages)

Other Support-For-Service Options to Consider:

As robust as a state-level loan repayment is likely to prove, there are other programmatic strategies. At least two other strategies should also be thoroughly examined: (a.) service-option loans, and (b.) direct incentives.

- *Strategy: Service-Option Loan Programs*

  Consider provision of educational loans to all citizens of Alaska who undertake health professions training, where the loans will be forgiven if they work within Alaska after graduation. This would provide added incentive for health care students who were raised in Alaska to return to Alaska to practice, rather than being wooed away by the states/communities where they receive their training. There is evidence that these have worked well elsewhere, given attention to key programmatic details. For Alaska, a service-option loan program should nicely complement a loan repayment program; because the former would address only Alaska residents and the latter would primarily attract those health practitioners coming from out-of-state.

- *Strategy: Direct Incentive Programs*

  Consider provision of direct incentive programs. In these, funding is provided to practitioners who agree to work in needy settings whether or not they have educational loans to be repaid. There is no reason to believe that only young practitioners-with-debt are suited to work in rural areas and/or with underserved populations.

  Loan repayment programs only target recent graduates who have weighty educational debts. For instance, as regards physicians, many recent graduates carry minimal debt (perhaps 40%). Further, a large portion of those physicians who are potentially recruit-able to Alaska are 10 or 20 years out of training and have no educational debts. It is possible, even likely, that "an Alaskan adventure" would appeal to some number of mid and late-career physicians. It may prove informative to assess the State's medical licensure files to learn the average/median/quartiles of age of physicians as to when they gain their first Alaska license. If, indeed, many are older, then this is a group that should be targeted. Direct incentive programs target those practitioners without loans, and, older practitioners.

Finally, support-for-service programs (of all types) constitute only one way to help bolster recruitment and retention of health care professionals. Alaska must develop a multi-pronged approach to confronting our growing healthcare workforce shortage.

Conclusion

Substantial evidence shows that Alaska currently experiences a shortage of healthcare professionals, and, that this shortage exists in several key occupational categories.

There are several types of support-for-service programs, and the national experience has proven loan repayment programs to be robust. These have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages. To quote from Pathman, et al. (2004),

> "As a whole, states' support-for-service programs bring physicians to needy communities where they find satisfying work caring for at-risk patient populations and remain for many years. Of all program types, the loan repayment and direct financial incentive forms, which target physicians after training, show the broadest successes. The successes of these state programs warrant their continued support and perhaps expansion to remedy the continuing maldistribution of physicians." (pg. 567).

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March 10, 2010

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the National Association of Social Workers – Alaska Chapter strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the Lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Health Care Professions Loan Repayment & Incentive Program proposal – SB 139 and HB 392 – bring to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

We recommend the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

/s/

LaVerne Demientieff
President, NASW-AK

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Iliuliuk Family and Health Services, Inc.

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Phone: (907) 581-1202
Fax: (907) 581-2331

Re: Support for HB 392 Incentives for Certain Medical Providers

March 11, 2010

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Iliuliuk Family and Health Services, Inc. (IFHS) strongly supports HB 392 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Our organization, IFHS, is the only comprehensive service provider for medical, dental and behavioral health services within 800 air miles of Unalaska. We are remote, and we frequently find that we are unable to compete with "lower 48" medical practices for providers, since we also cannot compete effectively with salaries. State loan repayment options for our providers would help us offer a competitive package.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

It takes IFHS over a year to recruit a single doctor; six months to recruit a behavioral health specialist, and the last time we recruited a dentist, it took us four years to do so. We cannot recruit RNs – until July of 2009, we had two open RN positions for over two years, and currently have one RN position that has been open for over three years. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. HB

392 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports HB 392 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Sonia Handforth-Kome
Executive Director

ALASKA
PRIMARY CARE ASSOCIATION

The Honorable Bob Herron
Alaska State House of Representatives
State Capitol, Room 411
Juneau, Alaska 99801

Re: Support for HB 392 Incentives for Certain Medical Providers

March 10, 2010

Dear Representative Herron,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans. The APCA represents 26 health care organizations operating 142 Community Health Center (CHC) clinic sites, as well as other primary care safety net providers, throughout Alaska. Currently, health professional workforce shortages are impacting the ability of CHC clinics and other health entities to provide access to health care services for Alaskans. The CHCs in Alaska exist to provide care for medically underserved populations and communities; however, the CHCs are having great difficulty recruiting and retaining providers. The CHCs provided primary health care services to over 81,000 patients (1 in 9 Alaskans) last year with the following estimated vacancies: 22 physicians, 20 physician assistants, 26 nurse practitioners, 6 dentists, and 10 licensed clinical social workers – to name a few.

