HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION February 2024

PRESIDENT'S COLUMN

What is ASMA doing for you?

Our last three ASMA newsletters have emphasized the Dunleavy administration's abandonment of the 80th percentile rule. The administration ended this rule January 1, 2024, and we are just starting to see the repercussions from this. We would appreciate knowing if your practice is either not offered a renewal contract with Premera or if the offered reimbursement rates are unreasonable. ASMA has helped lead the healthcare community in a lawsuit against the Division of Insurance, based upon faulty information being used as the basis for the rule change.

Steven Compton, MD

In this column I'd like to spend some time talking about other ongoing efforts being made by ASMA leadership on behalf of its members.

Frontier versus rural versus urban care

Alaska is the least densely populated state on a land mass that covers one-fifth the area of the United States, and this geography remains our single biggest barrier to practicing cost-efficient medicine. Rural care is more expensive to deliver than urban care, but Alaskan care is **frontier care, the most expensive yet.** Frontier care is delivered with a population density of fewer than six persons per square mile, or when time/distance to primary care exceeds 30 miles or 30 minutes.

Frontier health care delivery is intrinsically inefficient. We should not be surprised that health care in Alaska is more expensive than populous urban centers such as Seattle and San Francisco. Our entire state population would account for <10% of the San Francisco Bay area population and would be much cheaper to care for if we tucked our population into that area.

Since the mid 1960s, the Alaskan model has included Advanced Practice Professionals, including nurse practitioners, physician assistants, and village health aides.

Physician Assistant Scope of Practice

Areas of low population density do not support high levels of subspecialty care, and Alaska's model is a spoke and hub strategy that seeks to provide the highest maintainable levels of local care. Alaska is one of 27 states that

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Save the Date

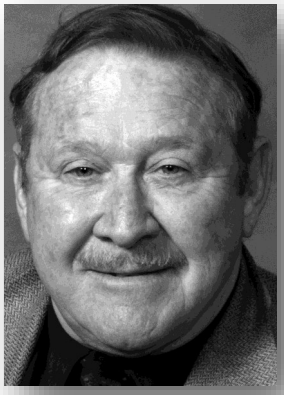
May 1, 2024

ASMA General Membership Meeting

5:00 to 8:00 pm

BP Energy Center and on Zoom

Dr. David Beal, past president of ASMA, passed away 15 November 2023 at his home in Anchorage.



Born in Montana in 1935, he attended University of Washington and University of Chicago Medical School, graduating from Pritzker School of Medicine in 1961. After graduation he served in the US Coast Guard. In 1968 he came to Alaska as Chief of Otolaryngology for the USPHS Regional Indian Center. In this role he traveled extensively throughout Alaska providing services to numerous villages. In 1970 he opened his private practice in Anchorage. He retired from his medical practice in 2022. In addition to serving a term as president of ASMA, he also served on the legislative committee and the medico-legal committee. His service to the association and to Alaskans is much appreciated.

ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
- If you don't have an address in the "personal" field you will not receive mailings. Please login to update your profile.
- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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New info regarding CME for Alaska Physicians

Your participation in accredited CME activities can now be reported directly to the Alaska State Medical Board. The Alaska Board is collaborating with the Accreditation Council for Continuing Medical Education (ACCME), with the goal of streamlining the CME credit reporting process and reducing your reporting burden so you can focus on your patients, rather than paperwork.

Participation in PARS in Alaska is optional, not required.

How does the collaboration work?

When you register for a CME activity, you should ask the organization providing CME to report your CME credit in ACCME's Program and Activity Reporting System (PARS). To have your credit reported, you will need to provide the following information:

First and last name
State of licensure
License number
Month/day of birth (not year)

Once the CME organization has reported your participation, and it has been accepted in ACCME's system, the Board will be able to view and verify your participation. If the CME organization does not know how to report your credit, they can email ACCME at info@accme.org.

If you are audited, the Board will look at your reported CME credit in the ACCME system to verify your credit. Given this is a new process, we will continue to accept CME certificates as proof for any CME credit that was not reported in ACCME's system.

