

SB

139

<target><bill>SB 139</bill><subject>SB
139</subject><comm>SF26</comm></target>

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

SENATOR ALBERT KOOKESH
SENATOR JOE THOMAS
SENATOR HOLLIS FRENCH
SENATOR LINDA MENARD



ALASKA STATE CAPITOL
ROOM 514
JUNEAU, AK, 99801-1182
(907) 465-3877
FAX: (907) 465-4821

Senate Bill 139 – Incentives for Certain Medical Providers

Version 26-LS0503\E

SPONSOR STATEMENT

Alaska is facing a serious shortage of healthcare practitioners, especially in the rural areas of our state, and it is projected to worsen significantly in the next few decades. Senate Bill 139 is intended to address this issue by establishing a program to immediately begin filling the vacant healthcare practitioner positions throughout the state.

This legislation will establish a loan repayment and incentive program in the Department of Health and Social Services. The program is designed to attract healthcare practitioners to Alaska. Currently, the WWAMI program serves a similar purpose by giving WWAMI medical students the option of paying off a portion of their loans by staying in Alaska to practice for a specified number of years. Last year, the number of WWAMI seats was increased from 10 to 20, and this year, SB 18 aims to raise that number to 24. However, expanding the WWAMI program only ensures that we have more healthcare practitioners in future years, as WWAMI participants must complete their education before they can begin their service. Therefore, it is not the immediate solution that we need. SB 139 would be an effective way to fill this gap in the very near future, and would attract healthcare practitioners from all areas of country, rather than just from the WWAMI participating states.

Senate Bill 139 will provide loan repayments and incentives for up to 90 applicants per year in 10 different health care occupations. Sixty of the slots will be reserved for “regular” site positions, which can be located anywhere in the state. Thirty of the slots will be reserved for “very-hard-to-fill” positions, which can be located only in areas that are designated by the

Commissioner of Health and Social Services. Priority will be given to sites that treat patients who are uninsured and who have medical assistance or Medicare coverage. The amount of monetary incentive will vary with each slot, according to location and the category of healthcare provided.

Prioritized Tier 1 slots are designated according to the relative need in the state, and will include physicians, pharmacists and dentists. A slot in this tier has incentives of up to \$35,000 per year for three years at a regular site, and up to \$47,000 per year for three years at a very-hard-to-fill site. Tier 2 slots are also designated according to the relative need in the state, and will include dental hygienists, registered nurses, certified nurse practitioners, physician assistants, physical therapists, clinical psychologists, and clinical social workers holding at least a master's degree in social work. A slot in this tier has incentives of up to \$20,000 per year for three years at a regular site, and up to \$27,000 per year for three years at a very-hard-to-fill site.

It is critical that we promptly address Alaska's healthcare shortages in order to ensure that all Alaskans have adequate access to medical care. SB 139 helps us to save and improve the lives of our constituents by allowing us to provide for those who cannot wait until tomorrow to get the care that they need today.

SENATE FINANCE COMMITTEE REPORT

DATE: 4/7/09

FURTHER:

DATE TURNED
IN TO OFFICE: _____

Finance Committee considered SENATE BILL NO. 139

SB 139 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

"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."

and recommends:

- be replaced with SCS or CS SB 139 (F.W.)
- adopt previous SCS or CS _____ ()
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:	
<input type="checkbox"/>	Same Title
<input checked="" type="checkbox"/>	New Title
<hr/>	
HOUSE BILL:	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	Technical Title Change
<input type="checkbox"/>	New Title w/ SCR # _____

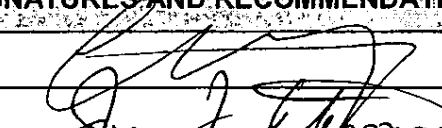
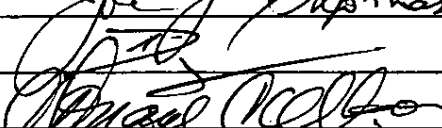
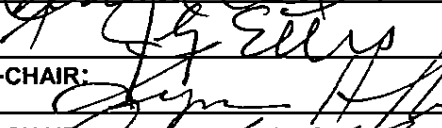

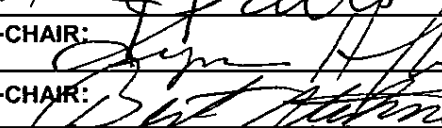

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	4/10/10	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Hugomas	X			
	Thomas	✓			
	Olson	X			
	Ellis	X			
CO-CHAIR: 	Hoffman	✓			
CO-CHAIR: 	Stedman	✓			

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSSB139(FIN)
 () Publish Date: _____

Identifier (file name): SB139CS(FIN)-04-10-10 Dept. Affected: Health & Social Services
 Title Incentives for certain Medical Providers RDU Health Care Services
 Component Medical Assistance Administration
 Sponsor Olson
 Requester Senate Finance Component Number 242

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services	89.3		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	6.0
Contractual	2,742.4		2,742.4	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	2.0
Equipment	7.6							
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	2,847.3	0.0	2,839.7	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	2,036.2
1004 GF	132.3		124.7	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	678.8
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	2,847.3	0.0	2,839.7	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		1.0	1.0	1.0	1.0	1.0
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

CS for SB 139(FIN) creates a cash incentive program 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 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 4/10/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date 4/10/2010

ANALYSIS CONTINUATION

Health Care Professions Incentive Program

The Division assumes it will need \$2,715.0 for practitioner incentive payments in FY2011. Maximum payments established for 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 direct incentives 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
Total:	\$2,742.4	\$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 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.

*Adopted
4/11/10*

26-LS0503\U
Mischel
4/9/10

CS FOR SENATE BILL NO. 139()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): SENATORS OLSON, Wielechowski, Meyer, Davis, French, Kookesh, Paskvan, Egan

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing an employment incentive program for certain health care**
2 **professionals employed in the state; and providing for an effective date."**

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

4 *** Section 1.** AS 18 is amended by adding a new chapter to read:

5 **Chapter 29. Health Care Professions Incentive Program.**

6 **Sec. 18.29.010. Legislative findings and intent.** (a) The legislature finds that

7 (1) the state is facing a serious shortage of health care practitioners and
8 the shortage is projected to worsen;

9 (2) the state is one of few states that does not offer direct incentives to
10 attract trained primary care providers to the state;

11 (3) the villages and towns in rural areas of the state are experiencing
12 the greatest shortage of health care practitioners.

13 (b) The incentive payments provided under this chapter are intended to ensure
14 that residents throughout the state, including recipients of medical assistance and

1 Medicare, have access to health care and that residents of rural areas of the state, in
2 particular, experience improved access to health care services.

3 **Sec. 18.29.015. Health care professions incentive program; purpose;**
4 **advisory body.** (a) The health care professions incentive program is established in the
5 department for the purpose of addressing the worsening shortage of certain health care
6 professionals in the state by increasing the number and improving the distribution of
7 health care professionals who provide direct patient care.

8 (b) The program established under this section must include

- 9 (1) direct incentives paid under AS 18.29.020;
- 10 (2) procedures for the commissioner's designation and prioritization of
11 sites eligible for participation in the program;
- 12 (3) an application process for participation in the program as
- 13 (A) an eligible site; or
- 14 (B) a tier I or tier II health care professional;
- 15 (4) the dissemination of public information and notices pertinent to the
16 program;
- 17 (5) classification by the commissioner of each eligible site as having
18 either regular or very hard-to-fill positions, or both;
- 19 (6) a lifetime maximum period of six years for participation in the
20 program by a tier I or tier II health care professional; and
- 21 (7) annual program evaluations and reports.

22 (c) The program shall be administered by the commissioner in consultation
23 with an advisory body appointed by the commissioner. The advisory body is made up
24 of members with health care expertise, including expertise in economic issues
25 affecting the hiring and retention of health care professionals in the state. Members of
26 the advisory body serve at the pleasure of the commissioner to provide
27 recommendations for and oversight and evaluation of all aspects of the program. The
28 commissioner shall accept a recommendation of the advisory body on a matter
29 pertaining to the identification and monitoring of areas of shortages, eligible sites,
30 payment priorities, or evaluation of the program, unless the commissioner finds, in
31 writing, that the recommendation cannot be financially or otherwise supported by the

1 department.

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

6 (1) before the employment period begins;

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

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

9 (b) Payments made under this section may not exceed

10 (1) \$35,000 annually for a tier I health care professional employed in a
11 regular position;

12 (2) \$47,000 annually for a tier I health care professional employed in a
13 very hard-to-fill position;

14 (3) \$20,000 annually for a tier II health care professional employed in
15 a regular position; or

16 (4) \$27,000 annually for a tier II health care professional employed in
17 a very hard-to-fill position.

18 (c) The commissioner shall calculate the annual incentive payment amount by
19 multiplying the annual maximum payment under (b) of this section by the percentage
20 of full-time-equivalent employment for each of not more than three years of qualified
21 employment less a matching payment amount as determined under (d) of this section.

22 (d) An employer or other entity that employs an eligible tier I or tier II health
23 care professional at an eligible site shall make nonrefundable quarterly matching
24 payments to the department. The payments must be in an amount that is

25 (1) not more than half of the annual incentive payment made under (c)
26 of this section, as determined by the commissioner; and

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

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

31 **Sec. 18.29.025. Number of participants.** (a) The number of participants to

1 whom the commissioner may provide a direct payment under the program established
2 under AS 18.29.015 may not exceed 90 participants annually as described in (b) of
3 this section, regardless of whether the participant is a new or continuing participant.

4 (b) The commissioner shall reserve sufficient funding for not fewer than three
5 positions in each of the 10 tier I and tier II health care professions in very hard-to-fill
6 positions at an eligible site.

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

- 9 (1) submit an application on a form approved by the commissioner;
10 (2) be engaged in qualified employment at an eligible site;
11 (3) be licensed as a tier I or tier II health care professional in the state
12 within 90 days after the first day of employment;
13 (4) meet a priority for payment established under (b) of this section;
14 and

15 (5) meet other criteria established by the commissioner.

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

- 20 (1) are uninsured;
21 (2) have or are eligible for medical assistance or Medicare coverage; or
22 (3) have or are eligible for other federal health program benefits.

23 (c) After June 30, 2017, the commissioner shall discontinue the approval of
24 new applicants under the program and provide incentives to eligible participants who
25 were approved previously and are continuing participants.

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

- 27 (1) "commissioner" means the commissioner of health and social
28 services;
29 (2) "department" means the Department of Health and Social Services;
30 (3) "eligible site" means a service area or health care facility that the
31 commissioner has designated as located in a health care services shortage area based

1 on a needs assessment and employment statistics for qualified tier I or tier II health
2 care professionals;

3 (4) "program" means the health care professions incentive program;

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

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

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

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

10 services;

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

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

17 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
18 read:

19 **HEALTH CARE INCENTIVE PROGRAM; REPORT.** On or before January 1, 2019,
20 the Department of Health and Social Services shall prepare and submit a report to the
21 legislature that describes the participation rates, costs, and the effect on health care profession
22 shortage areas, as designated by the commissioner, of the health care profession incentive
23 program established under AS 18.29.015.

24 * **Sec. 3.** AS 18.29.010, 18.29.015, 18.29.020, 18.29.025, 18.29.030, and 18.29.099, added
25 by sec. 1 of this Act, are repealed June 30, 2019.

26 * **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

adopted 3/23/10 *Replaced 4/11/10* 26-LS0503VN
Mischel
3/29/10

CS FOR SENATE BILL NO. 139()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

**Offered:
Referred:**

Sponsor(s): SENATORS OLSON, Wielechowski, Meyer, Davis, French, Kookesh, Paskvan, Egan

A BILL

FOR AN ACT ENTITLED

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

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

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

6 **Article 8A. Health Care Professions Loan Repayment.**

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

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

1 AS 14.43.430 - 14.43.449.

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

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

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

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

11 (3) meet other criteria established by the commission.

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

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

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

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

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

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

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

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

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

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

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

12 (b) The program established under this section must include

- 13 (1) loan repayments made under AS 14.43.430 - 14.43.449;
14 (2) direct incentives paid under AS 18.29.020;
15 (3) procedures for the commissioner's designation and prioritization of
16 sites eligible for participation in the program;
17 (4) an application process for participation in the program as
18 (A) an eligible site; or
19 (B) a tier I or tier II health care professional;
20 (5) the dissemination of public information and notices pertinent to the
21 program;
22 (6) classification by the commissioner of each eligible site as having
23 either regular or very hard-to-fill positions, or both;
24 (7) a lifetime maximum period of six years for participation in the loan
25 repayment and direct incentive aspects of the program by a tier I or tier II health care
26 professional; and
27 (8) annual program evaluations and reports.

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

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

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

12 (1) before the employment period begins;

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

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

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

17 (1) \$35,000 annually for a tier I health care professional employed in a
18 regular position;

19 (2) \$47,000 annually for a tier I health care professional employed in a
20 very hard-to-fill position;

21 (3) \$20,000 annually for a tier II health care professional employed in
22 a regular position; or

23 (4) \$27,000 annually for a tier II health care professional employed in
24 a very hard-to-fill position.

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

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

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

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

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

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

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

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

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

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

20 (2) be engaged in qualified employment;

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

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

25 (5) meet other criteria established by the commissioner.

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

30 (1) are uninsured;

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

(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).

Denise
3/31/10

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON



ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
FAX (907) 465-4821

Explanation of Changes Contained in CS for SB 139

This CS makes two changes to version "C".

- Language was added to page 1, line 8 to limit the loan repayments to only those loans held by the State of Alaska. It simply means that loan repayments for loans held by other states, the federal government or other entities are not offered. This is expected to make the implementation simpler and less administratively burdensome. Please note that it does nothing to change that all participants, including those with student loans held by the State of Alaska, are still eligible for the direct incentive provided they meet the criteria outlined in 18.29.020.
- A new section was added, Section 18.29.025 found on page 5, to limit the number of participants to 90 per year regardless of whether it is a new or continuing participant; and to allocate the slots between regular and very-hard-to-fill locations to ensure some slots are reserved for those very-hard-to-fill locations.

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

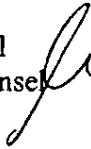
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 17, 2009

SUBJECT: Sectional Summary (SB 139; Work Order No. 26-LS0503\A)

TO: Senator Donald Olson
Attn: Kendri Cesar

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 base on the type of employment.

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

JMM:ljw
09-162.ljw

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSSB139 (FIN)
 () Publish Date: _____

Identifier (file name): CSSB139(FIN)-EED-ACPE-03-31-10 Dept. Affected: Education
 Title An Act establishing a loan repayment program and RDU ACPE
employment incentive program for certain health care... Component Program Administration and
 Sponsor Senator Donald Olson Operations
 Requester (S)Finance Component Number 2738

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

As currently amended, this legislation will require the Alaska Commission on Postsecondary Education (ACPE) to receive and apply loan repayment benefits for participants in a health care provider loan repayment and direct incentive program. The Department of Health and Social Services (HSS) is the primary administrative agency. Given ACPE's minimal involvement, there is no related fiscal impact to the agency.

Prepared by: Diane Barrans, Executive Director Phone 465-6740
 Division Alaska Commission on Postsecondary Education Date/Time 3/31/10 Noon
 Approved by: Diane Barrans, Executive Director Date 3/31/2010
Alaska Commission on Postsecondary Education

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSSB139
 () Publish Date: _____

Identifier (file name): CSSB139-EED-ACPE-03-30-10 Dept. Affected: Education
 Title An Act establishing a loan repayment program and employment RDU ACPE
 Component Program Administration and Operations
 Sponsor Senator Donald Olson
 Requester (S) Finance Component Number 2738

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

This legislation will require the Alaska Commission on Postsecondary Education (ACPE) to serve as disbursing agent for a loan repayment program for certain health care professionals employed in the state. As drafted, the Department of Health and Social Services (HSS) is the primary administrative agency. Based on HSS estimates of the number of individuals participating in the program, it will be of sufficient size that ACPE, in order to mitigate the need for manual processing and related personal services expenses, will need to procure services to develop a program database to ensure program benefits are paid out in compliance with program statutes and ensure accurate annual reporting of benefits paid to the Internal Revenue Service. We estimate the one-time contractual costs would be \$35 thousand and will be included in the HSS fiscal note associated for this bill. Due to the anticipated functionality of the database, including the ability to electronically share files between HSS and ACPE, no additional staffing will be needed to provide these fiscal agent services in support of the loan repayment program

Prepared by: Diane Barrans, Executive Director
 Division Alaska Commission on Postsecondary Education
 Approved by: Diane Barrans, Executive Director
Alaska Commission on Postsecondary Education

Phone 465-6740
 Date/Time 3/30/10 3:30 PM
 Date 3/30/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSSB139(HSS)
() Publish Date: _____

Identifier (file name): SB139CS(HSS)-DHSS-MAA-03-29-10 Dept. Affected: Health & Social Services
Title Incentives for Certain Medical Providers RDU Health Care Services
Component Medical Assistance Administration
Sponsor Olson, Wielechowski, Meyer, Davis
Requester Senate HSS Component Number 242

Expenditures/Revenue (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services	89.3		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	6.0
Contractual	2,777.4		2,742.4	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	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	2,839.7

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

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	2,036.2
1004 GF	167.3		124.7	124.7	124.7	124.7	124.7	124.7
1005 GF/Program Receipt	678.7		678.7	678.8	678.8	678.8	678.8	678.8
1037 GF/Mental Health								
Other Interagency Receipt								
TOTAL	2,882.3	0.0	2,839.7	2,839.7	2,839.7	2,839.7	2,839.7	2,839.7

Estimate of any current year (FY2010) cc _____

POSITIONS

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

ANALYSIS: (Attach a separate page if neces

SB 139 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 Phone (907) 334-2520
Division DHSS Health Care Services Date/Time 3/5/10 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner Date 3/29/2010
DHSS Finance & Management Services

(Revised 11/6/2009 CMB)

Page 1 of 2_

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. CSSB139(HSS)

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 SB139. 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.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

MEMORANDUM

DATE: April 1, 2009

TO: Senator Joe Paskvan
Senator Bettye Davis, Chair Senate Health & Social Services Committee
Senator Donald Olson

FROM: Commissioner Bill Hogan *WH*

SUBJECT: Questions regarding SB 139

Administration response to questions posed by Senator Paskvan during the 3/25/2009 Senate HSS hearing on SB 139

Question 1. I understand the administration does not support this bill. Does the administration recognize the need for attracting health care workers, or is the administration rejecting recognition of the need?

Response:

Yes, the administration recognizes the need for recruiting and retaining health care workers. The Alaska Dept. of Health and Social Services (DHSS) provided statements during the 3/25/2009 Senate HSS hearing that the department has prepared documents and conducted projects that recognize health care workforce shortages and strategies to resolve these shortages. Specifically, the department referenced the Physician Supply Task Force Report that was prepared in 2006, which was staffed by DHSS and funded by the University of Alaska. This report includes documentation of need for additional physicians as well as recommended strategies, such as loan repayment (p. 55), for addressing these shortages.

In addition, DHSS is working with the Alaska Mental Health Trust Authority and the University of Alaska to address shortages in the social services workforce (including behavioral health, developmental disabilities, senior services, etc.). In addition, DHSS, along with the Alaska Dental Action Coalition, is undertaking various needs assessments and developing strategies to address the oral health workforce shortages. DHSS has also participated in an analysis of health care workforce recruitment efforts across Alaska. DHSS has participated in researching and documenting strategies that are effective in attracting and retaining health care professionals, such as loan repayment and direct incentives (<http://hss.state.ak.us/dph/Healthplanning/publications>).

Finally, DHSS prepares health professional shortage area (HPSA) applications on behalf of communities/boroughs and submits them to U.S. Department of Health and Human Services Health Resources and Services Administration. Designation of a borough as a health professional

shortage area allows providers in that area to apply for National Health Service Corps loan repayment.

Question 2. Does the administration oppose the bill because it wants to reject certain fields as covered under the bills? Is there the recognition that some fields should be supported, and is there some lesser number of positions the administration would support? Or is it that, despite any recognition of need, the administration opposes spending the money?

Response: The administration's opposition to SB139 is not related to rejection of certain professional fields covered under the bill. The concerns of the administration are related to the fiscal note and the funding that would be required to place 90 professionals.

The department assumed 90 positions when developing the fiscal note in order to make a substantial impact on the workforce shortages. SB 139 cites the level of funding provided to each type of professional. The bill does not identify the number of professionals to be funded each year. Thus, the bill allows for placement of fewer than 90 professionals per year if the annual funding for the loan repayment and employment incentive program were made at a lesser total amount.

At this point, the administration cannot commit to supporting a loan repayment program, even for a reduced number of loans. Because of current economic conditions, the administration has recently introduced two other bills, SB 140 and HB 172, that would allow the Department of Revenue to enter into a bond purchase agreement and take other measures necessary to avoid a disruption in education loan services provided by the Alaska Student Loan Corporation. These measures are necessary to ensure the viability of the ASLC, and take precedence over creating additional obligations.

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;

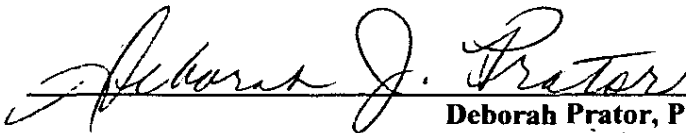
WHEREAS Alaska is competing with other states for the finite pool of available health care professionals; and over 40 states currently offer Support-for-Service Programs (SFSPs) that have influenced health professionals' geographic and specialty distributions;

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



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/localAreaProfileOSResults.asp?geogArea=0204000170&population+census+data=Population&BI=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/statePlanFinalFY08_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.hss.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>.



Alaska State Legislature

Please enter into the record my testimony to the Senate Finance
committee name

Committee on SB 139, dated 3-31-10
bill # / subject public hearing date

Dear Senators,

I am writing you with my concern regarding the omission of Licensed Professional Counselors (LPCs) in SB 139.

This is an important bill which I would support, with the inclusion of LPCs. Licensed Professional Counselors provide many of the front line direct mental/behavioral health services to the people of Alaska. We help to fulfill the realization of the vision of the Alaska Mental Health Act (Title 47) in serving to fill the mental/behavioral health vacuum throughout Alaska. To meet the needs that you seek to address, it is necessary to include LPCs in this legislation.

My colleagues and I, ask you to make this small but important addition to this important piece of legislation.

Sincerely,

J.R. Myers, LPC
President
Kenai Peninsula Counselors Association

Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians

Donald E. Pathman, MD, MPH,*† Thomas R. Konrad, PhD,* Tonya S. King, PhD,‡
Donald H. Taylor, Jr., PhD,§ and Gary G. Koch, PhD||

Context: Many states attempt to entice young generalist physicians into rural and medically underserved areas with financial support-for-service programs—scholarships, service-option loans, loan repayment, direct financial incentives, and resident support programs—with little documentation of their effectiveness.