Not only is Alaska suffering from labor shortages in most professional health care occupations,[2] but there is a national shortage of primary care providers as well. With most areas of Alaska designated as a Health Professional Shortage Area or a Medically Underserved Area,[3] the national shortages have made recruitment and retention even more challenging for clinics here. All but six of the fifty states have addressed similar professional health provider shortages by implementing state sponsored support-for-service programs which have helped to attract and retain health care providers.[4]

The APCA hears routinely from frustrated medical directors throughout Alaska that they are "losing candidates to other states." Expensive temporary hires and repeated recruitment costs are driving up the cost of health care. The lack of continuity of providers is impacting health care access and outcomes for Alaskans. It is time for

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Alaska to establish a state-sponsored loan repayment and incentive program to help mitigate the health care workforce shortage problem.

In closing, the Alaska Primary Care Association strongly supports HB 392 and the creation of a "Health Care Professions Loan Repayment and Incentive Program" in Alaska. Thank you for your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

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Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

Alaska Primary Care Association
Board of Directors

RESOLUTION 2009-02

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS the Alaska Primary Care Association strives toward the goal of a healthy population, it recognizes that a robust health care workforce is necessary to provide adequate health care access for all Alaskans and is a key ingredient in improving the public health of all Alaskans; and

WHEREAS Alaska is competing with other states and nations for the finite pool of available health care professionals; and

WHEREAS Alaska is suffering from labor shortages in most professional health care occupations[1], and these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS most of the State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;[2] and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSPs), and good outcomes have been achieved with these;[3] and

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective of the several SFSP strategies in terms of both recruitment and retention;[4] and

WHEREAS a key problem is that Alaska does not have a robust SFSP while most other states do, many have several, and further, some of those are growing;[5] and

WHEREAS most all other states have state-sponsored SFSPs that influence health professionals' geographic and specialty distributions;[6] and

WHEREAS it is well-established that many health care professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

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WHEREAS for areas in the state where providers are required to work in professional isolation due to remote settings, direct incentives are needed to attract more experienced health care providers who do not carry debt and are considered desirable placements; and

WHEREAS considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of health care personnel; and

WHEREAS in 2006, the Alaska Physician Supply Task Force recommends a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need, including creation of a SFSP, and the 2007 Alaska Workforce Vacancy Study and the 2005-2006 Status of Recruitment Resources and Strategies (SORRAS II) point to the need for a state loan repayment and incentive program in order for Alaska to compete with the lower 48 to recruit from a limited pool of numerous types of health care providers nationwide; and

WHEREAS a concept proposal submitted to the Alaska Primary Care Council by Pat Carr, Chief Health Planning and Systems Development for the Department of Health and Human Services, concludes the following:

> Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages;[7] and

WHEREAS the above proposal recommends that "Alaska create a 'Health Care Professions Loan Repayment Program.' "[8]

THEREFORE BE IT RESOLVED that the Alaska Primary Care Association supports the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" and will advocate for the necessary authorizing and fiduciary legislation.

SUBMITTED BY:
Regan Mattingly, State Affairs Coordinator
Shelley S. Hughes, Government Affairs Director
Marilyn Kasmar, Executive Director

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

DONE AND DATED THE 21st DAY OF January IN THE YEAR 2009

SIGNED BY _____

Sonia Handforth-Kome, APCA Board President

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[4] Ibid.

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[6] Ibid.

[7] Health Planning & Systems Development, Alaska Department of Health & Social Services. *Health Care Professions Loan Repayment Program Concept Proposal*, September 11, 2007.

[8] Ibid.

Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska

WHEREAS the Mat-Su Health Foundation's mission is to enhance the health of Alaskans living in Mat-Su, where health is in part determined by access to primary, behavioral, and dental care and preventive services;

WHEREAS an adequate healthcare workforce is necessary to provide this access, and according to the *2005-2015 Mat-Su Borough Health Plan*, Mat-Su has an "inadequate number of providers to meet the demands of a growing population" in both the core area and the outlying rural areas of the borough;[i]

WHEREAS Mat-Su is designated a Medically-Underserved Area/Population by the U.S. Health Resources and Services Administration and has sub-regions designated Primary Care Health Professional Shortage Area, Mental Health Professional Shortage Area, and Dental Care Health Professional Shortage Area;[ii]

WHEREAS the Mat-Su Borough is the fastest growing area of Alaska, growing from 5,188 in 1960 to 82,515 in 2008 due to both positive birth and in-migration rates; and the AK Department of Labor projects that all Mat-Su age groups will continue to grow through 2020;[iii]