View Transcripts in CME Passport

With this collaboration, you also have the option to view, track, and generate transcripts of your reported CME credit by creating a free, personal account in CME Passport. Any CME credit reported on your behalf to ACCME will show up in your CME Passport account. You may use your CME Passport account to share a transcript of your reported credit with any organization you choose. You will not need to share a transcript of your CME credit with the Alaska Board, since they have access to any credit reported on your behalf through this collaboration. CME Passport is also a great place to find CME activities that meet your educational needs.

Note: You are not able to upload your own CME credit into CME Passport. Only accredited CME organizations can report credit on your behalf. Learn more here.

For information regarding Alaska's CME requirements please consult Alaska regulations.

This licensing period ends December 31, 2024. Online renewal will begin in October 2024.

Physician Practice Billing Insert

At a recent Board of Trustees meeting the ASMA board decided to offer this wording that a medical practice could use as an insert with their billing to explain unexpected medical bill balances to patients whose physician was out-of-network with their insurance.

Dear Patient,

If your physician is out-of-network with your insurance plan, you may be responsible for unexpected balances due on your medical bills. This is most likely a result of the Division of Insurance repealing the 80th percentile rule that has been in place in Alaska since 2004. The repeal went into effect January 1, 2024.

Hundreds of Alaska physicians opposed repeal of this consumer protection rule that regulated what the insurance companies had to pay and limited the patient's out-of-pocket responsibility.

If you have concerns about what your insurance plan did or did not cover or how much they did or did not pay, please go to https://www.commerce.alaska.gov/web/ins/Consumers/Complaints/FileAComplaint.aspx to file a consumer complaint. Click on the gray box to file a complaint online.

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allow Nurse Practitioners to practice independently of physicians, under the exclusive licensure authority of the state Board of Nursing.

Physician Assistants currently practice under the authority of the board that licenses physicians, due to a training curriculum that differs from Nurse Practitioners. Alaska law requires that physician assistants have an active collaborative plan with a physician in order to practice medicine. Unsurprisingly, the degree of oversight and collaboration varies with each physician-PA relationship. The PAs are now looking to find an avenue to allow independent practice. The arguments are that PAs are sometimes required to pay physicians for the oversight relationship, that many remote PAs are working with very little actual oversight, and that there is a need for Advanced Practice Professionals to provide care in certain niches around the state.

ASMA is not a certifying board. The Alaska State Medical Board is responsible for the PA rules, and the current State Medical Board has been working on a re-write of the PA rules for practice. The revised regulations proposed by the Medical Board chairman last fall received significant public comment opposing those changes and spurred even more interest in independent PA practice. The PAs (Alaskan Academy of Physician Assistants) have opted to go over the heads of the ASMB by introducing state legislation in Juneau to allow independent practice by physician assistants.

ASMA opposes independent PA practice while supporting PA efforts to streamline the regulations governing PA practice. Overall ASMA policy is to support Advanced Practice Providers but agrees there is need to discuss minimum training requirements. The original PA bill stipulated 2000 hours of clinical experience as being enough to warrant clinical independence. That has been amended to 4000 hours. An emergency medicine resident, previously trained as an EMT, wrote in that they did not feel ready to independently treat patients after more than 8000 clinical hours. ASMA will continue to provide expert opinion to legislators.

Naturopath Scope of Practice

Naturopathy is defined as a system of alternative medicine based on the theory that diseases can be successfully treated or prevented without the use of drugs, by techniques such as control of diet, exercise, and massage. Interestingly, groups of naturopaths in Alaska have once again petitioned the state for authority to prescribe medications and perform minor procedures. In other states these medications have included hormones, opioids, and chemotherapy agents. Minor procedures performed by naturopaths in Arizona include the Brazilian butt-lift and liposuction. Naturopaths in Washington State are currently looking for approval to provide abortion services.

ASMA supports evidence-based care. Treatment philosophies that are not based upon the scientific method are low-efficacy and constitute low-value care. ASMA has been providing testimony against expansion of naturopathic practice.

Purchase of Medical Debt

Medical expenses are the leading cause of debt and bankruptcy in the U.S. Medical debt is uniquely unjust because usually it is not the result of people's voluntary choices. A number of nonprofit organizations have pursued a strategy of buying unpaid medical debts for pennies on the dollar and retiring those debts for people with low and moderate incomes. In the last two years, organizations in OH, PA, CT, NY, IL and others have used federal, state, and philanthropic sources to buy and forgive accumulated medical debt. We are looking into this strategy as a way to help unburden Alaskans. Stay tuned.