Objective: The objective of this study was to assess outcomes of states' support-for-service programs as a group and to compare outcomes of the 5 program types.

Design: We conducted a cross-sectional, primarily descriptive study.

Participants: We studied all 69 state programs operating in 1996 that provided financial support to medical students, residents, and practicing physicians in exchange for a period of service in underserved areas; federally funded initiatives were excluded. We also surveyed 434 generalist physicians who served in 29 of these state programs and a matched comparison group of 723 nonobligated young generalist physicians.

Data Collection: Information on eligible programs was collected by telephone, mail questionnaires, and from secondary sources. Obligated and nonobligated physicians were surveyed, with 80.3% and 72.8% response rates, respectively.

Main Outcome Measures: Levels of socioeconomic need of communities and patients served by physicians, programs' participant service completion and retention rates, and physicians' satisfaction levels.

Results: Compared with young nonobligated generalists, physicians serving obligations to state programs practiced in demonstrably needier areas and cared for more patients insured under Medicaid and uninsured (48.5% vs. 28.5%, $P < 0.001$). Service completion rates were uniformly high for loan repayment, direct incentive, and

resident-support programs (93% combined) but lower for student-targeting service-option loan (mean, 44.7%) and scholarship (mean, 66.5%) programs. State-obligated physicians were more satisfied than nonobligated physicians, and 9 of 10 indicated that they would enroll in their programs again. Obligated physicians also remained longer in their practices than nonobligated physicians ($P = 0.03$), with respective group retention rates of 71% versus 61% at 4 years and 55% versus 52% at 8 years. Retention rates were highest for loan repayment, direct incentive, and loan programs.

Conclusions: States' support-for-service programs bring physicians to needy communities where a strong majority work happily and with at-risk patient populations; half stay over 8 years. Loan repayment and direct financial incentive programs demonstrate the broadest successes.

Key Words: physicians, health services access, rural health, primary care, student loans and scholarships, loan repayment, state health policy

(*Med Care* 2004;42: 560–568)

■ *It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.*—*Louis Brandeis*
Supreme Court of the United States
*New State Ice Co. v. Liebmann, 1932; dissenting opinion*¹

States and federal agencies frequently use service-requiring scholarships, loans, loan repayment, and related incentives to entice physicians into medically underserved settings.^{2–4} As of 1996, 40 states offered 69 such physician-obligating programs, the federal National Health Service Corps (NHSC) and Indian Health Service (IHS)-sponsored scholarship and loan repayment initiatives,⁵ and the NHSC and states jointly sponsored an additional 29 loan repayment programs. Service-requiring programs collectively wield a sizable workforce, estimated at 2900 physicians in 1996, half each under state and federal auspices.⁵

The 5 recognized program types—scholarships, service-option loans, loan repayment, direct financial incentives,

From the *Cecil G. Sheps Center for Health Services Research, and the †Department of Family Medicine, UNC-Chapel Hill, Chapel Hill, North Carolina; the ‡Department of Health Evaluation Sciences, Pennsylvania State University, Philadelphia, Pennsylvania; the §Terry Sanford Institute of Public Policy Studies, Duke University, Durham, North Carolina; and the ||Department of Biostatistics, UNC-Chapel Hill, Chapel Hill, North Carolina.

Reprints: Donald E. Pathman, MD, MPH, Cecil G. Sheps Center for Health Services Research, UNC CB# 7590, Chapel Hill, NC 27599. E-mail: don_pathman@unc.edu.

Copyright © 2004 by Lippincott Williams & Wilkins

ISSN: 0025-7079/04/4206-0560

DOI: 10.1097/01.mlr.0000128003.81622.ef

and resident support⁵—share fundamental goals and an approach that links financial support to periods of service; however, these program variations differ in important ways. *Scholarship programs* obligate medical students early in their training and many years before they are to serve their obligations. Participants in scholarship programs are firmly expected to provide service, and hefty penalties are used to discourage participants from buying out their obligations should their career interests change. *Service-option loan programs* also target medical students but offer participants a choice of performing service or repaying program funds at standard interest rates.

Loan repayment and direct financial incentive programs commit physicians much later, near the completion of residency training when their service is to begin. They typically levy no or minimal penalties on physicians who fail to complete a period of service. With loan repayment programs, physicians receive assistance repaying traditional education loans they acquired years earlier as students, whereas financial incentive programs provide unrestricted funds.

The newest programs, the *resident support* type, respond to the growing financial pressures on residents⁶ with assistance in the form of scholarships, loan repayment, and direct financial incentives. Service is required and begins 1 to 2 years after a commitment is signed, at the end of residency.

Over the decades much has been said, with little supporting evidence, about the outcomes of these programs as a group and the relative strengths of the individual program types. It is generally believed, for example, that physicians in support-for-service programs are less satisfied and remain in their practices briefer than physicians without obligations. Many observers believe that stiff penalties are required to curtail otherwise high buyout rates, especially in programs that obligate individuals years in advance of service.⁷ Others worry, however, that high penalties trap some participants in ill-suited commitments who are then unhappy as they serve and unlikely to be retained.⁸⁻¹⁰ Proponents of loan repayment and direct incentive programs believe satisfaction and retention are better when physicians sign commitments after their training when they know their career interests, job options, and families' needs.¹¹ Scholarship defenders counter that only captive scholarship recipients can be drawn to the most desperately underserved communities because they are so unattractive.¹²

Few studies have assessed the outcomes of support-for-service programs, like the rates at which their practitioners complete their obligations with service and their practitioners' satisfaction and retention. Programs do not often undertake self-evaluations and those that do seldom have comparative data on other programs.^{2,13} States and federal agencies regularly add, drop, and modify their programs without firm evidence of their effectiveness.¹⁴⁻¹⁷

This study has 2 primary goals: 1) to assess outcomes of states' support-for-service programs as a group, and 2) to compare outcomes for the 5 program types. We assess program outcomes we believe are important to underserved communities, physicians, and policymakers: the levels of socioeconomic need of communities and patients served by participating physicians, participant service completion and retention rates, and satisfaction levels of participants and their families. We also test the assumptions that 1) higher buyout penalties increase the proportion of physicians who fulfill their obligations with service but at a cost of lower physician satisfaction and poorer retention, and 2) scholarship programs bring physicians into the neediest communities.

METHODS

Identifying Eligible State Programs

We identified all state support-for-service physician programs nationally as of 1996⁵ by supplementing previous lists of relevant programs^{3,18,19} with information from telephone calls to key contacts in every state and from available online sources and printed materials. Eligibility criteria for programs were that they 1) provided financial support to students, residents, and/or practicing physicians in 1996; 2) had a service requirement or option in defined medically needy settings located across a given state; and 3) received no direct federal support. Of the 69 identified eligible programs, 20 offered scholarships, 24 provided loan repayment incentives, 12 offered loans with service options, 7 offered direct financial incentives, and 6 offered support to residents.

Program Data

We obtained basic descriptive information for all programs through initial and follow-up telephone contacts with program directors and from programs' web sites, brochures, reports, and copies of their enacting legislation. This information was verified and supplemented through an 8-page mailed questionnaire completed by 45 programs (65%). Forty-eight (86%) of the 56 programs old enough to have had more than 20 physicians eligible for placement in service sites provided estimates of the service completion rate for their obligated physicians over the previous 3 years. Programs were approached for survey and other data in no particular order other than we started with the few directors we knew and tended to recruit all programs within a particular state at the same time.

Identifying State-Obligated and Comparison Group Physicians

Programs were asked to provide names and basic information on each physician who signed a first contract with them and/or had been placed in a first-service site in 1991 and 1996. These 2 years were selected because individuals who

committed to student programs in 1991 and loan repayment and direct incentive programs in 1996 would have begun serving their obligations in approximately 1996. Programs created after 1991 provided names of individuals contracted in their first year of operation; very large programs provided only a randomly selected subsample of names from 1991 and 1996, and smaller programs supplemented their samples with names of physicians obligated in proximate years (eg, 1992 and 1995). We elected not to request physician names from the last 12 eligible programs as a result of project time requirements. Of the 48 programs from which we requested physician data, 29 (60%) provided all data we needed to survey their obligated physicians. Programs from which we requested and received physician-specific information, programs from which we requested but did not receive this information, and programs from which this information was not requested were similar in size, physicians' contract terms, the types of geographic locations where their obligated practitioners served, and reported service completion rates.

We surveyed all 434 family physician, general internist, and general pediatrician participants (allopaths and osteopaths) identified by programs as then serving or having served their obligations. We excluded nongeneralists and physicians who defaulted or bought out their obligations without ever serving a day of their obligations. Programs reported no international medical graduates.

We constructed a comparison group of nonobligated generalists from the American Medical Association Physician Masterfile. A sampling frame of eligible subjects was constructed of all 8742 graduates of U.S. allopathic and osteopathic medical schools in 1988 and 1992 who 4 years after graduation were in clinical practice in the United States in family practice, general internal medicine, and general pediatrics. A stratified random sample of 723 of these physicians was selected, with oversampling of strata to match the state-obligated cohort in specialty distribution and geography, and to ensure diverse racial and ethnic representation.

Physician Surveys

In 1998 and early 1999, we sent up to 4 questionnaire mailings to the state-obligated and comparison group physicians. Of the 434 obligated physicians surveyed, 23 proved to be ineligible or were never located, and there were 330 eligible respondents (80.3%). Response rates for obligated physicians were comparable across service program types, physician specialties, and racial-ethnic groups.

In the comparison sample of 723 physicians, 56 subjects proved ineligible or were never located and 468 eligible physicians responded (72.8%). Response rates for the comparison sample did not vary by subjects' rural/urban location, gender, or specialty; rates were somewhat lower for blacks (52.4%). We excluded 100 physicians from the comparison

group who indicated that they had or were serving a state or federal obligation.

In the physician questionnaires, participants of state programs reported details of the first practice in which they served their obligations. On parallel questionnaire items, comparison group physicians described the first practice after residency in which they worked 9 months or longer. Both groups reported their incomes, satisfaction, their families' experiences, and their patients' insurance types. Nearly all questionnaire items had been used in earlier studies^{9,20,21} and were pilot-tested again for applicability to this study with 30 obligated and nonobligated physicians in North Carolina.

We appended 1990 U.S. Census data characterizing the towns and cities where physicians worked.²² County data on local physician-to-population numbers were appended for 1994 from the Area Resource File.²³

Analyses

We compared obligated and nonobligated physicians on a variety of outcomes, including satisfaction and retention rates. We also compared programs of each of the 5 types individually and with the other 4 program types as a group. We used chi-squared tests, independent sample 2-tailed *t* tests, and 1-way analysis of variance (ANOVA) to compare groups on normally distributed variables. The Kruskal-Wallis test was used to compare groups on 4 nonnormally distributed variables: physician income, town population, town per capita income, and county primary care physician-to-population ratios. Bivariate comparisons were followed with linear and logistic regression models (with log transformations of nonnormally distributed variables) to adjust for key potentially confounding or explanatory variables. Life tables were used to describe proportions of physician groups remaining in their practices for specified numbers of years. Kaplan-Meier plots and Cox proportional hazards models were used to compare estimates of retention for various physician groups over time.

We also assessed relationships between programs' buy-out costs and the various program outcomes with chi-squared and 2-tailed *t* tests. We further used multiple and logistic regression to test the relationships between buyout costs and the various outcomes for confounding by varying service obligation terms across programs and/or respondents' actual obligation periods. No confounding was found and we do not report these models.

Comparisons of obligated and nonobligated physicians were weighted to adjust for strata sampling fractions and response rates and run on the SUDAAN statistical software program (Research Triangle Institute, Research Triangle Park, NC). Analyses involving only obligated physicians were run on the SPSS statistical program (release 11.5.0; SPSS Inc., Chicago, IL) and not weighted. A level of statistical significance of $P \leq 0.05$ was used throughout.

RESULTS

State Programs

In 1996, the 69 eligible programs were relatively new and small, with a median age of just 6 years and median workforce of 11 physicians. Sixty-four programs were funded with state revenues, 2 had only private support, and 3 were self-supporting using buyout funds from earlier participants; 9 programs also used community matching funds. Forty-seven programs were based in state offices of rural health or other state agencies, 18 within individual medical schools, and 4 within private organizations.

Programs supported physicians with an average of \$14,000 for each year of obligated service with no significant differences across the 5 types of programs ($P = 0.55$). Average minimum service obligation terms did vary across program types, from 12 months in resident support programs, 18 months in scholarship programs, 19 months in service-option loan programs, 29 months in loan repayment programs, and 36 months in direct financial incentive programs ($P = 0.003$).

Physicians and Their Practices

Physicians obligated to state programs, compared with physicians without obligations, were more often male (63% vs. 53%, $P < 0.05$), more often married (84% vs. 75%, $P < 0.05$), slightly older (33 vs. 32 years on average, $P < 0.001$), but no more or less likely to be black or Hispanic (8.5% vs. 6.2%, $P = 0.10$). Obligated physicians were much more likely than nonobligated generalist physicians to be family physicians (72% vs. 38%, $P < 0.001$) and more often owned the practices where they worked (36% vs. 27%, $P < 0.05$), but earned comparable salaries (median, \$89,735 vs. \$89,622, $P = 0.2$).

Comparing physicians obligated to the 5 types of programs, we found no differences in gender, marital status, ethnicity, or income. Loan program participants, however, were less likely to be family physicians than participants of other programs (54% vs. 75%, $P = 0.02$), and physicians in incentive programs more often owned their practices (49% vs. 16%, $P = 0.01$).

Although minimum service obligation durations varied across programs of the 5 types, the average number of years this study's respondents were actually obligated to their programs did not differ for those in 4 of the types (range, 3.13–3.48 years, $P = 0.31$) but was shorter for participants of resident-support programs (2.72 years, $P = 0.02$).

Service Completion Rates

The 5 types of programs differed greatly in how often their physicians completed their obligations with service rather than buying out or defaulting ($P < 0.001$) (Fig. 1). Service-option loan programs reported the lowest average service completion rates (44.7%) followed by scholarship programs (66.5%). The 30 programs of the remaining 3 types, programs that committed physicians after training or as residents, reported uniformly high service rates (entire group mean, 93%; 92% after omitting the 5 of these 30 programs without a minimum service period).

Program directors reported obligation default rates, the proportion of obligated physicians who failed to provide either service or repay program funds, of 5.2% on average for all programs combined with no significant differences across program types ($P = 0.78$). In contrast, the percentage of physicians who bought out-of-service commitments differed greatly across the 5 program types, greatest in service-option loan programs (49.2%) and scholarship programs (27.2%).

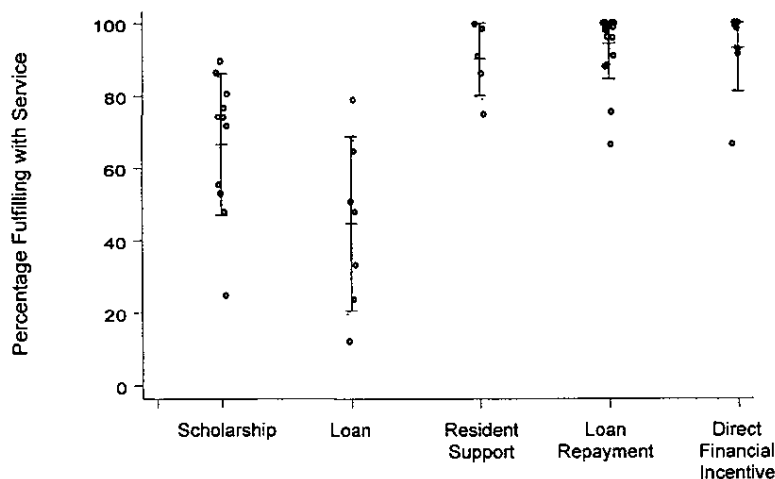


FIGURE 1. Percentage of recent physicians in each program (°) who fulfilled their obligations with service, grouped by program type.

Bars denote group means +/- standard deviations

Programs of the remaining 3 types reported comparable low buyout rates (2.3% combined). Thus, the high buyout rates of student programs account for their low service completion rates.

The costs that loan repayment, direct incentive, and resident support programs levy on physicians who buyout of obligations had no relationship with programs' service completion rates. Only among student programs, scholarships and service-option loans, were penalties and service completion rates related; specifically, rates averaged 80.3% for the 4 student programs that charged penalties of 3 times the amount of support provided compared with 48.6% for the 12 programs that charged less ($P = 0.02$).

Communities and Patients Served by Physicians

Physicians serving in state programs of all types combined, compared with the nonobligated physicians, worked in counties that were far more often rural and had lower primary care physician-to-population ratios, in cities and towns that were much smaller and poorer, and they reported more of their patients were uninsured or covered under Medicaid (Table 1). Even in analyses run separately for rural and urban-situated physicians and in multivariate models adjusting for physicians' rural versus urban location, specialty, and demographics, obligated physicians were still found to work in needier communities and with needier patients by all measures.

We explored whether county physician-to-population ratios were lower for obligated physicians simply because states with a greater need for physicians (and thus lower ratios) more often sponsored support-for-service programs.²⁴ We confirmed that, indeed, obligated physicians worked in counties with primary care physician-to-population ratios lower than their state's median county ratios more often than nonobligated physicians (37% vs. 11%, $P < 0.001$).

Among obligated physicians and weighing findings on all 5 measures of community need (Table 1), those serving in direct financial incentive programs worked in the neediest settings. Contrary to popular belief, the towns and counties where scholarship participants worked demonstrated no greater need than where participants of other programs worked.

Physician and Family Satisfaction

Physicians serving state obligations were more often satisfied with their work and practices and more often felt a sense of belonging to their communities than nonobligated physicians (Fig. 2). Obligated and nonobligated physicians gave comparable estimations of the satisfaction and needs-fulfillment of their spouses and children.

In virtually all ways tested, satisfaction was comparable for physicians and families participating in the 5 types of programs, the only exception being that scholarship program participants more often than others felt restricted by the practice sites available to them (36.6% vs. 19.3%; $P < 0.01$).

TABLE 1. Comparison of Community and Patient Characteristics of State-Obligated and Nonobligated Physicians; Physicians Serving in the 5 Types of Service Programs; and Physicians Obligated to Programs Using Different Types of Site-Eligibility Criteria

	Community and Patient Characteristics					
	(n Physicians/ Programs)	Rural (Nonmetropolitan) County (%)	Median Town/City Population	Median Town/City per Capita Income (\$)	Median County Primary Care Physician-to- Population Ratio	Mean Patients Covered by Medicaid or Uninsured (%)
Obligated vs. nonobligated						
Obligated, all types	(330/29)	68.4 [‡]	5094 [‡]	10,813 [‡]	78.5 [‡]	48.5 [‡]
Nonobligated	(368/NA)	11.6	56,129	14,090	118.1	28.5
Comparisons of 5 program types						
Scholarship	(30/5)	86.2*	3541	10,302	82	40.5
Service-option loan	(56/3)	50.0 [‡]	7284	12,082 [‡]	76	43.3
Resident support	(38/3)	51.4*	4062 [†]	10,958	57 [‡]	50.8
Loan repayment	(138/14)	73.3	5422*	10,681	91 [†]	48.0
Direct financial incentive	(68/4)	75.4	4410	9911 [‡]	64	55.5 [†]

* $P \leq 0.05$;

[†] $P \leq 0.01$;

[‡] $P \leq 0.001$; 2-tailed *t*-test, chi-square, and Kruskal-Wallis comparisons of nonobligated versus obligated physicians, and comparisons of physicians in each program type versus obligated physicians in all four other types of programs.

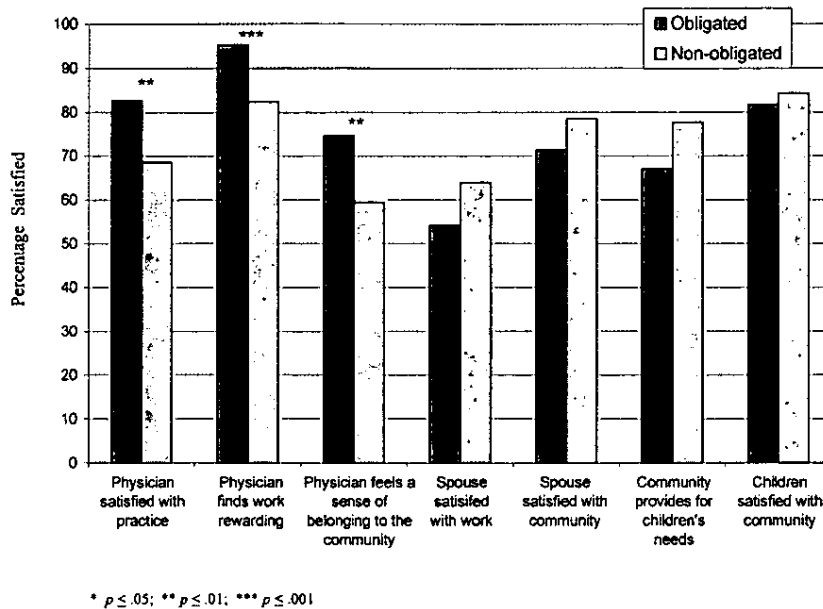


FIGURE 2. Satisfaction and needs fulfillment of physicians and their families serving in all state programs combined (n = 330) compared with nonobligated physicians (n = 368)

A remarkable 90.2% of obligated physicians indicated that they likely would enroll in their program if they had it to do all over again, including 64.2% who indicated that they definitely would do so. Differences across programs were found only for physicians in scholarship compared with loan repayment programs in which 47% versus 71% of physicians indicated that they would definitely sign up again ($P = 0.01$).

We explored the relationships between the buyout costs that programs levied and physicians' satisfaction, again finding associations only for medical student-targeted programs. When service-option loan and scholarship programs charged more than simple principal plus interest to buyout, most measures of physician satisfaction were lower, including fewer participants reporting, in retrospect, a definite willing-

ness to commit to their programs again (36% vs. 65%, $P = 0.04$).

Retention

Obligated physicians remained longer in their service practices than nonobligated physicians remained in their first jobs after training (hazard ratio [HR] for leaving, 0.70; 95% confidence interval [CI], 0.51–0.96; $P = 0.029$) (Table 2). Respective group retention rates from life tables at 2 years were 92% versus 77%, at 4 years 71% versus 61%, at 6 years 59% versus 55%, and at 8 years 55% versus 52%. Retention tended to be better for obligated physicians than nonobligated physicians even after adjusting for group differences in physicians' specialties and demographics, although the differ-

TABLE 2. Comparison of the Retention of State-Obligated versus Nonobligated Physicians

	Hazard Ratio	P Value	95% Confidence Interval
Model 1 (unadjusted)			
Obligated vs. nonobligated	0.70	0.029	(0.51–0.96)
Model 2 (adjusted)			
Obligated vs. nonobligated	0.75	0.080	(0.53–1.03)
Family physician vs. internist	0.91	0.688	(0.58–1.43)
Pediatrician vs. internist	0.80	0.533	(0.40–1.61)
Male vs. female	0.76	0.190	(0.50–1.15)
Married vs. unmarried	0.75	0.270	(0.46–1.25)
Age when physicians began serving obligations	1.01	0.675	(0.95–1.08)

ence fell under the threshold of statistical significance ($P = 0.08$).