WHEREAS the Mat-Su Borough is experiencing one of the highest rates of population growth in the state among senior citizens, who use the healthcare system disproportionately more than any other age group; and the Alaska Commission on Aging reports Mat-Su's senior growth rate at 11.6%, which includes a net gain from a senior in-migration rate that is almost double its senior out-migration rate;[iv]

WHEREAS the Alaska Health Care Commission has designated Medicare-access as one of its six focus areas; and the University of Alaska Anchorage Institute of Social and Economic Research has reported that access to primary care for Medicare beneficiaries is problematic in Mat-Su, where data reveals that only 57.7% of Mat-Su primary care physicians will see new Medicare patients;[v]

WHEREAS the Mat-Su Health Foundation believes that an investment in the education of Mat-Su residents will help to build the healthcare workforce of the future and an engaged citizenship with a higher capacity to address the health-related challenges impacting Mat-Su and Alaska; and to this end has offered scholarships to help defray the cost of higher education and encourage Mat-Su residents to complete a degree or certificate program that emphasizes health and/or wellness; but also recognizes that more needs to be done to bolster the healthcare workforce in Mat-Su and Alaska;

WHEREAS Mat-Su Regional Medical Center has spent $6,238,438 on contract labor over the last five years on temporary health professionals from outside the state to fill current needs;

WHEREAS Alaska is competing with other states for the finite pool of available health care professionals; and over 40 states currently offer Support-for-Service Programs (SFSPs) that have influenced health professionals' geographic and specialty distributions;

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective strategies in terms of both recruitment and retention;[vi]

WHEREAS without this incentive, it will be challenging for Alaska to compete for medical and health professionals, especially to work in rural areas;

BE IT THEREFORE RESOLVED that the Mat-Su Health Foundation promotes and advocates for the establishment of the Health Care Professions Loan Repayment & Employment Incentive Program to bring more qualified medical professionals to Alaska and will advocate for the necessary authorizing and fiduciary legislation.

***Approved by the Mat-Su Health Foundation Board of Directors on* January 18, 2010.**

Deborah Prator, President

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[i] 2005-2015 Mat-Su Borough Health Plan. Information Insights. January 2006. http://www.matsugov.us/planning/index.php?option=com_content&view=article&id=69:mayors-blue-ribbon-taskforce-on-forming-a-health-and-social-service-board&catid=29:health-and-human-services-board&Itemid=20147#.

[ii] U.S. Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. http://datawarehouse.hrsa.gov/GeoAdvisor/shortagedesignationadvisor.aspx.

[iii] Matanuska-Susitna Borough, Alaska Department of Labor, Division of Research & Analysis. http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileQSResults.asp?geogArea=0204000170&population=census:data:Population&B1=View+Report.

[iv] Alaska State Plan for Senior Services FY2008-FY2011. Alaska Commission on Aging. June 2007. http://www.hss.state.ak.us/acoa/documents/statePlan/FinalFY08_FY11.pdf.

[v] How Hard Is It for Alaska's Medicare Patients to Find Family Doctors? University of Alaska Anchorage Institute of Social and Economic Research. UA Research Summary No. 14. March 2009. http://www.nss.state.ak.us/healthcommission/200905/iser_doctors.pdf

[vi] Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. http://www.hss.state.ak.us/primarycare/assets/loan-proposal.pdf.

Shawnie Olson – Counseling Services

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Dear Representative Herron,

Recently I was informed about HB392 and SB139. The bill seeks to address the shortage of certain health care professionals in Alaska by increasing their numbers. Unfortunately the bill does not include Licensed Professional Counselors who now constitute one of the largest bodies (if not THE largest body) of mental health professionals working in our state. As Chair of the Board of Professional Counselors, I feel it is imperative to ask you to support an amendment to add this group of licensed professionals to this bill.

As you are probably aware, there are roughly 450 Licensed Professional Counselors in Alaska. These mental health care providers have gone through a process of qualifications that is demanding, academic, and professionally challenging. They must have a minimum of 3,000 hours of counseling and a sixty credit master's degree in counseling or a closely related field before they can even consider pursuing a license. In a field that has only existed for less than ten years in Alaska, LPCs have caught up to many of the other mental health care providers in numbers and have surpassed many of them with their requirements. I recently attended the American Association of State Counseling Boards yearly conference where I represent Alaska. At this meeting I always provide a workshop which enables me to closely compare notes with LPC requirements from other states. I can honestly report to you that Alaskan standards are the highest for licensure of LPCs.

