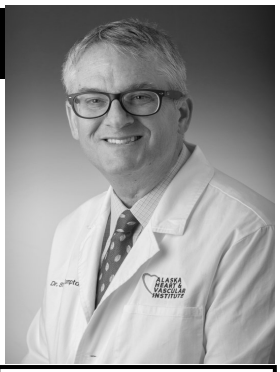
HEARTBEAT

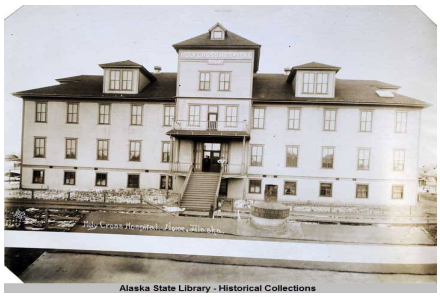
THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION December 2023

PRESIDENT'S COLUMN



Steven Compton, MD

Alaskans are familiar with the Nome Gold Rush, 1899-1909, that resulted in Alaska's first modern population boom. By the early 1900s Nome's population was over 20,000 citizens, with schools, churches, and a large hospital (Figure 1). At its heyday, Nome was by far the largest Alaskan community. By 1918, the Gold Rush was over, the hospital was converted to apartments and office space.



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A similar population boom was seen in Kennecott, Alaska, where prospectors identified a large copper deposit above the Kennecott glacier, the richest known concentration of copper in the world. J.P. Morgan and Daniel Guggenheim formed the Alaska Syndicate, to develop a mining concern. The "Guggenmorgan" forces began construction in 1907 and by 1916 the mine was producing copper ore valued over $30M/year. During this period, the Kennecott Hospital was the first and only facility in Alaska to have an X-ray machine. (Figure 2). The Kennecott venture ended in 1938, but the empty hospital still stands.

University of Alaska Anchorage. Archives & Manuscripts Dept.

Health care is not a primary economic driver, as illustrated by the Nome and Kennecott experiences. In both cases, local medical communities were created to serve growing populations, and in both cases, the demand for medical services dropped off with diminishing economic opportunity.

Any predictions about the future of Alaskan health care should account for shifts in the Alaskan economy, and shifts in Alaskan demographics. This column will explore the expected impacts of economic and demographic changes on health care delivery in the state.

Alaska's economy is unusual in that about 40% of the state GDP comes from two sources: resource extraction (mostly oil) and government spending (federal>state>local). Alaskan oil production accounts for ~20% of GDP (but only 4% of our jobs). North Slope oil production began in 1977 and peaked in 1989 at 2 million barrels/day. Current production is roughly 300 thousand

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MEMBERSHIP

ASMA Membership drive is winding down. Please make every effort to pay your 2024 dues before January 15 so you a have full listing in the printed directory, coming out in February.

Members receive one free copy; additional copies will be available for purchase.

If you haven't already, please log in to confirm the details of your profile. Only those with a complete profile will be included in the printed directory, non members will have an abridged listing.

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.
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State Medical Board Business – November 2023 board meeting

The State Medical Board held its quarterly meeting on November 17, 2023. Items of interest included the following:

Physician Assistant regulation project. The Medical Board had proposed regulations changes to the PA regulations, oral public comment was heard, and written comments received and reviewed. The vast majority of public comments were opposed to the proposed changes. After discussion the board voted to table the proposed regulations and form a workgroup including the board, the Alaska PA association and members of the public.

Medical license application changes. The State Medical Board approved removing the following items from the license application in order to streamline the application process:

Verification of hospital privileges. It was agreed that the burden was significantly greater than any benefit from getting hospital privilege data. Only three other states require this information. Hospital verification is out of the applicant's control and delays completion of the application. There is no record of denial of licensure based on this requirement. This requirement will be replaced with an attestation statement on the application that the physician applicant has no hospital disciplinary history.

Removal of the requirement for an AMA/AOA physician profile. These profiles contain the same information as the FSMB profile, cause delay and cost the applicant an additional fee for no additional benefit. Board staff already request the FSMB profile at no additional cost.