Among the 5 types of service-requiring programs, the longest group retention was seen for loan repayment recipients, 66% of whom remained in their service sites 8 years after starting work there, with a hazard ratio of departure compared with all other programs = 0.46 (95% CI, 0.30–0.70; $P < 0.001$) (Fig. 3). Retention was shortest for resident support programs (HR, 6.72; 95% CI, 4.05–11.12; $P < 0.002$). Scholarship participants demonstrated the second shortest retention (HR relative to service-option loan, loan repayment and direct incentive programs, 1.96; 95% CI, 0.97–3.97; $P = 0.061$).

Programs' buyout penalties were associated with retention, but once again only in scholarship and service-option loan programs, wherein penalties above simple principal plus interest were associated with lower odds of retention at 4 years (odds ratio, 12.4; $P = 0.012$).

DISCUSSION

Outcomes for states' support-for-service programs as a group were generally quite positive. Programs as a whole placed physicians in small and needy rural towns and counties, where physicians estimated that almost half of their patients were covered by Medicaid or were without health insurance. Physicians who served in these state programs were generally more satisfied with their work and communities and remained in their service sites longer than nonobligated "mainstream" generalists. We do not believe that the jobs and communities where these physicians served were inherently more pleasing; rather, we suspect that the benev-

olence of individuals who commit to and then fulfill service requirements predisposes them to find particular satisfaction from work that they believe in.^{25,26}

Loan repayment and direct financial incentive programs enjoyed the greatest successes among the various program types, confirming the wisdom of recruiting physicians at the end of their training.¹¹ Financial buyout penalties were generally not used or needed in these programs, because their service completion rates were excellent without financial threats. Several program directors spoke of how much easier loan repayment and financial incentive programs are to administer than student-targeted programs, in which program staff must monitor participants during their training and deal with the many who buy out.^{10,27} Direct financial incentive programs demonstrated an interesting niche among the program types, supporting physicians who often owned their practices, often in particularly needy settings.

Despite positive outcomes for programs overall, this study confirmed some commonly held concerns about scholarship programs. Very high penalties do seem to cut buyout rates by one third,⁷ but penalties of any amount were associated with lower physician satisfaction and shorter retention. Contrary to claims,¹² state scholarship program participants did not work in demonstrably needier settings than participants of other programs. Studies of the NHSC Scholarship Program have similarly found that its participants do not serve in needier settings than those in the NHSC Loan Repayment Program.^{11,27} The Congressional Government Accounting Office (GAO) and NHSC further similarly concluded that the NHSC Loan Repayment Program achieved better outcomes—higher service-completion rates, greater satisfaction, and longer retention—than the NHSC Scholarship Program, and also at a lower cost.^{11,15,28}

The affordable buyout terms of student service-option loan programs allowed half of their participants to opt out of service, but the half who did serve were satisfied and long retained. Service-option loans could play an important complementary role to programs that target graduates, appealing to aspiring medical students who might otherwise choose not to pursue a medical career rather than assume the typical \$100,000+ debt in traditional education loans. To embrace loan programs with service options, states must accept that it is not fatally undesirable for some participants to satisfy their loan contracts financially rather than with service. Indeed, most medical students fund their education with traditional loans, like the Health Education Assistance Loans (HEAL), where there is no option or enticement for service.⁶ Concerns that too many physicians buyout of loan-for-service programs leaving too few available for shortage communities can be addressed quite readily by making more awards up front, costing programs nothing more because nearly all who opt not to serve repay their loans with interest.

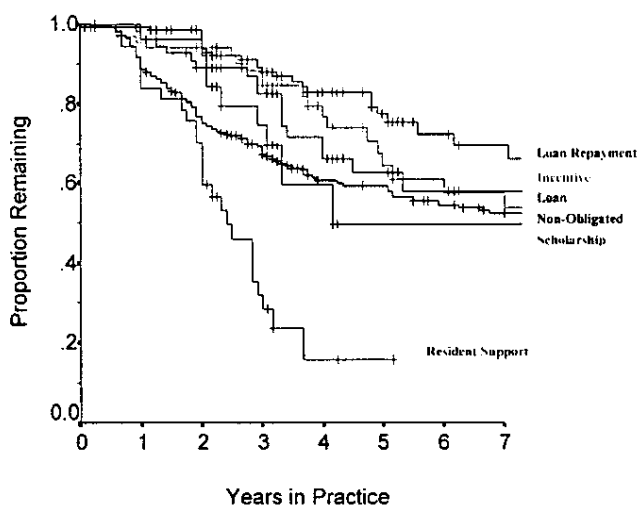


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians

Limitations and Unanswered Questions

Some of this study's data were self-reported and thus vulnerable to reporting inaccuracies. Directors provided figures on their programs' default and buyout rates and likely used a variety of methods to determine these rates. We are unaware, however, of any systematic inaccuracies likely to have biased our principal findings.

Some directors of scholarship and service-option loan programs who otherwise cooperated with our study would not provide the physician-specific information we needed to survey their participants, citing federal confidentiality protections of administrative data collected on students.²⁹ Given the demonstrated similarities between participating and nonparticipating programs, most importantly in the service completion rates of their participants, we do not suspect that the lower participation rates of student programs biased our outcomes. However, if less successful student programs withheld participants' names to hide their weaknesses, then loan repayment and direct incentive programs could actually be relatively even *more* successful than we judged (ie, bias, if present, was toward the null).

We had wanted to assess program costs and cost-effectiveness but program directors could not provide complete or comparable cost data. We also did not assess the experiences of physicians who signed up with these programs but chose not to serve.

We had no validated criteria on which to judge how often state-obligated physicians work in the very neediest settings, because states have not substantiated their site eligibility criteria and current federal criteria are inadequate.^{30,31} Nonetheless, because some state programs use very broad site eligibility criteria, it is very likely that some obligated physicians do not work in the neediest areas.^{5,32}

CONCLUSIONS AND RECOMMENDATIONS

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.

ACKNOWLEDGMENTS

The authors are grateful to the many state program directors, program staff, and participating physicians who provided data for this study. The authors thank the indispensable contributions of Kathleen Crook, MPA, to the data management aspects of this study, and the contributions of Tim Henderson, MSPH, of the National Conference of State

Legislatures and James Bernstein, MHA, and Thomas Tucker of the NC Office of Rural Health and Resources Development to our understanding of these state programs and interpretation of the data. The authors also thank the fellows of UNC's National Research Service Award Primary Care Research Fellowship for their thoughtful suggestions on various drafts of this paper. This study was funded by grant R01-HS09165 from the Agency for Healthcare Research and Quality.

REFERENCES

1. Brandeis L. *New State Ice Co. v. Liebmann*, dissenting opinion. No 463. Supreme Court of the United States. 285 US 262; 52 S. Ct. 371; 1932 US LEXIS 785;76 L. Ed. 747.
2. Donohue EA. Physician distribution and rural health care in the states: an overview of state legislative activity, 1984–1989. *Acad Med.* 1990; 65:S92–S113.
3. Henderson TM, Fox-Grage W. *Evaluation of State Efforts to Improve the Primary Care Workforce: Scholarship/Loan Programs and Medical Education Reforms*. Washington, DC: National Conference of State Legislatures; 1997.
4. National Health Service Corps. Available at: www.bphc.hrsa.gov/nhsc. Accessed January 6, 2001.
5. Pathman DE, Taylor DH, Konrad TR, et al. State scholarship, loan forgiveness, and related programs: the unheralded safety net. *JAMA.* 2000;284:2084–2092.
6. Beran RL, Lawson GE. Medical student financial assistance, 1996–1997. *JAMA.* 1998;280:819–820.
7. Dutera MJ, Blumenthal DS. Improving recruitment and retention of medical scholarship recipients in rural Georgia. *J Health Care Poor Underserved.* 2000;11:135–143.
8. Harbin RE. A Historical Perspective of the National Health Service Corps. Available at: www.clinicians.org/nhsc/history.html. Accessed January 6, 2001.
9. Pathman DE, Konrad TR, Ricketts TC. The National Health Service Corps experience for rural physicians in the late 1980s. *JAMA.* 1994; 272:1341–1348.
10. Helms LB, Helms CM. Forty years of litigation involving medical students and their education: II. Issues of finance. *Acad Med.* 1991;66:71–76.
11. National Health Service Corps. *Opportunities to Stretch Scarce Dollars and Improve Provider Placement* (GAO/HEHS-96-28). Washington, DC: US General Accounting Office; November 1995.
12. Bernstein JD. *Testimony Before the Subcommittee on Health and the Environment, Committee on Energy and Commerce*. Washington, DC: US House of Representatives; April 18, 1990.
13. Sparer MS. Laboratories and the health care marketplace: the limits of state workforce policy. *J Health Polit Policy Law.* 1997;22:789–814.
14. Mississippi Code 37-143-6, 2000.
15. *Programs for Underserved Populations Could Be Improved* (GAO/T-HEHS-00-81). Testimony by Janet Heinrich before the Subcommittee on Public Health and Safety, Committee on Health, Education, Labor and Pensions, US Senate. Washington, DC: US General Accounting Office; March 23, 2000.
16. Mullan F. The muscular Samaritan: The National Health Service Corps in the new century. *Health Aff (Millwood).* 1999;18:169–175.
17. Council on Graduate Medical Education. *Third Report. Improving Access to Health Care through Physician Workforce Reform: Directions for the 21st Century*. Report published by Health Resources and Services Administration, US Department of Health and Human Services; October 1992.
18. Association of the American Medical Colleges. *State and Other Loan Repayment/Forgiveness and Scholarship Programs*, 2nd ed. Washington, DC: AAMC Division of Student Affairs and Education Services; 1995.
19. Office of Data Analysis and Management. *Compendium of State Health Professions Distribution Programs*; 1986 (Report No. 2–87). Rockville, MD: US Bureau of Health Professions; 1986.
20. Pathman DE, Williams ES, Konrad TR. Rural physician satisfaction: its

- sources and relationship to retention. *J Rural Health*. 1996;12:366-377.
21. Pathman DE, Steiner BD, Williams BD, et al. The four community dimensions of primary care practice. *J Fam Pract*. 1998;46:293-303.
 22. US Census. Available at: <http://www.census.gov/geo/www/tiger/glossary.html>. Accessed January 6, 2001.
 23. Area Resource File (ARF) System. Available at: <http://bhpr.hrsa.gov/arf.htm>. Accessed January 6, 2001.
 24. Weissert CS, Knott JH, Stieber BE. Education and the health professions: explaining policy choices among the states. *J Health Polit Policy Law*. 1994;19:361-392.
 25. Eliason BC, Guse C, Gottlieb MS. Personal values of family physicians, practice satisfaction, and service to the underserved. *Arch Fam Med*. 2000;9:228-232.
 26. Kohrs FP, Mainous AG, Fernandez ES, et al. Family medicine faculty development fellowships and the medically underserved. *Fam Med*. 2001;33:124-127.
 27. Wheeler L, Goldstein AD. C. Suits Say 7 Doctors Failed to Repay Loans. *Washington Post*. May 7, 1992:C1, C5.
 28. Konrad TR, Leysieffer K, Stevens C, et al. *Evaluation of the Effectiveness of the National Health Service Corps*. Final Report to the Health Resources and Services Administration. Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research and Mathematica Policy Research; May 31, 2000.
 29. US Code, Title 20, Chapter 31, Subchapter III, section 1232g. Family Educational and Privacy Rights (Buckley Amendment).
 30. US Department of Health and Human Services. Designation of Medically Underserved Populations and Health Professional Shortage Areas; proposed rule (42 CFR Parts 5 and 51c). *Federal Register*. September 1, 1998;63:46538-46555. Available at: http://www.access.gpo.gov/su_docs/aces/aces140.html.
 31. Taylor DH. The natural life of policy indices: Geographical problem areas in the US and UK. *Soc Sci Med*. 1998;47:713-725.
 32. Strosberg MA, Mullan F, Winsberg GR. Service-conditional medical student aid programs: the experience of the states. *J Med Educ*. 1982;57:586-592.

State Scholarship, Loan Forgiveness, and Related Programs

The Unheralded Safety Net

Donald E. Pathman, MD, MPH

Donald H. Taylor, Jr, PhD

Thomas R. Konrad, PhD

Tonya S. King, PhD

Tyndall Harris, PhD

Tim M. Henderson, MSPH

James D. Bernstein, MHA

Thomas Tucker

Kathleen D. Crook, MPA

Cora Spaulding, MD, MPH

Gary G. Koch, PhD

DURING THE PAST 30 YEARS, the federal government has played a key role in efforts to encourage primary care physicians and other health care practitioners to work in underserved areas. The most visible federal program has been the National Health Service Corps (NHSC), which supports students and young practitioners with scholarships and loan repayment incentives in exchange for a specified period of work in shortage areas.¹⁻⁴ The NHSC has supported some 20 000 health care practitioners and received wide recognition for its efforts.

States also have offered programs to encourage physicians and others to work in underserved areas, although their efforts have been much less visible.⁵⁻¹⁰ Among the most common of these state safety-net efforts are those

See also p 2112.

Context In the mid-1980s, states expanded their initiatives of scholarships, loan repayment programs, and similar incentives to recruit primary care practitioners into underserved areas. With no national coordination or mandate to publicize these efforts, little is known about these state programs and their recent growth.

Objectives 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.

Design Cross-sectional, descriptive study of data collected by telephone, mail questionnaires, and through other available documents, (eg, program brochures, Web sites).

Setting and Participants All state programs operating in 1996 that provided financial support in exchange for service in defined underserved areas to student, resident, and practicing physicians; nurse practitioners; physician assistants; and nurse midwives. We excluded local community initiatives and programs that received federal support, including that from the National Health Service Corps.

Main Outcome Measures 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 state programs.

Results 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.

Conclusions In 1996, states fielded an obligated primary care workforce comparable in size to the better-known federal programs. These state programs constitute a major portion of the US health care safety net, and their activities should be monitored, coordinated, and evaluated. State programs should not be omitted from listings of safety-net initiatives or overlooked in future plans to further improve health care access.

JAMA. 2000;284:2084-2092

www.jama.com

similar to the NHSC's programs, in which financial support is provided to students and practitioners of health care professions in exchange for a period of service in underserved communities.⁹

Author Affiliations are listed at the end of this article.

Corresponding Author: Donald E. Pathman, MD, MPH, Cecil G. Sheps Center for Health Services Research, University of North Carolina, CB7590, Chapel Hill, NC 27599 (e-mail: don_pathman@unc.edu).

State involvement in these programs dates to Arkansas' creation of a medical scholarship program with a service requirement in 1940, 30 years before US Congress created the NHSC.^{8,11} By the mid-1980s, 26 states supported 29 programs that offered health care professionals financial support in return for service commitments.⁹ From 1985 through 1992, the pace of program growth quickened, with 35 states enacting legislation to create physician scholarships and similar programs.^{12,13}

Despite states' investments, little is known about their service-requiring programs. No national organization or central public agency monitors these programs. Partial lists of state programs have been assembled^{9,10,14-19} but there has not been a complete enumeration of them.²⁰ These programs also tend not to formally evaluate themselves or document their successes, as they often lack the funds, expertise, and mandate to do so.^{18,20} As a consequence, these state-level programs and their contributions have been hidden from national awareness, omitted from most listings of medical safety-net efforts,^{2,21-24} and overlooked in national access-to-care policy discussions.

We aimed to describe these overlooked state programs and to begin to understand their role in remedying the geographic maldistribution of health care practitioners. We addressed both public and private programs that operate within states and provide financial support to physicians and nonphysician primary care practitioners and trainees in exchange for service in underserved areas. We calculated comparative information on similar federal programs to add a sense of perspective to the characterization of these state programs.

METHODS

Identifying Eligible State Programs

Eligibility criteria for programs were refined through the course of this study as we learned about the numerous and varied state programs that support young practitioners. Ultimately, eligible programs were designated as those

that (1) provided financial support to students, resident or practicing physicians, physician assistants, nurse practitioners, or certified nurse midwives; (2) had a service requirement or option in a defined medically underserved setting; (3) supported practitioners with state public dollars, community funds, recurring program dollars, or funds from private non-profit sources (eg, state medical societies) but did not have direct federal support; (4) placed practitioners in underserved areas across a given state rather than solely in 1 region or community within a state; (5) delivered financial support directly to practitioners or to an educational or financial entity on their behalf, such as to a medical school or commercial lender; and (6) were operating in 1996. The calendar year 1996 is the period for which this evolving group of state programs is described because it was the most recent year for which programs could report complete information when data collection for this study began in 1997.

We excluded the 29 programs sponsored jointly by states and the federal government—called “state loan repayment programs” by the NHSC^{1,3}—because of their federal support and their differences under federal regulations from the fully independent and more varied programs created and managed solely by states. However, we included the nonfederal components of the few loan repayment programs that sponsored some practitioners with solely state funds under one set of contract terms and also supported other practitioners with combined state and federal funds under different contract terms. We also excluded programs with other types of federal support (eg, the Native Hawaiian Health Scholarship Program), programs run by individual employers and communities, and programs that provided funds directly to communities or other local entities for recruitment and retention activities even if used for loan repayment or other financial incentives. We further excluded service-requiring programs for registered nurses, dentists, pharma-

cists, and other health care workers if they were not open to physicians or midlevel practitioners or if these 2 latter groups did not compose a significant portion of obligated participants.

To identify all eligible programs, we augmented previous lists of relevant programs^{9,10,14-19} with information from telephone calls to key contacts in every state from mid-1997 through mid-1999. Contacts included individuals and program offices named in prior compendia, officials in state offices of rural health, state public health offices, state higher education financial aid authorities, financial aid offices of individual medical schools, and, in some cases, state medical and specialty societies and relevant within-state foundations. Contacts were queried about potentially eligible programs run by their organizations or by others in their states. Contacts for potential new programs were then called, sometimes leading to further contacts. No additional calls were made when contacts indicated that we were aware of all potentially eligible programs and when we were confident of the eligibility and fate of every program listed in prior compendia. Typically, 4 to 6 individuals were interviewed in each state.

Data Collection

Detailed information about eligible state programs, including their mission, history, types of obligated practitioners, field strengths, and contract terms, was obtained through the initial and subsequent telephone interviews, typically with program directors. All programs provided enough information by telephone to ascertain eligibility and most provided virtually all of the information on program characteristics reported here. This information was then confirmed and supplemented with mailed questionnaires that were returned by 67.1% of the directors of eligible programs, and for all programs with information from Internet Web sites, brochures, application materials, texts of enacting legislation, or prior in-state evaluations and compendia.

Further follow-up contacts were made to program directors to clarify ambiguous and conflicting information. In the 17 cases in which sources could not—or, in a few cases, would not—provide exact counts of new practitioner contracts and program field strength in 1996, we generated estimates from all available information, typically by averaging or extrapolating data from earlier and subsequent years. When information about a program differed among various sources, we heeded information from programs' printed reports and program directors over other sources.

We calculated the comparative field strength of the NHSC's scholarship, federal loan repayment, and state loan repayment programs as of September 1996 with data from the NHSC on all of its current and past practitioners. Data on practitioners serving in the Indian Health Service (IHS) loan repayment program²⁵ were from the IHS Office of Management Services. We were unable to obtain needed practitioner counts for several smaller federal programs, such as the NHSC Community Scholarship Program and the IHS Health Professions Scholarship Grant Program.^{3,26} However, with collectively fewer than 50 primary care practitioners at any point during the 1990s, we simply omitted these programs from the federal comparison data.

Analyses

We developed a classification of program types. Frequencies of eligible programs in 1996 were tabulated by type.

Tallies of the numbers and types of programs in operation each year from 1990 to 1996 were based on the reported start and end dates of all current programs and those that ceased operation between 1990 and 1996. The distribution of state programs across the states and US regions was described. National tallies of 1996 new practitioner contracts and total field strength were estimated by summing data across programs. Last, basic features of programs were described, including their missions, funding sources, eligible service sites, and terms of contracts with practitioners.

RESULTS

Types of State Programs

Discussions with program directors revealed that there were no universally accepted terms for denoting the various types of programs. For example, the terms *bonus*, *incentive*, *grant*, and *tuition reimbursement* used in program titles all indicated funds given to practitioners and graduating residents to be used for any desired purpose. Some other programs blurred the distinctions between loan and scholarship programs by using both terms in their titles and in program descriptions they provided to applicants, reasoning that when a contractual loan debt was repaid with service, it in effect became a scholarship. Other loan-writing programs retained the term *loan* in their titles and descriptions of practitioners' obligations, regardless of how individuals settled their debt.

From the great variability in program features and labels, 5 program types were distinguished: scholarship, loan, resident support, loan repayment, and direct financial incentive programs (TABLE 1). These program categories were based on (1) the career stage of targeted eligible applicants (ie, students, junior residents, senior residents, or practitioners); (2) whether service was required or optional (from which many other program characteristics followed, such as the criteria for selecting practitioners and the buyout terms of practitioners' contracts); and (3) whether programs' financial support to practitioners was to be used solely for up-front training costs, after-the-fact repayment of educational loans, or for unrestricted use. This typology of programs captured the key differences across programs and reflected the underlying rationale of virtually all programs. It also was consistent with the classification and labels used for federal programs. Furthermore, this typology distinguishes among the program options that practitioners encounter at various career stages. For example, students could opt for either a scholarship or loan program where available, whereas graduating residents and practitioners could commit to loan repayment or direct financial incentive programs.

State Program Numbers and Flux

In total, 82 eligible programs were identified in 41 states in 1996, with 9 states and the District of Columbia not offer-

Table 1. Classification of Support-for-Service Programs

Program Type	No. in 1996	Eligible Individuals	Service	Use of Funds	Typical Design
Scholarship	29	Students	Required	Up-front training costs	Funds to students for tuition, fees, books, and living expenses, with service expected after training
Loan	11	Students	Optional	Up-front training costs	Loans to students for tuition, fees, books, and living expenses; loan is repaid after training either financially or by providing service
Resident support	5	Junior residents	Required	Variable	Unrestricted funds for junior and, occasionally, senior residents, with service expected after training
Loan repayment	29	Senior residents and practitioners	Required	Repayment of educational loans	Funds to repay outstanding educational loans of graduating residents and practitioners in exchange for service
Direct financial incentive	8	Senior residents and practitioners	Required	Unrestricted	Unrestricted incentive funds for graduating residents and practitioners in exchange for service

ing an eligible program. (States named 79 eligible programs, of which 3 were dual programs that maintained 2 components, each of which fit 1 of the 5 program types. For clarity, ease of presentation, and because all other states treated similarly distinct components as 2 different programs, we present these 3 dual programs as 6 separate programs in this article.) Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Michigan, Rhode Island, and Wyoming had no qualifying programs.