Juneau Legislative Update

By the time you read this we will have completed an informational trip to Juneau, where ASMA board members will be reaching out to Alaskan legislators regarding the state level medical concerns above, as well as discussion of specific solutions for the 80th percentile problem. More to come!

Rheumatology Conference

Alyeska Resort

MAR | 22-24 | 2024

www.alaskarheumatology.org

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Lupus - Treat to Target - PsA Update
Rheumatology Clinical Pearls
...and more

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Included in your registration fee

- all sessions
- all meals, including Seven Glaciers welcome dinner

More details and registration instructions may be found at www.alaskarheumatology.org

Graduate Medical Education in Alaska
Part 2 of 2

This is the second of two articles about graduate medical education (GME) in Alaska. GME is the structured training of medical school graduates. This article summarizes issues other than funding and expands on recommendations to increase GME in Alaska.

Compared to all other states, Alaska has the fewest number of GME programs, the fewest number of GME trainees (medical residents), and the lowest GME trainee to state population ratio.[1] Eighty-five percent (85%) of GME funding comes through Medicare and Medicaid.[2] In 2021 Medicare GME was $13.4 billion.[3] Medicare GME funding in Alaska was third from lowest per state population and third from lowest per state Medicare population. In 2022, Medicaid GME was $7.3 billion.[4] Alaska does not use Medicaid to support GME.[4] The Department of Veterans Affairs (VA), the Health Resources and Services Administration (HRSA), and the Department of Defense (DOD) do not support GME in Alaska.[5,6]

Distinguishing Graduate Medical Education (GME) from Undergraduate Medical Education (UME)
Undergraduate medical education (UME) occurs in medical school. During the first two years medical students are primarily in the classroom. During the second two years medical students are in hospitals and clinics applying to patient care what was learned in the classroom. Medical students pay tuition, receive grants, or may have post-training service obligations. Medical students receive a medical doctor (MD) or doctor of osteopathy (DO) degree when graduating. New medical school graduates are not ready to provide patient care without supervision. All states require two-three years of GME prior to medical licensure.[7] Alaska requires two years of GME prior to medical licensure.[8]

GME is commonly referred to as medical residency or fellowship. Examples of primary care residencies are Family Medicine, Internal Medicine, and Pediatrics. Examples of specialty care residencies are Anesthesiology, Emergency Medicine, General Surgery, Neurology, Obstetrics and Gynecology, and Psychiatry. Examples of subspecialty residencies or fellowships are Cardiology, Cardiothoracic Surgery, Infectious Disease, Neonatology, and Child & Adolescent Psychiatry. Medical residents and fellows are taking care of patients. Medical residents and fellows are supervised by senior physicians. The Accreditation Council for Graduate Medical Education sets and monitors GME education standards.

Medical Residents and Fellows Are Essential Health Care Workers
The primary goals of GME are training physicians and providing patient care. Approximately one in seven US physicians is in a GME program (14.3%).[9,10] Medical residents provide 20% of the care for hospitalized patients and 40% of the care for patients without insurance.[11] The Association of American Medical Colleges (AAMC) estimates medical residents provide $8.4 billion in patient care per year.[11] The patient care provided by medical residents may not be billed to Medicare or Medicaid if the hospital or clinic receives federal GME support.

Medical residents provide patient care on weekdays, weekends, nights, and holidays. Medical residencies are required to manage medical resident duty hours to prevent impaired judgment due to resident fatigue. Medical resident salaries depend on training program and resident year in training. Alaska Family Medicine Residency (AFMR) salaries range from $68,000 (first year resident) to $74,000 (third year resident).[12] From a staffing perspective, medical residents may be less expensive than employing non-physicians.[13]

GME and Physician Recruitment & Retention
Most medical residents are in their 20s and 30s. This is an important period for personal, social, and professional development. Life-long collegial and social networks are formed. Spouses and partners begin careers. Children begin school. By the end of GME training, residents have usually developed strong community roots.