Remove the requirement for DEA clearance. No other state requires DEA clearance, the DEA objects to this additional workload and this requirement does not provide information that would not be available elsewhere. This will be replaced with an attestation statement that the physician has no prior history of DEA restriction.

Interstate Medical Licensure Compact (IMLC). The board discussed whether to move forward with efforts to join the IMLC and voted not to move forward with the IMLC at this time. Some board members saw the compact as 'just a matter of time' since so many other states have joined. One board member expressed grave concerns about the linkage between IMLC and the FSMB after receiving a letter from FSMB threatening loss of licensure for promoting medical disinformation. A public member of the board said that joining the IMLC without adequate public comment would be abandoning the board's responsibility to protect the public by giving licensing authority to another entity. The public member also stated that their personal physician had discharged them as a patient because the patient was not COVID vaccinated and attributed this to the FSMB. Additionally, there were concerns about telemedicine and radiologists seeking easy access to Alaska patients without any interest in the wellbeing of Alaska. Another board member expressed bias about large organizations assuming control of state functions. Board members recognized that this issue would likely come up again in the future.

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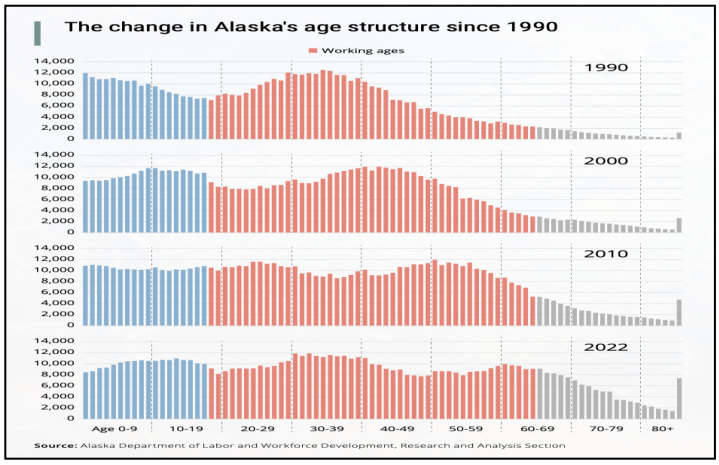
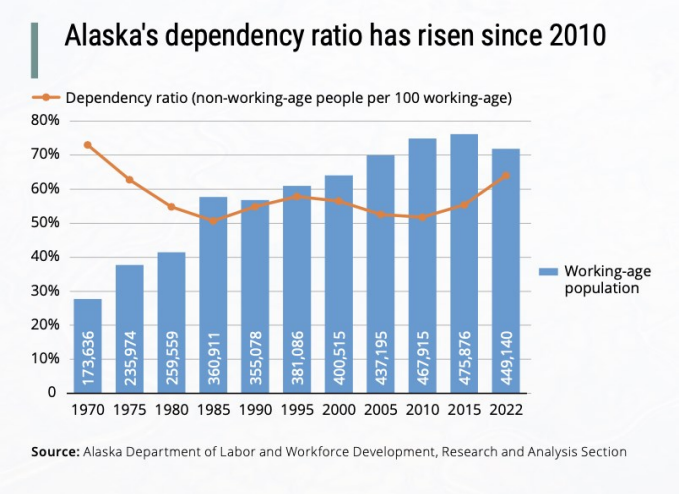
barrels/day, and fluctuating oil prices have not been helpful in regards to state income. Mostly as a result of the oil situation, Alaskan GDP has faltered in the past few years.



Alaska's current decline is less dramatic to the booms and busts of Nome and Kennecott, but any decline in the state's economic activity will affect all support services, including medicine. An optimist would point out that government spending, particularly federal spending, is a stabilizing force in our economy. The thousands of jobs involving military, social programs, communication and infrastructure are relatively immune to shifts in the economy, or the price of oil.