There were many state programs that were similar to the 82 eligible programs but that failed to meet 1 or 2 of the eligibility criteria. These not-quite-eligible programs included 6 generally large programs in which obligated practitioners were restricted to work within their states' borders but not in underserved areas. Also ineligible were 3 very large loan and scholarship programs that supported individuals from a wide array of professions, of whom only a few were physicians or midlevel health care practitioners.

Loan repayment (n=29) and scholarship (n=29) programs were the most numerous in 1996, with fewer loan (n=11), direct financial incentive (n=8), and resident support types (n=5). Among all programs, 84% (n=69) were available to medical students, residents, and physicians, whereas 44% (n=36) supported student or practicing physician assistants, nurse practitioners, or nurse midwives. Twenty-eight percent (n=23) targeted both groups. Twenty percent (n=16) also supported other types of health care workers, such as registered nurses, dentists, and podiatrists.

Year-by-year tallies of operating programs, based on all sources of information on current and past programs, revealed that these state programs more than doubled in number from 1990 to 1996, increasing from 39 to 82 (FIGURE). Nearly all of this growth was due to the tripling of loan repayment programs and doubling of scholarship programs. The first resident support program was created in 1992. We learned of 3 programs

that were terminated from 1990 through 1996 and another 3 that were transformed from one type of program into another (eg, a loan program created in 1965 became a scholarship program in 1995 when service changed from an option to a requirement and payback penalties were greatly increased).

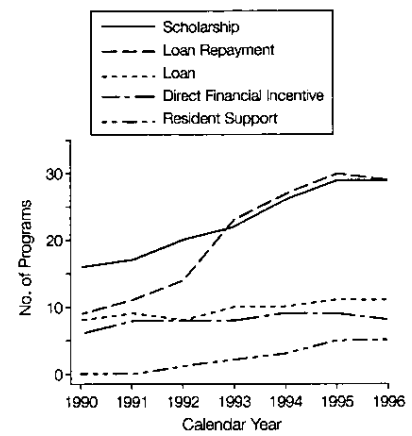
Of the programs in operation in 1996, 5 (6%) predated 1950, whereas 47 (59%) had been established or assumed their current form since January 1990. Among the newest programs in 1996 were 2 that had not yet signed a contract with a practitioner and another 5 programs that had signed contracts but had yet to place their first participating practitioner. At the other end of the program life span were 5 programs operating in 1996 that were being phased out. In nearly every case, program creations, eliminations, and transformations were undertaken at the initiative of state legislators, program officials, or local advocates in an effort to try newer and more promising program types, eliminate underperforming programs, or rectify perceived weaknesses in existing programs.

Distribution of Support-for-Service Programs Across States

Of the 41 states that offered eligible state-level support-for-service programs, 23 offered 2 or more such programs (TABLE 2). Twenty-four states offered both fully state-supported programs and programs with joint state and federal support. States that offered programs funded with purely in-state funds were no more or less likely to cosponsor joint state-federal programs (odds ratio, 1.07; $P = .93$). State-funded programs were somewhat less common among states in the West than in states in the South, Northeast, and North Central regions (61% vs 89%), whereas joint state-federal programs were more common among states in the Northeast than in other regions (100% vs 50%).

Some program director respondents working in offices that managed both state and joint state-federal loan repayment programs indicated that they first

Figure. Number of State Support-for-Service Programs in the United States, by Type and Year



attempted to place practitioners through their jointly funded programs to save state costs. However, informants also indicated that positions in purely state-funded programs often were more popular with practitioners because they generally offered a wider choice of practice sites and greater flexibility, despite having less lucrative financial terms.

Program Workforce

Programs funded solely within states tended to be small, with a median number of 8 new contracts in 1996 and a median field strength of 11 practitioners serving their obligations. Some programs were substantially larger, including 12 that signed more than 25 new contracts (the largest had 112 contracts) and 16 that maintained field strengths of more than 35 practitioners (the largest had 120 practitioners).

In 1996, the 82 state programs collectively signed initial contracts with an estimated 1215 practitioners, of whom 959 (79%) were physicians (TABLE 3). In the same year, these programs maintained an estimated collective field strength of 1676 practitioners working to fulfill their obligations, of whom 1306 (78%) were physicians.

The estimated total field strength of physician and midlevel practitioners in both state and federal support-for-service programs in 1996 was 3876 in-

Table 2. Qualifying State and Joint State-Federal Support-for-Service Programs for All 50 States and by Type, 1996*

State	State Programs					Joint State-Federal Programs (Loan Repayment)
	Scholarship	Loan	Resident Support	Loan Repayment	Direct Incentive	
South						
Alabama	1					
Arkansas	1	2			1	
Delaware						
Florida	1			1		1
Georgia	1	1				1
Kentucky	1				1	
Louisiana	1					1
Maryland	1					1
Mississippi	1					
North Carolina		2	1	2	1	1
Oklahoma	1		1		1	
South Carolina			1		2	
Tennessee					1	
Texas	1			1		1
Virginia	2					1
West Virginia	1	1				1
West						
Alaska						
Arizona	1					1
California						1
Colorado						1
Hawaii						
Idaho				1		
Montana				1		
Nevada				1		1
New Mexico	2			1		1
Oregon				1		
Utah	1			2		1
Washington	1			1		1
Wyoming						
Northeast						
Connecticut						1
Maine		2				1
Massachusetts		1				1
New Hampshire				1		1
New Jersey				1		1
New York	3		1	2		1
Pennsylvania				1		1
Rhode Island						1
Vermont				1		1
North Central						
Illinois	3					1
Indiana	1					
Iowa	1			2		1
Kansas	2					
Michigan						1
Minnesota				3		1
Missouri		2	1			1
Nebraska	1			1		
North Dakota				2		
Ohio				1		
South Dakota					1	
Wisconsin				2		

*The District of Columbia had neither a qualifying state program nor a joint state-federal program.

dividuals (Table 3). Of this number, approximately 1700 were serving in state programs, a roughly comparable number were serving in federal programs, and another 489 individuals were serving in joint state-federal programs. State programs supported a larger physician workforce than federal programs, whereas federal programs supported a larger workforce of midlevel practitioners.

Features of State Programs

The primary or joint mission of all but 3 of the 82 state programs was to influence the distribution of the health care workforce. Programs were administered by a variety of organizations and offices, including individual medical schools, state offices of rural health, and a few private organizations (TABLE 4). Three of 4 state programs were funded entirely or partially by annual appropriations from state legislatures, and others had received state funds earlier in their history. Only 3 programs were supported completely or in part by private funds.

Reliable revenue figures were unavailable for many programs, typically because program-specific funds could not be separated from lump-sum appropriations allocated to administering offices for a variety of programs. Many programs indicated, however, that they operated under very modest budgets, with funds allocated almost entirely to meet the stipend or incentive needs of participating practitioners and with little additional funding available for practitioners' other needs or for program administration.

States used a variety of approaches to define sites where practitioners could serve their obligations. Most programs (55%) used unique criteria specified in their enacting legislation or devised by a shortage area designation office within the state. State-defined community eligibility criteria varied from complex combinations of need indicators, such as physician-population ratios, indicators of population health status, and travel distances to nearest physicians, to simple ceiling sizes of town or county populations (eg, all towns smaller than 10000 were

deemed eligible). Only 10% of programs used the federal Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) criteria without modifications, and 35% of programs used the federal HPSA or MUA designations in combination with state-devised criteria. A sizable minority of programs (41%) placed practitioners exclusively or preferentially in rural areas. All but 1 of the 23 programs available to both physicians and midlevel practitioners used identical site eligibility designations for both groups.

Programs that supported physicians clearly targeted primary care physicians: all accepted family physicians and 93% accepted general internists and pediatricians. Far fewer programs accepted physicians of other specialties, and they sometimes accepted them only on a case-by-case basis to meet a particular community's needs.

In most programs, obligated practitioners were asked to identify their own practice opportunities within designated eligible communities, then seek approval from their program for their chosen site. Only 13 programs (16%) listed specific types of qualifying practice settings (eg, health departments, prisons, neighborhood health centers) or named specific practices where practitioners could fulfill their obligations.

Practitioners' contract terms varied greatly across programs. For physicians, financial support varied from \$3000 to \$38000 per year and the minimum obligation term varied from 1 to 60 months. Costs for those who bought out of their obligations financially rather than through service varied from nothing (in several programs that paid physicians only after they completed their service and had no need for penalties) to 3 times the outstanding principal plus interest. Contract terms for nonphysician practitioners were typically the same as those for physicians.

COMMENT

The number of state-run programs that leverage financial incentives to entice physicians and other primary care practitioners into underserved area

practices began to grow in the mid-1980s.^{8,12} This study demonstrates a continued and remarkable growth in these programs through the mid-1990s. In 1996, nearly 1700 physicians and midlevel practitioners were serving in 82 identified state programs, comparable with the number serving in the better-known federal NHSC and IHS. States and the federal government cosponsored another 489 primary care practitioners.

Because of their relatively recent and rapid expansion and lack of central coordination, little has been known about the contributions of state programs to the health care needs of underserved communities. We found that most state programs have missions and structures similar to those of federal loan repayment and scholarship programs. States also offer 2 new program variants, the resident support and direct financial incentive types, as well as traditional loan

programs with service options. As is common of state programs, support-for-service programs vary significantly in design and operations.²⁷ Variation arises from creative approaches to meet local needs and opportunities, or is a less deliberate outcome of political forces. In addition to wholly new program types, specific examples of innovation include a southern loan program that required its students to participate in a rural training curriculum, an Appalachian-region program in which financial benefits varied according to the level of need where physicians served, and a midwestern loan program for which acceptance into the program improved the chances of admission into in-state public medical schools. Some programs allowed practitioners to fulfill obligations with part-time work, an innovation now proposed for the NHSC.²⁸ Outcomes for these various program

Table 3. Number of Practitioners Signing First Contracts and Serving in State, Federal, and Joint State-Federal Support-for-Service Programs in 1996

Program Type	No. of Practitioners		
	Physicians	Nonphysicians*	Program Totals
Signing First Contract in 1996 (State Programs Only)			
Scholarship	368	113	481
Loan	175	58	233
Resident support	168	0	168
Loan repayment	209	76	285
Direct financial incentive	39	9	48
Total	959	256	1215
Serving in Programs in 1996			
State			
Scholarship	517	156	673
Loan	120	41	161
Resident support	65	0	65
Loan repayment	466	139	605
Direct financial incentive	138	34	172
Subtotal	1306	370	1676
Joint state-federal (NHSC state loan repayment programs)†	372	117	489
Federal‡			
NHSC scholarship and federal loan repayment programs	1000	515	1515
Indian Health Professions loan repayment program	162	34	196
Subtotal	1162	549	1711
Total	2840	1036	3876

*Nonphysicians included nurse practitioners, physician assistants, and certified nurse midwives.

†NHSC indicates National Health Service Corps.

‡Several very small federal programs (collective field strength <50 individuals) for which we were unable to obtain discipline-specific data are not listed; specifically, the NHSC Community Scholarship Program and the Indian Health Service Scholarship Grant Program.

Table 4. Characteristics of State Support-for-Service Programs (n = 82)

Primary program mission, No. (%)	
To influence the size or distribution of the health care workforce	70 (85)
To make health care careers affordable	3 (4)
Both of the above equally emphasized	9 (11)
Administrating organization, No. (%)	
Individual medical school	20 (24)
State office of rural health	14 (17)
State higher education financial aid authority	13 (16)
Other state health department office	17 (21)
Other state office	14 (17)
Private organization	4 (5)
Program funding sources, No. (%)*	
State appropriations	62 (76)
Communities	10 (12)
Recurring program dollars	8 (10)
Fees and taxes on health care providers	5 (6)
Private	3 (5)
Miscellaneous	5 (6)
Eligible service sites, No. (%)	
Criteria for eligible underserved sites	
State-specific designation	45 (55)
Federal HPSA and/or MUA	8 (10)
State designation combined with HPSA and/or MUA	29 (35)
Rural vs urban site eligibility restrictions	
Solely rural locations	23 (28)
Preference for rural locations	11 (13)
No preference for rural or urban locations	47 (57)
Solely urban locations	1 (1)
Eligible medical specialties (among 69 programs for physicians), No. (%)	
Family practice	69 (100)
General internal medicine	64 (93)
General pediatrics	64 (93)
Obstetrics/gynecology	28 (41)
Psychiatry	16 (23)
General surgery	13 (19)
Other specialties (including exceptions)	13 (19)
Contract terms for physicians	
Annual financial support, \$†	
Median and mode	10 000
Minimum	3000
Maximum	38 000
Minimum duration of service, mo	
Median	24
Mode	12
Minimum	1
Maximum	60
Financial buy-out costs	
Median and mode	Remaining principal plus interest
Minimum‡	None
Maximum	3 Times principal plus interest

*Some programs reported more than 1 funding source. HPSA indicates Health Professional Shortage Area; MUA, Medically Underserved Area.

†Maximum allowable annual support amount during the minimum service term.

‡Eight loan repayment and incentive programs provided support to practitioners only after they had provided service and did not assess fines if providers terminated participation early.

features are unknown and may vary from state to state. Such local innovations are interesting and promising but unproven.

Several factors prompt states to create their own support-for-service programs when federal programs are available. Program informants often indicated a belief that state-designed initiatives operating under state control better meet the needs of their communities, and that these locally tailored programs are more likely to yield lasting solutions for underserved areas.¹⁰ States also recognized that their programs' smaller size make them more manageable, and their closer relationships with communities give them advantages in innovation and flexibility.^{13,29,30} Indeed, the New Federalism doctrines in recent years have encouraged innovation by states as "policy laboratories."^{19,27,29}

State support-for-service programs also grew to fill a workforce void left when NHSC staffing dwindled in the late 1980s and when President Clinton's health care workforce reform proposals were defeated in the early 1990s.^{3,10,27,29} These experiences revealed states' vulnerability when relying completely on federal programs and leadership. States created their own programs as a solution that offered greater control and flexibility to meet their needs.¹⁰ A mixture of state and federal financial enticement programs is now the chosen course for half of states.

There have been repeated calls to expand federal support-for-service programs and even proposals to create a universal, mandatory service requirement for all newly trained physicians.^{2,22,27,31-35} Plans for such expansions and new initiatives must be mindful of all current types of support-for-service programs—including federal, state, community, and privately sponsored programs—which collectively field an obligated safety-net workforce more than double that generally recognized based on federal program data alone. If an expansion of federal programs is pursued, it should be coordinated with states' efforts. With fully informed considerations, perhaps a further

expansion of state programs will be found preferable. Continued uncoordinated growth in state programs and an unmindful broadening of federal efforts—whose requirements of practitioners always supersede those of states—raise the likelihood of conflicts between state and federal programs.³⁶ Some state programs already report competition for students and young practitioners willing to work in underserved areas, and some are now unable to fill all of their funded positions. Whether this is due to an exhausted pool of interested practitioners or unattractively designed programs is unclear. What is clear is that mutual recognition, communication, and coordination between federal and state initiatives in underserved areas is needed.^{4,37}

Many state program directors voiced a need to communicate with and learn from other programs. Directors working in individual medical schools and those in higher education financial aid state offices most often voiced or demonstrated their need for more communications with others because they had little contact with programs based in state offices of rural health and other public health agencies and had little experience managing students' obligations other than loans. Among the few current models of national collaboration are the promising centralized electronic listings of support-for-service opportunities maintained by the National Rural Recruitment and Retention Network (3R Net³⁸) and by the Association of American Medical Colleges.³⁹

Changing Spectrum of State Programs

The growth of state programs from 1990 to 1996 occurred primarily in new loan repayment and scholarship programs. The growth in loan repayment programs is not surprising given that the first such programs were created in the mid-1980s and their growth had been documented for the late 1980s.^{8,12} Loan repayment is perceived as a responsive mechanism to rapidly target needed specialties and practitioner types to specific underserved communities.^{4,24} Loan

repayment commitments, typically made as practitioners complete their training, come at a time in practitioners' careers when they can make informed practice commitments. The growing debt of today's young physicians also makes loan repayment assistance increasingly attractive to physicians and, thus, a stronger enticement mechanism for programs and communities.⁴⁰

The explanation for the growth in scholarship programs is less evident. Perhaps as the only model for obligating practitioners at the student level (service in loan programs is optional), scholarships remain a requisite choice for states that believe it is important to offer service-requiring support at several career stages through a constellation of programs.⁴¹ Paradoxically, while some states were creating new scholarship programs, others were replacing these programs with loan repayment incentives in an effort to decrease program costs and lessen the administrative and legal burdens that have been associated with programs that obligate individuals years in advance of required service.^{4,24,42}

Direct financial incentives are a less familiar program approach, as these programs are newer and exist in only 8 states, and there is no comparable federal model. Respondents identified 2 advantages for these programs over loan repayment programs: (1) they relieve programs of the need to verify the eligibility of applicants' educational loans; and (2) they broaden the number of individuals eligible to participate. As a program director stated, there is no reason to assume that only those with educational loans are worth recruiting to underserved areas.

Resident support programs also are new and uncommon. They emerged to capitalize on the growing financial pressures on residents—who now carry a median debt amount of more than \$75 000⁴⁰—and to help fill in-state residency positions and retain physicians within the states where they train.

How the 5 types of programs differ in their outcomes for communities and for participating physicians and other practitioners remains to be documented.

Limitations

Despite careful efforts, we may have overlooked several eligible state programs. The addition of data from these omitted programs, however, would further substantiate the collective size and, thus, importance of states' efforts. It is also likely that practitioner counts for some programs are inaccurate because programs sometimes found it difficult to reconstruct complete field strength numbers from their records. We anticipate that practitioner count inaccuracies tend to be underestimates because it was easy for programs to overlook individuals as they tallied names for our study. We do not expect any program to have misjudged their practitioner strength so greatly as to significantly affect our findings and conclusions.

Although we demonstrated growth in program numbers from 1990 through 1996, we were unable to assess how much the collective field strength of these programs grew over time because many programs could not provide the requisite data for trend analysis on their workforce size in the early 1990s. We also did not document how state service-requiring programs changed in number, size, or characteristics since 1996. Similar state initiatives for nurses, dentists, and other non-primary care health care professionals also were not assessed.

CONCLUSIONS AND RECOMMENDATIONS

The tremendous growth in state loan repayment, scholarship, and related programs is one of the most important developments in the US health care safety net over the past 15 years. Remarkably, this growth occurred without fanfare or deliberate design at a national level. The expansion and innovation in state programs is good news, for without them the safety net would be thinner and more vulnerable than it now is. However, much remains to be learned about these state programs and their contributions to promoting uniform access to health care.

Without some degree of cross-state linkage, these programs will remain underappreciated and their lessons hid-

den.²⁷ As proposed recently by the Council on Graduate Medical Education,²¹ we recommend establishment of a mechanism to track, evaluate, and offer coordination to the safety-net efforts of states and local communities, including their support-for-service programs. Joint evaluation and planning will help states and others clarify the optimal complementary roles for federal, state, local, and private efforts. With coordination, programs can avoid duplication and harmful competition, address gaps in existing program coverage, and identify synergistic opportunities.⁴

Many program directors desired more contact with other programs. Beyond assistance and collaboration, however, directors were not looking for the imposition of uniform standards, restrictive requirements, or federal oversight. Whatever coordinating approach is pursued, it should have the consent and contributing leadership of states. An appropriate seat for a coordinating center might be 1 of the existing national resource organizations for states, such as the National Governors' Association or the National Conference of State Legislatures. Alternatively, a new national association of state safety-net programs might be established or responsibility might be placed on a capable state office experienced with support-for-service programs; in either case, support by federal or foundation funding should exist.

Beyond new coordination for states' efforts, we recommend that all future national safety-net descriptions and proposals incorporate state initiatives and, when possible, community efforts. Despite the challenges of acquiring complete information on states' programs, planning based on federal data and remedies alone is inadequate, as it overlooks half of the full picture and can envision only some of the options.

Author Affiliations: Cecil G. Sheps Center for Health Services Research (Drs Pathman, Konrad, and Harris and Ms Crook), Department of Family Medicine (Dr Pathman), and Department of Biostatistics (Dr Koch), University of North Carolina at Chapel Hill; Terry Sanford Institute of Public Policy Studies, Duke University, Durham, NC (Dr Taylor); Department of Health Evaluation Sciences, Pennsylvania State University, Hershey (Dr King); National Conference of State Legislatures, Washington, DC (Mr Henderson); North Caro-

lina Office of Rural Health and Resource Development, Raleigh (Messrs Bernstein and Tucker); and Piedmont Health Services Inc, Carrboro, NC (Dr Spaulding). **Funding/Support:** This study was funded by grant R01-HS09165 from the Agency for Healthcare Research and Quality.

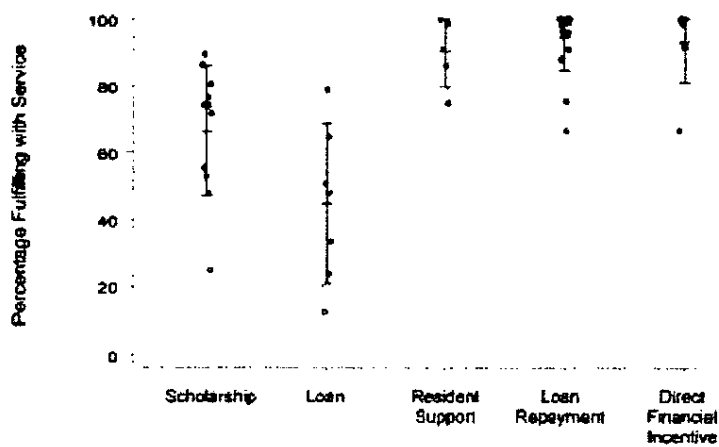
Acknowledgment: We are grateful to the many state program directors and staff who graciously participated in this study, generously giving their time and sharing openly about their programs. We also thank Barbara E. Starrett, MHA, and Michelle Blackwell for helping assemble survey data, and Janice Pope, MSLS, for assistance with library services.