Medical residents usually remain in the communities where they train. The AAMC reports fifty-seven percent (57.1%) of medical residents remain in the state where they completed training.[14] The Alaska Family Medicine Residency (AFMR) has one of the highest retention rates of any individual residency. Approximately seventy percent (70%) of AFMR trainees remain in Alaska after training.[14] AFMR recruits medical school graduates who want to train in Alaska. AFMR has more applicants than training positions.

Graduates of AFMR work in clinical settings across Alaska including rural and critical access sites. More than twenty-seven percent

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(27.3%) of Alaska's family medicine physicians completed their GME training at AFMR.[15] Some AFMR graduates leave Alaska for subspecialty training. Some AFMR graduates who have left Alaska return.

Alaska and Health Professional Shortage Areas (HPSAs)
Alaska has a well-documented shortage of medical doctors.[16,17,18,19,20,21] HRSA is a federal agency trying to improve access to health care to people who are geographically isolated or underserved. HRSA tracks Health Professional Shortage Areas (HPSAs) by geographic area, population group, and health care facility. To determine HPSAs, HRSA uses population to provider ratios for primary care physicians, dentists, psychiatrists, and other health professions. Last month HRSA reported that only 47.55% primary medical, only 32.36% dental, and only 27.11% mental health needs were being met nationally.[22] Ideally, 100% of needs would be met, not less than half.

The state-by-state table below summarizes the percent of primary care, dental, and mental health needs being met by state.[22] Alaska ranked 48th for primary medical needs being met (21.85%), 22nd for dental needs being met (34.98%), and 48th for mental health needs being met (11.90%).[22]

Percent Needs Being Met	United States	Alaska
Primary Care	47.55%	21.85%
Dental	32.36%	34.98%
Mental Health	27.11%	11.90%

Alaska Physician Demographics
According to the AAMC, there were 2,101 active physicians in Alaska in 2020.[23] Fifteen percent (15.7%) of Alaska's population is Alaska Native or Native American[24] but only 2.1% of Alaska's physicians identify as Alaska Native or Native American.[23] If Alaska's leaders want to increase the number of physicians who are Alaska Native and Native American, increasing GME in Alaska is essential.

In the US, twelve percent (12%) of physicians retire before age 60 and forty-two percent (42%) retire before age 65.[25] In 2020, thirty-four percent (34.2%) of Alaska's physicians were 60 years or older.[23] Alaska may not be able to recruit enough new physicians to replace retiring physicians to maintain current physician to population ratios. GME recruits medical school graduates and physicians-in-training. Increasing GME in Alaska will increase Alaska's supply of early career physicians.

Alaska Physician Recruitment
Health care organizations in Alaska compete with health care organizations in other states and with other Alaska health care organizations. Between 2003 and 2006, the Alaska Department of Health and Social Services comprehensively analyzed Alaska health care workforce vacancies and recruiting.[16,17] The analysis confirmed that Alaska health care worker turnover and recruiting were expensive. Barriers to successfully recruiting physicians were identifying qualified candidates and spousal job availability/compatibility. Alaska physician vacancy durations were often months to a year or longer depending on location and medical specialty. GME in Alaska is a high yield physician recruiting strategy. Increasing GME in Alaska will recruit more medical school graduates, more physicians-in-training, and more early career physicians.

Alaska and Non-Physician Alternatives
Since 1993, I have worked with, consulted with, and referred patients to non-physician health professionals. I have great respect for physician assistants, nurse practitioners, naturopaths, pharmacists, and other non-physician health care professionals. Each brings something unique and valuable to patient care. All are necessary and vital to a well-functioning health care system.