Demographic shifts represent the larger challenge to the health care community. The first shift is the dramatic increase in our elderly population (Figure 3). The 65-and-over crowd is shown as the gray bars. In the 1990s Alaska had a disproportionately small elderly population compared to the rest of the country. In the past few decades, this group has tripled in size because of two reasons: Baby Boomers are all now in their 60s and more of them are staying in Alaska. This demographic shift represents a new challenge for the state, because the older population has higher medical needs, with lower reimbursement (Medicare). Alaska has been hit harder by the 'silver tsunami' of elderly patients than any other state.



Another way to evaluate this shift is to consider the dependency ratio, i.e. the ratio of the working to the nonworking population (Figure 4). This ratio is used by economists to measure the economic pressure on the productive population. A cursory glance at this figure might be reassuring, as Alaska's ratio was even higher in the 1970s. In 1970, however, only 5% of nonworking Alaskans were elderly (95% were children); that number has increased over 7-fold as of 2022 (37% elderly). Needless to say, the over-65 crowd has higher medical expenses.

Alaskan health care costs face many other pressures. In 2008, the average annual price of a new drug in the US was $2115; in 2022 this number was $257,000. New, costly procedures such as transcatheter aortic valve replacement and atrial fibrillation ablation increase spending and extend lives. Increased longevity, a worthy goal, leads to even more medical expenditure.

Anchorage is the cheapest place to run a business in the state, but our private clinics have been unable to care for Medicare patients due to unsustainable operating costs. This problem has been burning for over a decade and remains unsolved. Delivery of care to Medicare patients is currently accomplished only by cost-shifting from private payors, and this is why phrases like "dependency ratio" become so important, as these forces directly impact private payors.

The Alaskan boom-bust economy continues. The escalating costs of private insurance have prompted the Dunleavy administration to eliminate the 80th percentile consumer protection rule, based upon demonstrably fraudulent data (see my prior columns). Insurance premiums have risen as physician payments have fallen. We predict that this move will result in further abuse of insured patients by the insurance industry, and loss of access to care by the most vulnerable segments of our population.

The 2024 Dunleavy move has already proved ineffective as Blue Cross has increased their billing premiums by 18% for 2024. ASMA has argued in these pages that eliminating the 80th move will not solve the cost problem. ASMA has shared these concerns with Governor Dunleavy, the Alaskan Congressional delegation, and the Director of Insurance. ASMA has supported a recently filed injunction from the Coalition for Reliable Medical Access in Anchorage Superior Court. Stay tuned to these pages, and by all means, recruit your colleagues to join ASMA, as we fight for our patients.

Federal Funding of Graduate Medical Education in Alaska

Part 1

Alaska has a shortage of medical doctors ("physicians").[1,2,3,4,5,6] The shortage is not new or unique to Alaska. Increasing graduate medical education in Alaska has been recommended by stakeholders.[3,5,6,7] Graduate medical education (GME) is the training of medical school graduates after medical school. Increasing the number of medical students in the WWAMI School of Medical Education will not directly increase the number of physicians working in Alaska because WWAMI medical students are in undergraduate medical education, not graduate medical education. All new medical school graduates, even WWAMI medical students, must participate in GME before providing medical care without supervision.[8]

Alaska has one independent GME program, the Alaska Family Medicine Residency (AFMR);[9] and two University of Washington Alaska tracks, the Pediatric Track and the Internal Medicine Track. Alaska has not launched another independent GME program despite the efforts of federal, state, Alaska Native, and not-for-profit stakeholders.

Regarding GME, Alaska is an outlier compared to all other states and Washington, DC:
Alaska has the fewest number of GME programs.[9]
Alaska has the fewest number of GME trainees (medical residents).[9]
Alaska has the lowest medical resident to state population ratio.[9]

Why is Alaska a GME outlier? Alaska is essentially outside federal GME funding systems. Why is this important? The federal government is the primary explicit funder of GME. Regarding federal GME funding, Alaska is an outlier compared to all other states and Washington, DC:
Medicare GME funding in Alaska is third from lowest per state population.[10]
Medicare GME funding in Alaska is third from lowest per state Medicare population.[10]
Only one Alaska hospital receives Medicare GME funding.[10]
The State of Alaska does not use Medicaid to fund GME.[11]
The Department of Veterans Affairs (VA) does not provide GME in Alaska.
The Health Resources and Services Administration (HRSA) does not currently fund GME in Alaska.[12,13]
The Department of Defense (DOD) does not provide GME in Alaska.