REFERENCES

- National Health Service Corps. Available at: <http://www.bphc.hrsa.gov/nhsc>. Accessed May 9, 2000.
- Council on Graduate Medical Education. *Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas*. Rockville, Md: Public Health Service, Health Resources and Services Administration; 1998.
- National Health Service Corps. *Report to the Congress for Years 1990-1994*. Rockville, Md: National Health Service Corps. Undated.
- US General Accounting Office. *Health Care Access: Programs for Underserved Populations Could Be Improved*. Washington, DC: US General Accounting Office; 2000. Publication GAO/T-HEHS-00-81.
- Henderson TM, Fox-Grage W. *State Incentives to Improve the Practice Environment in Underserved Areas*. Washington, DC: Intergovernmental Health Policy Project, George Washington University; 1996.
- Intergovernmental Health Policy Project. *A Review of State Legislation Related to Increasing the Training, Supply, Recruitment, and Retention of Primary Care Physicians (1985-1991)*. Washington, DC: Intergovernmental Health Policy Project, George Washington University; 1993.
- Carpenter ES, Seidman D. *National Compendium of Nonfederal Physician Distribution Incentive Programs*. Ann Arbor: University of Michigan; 1981.
- Donohue EA. Physician distribution and rural health care in the states. *Acad Med*. 1990;65:592-5113.
- Office of Data Analysis and Management. *Compendium of State Health Professions Distribution Programs, 1986*. Rockville, Md: Bureau of Health Professions; 1986. Report 2-87.
- US Congress, Office of Technology Assessment. *Health Care in Rural America*. Washington, DC: US Government Printing Office; 1990. Publication OTA-H-434.
- Strosberg MA, Mullan F, Winsberg GR. Service-conditional medical student aid programs: the experience of the states. *J Med Educ*. 1982;57:586-592.
- Rivo ML, Henderson TM, Jackson DM. State legislative strategies to improve the supply and distribution of generalist physicians, 1985 to 1992. *Am J Public Health*. 1995;85:405-407.
- Weissert CS, Knott JH, Stieber BE. Education and the health professions: explaining policy choices among the states. *J Health Polit Policy Law*. 1994;19:361-392.
- Association of American Medical Colleges. *State and Other Loan Repayment/Forgiveness and Scholarship Programs*. 2nd ed. Washington, DC: AAMC Division of Student Affairs and Education Services; 1995.
- Williams JL, Gibbons SL, Winsberg G. *Short-term Evaluation of State Educational Service Conditional Support Programs for Allopathic, Osteopathic, and Dental Students*. Silver Spring, Md: Macro Systems Inc; 1980.
- McCloskey AH, Luehrs J. *State Initiatives to Improve Rural Health Care*. Washington, DC: Health Policy Studies, Center for Policy Research, National Governors' Association; 1989.
- Gibbons B. *Placement and Retention Issues in State Scholarship and Loan Programs*. Grand Forks: University of North Dakota Rural Health Resource Center; 1994.
- Henderson TM, Fox-Grage W. *Evaluation of State Efforts to Improve the Primary Care Workforce*. Washington, DC: National Conference of State Legislatures; 1997.
- Henderson TM. *State Efforts to Increase Community-Based Medical Education*. Washington, DC: Intergovernmental Health Policy Project, George Washington University; 1994.
- Weissert CS, Knott JH. *The States' Role in the Reform of Health Professions Education*. East Lansing: Michigan State University; 1992.
- Council on Graduate Medical Education. *Fourteenth Report: Recent Developments and Remaining Challenges in Meeting National Goals*. Rockville, Md: Public Health Service, Health Resources and Services Administration; 1999.
- Hughes RG, Barker DC, Reynolds RC. Are we mortgaging the medical profession? *N Engl J Med*. 1991;325:404-407.
- Siegel S. *Access to Primary Care: Tracking the States*. Washington, DC: Health Policy Tracking Services, National Conference of State Legislatures; 1998.
- Special Committee on Aging, US Senate. *The Rural Health Care Challenge*. Washington, DC: US Government Printing Office; 1988. Serial No. 100-N.
- Indian Health Service, Office of Management Services, Public Health Service. Available at: <http://www.ihs.gov>. Accessed May 9, 2000.
- US General Accounting Office, Indian Health Service. *Efforts to Recruit Health Care Professionals*. Washington, DC: US General Accounting Office; 1994. Publication GAO/HEHS-94-180FS.
- Sparer MS. Laboratories and the health care marketplace. *J Health Polit Policy Law*. 1997;22:789-814.
- Marwick C. National Health Service Corps faces reauthorization during a risky time. *JAMA*. 2000;283:2641-2642.
- Leichter HM. *Health Policy Reform in America*. Armonk, NY: ME Sharpe Inc; 1992.
- National Governors' Association. *Rural Health Care Policy Statement*. Washington, DC: National Governors' Association; 1989.
- Pew Health Professions Commission. *Primary Care Workforce 2000: Federal Policy Paper*. San Francisco: University of California, San Francisco, Center for Health Professions; 1994.
- Mullan F. The muscular samaritan. *Health Aff (Millwood)*. 1999;18:168-175.
- Johns MME. Mandatory national health service. *JAMA*. 1993;269:3156-3157.
- Avery CH. Educational implications of a National Health Service Corps. *JAMA*. 1971;218:1194-1197.
- Reynolds RC. Make health care reform work. Draft doctors. *New York Times*. June 1, 1993:A17.
- Swanson AG. Mandatory requirement versus voluntary opportunity for service in the National Health Service Corps. *J Med Educ*. 1975;50:406-408.
- US Congress, Office of Technology Assessment. *Rural America at the Crossroads: Networking for the Future*. Washington, DC: US Government Printing Office; 1991.
- National Rural Recruitment and Retention Network. Available at: <http://www.3rnet.org>. Accessed May 31, 2000.
- State and other loan repayment/forgiveness and scholarship programs. Available at: <http://www.aamc.org/about/gsa/stloan/start.htm>. Accessed May 31, 2000.
- Beran RL, Lawson GE. Medical student financial assistance, 1996-1997. *JAMA*. 1998;280:819-820.
- Advisory Council of the National Health Service Corps. *Proposed Strategies for Fulfilling Primary Care Manpower Needs: A White Paper*. Rockville, Md: National Health Service Corps; 1989.
- Helms LB, Helms CM. Forty years of litigation involving medical students and their education, II: issues of finance. *Acad Med*. 1991;66:71-76.

From: Pathman DE, Konrad TR, King TS, Taylor DH, Koch GG. Outcomes of states' scholarship, loan repayment, and related programs for physicians. *Medical Care*. 2004;42:560-568.

FIGURE 1. Percentage of recent physicians in each program (%) who fulfilled their obligations with service, grouped by program type.



Bars denote group means \pm standard deviations

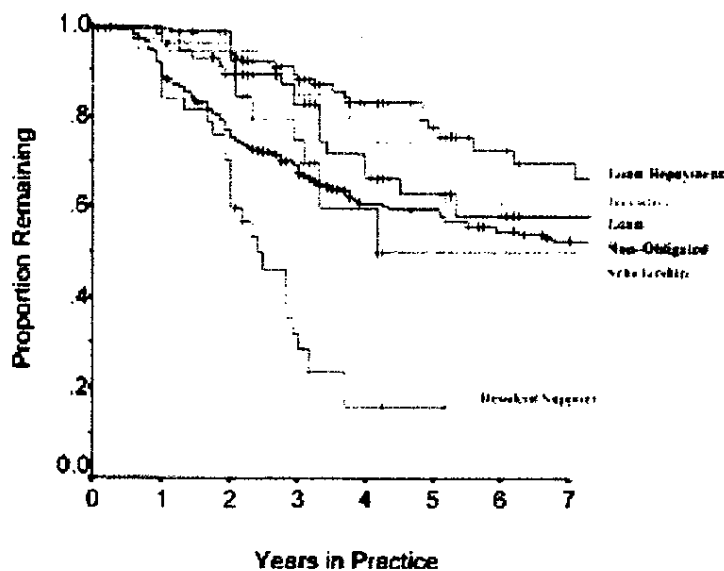


FIGURE 3. Retention of obligated physicians within their service practices: Kaplan-Meier estimations by type of program and compared with nonobligated physicians

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

Senator Donald Olson
Alaska Capitol, Room 508
Juneau, AK 99801-1182

Subject: Support for CSSB 139, Incentives for Certain Medical Providers

Dear Senator Olson:

The Alaska Commission on Aging (ACoA) is pleased to support CSSB 139, 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 you.

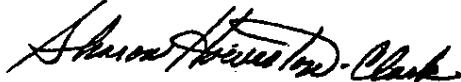
Alaska, as with the rest of the nation, is experiencing a shortage of health care workers as fewer students are entering the health care profession and many of those already working in health care are preparing for retirement. Alaska is one of five states that does not offer a state-sponsored loan repayment 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.

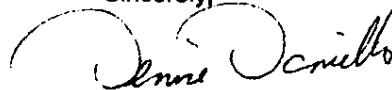
ACoA supports CSSB 139 and believes that the proposed legislation will help to build a qualified health care workforce who will be available to meet the health care needs of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) 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

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 HPSA 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 HPSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

USDHHS HPSA: More about shortage areas

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

"Yes" in HPSA columns means there is a "geographic" HPSA designation approved by HPSA 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 automatic 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



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.

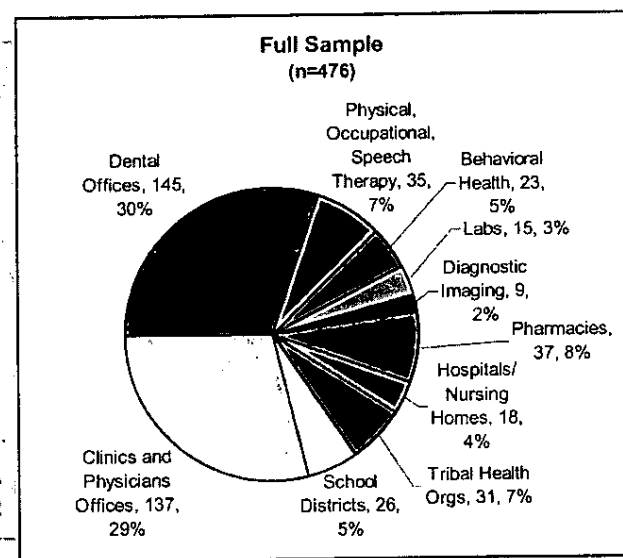


Figure 1

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).

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 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%

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.

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

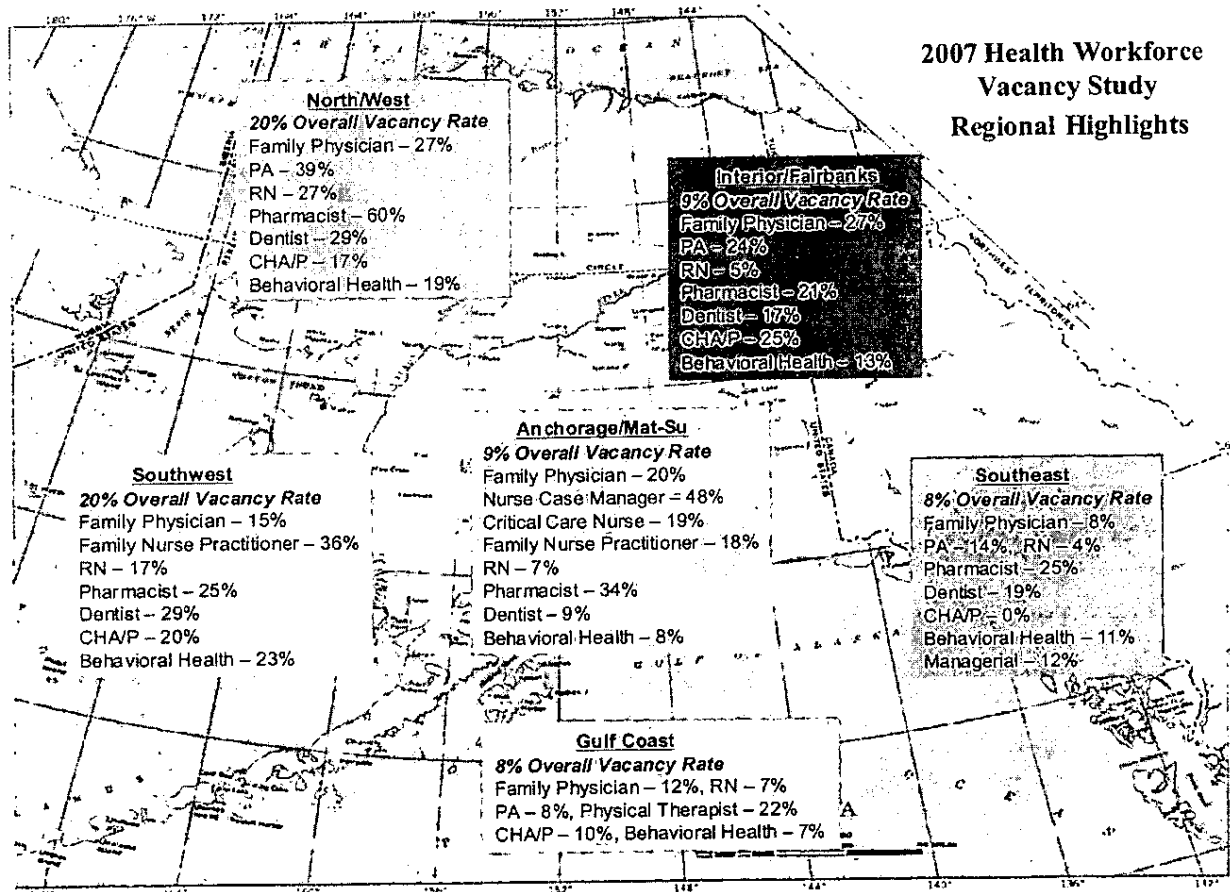


Figure 2. Regional Highlights

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.

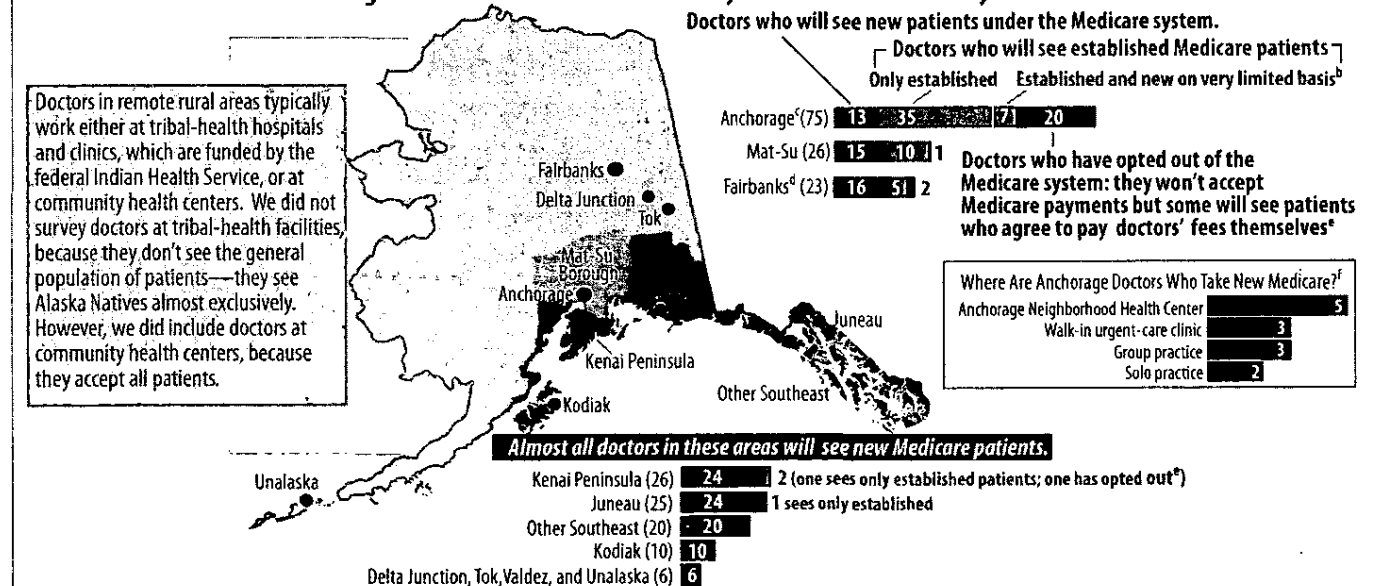
But Medicare payments for Alaska doctors increased in 2009, thanks to efforts of Alaska's U.S. senators. So we recently called back the doctors who had told us they weren't taking new Medicare patients. None of them had opened their doors to significant numbers of new Medicare patients. Four said they 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



^aIn 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. ^bTen 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. ^cIncludes Eagle River/Chugiak. ^dIncludes North Pole. ^eSee Figure 9. ^fSee page 3.

^gNationwide, 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.

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.

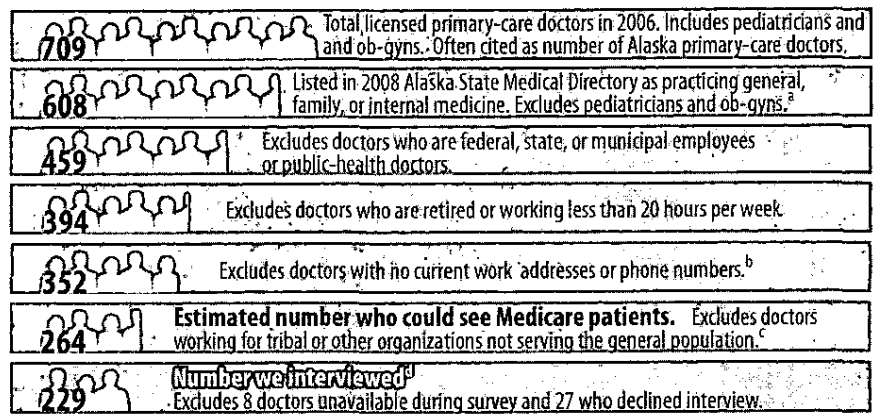
The CMS formula actually includes three geographic differentials: one for "physician work" itself, one for doctors' costs of operating practices, and one for doctors' costs of carrying liability insurance.

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).

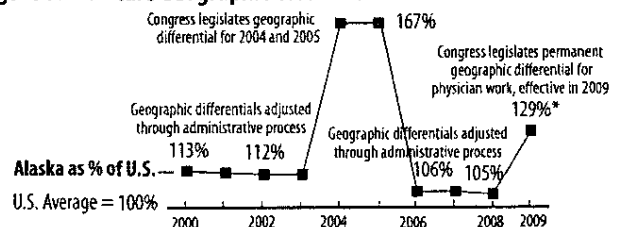
Figure 2. How Many Primary-Care Doctors Are Available to See Medicare Patients?
(Among Alaska Doctors Practicing General, Family, or Internal Medicine at Least 20 Hours per Week)



^aWe excluded pediatricians and obstetrician-gynecologists, who are often included in definitions of primary-care doctors, because they don't routinely see older patients. ^bAbout 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. ^cWe 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. ^dWe interviewed either doctors or members of their staffs.

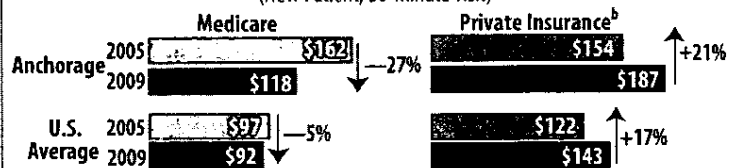
- After that legislation expired, the Medicare differential dropped sharply, to about 5% above the U.S. average from 2006 to 2008.
- In 2009, the cost differential for Alaska doctors climbed to 29% above the U.S. average, due to new federal legislation—as we just discussed. But Medicare still pays doctors 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)



^aFigures include the amount Medicare or private insurance pays and the amount the patient pays. ^bMedian 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.

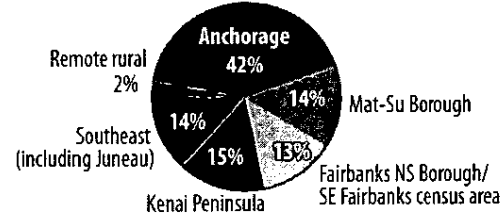
• Anchorage's Medicare patients don't seem to be turning more to emergency rooms. Data from Providence Hospital's emergency room show that visits by older patients have stayed mostly steady, with seasonal variations, since 2004 (Figure 7). But some health-care providers think that Medicare patients may 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.

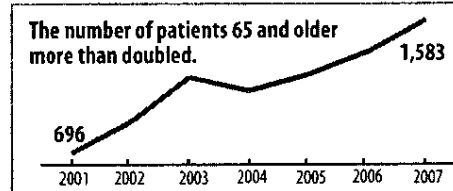
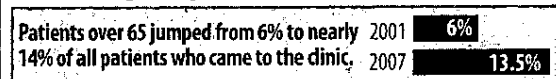
• Medicare pays health centers the same fee for seeing Medicare patients for any visit, but private doctors more for longer, more complex visits. Figure 8 compares payments for 30- and 60-minute visits with new patients, at doctors' offices and the Anchorage Neighborhood Health Center (ANHC). For a 30-minute 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

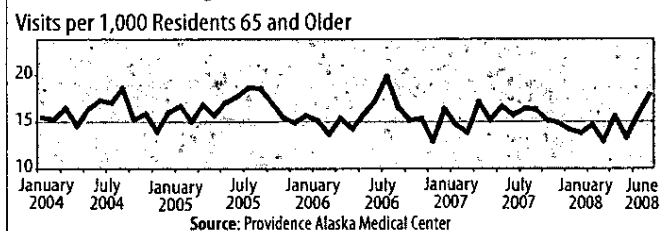
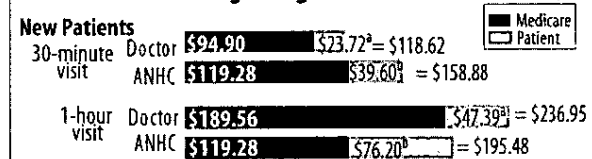


Figure 8. Medicare and Patient Payments to Private Doctors and Anchorage Neighborhood Health Center, 2009



^aPatient co-pay; 20% of total payment. ^bFacility 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.

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.

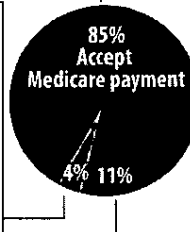
In a publication later this year, we'll look at the implications of various ways of trying to improve access for Medicare patients. We'll also report what family doctors themselves told us—how they make decisions about seeing Medicare patients and what might make them willing to see more.

Figure 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 ^b	Entire doctor's fee ^b

^aPatients can bill secondary insurance to help pay their share.

^bPatients can't bill secondary insurance to pay any amount.