Some advocate for expanding the scope of practice of non-physicians to solve Alaska's shortage of physicians. But physician and non-physician training is different – different knowledge base, different skill mastery, and different clinical judgement.[26] For example, only physicians are required to complete structured clinical training after graduate school. In general, a physician has 7-11 years of training with 12,000-16,000 hours of supervised patient care prior to independent practice. A physician assistant has 2-3 years of training with 2,000 hours of supervised patient care prior to licensure eligibility. A nurse practitioner has 2-4 years of training with

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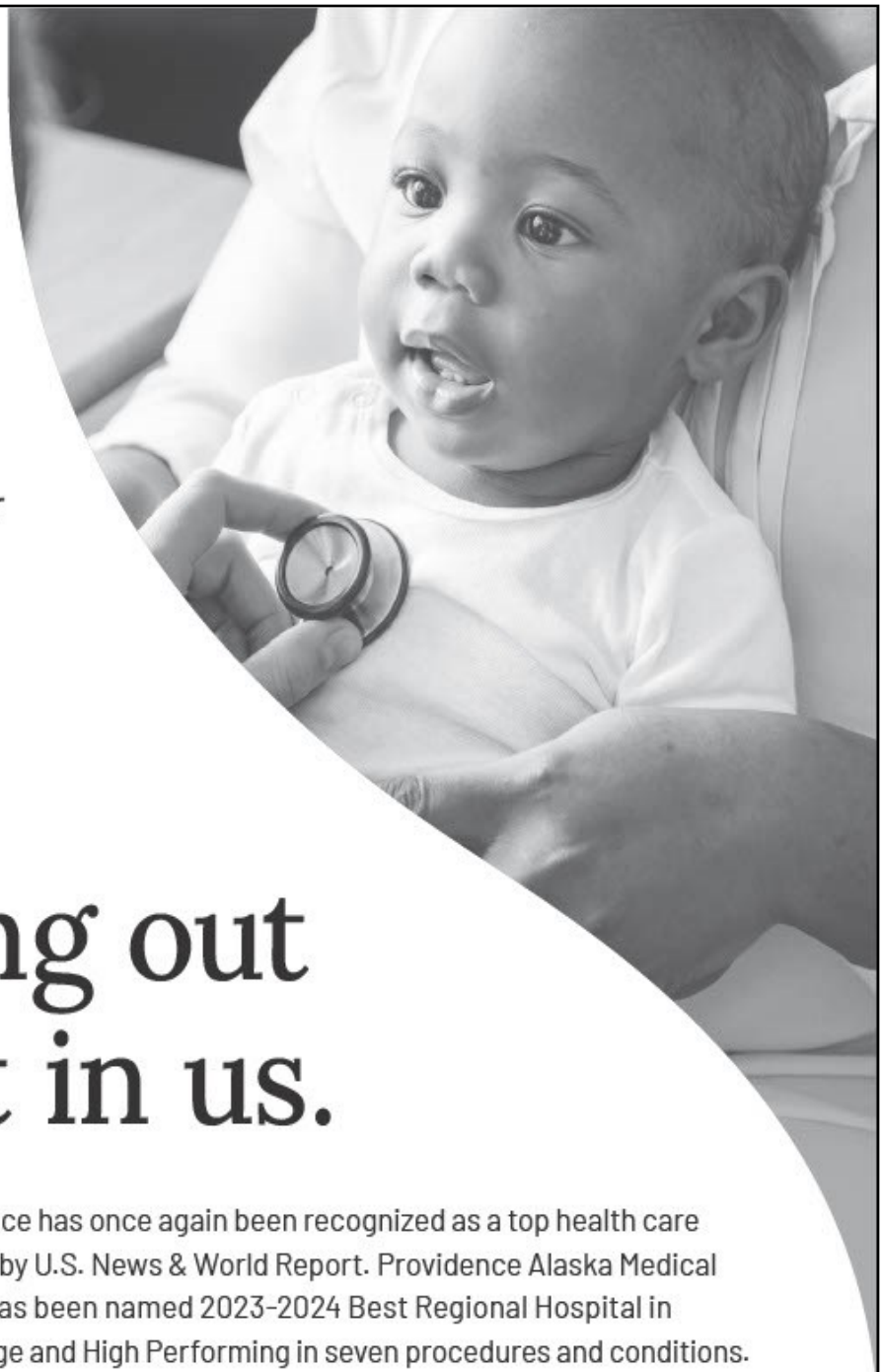

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HIGH PERFORMING HOSPITALS U.S.News 2023-2024 COPD
HIGH PERFORMING HOSPITALS U.S.News 2023-2024 HEART ATTACK
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HIGH PERFORMING HOSPITALS U.S.News 2023-2024 HIP FRACTURE
HIGH PERFORMING HOSPITALS U.S.News 2023-2024 KIDNEY FAILURE
HIGH PERFORMING HOSPITALS U.S.News 2023-2024 SPINAL FUSION
HIGH PERFORMING HOSPITALS U.S.News 2023-2024 STROKE

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500-750 hours of supervised patient care prior to independent practice. A naturopath has 4 years of training with 720-1,200 hours of supervised clinical care prior to licensure eligibility. How could trainees with 12,000, 2,000, 1,200, or 750 hours of supervised patient care experience have the same knowledge, skill, and judgement when transitioning to independent practice? Alaska needs more non-physicians but non-physicians do not replace physicians.