This is the first of two articles. This article summarizes federal GME funding systems. The second article recommends three steps to increase GME in Alaska. Increasing GME in Alaska will increase the number of physicians in Alaska; and will improve access, quality, and outcomes of medical care.

Background
GME is the training of physicians after medical school. Medical residents (interns, residents, and fellows) provide patient care with the supervision of senior physicians. All states require at least two or three years of GME prior to being eligible for an unrestricted medical license.[8] Alaska requires at least two years of GME.[14]

Since 1965 the federal government has been the primary funder of GME. Federal GME support comes through Medicare, Medicaid, Department of Veterans Affairs (VA), Health Resources and Services Administration (HRSA), and the Department of Defense (DOD).[15] More than eighty-five percent (85%) of all federal GME funding comes through Medicare and Medicaid.[15] In 2021, Medicare GME was $13.4 billion.[10] In 2022, Medicaid GME was $7.3 billion.[11] Medicare is largely passive about physician workforce priorities. Medicaid GME is determined by individual states to meet state health profession workforce goals.

Less than fifteen percent (15%) of all federal GME funding comes through the VA, HRSA, and DOD.[15] The VA, HRSA, and DOD fund GME for specific physician workforce priorities and none are currently funding GME in Alaska.

Medicare
Medicare is the largest explicit funder of GME.[15,16] In 2021, 65 million people were enrolled in Medicare (18.7% of the US population).[17] Total Medicare payments were $829 billion[17] and total Medicare GME payments were $13.4 billion.[10]

Medicare is the federal health insurance program for people 65 years and older and for people with certain medical conditions and disabilities.[18] Medicare was created by Congress in 1965. At that time, Congress decided Medicare would reimburse teaching hospitals for training physicians to care for current and future Medicare beneficiaries. Historically, Medicare reimbursed teaching hospitals the cost of training medical residents. In 1997, Congress took steps to contain the growing federal cost of GME. Medicare capped the number of medical residents eligible for Medicare GME reimbursement (the "cap") and split reimbursement into direct training cost reimbursement (DGME) and indirect patient care cost reimbursement (IME). DGME and IME payments are calculated using statutory formulas. Total Medicare IME payments are approximately twice total Medicare DGME payments. DGME and IME reimbursement rates differ significantly across the country. The Medicare GME payment methodology has been criticized for not accurately reflecting training costs or patient care costs.[19,20,21,22,23,24] Since 2005, there have been attempts to redistribute Medicare GME funding to rural hospitals. These efforts have not increased GME in Alaska.

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Federal Funding Continued from Page 6

The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for GME. ACGME has supported efforts to develop GME in rural communities. However, most hospitals outside Anchorage, Fairbanks, Juneau, and Mat-Su may not have a sufficiently diverse patient population or large enough teaching faculty to sponsor independent GME. Hospitals in larger communities may partner with hospitals and clinics in smaller communities to create rural GME training programs.

AFMR is the only independent GME program in Alaska. AFMR launched just prior to Congress enacting resident caps and the DGME/IME reimbursement methodology. Providence Alaska Medical Center (PAMC) sponsors AFMR. In 2021, Medicare reimbursed PAMC $3 million for AFMR.[10] AFMR has 36 residents but PAMC's Medicare cap is 22.40 residents.[10] In 2021, PAMC was forty percent (40%) above its Medicare cap. PAMC cannot add any new Medicare funded residents. The Alaska Native Medical Center, Alaska Regional Hospital, Fairbanks Memorial Hospital, and Mat-Su Regional Medical Center may not yet have Medicare resident caps.[25]

The state-by-state table below summarizes Medicare Enrollees (2021), Medicare Total GME Payments (2021), and Medicare Payments Per Medicare Enrollee (2021).