To my knowledge, Psychological Associate Licenses are not given in other states. Many of the students graduating with a master's level psychology degree end up before my board requesting an LPC. Licensed Profession Counseling Licenses are easily transferable 'outside'. LPC work is almost identical to PA work with the exception of two types of psychological testing that LPCs do not provide (although we do many other types of testing).

I am requesting that you consider amending HB392 Sec. 18/29/009 (b)(7) to include counselors who have a master's degree from a program that qualified them as a professional counselor. As you know, the need for mental health professionals in Alaska continues to grow and here is a qualified group of people ready to take up the challenge

Most Sincerely,
Shawnie Olson
Board of Professional Counselors, Chair
LPC license 25

Nikoosh Carlo

From: Linda King [lrking@hotmail.com]
Sent: Saturday, February 27, 2010 10:18 PM
To: Rep. Bob Herron

Dear Representative Herron,

As the President of AKAMFT, I am writing you on behalf of our members and profession.

Just this morning I was informed about HB392 and SB139. The stated objective of the bills is to address "the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care", yet the bill omits one of the largest bodies of mental health professionals working in Alaska.

It is my understanding that currently LPC's and MFT's make up the majority of licensed counselors in our state. There is not a school in Alaska that offers a Marriage and Family Therapist program, so most therapists in Alaska have received their education in others states or were grandfathered in. This year MFT's became recognized in all fifty states and is a recognized licensure by the VA and other federal programs. I have personally know several people who have left our state to get a MFT degree and then returned to work in Alaska. To get a MFT license more education is required in families, systems and working with couples. Licensing requirements for MFT's in all fifty states are as stringent or higher than that of psychologist and master level clinicial social workers.

I don't understand the omission of both LPC and LMFT qualified master's level graduates. Alaska Pacific University graduates about 20 master's level psychologists per year—they eventually get the LPC license. UAA and UAF graduates scores of people yearly with master's degrees—many of whom also seek the LPC. The reason master's level grads go for the LPC is because the master's level Psychological Associate license is not recognized outside of Alaska. However the LPC is now a license type in all 50 states. We may be late to the party, but we have a big presence—especially here where in fewer than 10 years of licensing LPC's have virtually caught up with social workers for numbers and presence across the state. We do all of the same work as the other disciplines with the exception of two types of psychological testing—but can do all other types of testing.

The bottom line is that I am encouraging you to amend HB392 Sec. 18.29.009 (b)(7) to include something like the following language: or a counselor holding a master's degree from a program that qualifies them for professional counselor or marital and family therapist license. I also believe that hundreds of other licensed professionals--who will also not utilize the opportunities of this bill, would encourage the passage of this bill. There are too few of us and the need is great.

This change will optimize the possibilities for increasing access to behavioral health/mental health professionals in rural Alaska.

Thank you for your support.

Linda R. KIng, MS, LMFT Alaska License #230
President, AKAMFT

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Anchorage Daily News

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Group advocates incentives to lure health care workers

SHORTAGE: Problem is especially acute in alaska's rural areas, planner says.

By ROSEMARY SHINOHARA
rshinohara@adn.com

(02/15/10 21:37:22)

Armed with reports of continued shortages of doctors and other health care workers in Alaska, a group of health care organizations is pushing for the state to begin offering doctors, dentists, nurses and others money to come practice in Alaska.

Shelley Hughes of the Alaska Primary Care Association, one of the backers of financial incentives for health care workers, led a workshop to talk about the idea Monday at the Alaska Native Tribal Health Consortium.

Her group represented 142 community health clinics -- nonprofits that offer health care on a sliding scale to anyone. Their turnover of doctors, physician assistants and nurse practitioners is about one-third every year, Hughes said.

Statewide, the number of doctors with active licenses in Alaska increased by 2 percent from 2007 to 2009 -- barely keeping up with population growth, and not keeping up with the health care needs of Alaska's growing number of senior citizens, said Alice Rarig, a planner with the state Department of Health and Social Services.

Rarig said the problem is especially acute in some rural areas and for primary care doctors. For example, in Anchorage and Mat-Su, there's a doctor for every 352 people, but in northern and Southwest Alaska, the ratio is closer to one doctor for more than 950 people.

Alaska has a pretty good supply of specialists in urban areas but not enough internists -- primary care doctors -- and psychiatrists, she said.

The Primary Care Association, Alaska State Hospital and Nursing Home Association, Alaska State Medical Association, Alaska Native Health Board, AARP-Alaska and numerous other groups are supporting SB 139, a bill in the Legislature that calls for the state to spend $7.9 million over the next three years on drawing people to work in medical professions in Alaska.