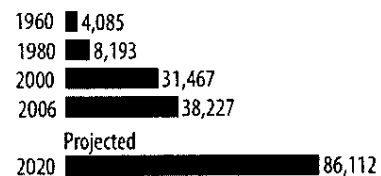
Sources: American Academy of Family Physicians; Government Accountability Office

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.

This research is part of ISER's Understanding Alaska Choices research initiative, funded by the University of Alaska Foundation. Karen Perdue, associate vice president for health programs, University of Alaska, provided additional funds.

Editor: Linda Leask

Graphics: Clemencia Merrill

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.

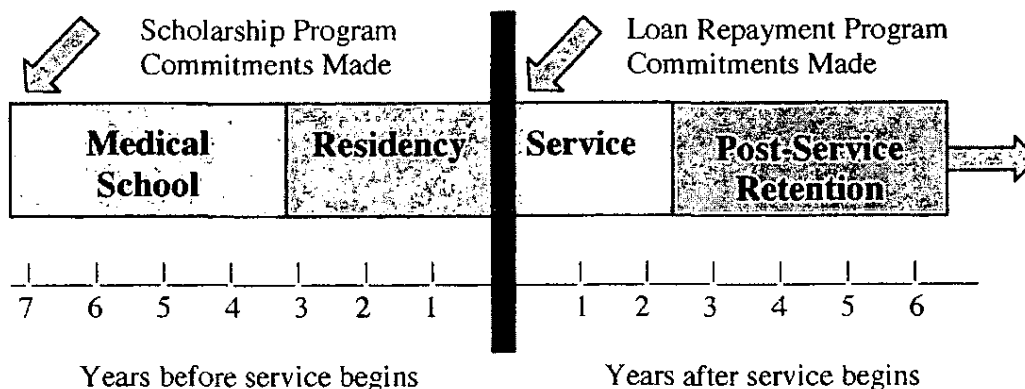
Medical Training Debt & Service Commitments: Pathman, et al (2000) assessed how student loan debt and scholarships, loan repayment and related programs with service requirements influence the incomes young physicians seek and attain, influence whether they choose to work in rural practice settings and 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"

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

Table 1: "State Program" (continued)

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

State-Level Offices: Service-for-Support Programs

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

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

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

(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 underserved 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 underserved 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).

References

1. *Alaska Health Care Databook: Selected Measures* (2007). Health Planning & Systems Development. Alaska Department of Health & Social Services.
2. Association of the American Medical Colleges, Division of Medical School Services and Studies. (2004). *AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals*. LeEtta Robinson, Editor. Washington, DC: AAMC.
3. Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services (2005). *National Health Service Corps*. Available at <http://nhsc.bhpr.hrsa.gov>.
4. Chaconas J.A. (2001). Loan repayment program provides financial incentives to practice in Delaware's health professional shortage areas. *Del Med J*. 2001 Aug; 73(8):305-6.
5. Daniels, Z.M., Vanleit, B.J., Skipper, B.J., Sanders, M.L., & Rhyne, R.L. (2007). Factors in recruiting and retaining health professionals for rural practice. *J Rural Health*. 23(1): 62-71.
6. Fried, N. & Keith, B. (2003). Alaska's Health Care Industry. *Alaska Economic Trends*, 23(4): 3-11.
7. Heinrich, J. (2001) *Health workforce: Ensuring adequate supply and distribution remains challenging*. Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives (Aug. 1st, 2001).

8. Jackson, J., Shannon, C.K., Pathman, D.E., Mason, E., & Nemitz, J.W. (2003). A Comparative Assessment of West Virginia's Financial Incentive Programs for Rural Physicians. J Rural Health, 19 (suppl): 329-339.
9. Johnson, D.R. & Norris, T.E. (1997). Geographic distribution, supply and need for generalist physicians in Alaska. West J Med. 167(5): 330-335.
10. Jolly P. (2005). Medical school tuition and young physicians' indebtedness. Health Affairs, 24:527-535.
11. Miller, J.B. & Crittenden, R.A. (2001). The effects of payback and loan repayment programs on medical student career plans. J Rural Health. 17(3): 160-164.
12. National Organization of State Offices of Rural Health (2006). National Rural Health Issues: NOSORH National Priorities, 2006. (accessed website 8/15/07: http://www.nosorh.org/pdf/Rural_Impact_Study_States_IT.pdf)
13. Pathman, D.E. (2007). Personal communication. (Cecil G. Sheps Center for Health Services Research Department of Family Medicine University of North Carolina at Chapel Hill).
14. Pathman DE. (2006). What outcomes should we expect from programs that pay physicians' training expenses in exchange for service? North Carolina Medical Journal. 67:77-82.
15. Pathman DE, Fryer GE, Phillips RL, Smucny J, Miyoshi T, Green LA. (2006). National Health Service Corps staffing and the growth of the local rural non-NHSC primary care physician workforce. Journal of Rural Health. 22(4):285-293.
16. Pathman D.E., Konrad T.R., Dann, R., Koch, G. (2004). Retention of primary care physicians in rural health professional shortage areas. Am J Public Health, 94:1723-1729.
17. Pathman, D.E, Konrad, T.R, King, T.S., Spaulding, C. & Taylor, D.H. (2000). Medical training debt and service commitments: the rural consequences. J. Rural Health. 16(3): 264-272.
18. D.E., Konrad, T.R., King, T.S., Taylor, D.H., & Koch G.G. (2004). Outcomes of states' scholarship, loan repayment, and related programs for physicians. Medical Care, 42(6): 560-568.
19. Pathman, D.E., Taylor, D.H. Jr., Konrad, T.R., King, T.S., Harris, T., Henderson, T.M., Bernstein, J.D., Tucker, T., Crook, K.D., Spaulding, C., & Koch, G.G. (2000). State scholarship, loan forgiveness, and related programs: the unheralded safety net. JAMA 284:2084-2092.
20. Rosenblatt, R.A., Andrilla, C.H., Curtin, T., and Hart, L.G. (2006). Shortages of medical personnel at community health centers: implications for planned expansion. JAMA 295(9): 1042-1049.

21. Rosenblatt, R.A. & Andrilla, C.H. (2005). Impact of U.S. medical students' debt on their choice of primary care careers: An analysis of data from the 2002 Medical School Graduation Questionnaire. Academic Medicine, 80(9), 815-819.
22. Securing an Adequate Number of Physicians for Alaska's Needs (2006). Health Planning & Systems Development Office, Dept Health & Social Services, State of Alaska. (<http://www.hss.state.ak.us/commissioner/PhysicianSupply.htm>).
23. Sempowski, I.P. (2004). Effectiveness of financial incentives in exchange for rural and underserved area return-of-service commitments: systematic review of the literature. Can J Rural Med, 9(2): 82-88.
24. Thaker SI, Pathman DE, Mark BA, Ricketts TC. (2007). Service-Linked Scholarships, Loans and Loan-Repayment Programs for Nurses in the Southeast. Journal of Professional Nursing (in press).
25. US General Accounting Office (1995). Health Care Shortage Areas. Designations Not a Useful Tool for Directing Resources to the Underserved. Washington DC, (GAO/HEHS-95-200, September 1995).

Money seen as cure for shortage of doctors in Alaska

PRIMARY CARE: State considers help for more medical students; paying physicians to move north.

By ROSEMARY SHINOHARA
rshinohara@adn.com

(12/16/09 16:10:18)

Citing a continuing shortage of primary care doctors in Alaska, a state commission recommends the state spend considerably more money to train new doctors and lure more already-qualified doctors to the state.

Exactly how many primary care physicians Alaska needs isn't clear, but it's certain we need more, said Dr. Ward Hurlburt, chief medical officer for the Alaska Department of Health and Social Services and chair of the Alaska Health Care Commission, which made the recommendations.

Getting more primary care doctors will help deal with the crisis in care for senior citizens on Medicare, too, the commission believes. Doctors say reimbursement rates for Medicare are too low, and many primary care physicians won't take new Medicare patients.

If there were more doctors available, though, they could spread the Medicare population around.

The proposals include:

- Adding four students annually to the WWAMI medical school jointly operated by University of Alaska Anchorage and the University of Washington, taking each class up from 20 to 24 students. The state pays about \$50,000 per student to UW for each of the second, third and fourth years of their schooling. The first year is spent at UAA.
- Starting up three new residency programs to turn medical school graduates into fully qualified psychiatrists, pediatricians and primary care internists. The cost is unknown, but the state pays \$2 million per year to support Alaska's only full-fledged residency program: Alaska Family Medicine Residency.
- Paying primary care doctors to get them to move to and practice in Alaska.

The health care commission, comprised of seven people most of whom work in health care, was appointed by then-Gov. Sarah Palin in January. The report completed so far is a draft. The group's final report is to be delivered to the governor and the Legislature by Jan. 15.

A spokesman for Gov. Sean Parnell said it's too early for him to comment.

The commission suggested other ways to improve health care in Alaska beyond increasing the supply of doctors, but put some issues -- such as expanding health insurance, and improving water and sanitation systems around Alaska -- aside for later.

ALASKANS IN MEDICAL SCHOOL

The commission recommends that the state's financial resources target increasing the supply of primary care providers, including doctors, physician assistants and nurse practitioners.

In one case, at least, this single-minded focus is controversial: their approach to the WWAMI program, in which Alaska medical school students do part of their studies at the UAA and the rest at the University of Washington.

The state subsidizes each Alaskan in WWAMI. The commission proposes the students be required to pay the state subsidy back in full if they don't practice as primary care physicians in Alaska for five years. Currently, there's a requirement that Alaska students pay back half the state contribution if they don't practice in Alaska for five years.

Dennis Valenzano, director of the Alaska WWAMI program, said in an interview that he's afraid the 100 percent payback provision could actually discourage med school graduates from going into primary care.

They come out of medical school with about \$100,000 in other debt anyway, he said. If they also have to repay some \$150,000 plus interest to the state, the medical school graduates might think they can't afford to go into primary care -- a career that pays half or a third as much as some other specialties, said Valenzano.

"My fear is this is going to be another disincentive," he said.

WWAMI does have the space to add four more students as recommended, said Valenzano, but the earliest it could do so would be the fall of 2011.

PAY AND THEY WILL COMEThe quickest way to get more doctors to Alaska, without doubt, is to pay doctors who have already finished their training to come here.

Research shows that's also the most cost effective way to get primary care doctors, said Hurlbert. "It's convincing."

A bill pending in the Legislature, SB 139, calls for paying doctors, nurses or specified other health workers incentives to take certain Alaska jobs -- from \$35,000 to \$47,000 for doctor positions, depending on how hard they are to fill.

The commission also suggests the state should figure out how to deliver primary care to Alaskans more efficiently, and how to make better use of "physician extenders" like advanced nurse practitioners, who do some of the same work as a doctor.

The Alaska Health Care Commission's proposals include three new residency programs to turn med school graduates into fully qualified psychiatrists, pediatricians and primary care internal medicine.

Two of those programs are already more than just a dream: Residency programs for psychiatrists and pediatricians are in the planning stages for Alaska, said Dr. Harold Johnston, director of the Alaska Family Medicine Residency.

Both of the new programs would be partnerships with University of Washington. Multiagency steering committees are putting together the pediatric and psychiatric residency proposals.

"We think it's very realistic, very doable. It will require some funding. We don't know how much," Johnston said.

Both Johnston and Susan Humphrey-Barnett, area operations administrator for Providence Health

and Services Alaska, say Alaska's most critical shortage appears to be in psychiatrists.

The need for more pediatricians doesn't seem to be as urgent, said Dr. Richard Mandsager, chief executive of Providence Alaska Medical Center, but there is an opportunity available -- Seattle Children's Hospital and UW are interested in starting a pediatrics residency in Alaska, he said.

An internal medicine residency for primary care doctors -- arguably the one that would help older Alaskans the most -- doesn't appear to be off the ground yet.

Find Rosemary Shinohara online at adn.com/contact/rshinohara or call her at 257-4340.

Print Page

Close Window

Copyright © Mon Dec 21 11:00:44 UTC-0900 20091900 The Anchorage Daily News (www.adn.com)



**Alaska Native
Tribal Health Consortium**

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: March 12, 2010

RE: SB 139 – Incentives for Certain Medical Providers

POSITION: Support

ANTHC is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. ANTHC is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC hospital and SCF clinic facilities together employ 161 physicians, 37 dentists and 509 nurses, along with many more employees working in health-related professions. We face the same workforce challenges as our partner health organizations, competing with employers in the Lower 48 to recruit and retain a quality workforce.

Current reports prepared by the Indian Health Service on physician positions within the tribal system and by Alaska tribal facilities on nursing positions provide a good snapshot of workforce challenges.

<i>Profession</i>	<i>Positions Authorized</i>	<i>Vacancies</i>	<i>Percentage</i>
Physicians – statewide	305	81	26.6%
Physicians – ANTHC/SCF	161	35	21.7%
RN – statewide	775	113	15%
LPN – statewide	92	26	28%
APN – statewide	120	28	23%

Ideally we would grow our own health professionals in numbers that would meet our workforce needs, and we have made progress over the years. The tribal health system offers internships and scholarships that bring some of our best and brightest to the medical field. More Alaska Natives are choosing Medical and Dental careers; a University of Alaska Anchorage program, Recruitment and Retention of Alaska Natives into Nursing, is graduating Alaska Native nurses; many of our Community Health Aides have built on their basic training opportunities to prepare for advancing careers; and the Dental Health Aide Program is graduating students who fill a need for dental health services and patient education. We are inching forward, but more work needs to be done.

HB 392 is a strategy to attract skilled health professional to Alaska jobs. It would work in tandem with other efforts as Alaska’s health provider community work to provide quality care to our residents. ANTHC urges your favorable consideration and passage of HB 392 to help us turn the corner on Alaska’s health care workforce.

INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM
PHYSICIAN SITE SCORING FY 2010

Site	Department	NUMBER OF FUNDED PHYSICIAN POSITIONS	NUMBER OF VACANT PHYSICIAN POSITIONS	VACANCY RATE Non-Solo Site or Dept. Score 3 pts./5% of Vacancy Rate (MAX SCORE 60)	LONGEVITY OF VACANCY 5 points for vacancies => 6 months; 10 points for vacancies => 12 months (MAX SCORE 10 POINTS)	Recruiter/ CMO Adjustment (MAX SCORE 40 POINTS)	Total Score (MAX. = 100)
ANMC	Anesthesiology	4	1	15	10	40	65
ANMC	Cardiology	3	1	20		40	60
ANMC	Dermatology	1	0			40	100
ANMC	Diabetes Program	2	0			40	40
ANMC	ENT	9	0			40	40
ANMC	Emergency	9	0			40	40
ANMC	General Surgery	9	0			40	40
ANMC	Pediatric Intensivist	3	0			40	40
ANMC	Hospitalists	7	5	42	10	40	92
ANMC	Internal Medicine	2	1	30	10	40	80
ANMC	Neurology	1	0			40	100
ANMC	Neurosurgery	2	1	30	10	40	80
ANMC	Oncology	1	0			40	100
ANMC	Ophthalmology	3	0			40	40
ANMC	Orthopedic surgery	6	0			40	40
ANMC	Pathology	3	0			40	40
ANMC	Pulmonology	3	1	20	10	40	70
ANMC	Radiology	9	0			40	40
ANMC	Urology	3	1	20		40	60
ANTHC	Ryan White Early Intervention	1	0			40	100
ANTHC	Immunizations	1	0			40	100
ANTHC	Epidemiology	1	0			40	100
ANTHC	Hepatitis Program	3	0			40	40
Arctic Slope Native Association	Family Medicine	8	4	30	10	40	80
Bristol Bay Area Health Corp	Family Medicine	8	3	22	10	40	72
Bristol Bay Area Health Corp	Pediatrician	1	1	60	10	40	100
Chugachmiut – North Star Clinic	Family Medicine	1	0			40	100
Chugachmiut – Ilanka Community Health Center	Family Medicine	1	0			40	100
Hoonah Indian Association	Family Medicine	1	0			40	100
Ketchikan Indian Community	Family Medicine	4	1	15	10	40	65
Kodiak Area Native Association	Family Medicine	4	1	15	5	40	60
Manilaq Association	Family Medicine	11.5	3.5	18	10	40	68
Metlakatla Indian Community	Family Medicine	2	0			40	40
Norton Sound Health Corp	Family Medicine	8	5	37	10	40	87
Norton Sound Health Corp	Psychiatrist	1	1	60	10	40	100

EDIT A REPORT - MAIN

[Return to normal view](#)

Facility: Alaska Native Tribal Health Consortium, Anchorage, AK Quarter: 4th/2009 Date: 01/29/2010
 Service Type: Tribal Area: Alaska

First Name: Gloria Middle Init: L Last Name: Rhodes
 Phone: 907-729-1319
 Email: glrhodes@anthc.org

A	B	C	D	E	F	G	H
Group: Category	Total Positions Allocated	Total Positions Filled	Total Positions Vacant	Total Accessions	Total Separations	Vacancy Rate	Turnover Rate
RN: Chief Nurse Administrator	1	1	0	1	0	0 %	0 %
RN: Supervisory Clinical Nurse	23	23	0	0	0	0 %	0 %
RN: OB/L&D	42	40	2	1	0	5 %	0 %
RN: ICU	58	54	4	4	3	7 %	5 %
RN: ER	24	19	5	4	3	21 %	13 %
RN: OR	42	34	8	2	2	19 %	5 %
RN: PACU	17	11	6	1	2	35 %	12 %
RN: Medical/Surgical	115	94	21	7	4	18 %	3 %
RN: Generalists	0	0	0	0	0	N/A	N/A
RN: Public Health Nurse	0	0	0	0	0	N/A	N/A
RN: Nurse Educator	6	2	4	0	0	67 %	0 %
RN: Diabetes Nurse	1	0	1	0	0	100 %	0 %
RN: Ambulatory Care Nurse	38	30	8	0	2	21 %	5 %
RN: Pediatric Nurses	54	40	14	2	3	26 %	6 %
RN: Psychiatric Nurses	0	0	0	0	0	N/A	N/A
RN: Nurse Specialist	0	0	0	0	0	N/A	N/A
TOTAL RNs:	421	348	73	22	19	17 %	5 %
APN: Nurse Practitioner	7	4	3	0	0	43 %	0 %
APN: CNM	0	0	0	0	0	N/A	N/A
APN: CRNA	19	16	3	0	0	16 %	0 %
TOTAL APNs:	26	20	6	0	0	23 %	0 %
TOTAL RN/APNs:	447	368	79	22	19	18 %	4 %
LPN: LPN	20	13	7	0	1	35 %	5 %

B-C=D

D/B*100 F/B*100

EDIT A REPORT - MAIN

[Return to normal view](#)

Facility: South Central Foundation, Anchorage, AK Quarter: 4th/2009 Date: 01/05/2010
 Service Type: Tribal Area: Alaska

First Name: Anna Last Name: King
 Phone: 907-729-4919
 Email: aking@scf.cc

A	B	C	D	E	F	G	H
Group: Category	Total Positions Allocated	Total Positions Filled	Total Positions Vacant	Total Accessions	Total Separations	Vacancy Rate	Turnover Rate
RN: Chief Nurse Administrator	5	3	2	0	0	40 %	0 %
RN: Supervisory Clinical Nurse	0	0	0	0	0	N/A	N/A
RN: OB/L&D	9	7	2	1	0	22 %	0 %
RN: ICU	0	0	0	0	0	N/A	N/A
RN: ER	0	0	0	0	0	N/A	N/A
RN: OR	0	0	0	0	0	N/A	N/A
RN: PACU	0	0	0	0	0	N/A	N/A
RN: Medical/Surgical	0	0	0	0	0	N/A	N/A
RN: Generalists	0	0	0	0	0	N/A	N/A
RN: Public Health Nurse	16	15	1	1	2	6 %	13 %
RN: Nurse Educator	0	0	0	0	0	N/A	N/A
RN: Diabetes Nurse	0	0	0	0	0	N/A	N/A
RN: Ambulatory Care Nurse	0	0	0	0	0	N/A	N/A
RN: Pediatric Nurses	15	14	1	0	0	7 %	0 %
RN: Psychiatric Nurses	0	0	0	0	0	N/A	N/A
RN: Nurse Specialist	43	43	0	2	0	0 %	0 %
TOTAL RNs:	88	82	6	4	2	7 %	2 %
APN: Nurse Practitioner	29	29	0	1	0	0 %	0 %
APN: CNM	17	14	3	0	0	18 %	0 %
APN: CRNA	0	0	0	0	0	N/A	N/A
TOTAL APNs:	46	43	3	1	0	7 %	0 %
TOTAL RN/APNs:	134	125	9	5	2	7 %	1 %
LPN: LPN	28	20	8	4	1	29 %	4 %

B-C=D

D/B*100 F/B*100




Comments Regarding Senate Bill 139

These comments are unsolicited support for Senate Bill 139.


My name is David Head, M.D. I have practiced medicine in Nome, Alaska at Norton Sound Health Corporation nearly 21 years, 20 of those years as Chief of Staff. I have also served on the Alaska State Medical Board for the last 7 years, 4 of those years as the Chairman for the Board. In addition I have served on multiple State and National committees and advisory groups regarding Physician Shortage and recruitment and retention strategies.

It is these experiences that cause me to be such a strong supporter for Senate Bill 139.



At this time Alaska is entering a crisis situation when it comes to adequate medical providers. For the first 15 years that I was in Nome, if we had a vacancy open up we were able to pick and choose between several qualified, experienced and well educated physicians to fill that slot. We had no difficulty maintaining a full staff. During the last 5 years this has changed dramatically. The national shortage of primary care physicians, along with the dramatic increase in the cost of living in Bush Alaska has led us into operating in crisis mode. We have slowly gone from a full time staff of 8 physicians to now 3. We scramble to maintain adequate coverage with temporary "traveling doctors", often going through 20-30 different physicians per year to provide basic care. This makes it near impossible to maintain the high quality level of care that the people of this area have become accustomed to, as well as burning out our regular doctors. We have hired recruitment firms that over the last 3 years have only been able to find 2 doctors that would even come for interview. Although I do not see Senate Bill 139 as the "cure all", I do believe it offers immediate aid and will greatly help give us additional chips to play in this game of attracting the professionals that we so greatly need until other more long term answers can be found.

Thank you for your time and dedicated service.



David Head, M.D
Chief of Staff
Norton Sound Health Corporation
Nome, Alaska

Christina Apathy

From: Coady [coady@alaska.net]
Sent: Tuesday, January 26, 2010 3:03 PM
To: Sen. Donny Olson
Subject: SB 139


Dear Senator Olson...Donny:

...a voice from the past, in Nome. It's hard to believe that our family moved from Nome back to Fairbanks 18 years ago. We still have the same C-180 as we did in Nome, and I'm doing some flight instruction to keep my hand in the flying business.