In 2021, Alaska had the fewest Medicare enrollees (108,116) and the third from lowest Medicare payment per Medicare enrollee ($28.32). Medicare GME for Alaska would have been $14 million rather than $3 million if Alaska had received the median Medicare GME support per Medicare enrollee ($130.89).

Medicaid

Medicaid is the second largest explicit funder of GME.[11] In 2022, total Medicaid GME was $7.3 billion.[11] This year, 266,110 Alaskans are enrolled in Medicaid (26% of the Alaska population).[26]

Medicaid is a joint federal-state program that finances health care services for low-income children and adults; and for some individuals with disabilities.[27] Since 2014, forty (40) states and Washington DC have adopted Medicaid expansion.[28] Each state designs their Medicaid program within the federal framework.[11,27] States may use Medicaid to support GME.[11] Medicaid GME funding comes from states and the federal government.[11] The state's share usually comes from the state's general fund, local governments, or hospital taxes.[11] The federal share may be more than,

Federal Funding Continued ….

equal to, or less than the state share. Individual states use Medicaid GME for state determined goals.[11] In general, Medicaid GME supports existing GME, expands GME for specific medical specialties, expands GME in high need geographic locations, or trains non-physician health professionals.[11]

The state-by-state table below summarizes Total Census (2022), Medicaid Total GME Payments (2022), Medicaid Payments Per Population (2022), and GME Trainees Per 100,000 Population (2021-2022).

In 2022, forty-three (43) states used Medicaid to support state GME goals.[11] Alaska was one of seven states to not use Medicaid to support GME. The State of Washington used Medicaid to support GME but is added to states not using Medicaid for GME in this analysis because the amount was not available when surveyed.[11] The median Medicaid GME per state resident was $10.38. In 2022, Alaska Medicaid GME would have been $7.6 million if Alaska had invested $10.38 per state resident.

Alaska has the lowest medical resident to population ratio in the US.[9] Alaska has 4.91 medical residents per 100,000 population.[9] In 2022, the median was 35.42 trainees per 100,000 population.[9] In 2022, Alaska would have trained 258.6 medical residents if Alaska had trained the median medical resident to population ratio (35.42 trainees per 100,000 population).

Veterans Affairs, Health Resources and Services Administration, and Department of Defense
The VA, HRSA, and DOD provide less than fifteen percent (15%) of all federal GME funding.[15] Currently, the VA, HRSA, and DOD are not funding GME in Alaska.

The VA has a statutory mission to train health care professionals to care for VA beneficiaries. The VA provides more medical education and training in the US than any other health care organization.[29] GME is provided at ninety percent (90%) of VA facilities.[29] 75,000 medical residents train and work in VA facilities each year.[29] In general, the VA partners with university and community-based GME programs rather than operating independent GME programs.

Alaska has the highest Veteran to adult population ratio in the US (8,836 per 100,000).[30,31] Ten years ago, the Alaska VA tried to increase GME in Alaska. The Alaska VA partnered with DOD, Alaska Native organizations, Alaska non-profit organizations, and several State of Alaska agencies but the Alaska Legislature was unwilling to commit funding to support that effort. Subsequently, Alaska was the only state to not receive any VA

Federal Funding Continued ….

GME funded positions in the Veterans Access, Choice, and Accountability Act of 2014.[32]

HRSA supports workforce development of high need health professions and clinical care in low resource settings. HRSA funds GME at teaching health centers and children's hospitals. A teaching health center is a multidisciplinary outpatient clinic operated by a local consortium. Between 2022 and 2024, HRSA is providing $330 million for GME at teaching health centers.[12,13] Alaska does not have a teaching health center that has applied for HRSA GME support.

DOD allocates GME funding to meet military service priorities.[15] DOD does not provide GME in Alaska. When Fort Richardson and Elmendorf Air Force Base were consolidated to Joint Base Elmendorf Richardson (JBER), and the Alaska VA clinic was bult next to JBER Hospital, there may have been an expectation that VA clinical staff would provide JBER Hospital coverage when DOD physicians were deployed. But like most other Alaska health care organizations, the Alaska VA is short staffed.