The bill, introduced by Sen. Donny Olson of Nome, has been approved by one committee and now sits in the Senate Finance Committee.

Under the bill, the state would repay student loans over a three-year period for health care professionals recently out of school. It would give direct payments to already-established health care workers in exchange for their practicing in Alaska, also over three years.

The $7.9 million would cover at least 90 positions, with payments ranging from $20,000 to $27,000 per year for those in jobs such as nurse practitioner, physician assistant and physical therapist, and $35,000 to $47,000 annually for doctors, dentists and pharmacists, said Hughes.

People who took especially hard-to-fill positions, such as in remote areas, would get the highest

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 18, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska State Capitol, Room 411
Juneau, AK 99801-1182

Subject: Support for HB 392, Incentives for Certain Medical Providers

Dear Chair Keller and Chair Herron:

The Alaska Commission on Aging (ACoA) encourages support for HB 392 by the House HSS Committee, a bill to establish a loan repayment program to build Alaska's health care workforce by increasing the recruitment and retention of targeted health care professionals in urban and rural, underserved communities. This bill is authored by Representative Bob Herron.

Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment program for health care professions. As a result, our hospitals, clinics, and communities lose potential health care workers to other states that incentivize their workforce with loan repayment programs.

Access to quality health care is a priority for all Alaskans and a critical need for people age 65 years and older. Older Alaskans benefit from regular health care services which enhance their overall health and decrease the need for more expensive, intensive treatment and emergency visits.

Alaska continues to lead all states with the fastest growing senior population currently comprising about 12 percent of our state's population and is projected to increase by five to six percent each year until 2020. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors, as demand increases and providers are reaching retirement age. If older Alaskans are unable to find a health care provider, they may be forced to leave the state in search of access to health care professionals. As a result, Alaska could suffer from a loss of retirees, who contribute more than $1.7 billion to the state's economy in addition to their significant volunteer service, caregiving activities, and community leadership.

ACoA supports HB 392 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information about our position. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Cc: Representative Tammie Wilson, Vice-Chair
Representative Bob Lynn
Representative Paul Seaton

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Representative Sharon Cissna
Representative Lindsey Holmes

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA

March 18, 2010

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Public Health Association (ALPHA) strongly supports HB 392 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

ALPHA supports HB 392 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Sandra Woods, RN-C, MS
President
ALPHA Board of Directors

212 Front Street, Suite 100 Fairbanks, AK 99701 907.450.2459e-*mail:* publichealth@alaska.net
www.alaskapublichealth.org

Rob Earl

From: Janie Fillman [akjanie1@hotmail.com]
Sent: Thursday, March 18, 2010 12:52 PM
To: Rob Earl
Subject: HB 392 Makes Sense: Please Support

Representative Herron

I live in a rural area, Glennallen, Alaska. We have one primary care center to serve the entire Copper River Valley which is the size of the entire state of Ohio. Our residents range from upper middle class and below (I believe). Cross Road Medical Center has a high turnover of providers, making it hard to have continuity of care; many people drive the approximately 400 mile round trip to get primary care. We have many seniors who simply leave our area. Please support HB 392 as it will help rural under served area's such as the one I live in, plus help our urban areas to have higher level providers (ie there is no cardiologist in all of South East Alaska. UA has a "grow our own" philosophy, but cannot grow enough of our own fast enough; some schooling isn't even available in Alaska such as dentistry and pharmacy. We truly need your help!

Sincerely,

Janie Fillman
PO Box 575
Glennallen, AK 99588

Rob Earl

From: Darlene Butttolph [lindab@ptialaska.net]
Sent: Thursday, March 18, 2010 11:58 AM
To: Rob Earl
Subject: I support HB 392 We need your help.

Representative Herron

I support HB 392 as we need it so bad. I also believe All Doctors should have to take a % of Medicare. I bless the ones that do. They care for the people not their pockets. We need this bill so bad.What are we seniors to do for a Doctor??? No one can find one to care for us. We all have paid into Medicare all our lives for what ? One of the best progaims the government every come up with. It needs to go on plus social security. It adds to our retirement so one can retire. Everyone goes on Medicare at 65 so we need to support HB 392

Sincerely,

Darlene Butttolph
2001 Shore Dr
Anchorage, AK 99515

Rob Earl

From: Ann Ehret [aehret@ifhs.org]
Sent: Thursday, March 18, 2010 11:40 AM
To: Rob Earl
Subject: HB 392 - Loan repayment

Representative Herron

I am writing to urge you to support this legislation for the loan repayment and incentive program in Alaska. As a physician who works 75% time in the Aleutians I am not eligible for federal loan repayment toward my $150,000.00 medical school loans. After three years in our community health center at a average salary, I am no longer financially able to sustain the cost of living, monthly loan payments without loan repayment of some sort. I am seriously considering moving out of state to obtain more flexibility in the reimbursement options. If this legislation passes, I will stay in Alaska to provide rural primary care to under served populations.