Profession	Length of graduate-level education	Years of residency/ fellowship training	Total patient care hours required during training
Physician	4 years	3-7 years	12,000-16,000 hours
Physician Assistant	2-3 years	Not required	2,000 hours
Nurse Practitioner	2-4 years	Not required	500-750 hours
Naturopath	4 years	Not required	1,200 hours

AMA Scope of Practice: Education Matters. https://www.ama-assn.org/practice-management/scope-practice/scope-practice-education-matters

Telemedicine

Telemedicine was used by Alaska health care organizations to increase access to care long before the COVID pandemic. Telemedicine became a necessity during the pandemic. Now, some Alaska health care organizations rely on telemedicine by physicians and non-physicians who have no first-hand knowledge or experience with Alaska's geography, climate, and systems of care. Is there research examining telemedicine delivered by physicians and non-physicians who do not understand or consider Alaska's uniqueness? Are there differences in patient care quality, outcomes, or total cost?

Alaska has a history of well-intended out of state physicians and non-physicians who increase access to care but who do not provide follow up care, continuity of care, or coordination of care with patients' Alaska physicians and non-physicians. Is this high-quality care?

In general, I am an advocate for telemedicine but since the pandemic I have seen more telemedicine care that does not meet a reasonable standard of care. Telemedicine must be more than increasing access to care. Poor quality telemedicine care is poor quality medical care.

The ideal way to train physicians how to provide high quality telemedicine care for Alaskans is during training in Alaska.

Washington, Wyoming, Alaska, Montana, & Idaho (WWAMI)

The University of Washington (UW) is the hub medical school for the WWAMI region. WWAMI Alaska began in 1971 with nine medical students in Fairbanks.[27] Currently, there are approximately 85 Alaska medical students and 1,000 WWAMI medical students in the five-state region.

There are two additional medical schools in the Pacific Northwest; Pacific Northwest University of Health Sciences College of Osteopathic Medicine (PNWU) in Yakima Washington, and Washington State University Elson S. Floyd College of Medicine (WSU) in Spokane Washington. PNWU opened in 2005 and WSU opened in 2015. UW, PNWU, and WSU provide undergraduate medical education (UME).

WSU sponsors three GME programs: Family Medicine, Internal Medicine, and Pediatrics. UW sponsors more than 120 GME programs.

UW has a long history of partnering with hospitals and clinics in the WWAMI region to develop and operate residency tracks, such as the Alaska Pediatrics Track and the Alaska Internal Medicine Track. UW helps recruit residents and trains residents in patient care the partners are unable to provide. These tracks help states launch and operate GME programs to increase state physician workforces.

UW also fosters and coordinates GME networks. For example, the WWAMI Family Medicine Network is a group of 33 Family Medicine residency programs and 10 rural training tracks.[28] The network collects and shares ideas, research, and provides mentorships.

Alaska GME Including Tracks

Alaska has one independent GME program, the Alaska Family Medicine Residency (AFMR). AFMR is sponsored by Providence Alaska Medical Center. AFMR has more applicants than training positions and has demonstrated GME in Alaska retains graduates for clinical practice in Alaska. Approximately seventy percent (70.8%) of AFMR trainees remain in Alaska after training.[14] Twenty seven percent (27.3%) of Alaska's family medicine physicians completed AFMR training.[15] Alaska has two UW Alaska tracks: the Pediatrics Track and the Internal Medicine Track. The Pediatrics Track graduates three residents per year. The Internal Medicine Track is currently recruiting its first cohort of three residents.