Carol and I noted your Bill SB139, and it made us think of a situation with one of our daughters: Erica will complete a 2 year post-doctoral fellowship in neuropsychology at UCLA this summer. Her work has focused on neurocognitive testing of patients with brain tumors, memory issues, aphasias, movement disorders, HIV, brain injuries, as well as other neurological problems associated with both clinical and forensic cases. She would love to return to Alaska (I'm told there is only one board-certified neuropsychologist in Alaska), but with \$100,000 in student loans to pay off she has no choice but to remain in California or other South 48 location where salaries are high enough to make reasonable progress in paying down her education debt. A cash incentive or loan forgiveness program that would include her profession would be a major step in bring her skills and training back home to Alaska.

We trust all is well with you and your family. Please contact us on your next trip to Fairbanks (cell 907-750-5083). It would be great to get together for a visit. Best regards for now.


John Coady



From: Barbara Hale [mailto:bfhale1@msn.com]
Sent: Sunday, April 05, 2009 3:44 PM
To: Sen. Bettye Davis; Sen. Joe Paskvan; Sen. Johnny Ellis; Sen. Joe Thomas; Sen. Fred Dyson
Cc: Sen. Donny Olson; Sen. Bill Wielechowski; Sen. Kevin Meyer; Natalie Hale
Subject: The Alaska Health Care Professions Loan Repayment & Incentive Program
Importance: High

Dear Senators Davis, Paskvan, Ellis, Thomas and Dyson,

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. Competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist 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. This 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. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. This proposal is more cost-efficient and results-producing than other methods.



My daughter, Natalie Hale, will be entering her first year of medical school in August at the University of Washington WWAMI program in Anchorage. With more than \$50,000 in student loan debt from her undergraduate studies at Yale already, the Alaska Health Care Professions Loan Repayment and Incentive Program will offer an incentive and encouragement for her to be able to pursue her first love, public health policy and primary care, here in Alaska. Thank you all for your consideration of this important policy under SB 139 to help alleviate health care shortages that Alaska is experiencing and to help retain providers who begin their studies here.

Best Regards,
Barbara Hale
P.O. Box 240211
Douglas, AK 99824-0211
907-586-6590

Christina Apathy

From: Julie Lynch McDonald [julie.cpf@gmail.com]
Sent: Wednesday, March 03, 2010 8:47 AM
To: Sen. Donny Olson
Cc: Denise Liccioli
Subject: SB 139 Support by Pharmacist Interested in Working in Alaska
Attachments: SB139_Julie_McDonald_3-2-10.pdf

Dear Senator Olson,

I am a pharmacist in south Florida who previously interned in Alaska. I would like to share my story and subsequent support for SB 139 *Incentives for Certain Medical Providers* due to my desire to return and work in Alaska. Please include my attached letter as written testimony for the SB 139 hearing.

After putting myself through college to earn a bachelors degree in environmental science, I decided to move back into my parent's home in order to save for a place of my own and to begin aggressively repaying my nearly twenty thousand in student loans. After a year of working as a field biologist and living on a restricted budget, I was very excited to purchase a garden apartment. However, during this year had been very involved with a children's hospital and nursing home. This volunteer work inspired me to return to college in order to pursue a career that offered the daily opportunity to help alleviate suffering and improve the health of those in my community. I decided the best career would be the profession of pharmacy. As a result, I spent the following year continuing my same employment as a field biologist, completing prerequisite courses in the evening, volunteering on the weekends, living with my parents, and renting my apartment. I was accepted into two private colleges of pharmacy and one out of state college. I knew any choice would result in massive student loans accrued during the four years required for a Doctor of Pharmacy degree (tuition alone exceeded eighty thousand). Therefore, I choose a local college of pharmacy that allowed me to continue living with my parents throughout pharmacy school and rented my apartment that I sold a few years later without having the pleasure of ever living in it.

The summer after my first year in pharmacy school, I was thrilled to have the opportunity to spend a month working at the Prescription Center Pharmacy in Fairbanks and volunteering with the Fairbanks Native Bible Church. I anticipated enjoying the beauty of the Alaskan outdoors, but did not expect to fall in love with the people and culture of Alaska. One small example is the quick bond I developed with those who simply rode the same bus route. One day a co-worker generously offered to pick me up for work. I can still recall on the following morning how those on the bus shared they had been truly concerned since I had not been on the bus the previous day. My time in Alaska made a marked impression. Therefore, I was saddened to leave when the month was over and have hoped to return to Alaska ever since.

After graduation from pharmacy school, I felt a great responsibility to begin immediately paying down my student loans. As a result, I did not choose to defer my loans in order to complete a residency and subsequently enter into a more sought-after field of pharmacy. Rather, I entered the very demanding field of retail pharmacy. I have spent nearly two years working fulltime at an independent retail pharmacy and as a relief pharmacist at another independent pharmacy. I have come to value and respect the vital role a local retail pharmacist has in counseling and advising patients, collaborating with practitioners on patients' medication therapy, seeking innovative ways to meet individual patient's needs (i.e. compounding medications), and often serving as a listening friend. It is a physically demanding and emotionally draining, but richly rewarding by the relationships built with your patients.

Currently my husband, who has a bachelors in business, and I are considering moving to Craig. We would be working at an independent retail pharmacy and are enthused to become a part of the Prince of Wales

community. Additionally, I serve on the board of directors for a pharmacy organization where I oversee seventy-six student chapters nationwide and internationally. Part of my work in Craig would be encouraging pharmacy students from numerous states to come to Alaska for a summer position or complete a rotation during their final year of pharmacy school. My husband and I are confident the culture and spirit of Alaska would be of great benefit for us and we would continually seek to benefit the community through our combined diverse background in medicine, environmental science, business, accounting, and construction. However, my monthly student loan payment is significantly greater than our mortgage payment. My husband and I would like to relocate to Craig, but my more than two hundred thousand in student loans causes us to be very cautious with our choices.

From my perspective, SB139 would be a powerful incentive to draw pharmacists to the great state of Alaska. I have witnessed much legislation that is well intentioned, but often a significant portion ends up benefiting or rewarding those who have not necessarily made the hard choices. In contrast, I personally found SB139 to be distinctive and very encouraging. The reason for this is twofold. First, SB139 will attract medical professionals to Alaska and rural areas in particular, thus benefitting those who live in those areas and are often underserved. Second, SB139 will actually assist those who have made the continuous rigorous sacrifices of time, energy, and finances to enter the medical profession in an effort to give of themselves in the service of others.

Thank you for your time and consideration!

Sincerely,

Julie McDonald
Julie.CPFI@gmail.com
561.222.3330

Alaska Primary Care Association

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



The Honorable Senator Olson
Alaska State Senate
State Capitol, Room 514
Juneau, Alaska 99801-1182

Re: Support for Incentives for Certain Medical Providers – SB 139

March 18, 2008

Dear Senator Olson,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 141 Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. The APCA knows firsthand that workforce shortages can affect access to health care services in Alaska's Community Health Centers. In 2007, our sites provided primary health care services to over 80,000 patients despite suffering a severe 35% shortage of primary care physicians and a 22% shortage of midlevel providers at Community Health Centers.¹ In fact, Alaska's CHCs have current vacancies for an estimated 22 physicians, 20 physician assistants, 26 nurse practitioners, 6 dentists, and 10 licensed certified social workers – to name a few.

Alaska is suffering from labor shortages in most professional health care occupations², while most of the State of Alaska has been designated either as a Health Professional Shortage Area or a Medically Underserved Area³. All but six states have addressed similar professional health provider shortages by implementing support-for-service programs which have helped to attract and retain health care providers⁴.

The Alaska Primary Care Association supports SB 139 and the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" to help fill vacancies and help health care facilities recruit and retain health care professionals.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

¹ Bureau of Primary Health Care. "Alaska Section 330 Grantees Uniform Data System (Provider Utilization)."

² Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007.
http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

³ US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage

⁴ Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska

Alaska Primary Care Association
903 W Northern Lights Blvd, Suite 200
Anchorage, AK 99503

ph. 907-929-2722
fx. 907-929-2734
www.alaskapca.org

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 occupations¹, 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

Phone 907-929-2722 • Fax 907-929-2734 • www.alaskapca.org • alaskapca@alaskapra.org

903 West Northern Lights Blvd., Suite 200 • Anchorage, AK 99503-2400

1

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

¹ Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007.

http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

² US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. <http://hpsafind.hrsa.gov/>.

³ 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>.

⁴ Ibid.

⁵ Ibid.

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.



Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)


March 17, 2009

Honorable Donald Olson
Alaska State Senate
Capitol, Room 514
Juneau, Alaska

RE: SB 139 -- Recruitment Increments for Certain Health Care Professionals

Dear Senator Olson:

As you know, Dr. Olson, the Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.



On behalf of all ASMA members, I thank-you for introducing SB 139. ASMA participated as one of the stake holders who came together to develop the concept for the loan repayment and direct incentive program embodied in SB 139. ASMA strongly supports SB 139 as an effective recruitment tool for physicians as well as the other health care professionals covered by the program.


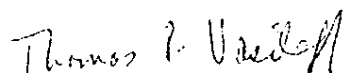
Alaska competes with all other states in the recruitment of an ever shrinking pool of physicians practicing general internal medicine or family medicine. Currently only 2% of medical school graduates are choosing general internal medicine or family medicine residencies. 44 of those states already have a loan repayment or direct incentive program.

SB 139 will help to provide an important part in solving Alaska's chronic and acute (in certain practice specialties) physician workforce shortages. All of the health care system reforms aimed at providing some form of universal insurance coverage provides an empty promise so long as sufficient numbers of appropriately trained physicians (and other health care professionals) do not exist.

ASMA supports SB 139 and urges passage of this important legislation.

Again, ASMA, thanks you in your leadership and efforts to introduce and secure passage of the Alaska Health Care Professions Loan Repayment and Incentive Program.

Sincerely,



By: Thomas Vasileff, MD, President
For: The Alaska State Medical Association

Re: Support for SB 139 Incentives for Certain Medical Providers

March, 19, 2009

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, I strongly support SB 139 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.

In my roll as clinical site director for the U.W. DENTEX Training Center, I have had the opportunity to hear about the difficulties health care facilities in Alaska have in recruiting and retaining providers.

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 pharmacist 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.

There is already a crisis of dental care access in rural Alaska. We have large numbers of our Alaska Native population who cannot access even the basic services needed, such as a yearly exam or treatment for urgent dental needs. The caries rate is 2 1/2 times the national rate in our rural communities. Headstart programs struggle to find local providers to perform the mandatory evaluations for their students, many programs resort to bringing in outside providers at great expense. Teeth are left untreated until it is too late to restore them, because there are not appointments available for routine care. Our communities should not have to suffer with the pain and cost of untreated disease.

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.

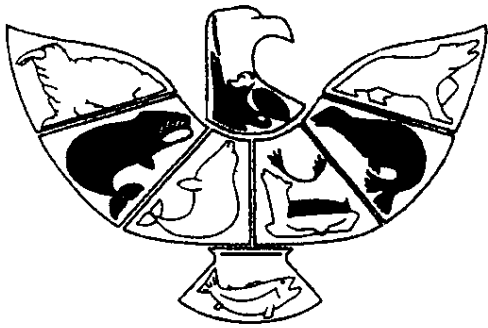


I support SB 139 and urge passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Mary E. Williard, DDS
Clinical Site Director
ANTHC Division of Community Health Services
U.W. DENTEX Training Center
4200 Lake Otis Parkway, Suite 204
Anchorage, AK 99508





Alaska Native Health Board

1840 Bragaw Street, Suite 220
Anchorage, Alaska 99508

Phone: (907) 562-6006
Fax: (907) 563-2001

January 25, 2010

Senator Donny Olson
State Capital Building, Room 514
Juneau, Alaska 99801-1182

Dear Senator Olson,

We write to express the Alaska Native Health Board's support for SB 139, establishing a health professions loan repayment and employment incentive program. Alaska is one of only six states without a state-sponsored health professions support-for-service program.

Overall, Alaska health workforce vacancy rates are now over 10% and growing, particularly for hard-to-fill positions in rural locations where most providers are "safety net" providers who deliver care to primarily to Medicaid and Medicare beneficiaries and the uninsured.

Among tribal providers, who are the only provider of health services in many areas of the state, health professional vacancy rates exceed the statewide rates across the board by 150-200%.

The challenges are daunting: The average time it takes for a tribal provider to fill a physician vacancy is over a year, while the average time to fill a mid-level vacancy is six months. **As of November 2009, within the Alaska tribal health system alone, there were over 80 physician vacancies.** These severe workforce shortages compound the challenge of providing good access to quality healthcare for all Alaskans, particularly in the rural areas.

SB 139, The Alaska Health Care Professions Loan Repayment & Incentive Program, is an important part of the solution to Alaska's health workforce shortage. It 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 alleviate shortage problems in other states, and we are certain that SB 139 will work because it has been thoroughly reviewed and customized for Alaska.

Sincerely,

Evangelyn "Angel" Dotomain
President/CEO



P.O. Box 240247 " Anchorage, AK 99524 " www.asdha.com

Re: Support for SB 139—Incentives for Certain Medical Providers

March 23, 2009

Dear Senate and House Members of the Alaska State Legislature:

The Alaska State Dental Hygienists' Association (ASDHA) supports Senate Bill 139 to establish a loan repayment and incentive program. This legislation addresses the shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals that provide direct patient care.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. 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. This legislation would allow Alaska to compete with other states in the recruitment of numerous providers and help fill the alarming number of vacancies that exist.

Senate Bill 139 provides incentives for dental professionals, including dentists and dental hygienists. While current practice act limitations exist for direct patient care by dental hygienists, we are hopeful SB 139 will attract more dentists and dental hygienists to our state and to rural communities. With up to eighteen dental hygiene students graduating from Alaska universities yearly, we believe SB 139 would provide an additional incentive for them to stay.

The ASDHA supports SB 139 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,

Gail Walden, RDH
Alaska State Dental Hygienists' Association



Alaska Osteopathic Medical Association

142 East Ontario Street | Chicago, IL 60611
Phone 800.821.1773, ext. 8128 | Fax 312.202.8428 | Email: AKOMA@osteopathic.org

December 3, 2008

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 Alaska Osteopathic Medical Association (AKOMA) 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.

The mission of the AKOMA is to promote public health through providing quality, relevant and professional CME that enhances the body of knowledge and skills of those in attendance. Emphasis will be placed upon Osteopathic Practice and Principles to enable attending physicians to better serve the needs of their patients.

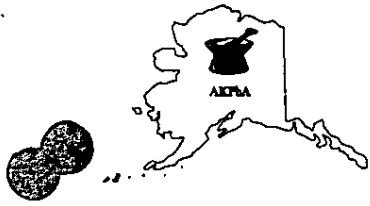
With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist 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 brings 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.

AKOMA recommends 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,

Todd Capistrant, DO
President



Alaska Pharmacists Association

RE: Support for SB 139
Alaska Health Care Professions Loan Repayment & Incentive Program

March 24, 2009

Dear Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, putting Alaskans in jeopardy, the Alaska Pharmacists Association 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 limited and shrinking national pool.

"The Mission of the Alaska Pharmacists Association is to preserve, promote and lead the profession of pharmacy in Alaska."

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 pharmacist 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, LCSWs (licensed, clinical social workers), and physical therapists are all in short supply in Alaska.

Based on statistics provided by Laura Miller, PhD, Senior Economist with the National Association of Chain Drug Stores, the national average of community pharmacists per 10,000 people is 5.36. For Alaska, the figure is 3.35. To get to the national average, Alaska would need an additional 137 pharmacists. The average number of people per community retail pharmacy is about 5,300 nationally, and in Alaska it is 8,900. Even if you add in the 15 Indian Health Service (IHS) pharmacies, Alaska's pharmacies average about 7,500 people, much higher than the national average.

The Health Care Professions Loan Repayment & Incentive Program proposal brings 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.

Respectfully,

Nancy O. Davis
Executive Director

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880



Alaska Pharmacists Association

Alaska Pharmacists Association
Board of Directors

RESOLUTION 2009-01

Health Care Professions Loan Repayment and Incentive Program for Alaska

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

WHEREAS Alaska is suffering labor shortages in most professional healthcare occupations, and that these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS the harsh conditions of Alaska and the fiscal limitations of safety net clinics makes it difficult for Alaska to compete in the hiring market; and

WHEREAS the entire State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;¹ and

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

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

WHEREAS 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; and

WHEREAS most all other states have state-sponsored SFSP programs that influence health professionals' geographic and specialty distributions; and

WHEREAS 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; 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 healthcare personnel; and

E-mail: akphrmcv@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

WHEREAS 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, including creation of a loan repayment program; and

WHEREAS AkPhA serves as a voice on behalf of Pharmacists to preserve, promote and lead the profession of pharmacy in Alaska;

THEREFORE BE IT RESOLVED that the Alaska Pharmacists Association (AkPhA) 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:

Melanie Gibson, AkPhA President

Nancy Davis, Executive Director

DONE AND DATED THE 25th DAY OF AUGUST IN THE YEAR 2008

SIGNED BY

Melanie Gibson, AkPhA Board President

¹Alaska Center for Rural Health. 2007 Alaska Health Workforce Vacancy Study. July 2007.
http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body_final.pdf.

E-mail: akpharmcv@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880



ALASKA PHYSICAL THERAPY ASSOCIATION, INC.

A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
PO BOX 140351 ANCHORAGE, AK 99514-0351
PHONE (907) 566-3749

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

November, 26, 2008

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 Alaska Physical Therapy Association 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.

The Alaska Physical Therapy Associations mission is that it's a member driven organization (290 members) is to represent and advocate for the profession of physical therapy and promote excellent, ethical, and autonomous practice, which serves the culturally diverse population of Alaska.

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 pharmacist 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.

At any given time you can contact most remote hospitals and clinics and find at least 1-2 vacancies, or openings for physical therapists. Even urban clinics are constantly recruiting for providers due to turnover, retirement, or keeping up with population growth in their respective communities. There are companies that provide temporary travelling Physical Therapists for 13-16 week assignments which can be extremely expensive for coverage, and again the turn over rate creates changes for patients and can also cause breaks in care or shortage of man power coverage.

The Health Care Professions Loan Repayment & Incentive Program proposal brings 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.



 **APTA**
American Physical Therapy Association

The Alaska Physical Therapy Association highly recommends and advocates for 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 for health related assistance to our states residents.

Respectfully,

Sundi M Hondl, PT, OCS

Sundi M Hondl, PT, OCS
Alaska Physical Therapy Association President



March 20, 2009

Re: Support for SB 139 Incentives for Certain Medical Providers

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 Behavioral Health Association strongly supports SB 139 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.

One of our primary goals deals with Workforce Development and this bill fits well within the goal to assure that a well trained adequate workforce is available to behavioral health providers.

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 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants, behavioral health clinicians, addiction professionals, 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.

The Alaska Behavioral Health Association supports SB 139 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.

In Health,

Steve Horn
Executive Director

2009 abha Membership

Organization	Community
Akeela	Anchorage
Alaska Children's Services	Anchorage
Alaska Family Services	Palmer
Alaska Island Community Services	Wrangell
Alaska Youth & Family Network	Anchorage
Anchorage Community Mental Health Services (Southcentral Counseling)	Anchorage
Arc of Anchorage	Anchorage
Assets, Inc.	Anchorage
Mat-Su Health Services	Wasilla
Bristol Bay Counseling Center (BBAHC)	Dillingham
Boys and Girls Home of Alaska	Fairbanks
Catholic Community Service	Juneau
The Center	Homer
Community Connections, Inc.	Ketchikan
Denali Family Services	Anchorage
Edgar Nolner Health Center	Galena
Fairbanks Community Behavioral Health Center, Inc.	Fairbanks
Fairbanks Native Association	Fairbanks
Family Centered Services of Alaska	Fairbanks

Organization	Community
Frontier Community Services	Soldotna
Gateway Center for Human Services	Ketchikan
Impact Counseling	Haines
Juneau Alliance for Mental Health, Inc.	Juneau
Juneau Youth Services	Juneau
Kenai Peninsula Care Center	Kehai
Lynn Canal Counseling	Haines
Maniilaq Association	Kotzebue
North Star Behavioral Health System	Anchorage
Peninsula Community Health Services	Soldotna
Petersburg Mental Health Services, Inc.	Petersburg
Railbelt MH and Addictions	Nenana
SEARHC - Behavioral Health Service Division	Sitka
SeaView Community Services	Seward
Sitka Counseling and Prevention Services	Sitka
Southcentral Foundation Behavioral Health Services	Anchorage
Volunteers of America of AK	Anchorage
Yukon-Kuskokwim Health Corporation	Bethel



Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 25, 2009

Senator Donald Olson
Alaska State Capitol, Room 514
Juneau, Alaska 99801

Re: SB139 – Loan Repayment and Employment Incentive Program

Dear Senator Olson,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board appreciate your support for Alaska's health care workforce. The Boards support the intent of SB 139, and look forward to continued dialogue about how best to support our health care professionals and encourage more Alaskans to enter the field.

As you know, the health care industry has been one of our fastest growing employment sectors. Despite that, health care providers — including mental health and substance abuse providers — report an inability to maintain a workforce that meets the demand for services. The Alaska Department of Labor and Workforce Development reported that growth in health care jobs has slowed since 2006 (reporting growth of only 1% in Anchorage in 2008) and forecasts only modest growth in 2009. In this environment, we need measures to sustain the workforce we have and to encourage more Alaskans to enter the health care fields.

Loan repayment programs prove to be very effective ways to encourage health care professionals to serve rural and underserved populations, and often result in longer terms of service in these communities. Offering this much needed support to our current health care workforce will help promote stability for our providers and encourage more people to pursue health care careers.

We recognize the immense amount of effort that has gone into SB 139, and applaud the fact that it involved a cooperative effort by a coalition of stakeholders. We also recognize the concerns about the potential cost of the program and the infrastructure necessary to implement the program. We are hopeful that as SB 139 progresses through committee, there will be greater understanding about these issues.

Thank you for your work this session, and always, on behalf of Alaska.

Sincerely,

Lonnie Walters, Chair
ABADA

Debi Keith, Chair
AMHB



The TRUST


The Alaska Mental Health Trust Authority

November 10, 2008

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

Dear Governor and Members of the Alaska State Legislature:

The Alaska Mental Health Trust Authority (The Trust) strongly supports the concept of a state-sponsored health professional loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.