Sincerely,

Dr. Ann Nora Ehret
PO Box 920091
Dutch Harbor, AK 99692

Rob Earl

From: Sharon Montagnino [smontagnino@sunshineclinic.org]
Sent: Thursday, March 18, 2010 10:21 AM
To: Rob Earl
Subject: HB 392 Good solution for health care workforce strategy

Representative Herron

As executive director for the Sunshine Community Health Center, I cannot tell you how valuable a loan repayment and incentive program is to recruiting potential medical and dental providers.

Sunshine has been actively recruiting for a dentist now for 14 months and while there are other obstacles (i.e. licensing for one) that hamper our efforts, loan repayment has become the number one question asked by candidates. In addition to our dental vacancy, we have been recruiting for a medical provider and the last three candidates said loan repayment was critical in their choice of employment.

While AK certainly has a lot of offer we cannot compete with clinics and centers in the lower 48 if the playing field is not level. One-way to make this happen to approve a loan and incentive program in Alaska.

I urge you to support this bill because without it there is the potential of clinics closing or scaling back hours due to no providers/staff (happened in S.E. when dentist retired and there was no replacement).

Sincerely,

Sharon Montagnino
HC 89 Box 8190
Talkeetna, AK 99676

Rob Earl

From: Nancy Bryan [nabryan46@yahoo.com]
Sent: Friday, March 19, 2010 4:46 PM
To: Rob Earl
Subject: Written HB 392 Testimony (H)HSS

Representative Herron

To have seasoned professional Medical staff able to come to Alaska and build our health community, in my opinion, is so valuable for our growing needs.
This would perhaps be a step forward to making this state competitive to lower 48 states with new ideas, that open up great incentives to better the health care areas here.
To become self sufficient in Alaska has always been our motto of looking forward has it not?
Then make it possible to help those that want to make the journey here perhaps for the first time, and stay in our great state and bring the knowledge they have as well as their wonderful medical ideas to us.
Thank you.
Nancy Bryan

Sincerely,

Nancy Bryan
22479 E Clare Way
Palmer, AK 99645

ASHNHA
Alaska State Hospital and Nursing Home Association

426 Main St
Juneau, Alaska 99801
(907) 586-1790
www.ashnha.org

TESTIMONY ON House Bill 392
March 17, 2010

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership strongly supports **HB 392.**

Health care occupation workforce shortages continue to persist throughout Alaska but are most critical in rural areas of the State.

The Alaska Legislature has been extremely responsive to addressing these shortages by providing increased funding to the University of Alaska to expand health care education programming, and by expanding the WWAMI program from 10 to 20 educational placements each year.

HB 392 complements these other initiatives by establishing a new program that will give the Department of Health & Social Services authority to attract already trained health care professionals in 10 critical occupation categories. The Department will offer either loan repayment or cash incentives commitment to willing providers in exchange for time served in health care shortage areas in Alaska. Up to 90 health care professionals could be attracted to Alaska each year through this program.

Extensive study of Alaska's health care workforce needs have been completed and those data disclose shortages that cannot be overcome by expanded educational programming or WWAMI enrollments alone. These investments, while extremely important, will take from 4 years to 10 years to produce trained clinicians depending on the health care occupation chosen for study. HB 392 will bridge the gap Alaskans face today in many rural and underserved communities throughout the State.

ASHNHA has worked with a large group of other stakeholders to help develop the program outline contained in HB 392. Passage of this measure will help Alaska become competitive with other states in attracting 'practice ready' professionals from around the country.

HB 392 has the strong support of many organizations concerned about the severe shortage of health care professionals in many rural areas of the State. The Alaska Health Care Commission recommended consideration of a loan repayment and incentive program in their report to the Governor and the Legislature.

ASHNHA respectfully urges your support for HB 392 and passage of this bill from House HSS to the next committee of referral.

Thank you for your consideration.

For questions please contact:
Rod Betit, President & CEO
ASHNHA
rbetit@ashnha.com or call 907 586-1790

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

AARP Alaska
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March 17, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 411
Juneau, AK 99801-1182

RE: HB 392 (Herron)—Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 392, authored by Committee Co-Chair Herron.

The intent of HB 392 is to provide incentives for health care providers, especially for expertise that is in short supply in Alaska as well as to secure providers in our many underserved geographic areas.