Alaska has two subspecialty fellowships, Hospice & Palliative Care Medicine, and Addiction Medicine. Hospice & Palliative Care Medicine usually trains one fellow per year. Addiction Medicine is training its first fellow this year. Both fellowships are sponsored by Providence Alaska Medical Center.

Alaska GME Program	Residency Sponsor: PAMC	Alaska Track Sponsor: UW	Fellowship Sponsor: PAMC
Family Medicine* (AFMR)	12 Residents/Year Duration: 3 Years		
Pediatrics		3 Residents/Year Duration: 3 Years	
Internal Medicine		3 Residents/Year Duration: 3 Years	
Hospice & Palliative Care			1-2 Fellows/Year Duration: 1 Year
Addiction Medicine			1-2 Fellows/Year Duration: 1 Year

* AFMR is the only independent GME program in Alaska.

Summary

Alaska has a shortage of physicians. Alaska has only one independent GME program - AFMR. AFMR has more applicants than training slots and trains physicians specifically for primary care practice in Alaska. AFMR has one of the highest retention rates of any GME program – approximately seventy percent (70.8%) of graduates remain in Alaska. More than 25% of Alaska's family medicine physicians completed AFMR training.

The first article summarized GME funding and how Alaska is largely outside federal GME funding systems. This article distinguishes WWAMI, UW, UME, GME and summarizes selected Alaska physician workforce issues.

Since 1997, there have been efforts to increase GME in Alaska. Lack of understanding about GME and limited sustainable funding were obstacles. Alaska policy leaders focused more on increasing the training of non-physicians, broadening the scope of practice of non-physicians, and expanding telemedicine. Other states with similar challenges found pathways to meet these challenges.

Increasing GME in Alaska would increase the number of physicians in Alaska and would improve access to care, quality of care, and outcomes of care.[29,30] What steps could Alaska policy leaders take to increase GME?

Recommendation 1: Alaska GME Council

Idaho, Montana, and New Mexico created GME councils. GME councils have been instrumental in developing GME in their respective states. An Alaska GME council would be composed of Alaska physician workforce stakeholders and could report directly to the Alaska governor and legislature. An Alaska GME council could measure, track, and recommend GME priorities to the Alaska governor and legislature. The Alaska GME council mission, duties, and membership could be formalized in Alaska statutes like other boards, commissions, and advisory committees.

Currently, there are multiple bills in the US Congress to increase and expand GME in high need communities and for high need medical specialties. An Alaska GME council would be more effective than multiple individual GME stakeholder groups. Alaska would benefit from a clear and unified GME vision and mission.

Recommendation 2: Alaska Medicaid

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Compared to other states, Alaska already has the fewest number of independent GME programs, fewest number of medical residents, and the lowest medical resident to population ratio in the US. GME expansion in Alaska may be insurmountable given the current limited federal support for Alaska GME.

Most states use Medicaid to support state-determined GME priorities. In 2022, Medicaid GME totaled $7.34 billion. Forty-three (43) states, the District of Columbia, and Puerto Rico used Medicaid to support GME. If Alaska Medicaid supported GME at the national median per state resident amount ($10.60), Alaska would have invested $7.78 million with at least half being provided by the federal government. There is a precedent for Alaska Medicaid supporting GME. Alaska Medicaid supported GME in 2002, 2005, 2009, and 2012.

If Alaska Medicaid supported GME, it would signal to Alaska health care organizations, HRSA, the VA, and philanthropic organizations that the State of Alaska believes increasing GME in Alaska is a priority. This would increase the likelihood of HRSA and VA GME funding.

Recommendation 3: Teaching Health Center

A teaching health center is a multidisciplinary outpatient clinic operated by a local consortium. Alaska does not have a teaching health center that has applied for HRSA GME funding. Between 2022 and 2024 HRSA provided $330 million for the development and operation of GME teaching health centers in 24 states. Currently, no organization in Alaska is leading an effort to create a GME teaching health center. A GME teaching health center would provide interdisciplinary training around primary care and could prioritize telemedicine and rural community consultation. A GME teaching health center would improve access to care.