The Trust has invested in workforce development around providers serving our beneficiaries for many years, often partnering with both state and non-state entities. The Trust will be investing over \$3,300,000 in FY 10 in our Workforce Development Focus Area and partners such as the University of Alaska will invest much more in this important area. Currently The Trust's Workforce Development Focus Area is investing \$200,000 in a loan repayment strategy for behavioral health professionals in underserved areas and another \$200,000 in cash incentives because research indicated this is an effective strategy for recruitment and retention. The Trust believes that in order to continue to address health professional recruitment and retention we will have to be innovative and aggressive, and with many other states and the federal government using loan repayment as a key strategy, we must also have a program that is available to our health professional organizations serving Alaska's residents.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. The Department of Labor and Workforce Development's labor data tell us that health and social services jobs are and will be some of the top growth job opportunities in Alaska for the next 10 years. Strategies such as loan repayment are critical to meeting the demand in this high job growth area and 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 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists, psychiatrists, physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, certified social workers), and physical therapists are all in short demand in Alaska.

The Trust invests in a semi-annual vacancy rate study conducted by the Alaska Center for Rural Health which shows that behavioral health vacancy rates are some of the highest of all health professionals. Psychiatrist's in all of our public mental health systems have become a critical problem with a mean vacancy length of 34.5 months.

Tel

Fax



The TRUST

The Alaska Mental Health Trust Authority

The Health Care Professions Loan Repayment & Incentive Program proposal brings 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.

The Trust recommends 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,



Delisa Culpepper
Chief Operating Officer





ALPHA

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

March 20, 2009

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 SB 139 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 pharmacist 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 SB 139 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,

Jayne Andreen

President
ALPHA Board of Directors

P.O. Box 9-1825 Anchorage, AK 99509 907/332-1030 e-mail: publichealth@alaska.net
www.alaskapublichealth.org



Илиулюк

Iliuliuk Family and Health Services, Inc.

P.O. Box 144
Unalaska, Alaska 99685

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

Re: Support for SB 139 Incentives for Certain Medical Providers

March 17, 2009

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 SB 139 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 pharmacist 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 – we have had two open RN positions for over two years. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

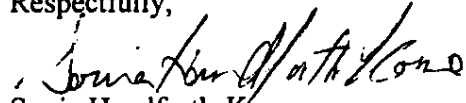
The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders 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. SB

"Serving Unalaska, the Aleutian Islands and the Bering Sea"

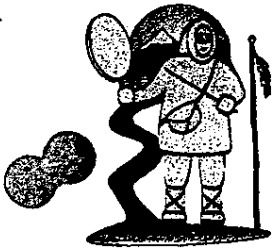
139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports SB 139 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,

A handwritten signature in cursive script, appearing to read "Sonia Handforth-Kome".

Sonia Handforth-Kome
Executive Director



Maniilaq Association

Maniilaq Health Center

Administration

Phyllis Boskofsky RN
Hospital Administrator
P.O. Box 43, 436 5th & Stevens Way
Kotzebue, AK 99752
Phone (907) 442-7319
FAX (907) 442-7250

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

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, especially in remote regions such as ours, the Maniilaq Health Center (MHC) strongly supports SB 139 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.

In order for the Maniilaq Health Center to meet its Mission Statement:

"The Maniilaq Health Center provides comprehensive health care to all the people in our service area while promoting prevention, fitness, wellness, holistic strategies, and incorporating local traditional core values and beliefs", its Vision Statement: ***"All customers of Maniilaq health services, including its employees, are empowered, and involved partners in its high quality services and healing atmosphere"***, and its Purpose statement: ***"We are a family of care, helping every person live a healthier life"***, We must have a trained healthcare workforce.

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, and becomes even more difficult as you leave urban area facilities for remote facilities such as MHC. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist 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.

Maniilaq Health Centers Professional Vacancy Rates

MD/DO Vacancies	3 vacancies out of 9 positions = 30% vacancy rate
Dentist Vacancies	3 vacancies out of 5 positions = 60% vacancy rate
Pharmacist Vacancies	3 vacancies out of 4 positions = 75% vacancy rate
Registered Nurse Vacancies	12 vacancies out of 24 positions = 50% vacancy rate
Physical Therapist	1 vacancy for > 2 years = 100% vacancy rate

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.

The Maniilaq Health Center supports SB 139 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,

Phyllis A. Boskofsky
Hospital Administrator

Member Villages

Ivissaappaat, Nunatchiaq, Ipnatchiaq, Katyaak, Kivaliniq, Laugviik, Qikiqtagruk, Naitaaq, Nuurvik, Tikigaq, Akuligaq, Isinnaq, Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noatak, Noorvik, Point Hope, Selawik, Shungnak

**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;

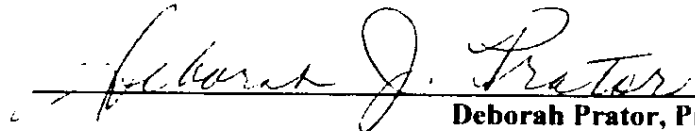
WHEREAS Alaska is competing with other states for the finite pool of available health care professionals; and over 40 states currently offer Support-for-Service Programs (SFSPs) that have influenced health professionals' geographic and specialty distributions;

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

¹ 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#.

² U.S. Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. <http://datawarehouse.hrsa.gov/GeoAdvisor/shortagedesignationadvisor.aspx>.

³ Matanuska-Susitna Borough. Alaska Department of Labor, Division of Research & Analysis.

http://laborstats.alaska.gov/cgi_databrowsing/localArea/profileQSRresults.asp?geogArea_0204000170&population+census+data+Population&BI_View=Report.

⁴ Alaska State Plan for Senior Services FY2008-FY2011. Alaska Commission on Aging. June 2007.

http://www.hss.state.ak.us/acoa/documents/statePlanFinalFY08_FY11.pdf.

⁵ 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.hss.state.ak.us/healthcommission/200905/iser_doctors.pdf

⁶ 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>.

Christina Apathy

From: RIPLEY, ELIZABETH [E.Ripley@MSrhc.com]
Sent: Monday, January 25, 2010 11:40 AM
To: Sen. Donny Olson
Subject: Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska
Attachments: MSHF Resolution in Support of Loan Repayment & Incentive Program 10.pdf

Sen. Olson, In reference to your sponsorship of SB 139, please consider the attached **Mat-Su Health Foundation Resolution to Support Health Care Professions Loan Repayment & Incentive Program for Alaska** in support of your efforts. Many thanks!

Elizabeth Ripley

Elizabeth Ripley | Executive Director | Mat-Su Health Foundation | 950 E. Bogard Road | Wasilla, AK 99654 | Direct: 907-352-2896 | Main Office: 907-352-2863 | Fax: 907-352-2865 | e.ripley@msrhc.com | <http://www.matsuhealthfoundation.org>

Proprietary/Confidential Information may be contained in this message. If you are not a recipient indicated or intended in this message (or responsible for delivery of this message to such person), or you think for any reason that this message may have been addressed to you in error, you may not use or copy or deliver this message to anyone else. In such case, you should delete this message and notify the sender of the problem.

Disclaimer: This electronic message may contain information that is Proprietary, Confidential, or legally privileged or protected. It is intended only for the use of the individual(s) and entity named in the message. If you are not an intended recipient of this message, please notify the sender immediately and delete the material from your computer. Do not deliver, distribute or copy this message and do not disclose its contents or take any action in reliance on the information it contains.

Christina Apathy

From: Nancy St.John-Smith [nsjsmith@pchsak.org]
Sent: Tuesday, February 09, 2010 5:01 PM
To: Sen. Donny Olson
Subject: Capitol Hill Visit

Dear Senator Olson and staff,

Thank you for your hospitality during our capitol hill visit on February 2 and 3, 2010. It was my first visit to Juneau and you all made us feel right at home. We know that we can count you as a friend to community health centers across the state and we appreciate the time and attention you were able to give to our cause.

An amazing fact that you can share with others who need to know about the importance of community health centers in our great state is that Peninsula Community Health Services provided either medical, dental, or behavioral health care to about 25% of the central peninsula's population last year. The demands on community health centers continue to grow as there are more and more uninsured and underinsured consumers in our state. As always, we treat all comers and do not turn consumers away based on their ability to pay. Due to the high quality of care received at our facilities, people from all walks of life access their health care through us. Unfortunately, we are not able to keep up with the rising costs of providing care and recruiting providers.

As members of the Alaska Primary Care Association, we are in support of SB 139, which provides loan repayment and incentives for health care providers to work and live in the state of Alaska. We have asked for \$ 400,282.00 in funding for senior access. Alaska's community health centers are asking for \$2 million for operating funds to cover the rising costs of doing business, such as insurance premiums. We support increasing the Denali Kid Care eligibility limit to 200% of the federal poverty level.

We look to you and our other legislators to provide the leadership and support to accessing funding from the state of Alaska for community health centers in Alaska. We are one of only 5 states which do not routinely fund their community health centers.

Sincerely,
Nancy

Nancy St.John-Smith
Manager of Dental Support Services
Aspen Dental Center, a clinic of
Peninsula Community Health Services
395 Main Street Loop
Kenai, Alaska 99611
907.283.7759



3245 Hospital Drive, Juneau, AK 99801
907 463-4000 • www.searhc.org

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

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 SEARHC Ethel Lund Medical Center strongly supports SB 139 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.

The SEARHC Ethel Lund Medical Center provides comprehensive outpatient care to Alaska Native/Native American patients in the Juneau area (over 7,000 active patients). We have found recruitment of health providers to be extremely challenging, including physicians, physician assistants, pharmacists, physical therapists, optometrists, and other health care professionals. Almost all potential applicants request loan repayment. Juneau does not qualify for any loan-repayment program, and this puts us at a significant disadvantage in recruiting health care providers.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage that we here at SEARHC Juneau, and that the rest of 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.


The SEARHC Ethel Lund Medical Center supports SB 139 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,

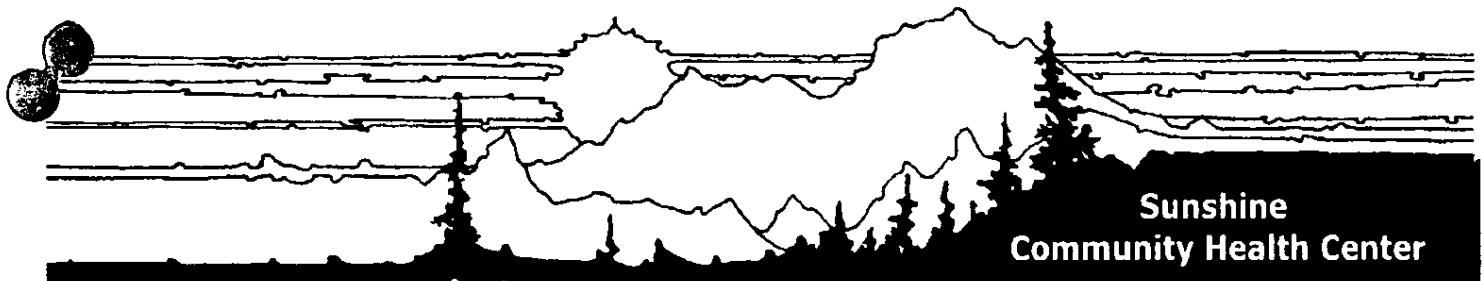


Janice Sheufelt, MD

Janice Sheufelt, MD
Medical Director
SEARHC Ethel Lund Medical Center
Juneau, Alaska



Your Partner in Health



P.O. Box 787 (Mile 4.4 Talkeetna Spur Road) Talkeetna, AK 99876 (Ph) (907) 733-2273 (Fax) (907) 733-1735 schc@sunshineclinic.org

RE: Support for SB 139 Incentives Alaska Health Care Professions Loan Repayment & Incentive Program

March 25, 2009

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, Sunshine Community Health Center (SCHC) strongly supports SB 139 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.

SCHC's mission is to assist people in the upper Susitna Valley to meet their health care responsibilities by providing affordable, accessible, quality health care, including preventive aspects, to all people regardless of their ability to pay for services. We are a safety-net provider, with our primary focus on patients who are uninsured and unable to pay for basic medical care. We operate two clinics, one in Talkeetna that is open 6 days a week and one in Willow that is open 5 days a week.

The biggest obstacle to accomplishing our mission is our inability to fully staff the organization with the number of medical, dental, and mental health providers we need. As of this writing, SCHC has been recruiting unsuccessfully for a medical provider to staff our Willow clinic for 3 years. We have been recruiting for a full-time mental health professional for 2 years, a nurse for 1 year, and a dentist for 6 months. Two years ago, unsuccessful recruiting and unexpected vacancies shrank our staff of five medical providers (not including dental and mental health) to just two medical providers covering both clinics, and since then we have never been fully staffed.

Our efforts at recruitment during this period have attracted a high level of interest from providers interested in relocating to our community because of the attractive quality of life we offer. Unfortunately, once excitement gives way to realism, the following factors dissuade them from actually accepting a position and moving here:

- the high cost of student loans; medical and dental graduates average over \$100,000 of student debt;
- moving expenses;
- high cost of living in Alaska;
- the escalating cost of health insurance.



SCHC's experience is not unusual. With alarming and rising vacancy rates, Alaska is poised for a crisis unless there is some new intervention. Alaska is one of only six states without a state-sponsored incentive program such as a loan repayment program. 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 pharmacist 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.

Sunshine Community Health Center supports SB 139 and urges passage of this important legislation. Your support and action on this matter are greatly appreciated.

Respectfully,



Mary Loeb, MD
Medical Director of Sunshine Community Health Center



March 9, 2010

To Senator Olson

Re: SB 139

The Alaska Nurses Association supports SB 139 Education Reinvestment Act that will provide loan repayment and incentives to health professionals who commit to continued professional practice in Alaska. The elements of SB 139 that provide incentives to health professionals who have completed their education and are ready to provide critical health services are excellent recruitment and retention strategies for those professionals in short supply.

SB 139 provides a fast start to making a difference in our health professional shortages. Incentives and loan repayment are key concerns for recruitment and the mechanism for staging the incentive payments on a quarterly basis increase the likelihood that it will also serve as an excellent retention tool.

Alaska faces an uphill struggle to attract qualified health professionals to work here. A number of other states have enacted incentives and loan repayment programs that stiffen the competition for our state. Although our state has many unparalleled opportunities, the economic burdens for health professionals to move to Alaska, get set up in a practice, and repay enormous loans for education, make it impossible for many to even consider working in our state. SB 139 not only helps level that economic field, but it speaks volumes to Alaska's commitment to solving our health professional shortages

The Alaska Nurses Association with a membership of over 1100 Registered Nurses in Alaska appreciates your sponsoring SB 139 and looks forward to working with you in support of this important legislation. Alaskans deserve our best efforts to protect and promote their health. A qualified workforce of health professionals is essential to that goal.

Sincerely,

Nancy C. Davis, RN, MS
AaNA President
907-274-0827 Office

Debbie Thompson, BSN, RN, CNOR
AaNA Executive/Labor Program Director
907-274-0827 Office



AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 25, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 139 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 139, authored by Senator Donald Olson and co-sponsored by Senators Bill Wielechowski, Kevin Meyer and you.

As you know, Alaska has a chronic shortage of health professionals. We compete with the other states who all have their own shortages. SB 139 follows a proven tradition of recruitment incentives by providing loan forgiveness and economic incentives to encourage health professionals to practice in our state. We understand that there is a cost to recruitment and retention. We also understand that there is a greater cost when our citizens are unable to secure the services of health professionals.

AARP requests an "AYE" vote on SB 139.

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

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson



COMMONWEALTH
NORTH

Resolution 2009-2
In support of Incentives for Certain Medical
Providers as proposed in Senate Bill 139
April 14, 2009

This resolution is based on the 2005 Commonwealth North study entitled "Alaska Primary Health Care: Opportunities and Challenges."

Commonwealth North:

Encourages and promotes the establishment of incentives to bring more qualified Medical professionals to Alaska.

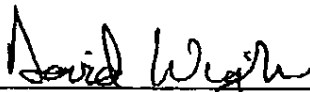
Requests all state legislators to approve authorizing legislation in Senate Bill 139; and

Forwards this resolution to all members of the Alaska State Legislature, Governor Sarah Palin, and Alaska's congressional delegation.

Resolved for the following reasons:

1. There are critical health manpower shortages in both our urban and rural areas
2. The State of Alaska is in competition with over forty states who already offer similar programs
3. Without this incentive, it will be difficult for Alaska to compete for medical and health professionals
4. Multiple millions of dollars are being spent annually in Alaska to have temporary health professionals from Outside fill our current needs
5. Current and potential future shortages can be identified in specific specialties including family practice physicians, internists, nurse practitioners, physician's assistants, nurses and clinical support health manpower areas such as physical therapist, x-ray and laboratory technicians

Approved by the Commonwealth North Board of Directors
April 14, 2009



David Wight, President

**Nome Eskimo Community**Box 1090
Nome, Alaska 99762Phone (907) 443-2246
Fax (907) 443-3539

March 23, 2009

RE: Support for SB 139 Incentives for Health Care Professions

Dear Senate and House Members of the Alaska State Legislature:

The Nome Eskimo Community strongly supports SB 139 that would establish a loan repayment and incentive program for health care professions in Alaska. The on-going healthcare workforce shortage in Alaska significantly impacts access to and continuity of health care for our residents and the creation of such a program could be a solution to address a critical shortage in our state.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult and the establishment of this program would allow Alaska to compete with the lower 48 for the recruitment of much needed medical providers. Alaska is experiencing a crisis: we have more than 90 pharmacist vacancies in Alaska; many communities have inadequate, if any, access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit, and nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply statewide.

Loan repayment and incentive programs have been proven to effectively alleviate workforce shortage problems in other states and the Alaska Health Care Professions Loan Repayment & Incentive Program could be part of the solution to address this issue in Alaska. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention, and with input from stakeholders statewide that includes consideration of factors that are unique to Alaska; SB 139 will establish a program customized for Alaska.

The Nome Eskimo Community fully supports and encourages the passage of SB 139. Your support to assure the establishment of the Alaska Health Care Professions and Loan Repayment & Incentive program is greatly appreciated.

Respectfully,

NOME ESKIMO COMMUNITY

Denise Barengo, Executive Director

Christina Apathy

From: Pamela J Embler [afpje@uaa.alaska.edu]
Sent: Wednesday, February 03, 2010 7:23 AM
To: Sen. Donny Olson
Subject: SB139

Senator Olsen -

Thank you for sponsoring such an important piece of legislation which has the potential to positively impact the residents of our great state. I would like to ask that you consider adding nurse educators to the list of qualified applicants. I am a faculty member at the University of Alaska Anchorage, School of Nursing. I recently received my masters in nurse education, that is my specialty area of nursing practice. Nurse educator certification has been recognized by the National League of Nursing as an advance practice specialty. I have been accepted to the University of Tennessee's nurse PhD program, an online/onsight program. The PhD is the expected terminal degree for nurse educators.

Alaska, the University of Alaska needs nurse educators to prepare the nurses of tomorrow, nurses for tomorrow that can meet the needs of the residents of Alaska. Many students are traveling outside to obtain a their nurse education, many who leave may not return. If we want the students to stay in Alaska after obtaining their education we need to be able to educate them here, to that end we need more nurse educators.

Thank you for your time and your consideration.

Respectfully,
Pam Embler

Pam Embler, MSN, RN
Assistant Professor
University of Alaska Anchorage
3211 Providence Drive
PSB 110A
Anchorage, AK 99645
afepje@uaa.alaska.edu
(907)786-4509 Office
(907)786-4559 Fax
(907)775-3428 Cell



UAA UNIVERSITY of ALASKA ANCHORAGE
Dental Clinic

Re: Support for SB 139 Incentives for Certain Medical Providers

March 15 2009

Dear Senate and House Members of the Alaska State Legislature:
Senator Bettye Davis, Chair, and Members of the Senate HSS Committee

The University of Alaska Anchorage Dental Hygiene Program has produced successful candidates for over thirty years, our graduates placing second nationally in two of the last three years. Our goal is to prepare professionals who are familiar with the most advanced technology and evidenced-based practice and proficient in providing a wide range of dental services to diverse populations in a caring manner. It is a well known fact that we face an increasing demand for dental care with the burgeoning senior population, in addition to the many citizens who lack access to care. Poor dental health directly compromises systemic health, and contributes to a myriad of complications when not addressed. Our rural population suffers the most. Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the University of Alaska Anchorage Dental Hygiene Program strongly supports SB 139 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.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult. Due to alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists or hygienists; physician assistants and nurse practitioners are increasingly difficult to recruit. 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 by providing more support to those willing to serve at risk populations. 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. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states, proving less costly and more effective than other methods. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.



The University of Alaska Anchorage Dental Hygiene Program supports SB 139 and strongly recommends passage of this important legislation.

Respectfully,

Elizabeth Barnett, Clinic Director
UAA Dental Hygiene Program
3211 Providence Drive
Allied Health Science Bldg #121
Anchorage, Alaska 99508
barnett@uaa.alaska.edu
907.786.6926



Christina Apathy

From: Becca [Becca@Juneaubirthcenter.org]
Sent: Tuesday, March 30, 2010 3:42 PM
To: Sen. Donny Olson
Subject: testimony for SB 139

Dear Sir,

I am a Certified Nurse-Midwife and Advanced Nurse Practitioner, offering healthcare to women here in Juneau at the Juneau Family Health and Birth Center. I am unable to attend tomorrow's hearing of SB 139. However I would like to offer my testimony: I trained at Yale University, and completed my degree with educational debt of \$140,000.00. I am struggling to manage this debt based on high cost of living in this state, and because of lack of Loan Repayment options. On many occasions I have considered relocating to a state in which better Loan Repayment options and lower cost of living exist. I think this is a shame, in that there is incredible need for skilled and compassionate healthcare providers in this state. SB 139, if passed, would provide incentive for existing providers in this state to continue their healthcare offerings; it would also create incredible incentive to prospective healthcare providers, especially those newly graduated and therefore most up to date in their provision of care.

I would be delighted to discuss this further, should it be helpful to you.

Yours very truly,

Rebecca M. Van De Water CNM, ANP
Certified Nurse-Midwife, Advanced Nurse Practitioner

Midwifery Director; Director of The Birth Center
Juneau Family Health and Birth Center
1601 Salmon Creek Lane
Juneau, AK 99801
Tel. 907.586.1203, fax 907.586.5765

Replaced

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: CSSB139(HSS)
() Publish Date: _____

Identifier (file name): SB139CS(HSS)-DHSS-MAA-03-29-10 Dept. Affected: Health & Social Services
Title: Incentives for Certain Medical Providers RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Olson, Wielechowski, Meyer, Davis
Requester: Senate HSS Component Number: 242

Expenditures/Revenue (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURE								
Personal Services	89.3		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	6.0
Contractual	2,777.4		2,742.4	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	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	2,839.7

CAPITAL EXPENDITURE								
----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES								
---------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
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) cc _____

POSITIONS

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if neces

SB 139 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) 334-2520
Date/Time: 3/5/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Date: 3/29/2010

(Revised 11/6/2009 OMB)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. CSSB139(HSS)

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 S8139. 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.