AARP approaches HB 392 from the standpoint of the customer. Our members are the group most likely to need health care services and are often the first ones to face critical health care problems because they cannot find a provider.

You are well aware of our health care workforce shortages in Alaska. If our members cannot find a health provider, the results can be bad for them as well as for the state.

Postponing a needed health visit often results in health deterioration and, in many cases, more intense and more expensive treatment. With an increase in providers, our members are more likely to seek prevention and early treatment. The overall health status of older Alaskans will improve.

However, if our members cannot find a health care provider, Alaska will be the loser.

As you know, prior to 1990 many older Alaskans left the state after retirement because they could not count on finding medical facilities and providers to meet their needs.

This trend reversed and now Alaska has the highest percentage of older people who decide to stay in their home state after retirement. The economic value of these retirees is estimated at over $1.7 billion.

We want our citizens to stay here after retirement. The most significant determination of where retirees decide to live is the availability of quality health care. We must have an adequate health care workforce if we are going to keep older Alaskans in our state.

HB 392 will go a long way in helping us secure that workforce.

AARP recommends an "AYE" vote on HB 392.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Representative Tammie Wilson
Representative Bob Lynn
Representative Paul Seaton
Representative Sharon Cissna
Representative Lindsey Holmes

Rob Earl

From: Sonia Handforth-Kome [skome@ifhs.org]
Sent: Tuesday, March 23, 2010 11:06 AM
To: Rob Earl
Subject: HB 392 Testimony (H)HSS

Representative Herron

I am writing to urge you to support and pass HB 392. I am the executive director of the community health center in Unalaska. We budget for four physicians, three mid-levels, three RNs, two counselors, one physical therapist and one dentist. Our center currently has two open RN positions, one of which has been open for three years, one open counselor position and one open physical therapy position. One of our physicians is considering leaving because, even several years out of school, she still owes over $100,000 and is not eligible for NHSC loan repayment. Our dentist gave us a three year notice six months ago because he knew it would take that long to fill the position. We must compete nationally for our health care providers. HB 392 would be enormously helpful to us in recruiting and retaining vital staff members. Please support HB392. Thank you.

Sincerely,

Sonia Handforth-Kome
Executive Director
Iliuliuk Family and Health Services, Inc.
PO Box 144
Unalaska, AK 99685

Nikoosh Carlo

From: drobbins@gci.net on behalf of Doris Robbins [drobbins@gci.net]
Sent: Tuesday, March 23, 2010 12:23 PM
To: Rep. Tammie Wilson; Rep. Wes Keller; Rep. Bob Herron
Cc: Rep. Lindsey Holmes; Rep. Sharon Cissna; Rep. Paul Seaton; Rep. Bob Lynn
Subject: Support for HB 392 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

Co-Chair Herron,
Co-Chair Keller,
Vice-Chair Wilson,
House HSS Committee,

RE: HB 392 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

For several election cycles I have watched us lose more professionals who treat patients for their illnesses one-on-one and in auxiliary roles as well. Support for physicians and medical professionals to practice in Alaska is so long overdue. We have a crisis in interior Alaska!

The lack of proper care resulted in my daughter, who has very good insurance, being rushed through a quick clinic, being told that she just had a virus and to go home and treat it with fluids and rest. A week later, no better, she went back again. She went back for additional treatment, was handled quickly, and given some kind of antibiotic as she continued to cough and become more weak.

Finally, she wrangled an office visit with a physician in an outlying area through a family contact. He examined her thoroughly to find that she had been trying to function with walking pneumonia and had developed damage to one lung. She was required to have bed rest with antibiotics and inhalers, and then was restricted to only very minimal activity, as necessary to prevent the loss of her job, so that her lung could heal. She, having deteriorated from lack of early care, had more antibiotics, inhalers and months of re-exams and repeated X-rays to make sure her lung healed. This is a lady who has completed the Fairbanks Equinox Marathon at least 5 times, so it wasn't because she was a softie!

This is one reason that we must act to make physicians and other medical professionals work in Alaska. Remember that Alaska serves a large number of military dependents that add to our patient population. It is no longer only those who are on Medicare. We have a critical shortage for a conglomerate of reasons. Typically, an appointment for someone who is currently ill, not a check-up, has a 6-week wait. If you get very ill, rather than have a regular patient go into emergency for a "temporary patch job" your doctor will likely try to get you in where someone cancelled or between appointments during his lunch time.

Please pass HB 392 so that over time we will have some improvements in our situation.