Recommendation Summary

These recommendations would increase the number of physicians in Alaska and would improve access to medical care in Alaska. A GME council would help the Alaska governor and legislators understand GME. A GME council would provide recommendations about GME expansion. Using Alaska Medicaid for GME may create opportunities for VA GME funding, HRSA GME funding, and maybe Medicare GME funding (for hospitals that do not yet have a Medicare resident cap). Alaska VA GME would increase access to care for Alaska's Veterans. A HRSA supported GME teaching health center would increase access to care and would train physicians and others specifically for providing care to Alaskans.

Increasing GME in Alaska will increase the number of physicians in Alaska and will improve access, quality, and outcomes of medical care – goals we all share.

Do you want to learn more?

A GME Summit will be held in Anchorage at the BP Energy Center April 25-26, 2024. Please attend if you would like to learn more about GME and how other states overcame obstacles to expand GME. https://www.uwmedicine.org/school-of-medicine/resources/gme-summit

Alexander von Hafften, MD
Member, Alaska State Medical Association

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State As of December 31, 2023	Designated Health Professional Shortage Areas (HPSAs) Percent of Need Met Primary Medical	Dental	Mental Health
Alabama	64.10	21.85	25.43
Alaska	**21.85**	**34.98**	**11.90**
Arizona	39.21	33.67	9.05
Arkansas	64.41	36.78	33.67
California	50.29	35.80	23.83
Colorado	44.40	53.48	34.33
Connecticut	60.86	21.98	18.01
Delaware	16.36	4.98	11.59
District of Columbia	33.08	2.90	39.33
Florida	32.91	16.68	21.80
Georgia	39.94	18.02	43.17
Hawaii	43.55	45.67	14.13
Idaho	45.95	48.32	26.42
Illinois	49.82	29.08	22.01
Indiana	64.56	33.18	31.20
Iowa	41.69	28.87	28.44
Kansas	50.09	38.69	25.42
Kentucky	47.69	16.36	24.95
Louisiana	64.44	49.94	26.15
Maine	41.71	31.92	19.45
Maryland	38.81	33.94	22.46
Massachusetts	44.31	74.31	41.12
Michigan	50.39	26.62	36.06
Minnesota	55.33	38.73	27.32
Mississippi	51.24	54.98	38.26
Missouri	20.26	22.89	12.36
Montana	42.07	40.63	27.29
Nebraska	40.02	54.26	48.31
Nevada	42.68	30.11	27.87
New Hampshire	71.23	21.48	51.06
New Jersey	26.93	29.18	57.79
New Mexico	38.76	22.81	17.88
New York	37.28	16.68	14.23
North Carolina	51.33	26.83	12.78
North Dakota	31.00	50.51	22.32
Ohio	47.90	27.61	30.91
Oklahoma	39.62	34.55	33.59
Oregon	63.43	33.27	26.98
Pennsylvania	53.40	37.27	37.72
Rhode Island	72.13	35.90	61.93
South Carolina	69.23	44.80	33.49
South Dakota	37.93	31.09	26.39
Tennessee	65.59	34.17	16.25
Texas	56.71	41.52	30.86
Utah	61.59	55.58	52.57
Vermont	56.53	58.57	Not reported
Virginia	66.96	55.85	41.02

Alaska Division of Insurance

As you know, the Alaska Division of Insurance, on the Governor's order, repealed the 80th Percentile Rule effective January 1, 2024. This rule was repealed without any other consumer protection being put in place. Litigation has been filed against the Division of Insurance. Legislators are becoming aware of physician and other provider concerns and the Senate Health and Social Services committee has heard a presentation from Lori Wing-Heier about the 80th percentile rule.

If physicians or medical practices have complaints about improper insurance reimbursements, they should file a complaint with the Division of Insurance.

https://www.commerce.alaska.gov/web/ins/ProviderComplaints.aspx

If patients have complaints about their insurance processing of claims or balance bills from out-of-network providers, they should also contact the Division of Insurance. https://www.commerce.alaska.gov/web/ins/Consumers/Complaints.aspx

Medicaid Renewals

There is an online toolkit at medicaidrenewals.alaska.gov that has been updated recently. The key message has been updated from a "Get ready to renew" message to reflect the questions the department is hearing about. You are welcome to print these items from the state's website: https://health.alaska.gov/dpa/Pages/medicaid/Medicaid-Renewals.aspx

This includes newer:

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