Thank you,

Doris Robbins

1281 Overhill Dr.
Fairbanks AK 99709
(907) 374-0597
drobbins@gci.net

Rob Earl

From: James Atti [jamesatti8@gmail.com]
Sent: Tuesday, March 23, 2010 12:59 PM
To: Rob Earl
Subject: Please support HB 392 in House HSS

Representative Herron

Please support and pass HB 392.
We need Health Care Providers and this bill will help us attain our providers as a great incentive to work at our Community Health Clinic. We certainly need leverage to attract health professionals in our clinic.
Thank-you for your support.

Sincerely,

James Atti
PO Box 2714
Bethel, AK 99559

Rob Earl

From: Mabel Smeltzer [mmses@kpunet.net]
Sent: Monday, March 22, 2010 6:13 PM
To: Rob Earl
Subject: Request that you please support HB392

Representative Herron

We need to retain our providers in order to give the care that is needed and to support caregivers. There is a shortage of practitioners in Alaska which hinders adequate health care that is needed.

We urge you to vote in favor of this bill in order to fill the vacancies that exist throughout the area and bring medical care to the community.

Please vote your support of HB392

Sincerely,

Mabel Smeltzer
2729 Tongass Ave Apt 304
Ketchikan, AK 99901

Rob Earl

From: James Lepich [j.lepich@skagway.org]
Sent: Tuesday, March 23, 2010 8:57 AM
To: Rob Earl
Subject: Support and Testimony for HB 392

Representative Herron

I am writing you in regards to HB 392. I believe this bill to be of utmost importance to the future health of Alaska residents. I came to Alaska this past summer in hopes of acquiring loan repayment through the National Health Service Corps, a process that is arduous and drawn-out. When preparing for this move, I had spoken with several colleagues who had stated that they would be greatly interested in joining the ranks of Alaska Health Care Professionals, however, there is little incentive to do so. They spoke of the high cost of living and that their loans were minimal or already payed down. These are experienced individuals who have a great deal to give to this state. HB 392 and its incentive aspect would be a considerable draw for these people.

The National Health Service Corps does indeed bring many people to this state to fill openings in the health care system, however, as I stated previously, this can be a monstrous undertaking due to working with the Federal bureaucracy. This system also is flawed in that the required time of service is two years, then the people have a choice to stay or move on. It also pays up front, where HB 392 pays out after time has been delivered. My understanding of HB 392 is that it would help people choose to stay in the state due to these requirements.

By taking hold of this at the state level, Alaska can bring in qualified individuals to work and stay in our communities, many of whom will bring a great deal of needed experience.

Thank you considering my testimony and, Please, consider this bill's passing.

Sincerely,

James Lepich
Advanced Nurse Practitioner
PO Box 537
Skagway, AK 99840

Rob Earl

From: Donna Phillips [donnaphill@acsalaska.net]
Sent: Monday, March 22, 2010 6:53 PM
To: Rob Earl
Subject: Please support loan repayment for health care professionals

Representative Herron

I have been an RN in hospital facilities for the past 31 year. I have spent 15 years in AK caring for the critically ill AK citizens and visitors to this state. Many of my new nurse colleagues come out of school with several thousands of dollars in school loans. The only facility that I am aware of that helps with loan repayment is the ANMC. It would help to keep the students educated in AK to stay in AK if they would get loan repayment assistance. I like this bill because the cost to the state is as the professional completes a certain length of time, they then receive payment.
Many states and facilities offer competitive loan repayment programs in order to get professionals to work in their state.
I urge you to look at this bill closely for securing the health care future for the state.
Thanks.

Sincerely,

Donna Phillips
PO Box 1178
Girdwood, AK 99587

Rob Earl

From: Sandra Knight [twowild2@yahoo.com]
Sent: Tuesday, March 23, 2010 7:15 AM
To: Rob Earl
Subject: HB 392 health care workforce

Representative Herron

I am a retiree and concerned about the dirth of available health care for our great State of Alaska.

As I read this bill, it would provide rather immediate financial incentive for sorely needed professionals statewide. Please support HB 392.

Thank you.

Sincerely,

Sandra Knight
8101 Peck Ave
Anchorage, AK 99504

Rob Earl

From: Marguerite Stetson [mstetso1@alaska.edu]
Sent: Tuesday, March 23, 2010 7:39 AM
To: Rob Earl
Subject: HB 392 Alaska needs help in getting more health care professionals

Representative Herron

I have experienced the shortage of physicians and nurses in Alaska. I would urge that you pass this legislation to provide loan repayment and incentive programs for Alaska.

Sincerely,

Marguerite Stetson
1810 Ponds Cir
Anchorage, AK 99507