Summary

Alaska has a shortage of medical doctors. GME is the training of medical school graduates after medical school. The lack of GME in Alaska is the rate-limiting step for increasing physicians in Alaska during training. Alaska has only one independent GME program. Despite the efforts of many stakeholders, no organization in Alaska has been able to launch another independent GME program. Consequently, Alaska has the lowest GME trainee per population ratio in the US (4.91 trainees per 100,000 population).[9]

The federal government is the primary explicit funder of GME.[15] Alaska is essentially outside federal GME funding systems. Medicare and Medicaid support more than eighty-five percent (85%) of GME.[15] Currently, only one Alaska hospital receives Medicare GME support and that hospital cannot add new Medicare funded residents. In comparison to other states, Alaska receives third from the lowest GME investment per Medicare enrollee ($28 per enrollee).[10] This is a fraction of the median GME investment per Medicare enrollee ($130 per enrollee). Most other hospitals in larger Alaska communities may not yet have a Medicare GME resident cap.[25] Most hospitals in smaller Alaska communities may not have a sufficiently diverse patient population or large enough teaching faculty to be accredited as an independent GME program. Currently, the State of Alaska does not use Alaska Medicaid to support GME. In 2022, forty-three states (43) used Medicaid to support GME. The national median Medicaid GME investment per state resident was $10.[11]

The VA, HRSA, and DOD do not provide or fund GME in Alaska. The Alaska VA Health Care System and DOD have participated in efforts to develop GME in Alaska but been turned away by the Alaska Legislature. HRSA provides GME funding to teaching health centers. Alaska currently does not have a teaching health center that has applied for HRSA GME support.

The second article will recommend three steps to increase GME in Alaska. In short, the three steps include:
Create an Alaska GME Council.
Use Medicaid to support GME in Alaska.
Identify an eligible institution or health care organization to apply for HRSA teaching health center GME funding.

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.

Alexander von Hafften, MD
Member, Alaska State Medical Association

Cited References

1. State of Alaska Department of Health and Social Services Primary Care and Rural Health Unit. (2003-2004). Status of Recruitment Resources and Strategies (SORRAS).
2. State of Alaska Department of Health and Social Services Alaska Center for Rural Health. (2005-2006). Status of Recruitment Resources and Strategies (SORRAS II).
3. Alaska Physician Supply Task Force. (August 2006). Securing an Adequate Number of Physicians for Alaska's Needs.
4. Alaska Center for Rural Health. (July 2007). 2007 Alaska Health Workforce Vacancy Study.
5. Health Workforce Planning Coalition. (May 2010). Alaska Health Workforce Development Plan. Available at https://www.alaska.edu/research/wd/plans/health/HealthWFDPlan.pdf.
6. Robert Graham Center. Alaska: Projecting Primary Care Physician Workforce. (September 2013). Available at https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Alaska.pdf.
7. Dahal A, Skillman SM. Alaska's Physician Workforce in 2021. University of Washington Center for Health Workforce Studies. Available at https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/08/Alaska_Physicians_FR_2022_July.pdfhttps://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/08/Alaska_Physicians_FR_2022_July.pdf.
8. Herz EJ, Tilson S. (June 20, 2008). Medicaid and Graduate Medical Education. Congressional Research Service. Report RS22842.
9. Accreditation Council for Graduate Medical Education. Data Resource Book Academic Year 2021-2022. Available at https://www.acgme.org/globalassets/pfassets/publicationsbooks/2021-2022_acgme__databook_document.pdf
10. Robert Graham Center. Data Tables: Graduate Medical Education for Teaching Hospitals Fiscal Year 2021. Available at https://www.graham-center.org/maps-data-tools/gme-data-tables.html
11. Henderson T. Medicaid Graduate Medical Education Payments Results From the 2022 50-State Survey, 2023. Available at https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html

Federal Funding Continued

12. Health Resources & Services Administration. Teaching Health Center Graduate Medical Education (THCGME) Academic Year 2023-2024 Awardees. Available at https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education/ay2023-2024-awardees
13. Health Resources & Services Administration. Teaching Health Center Graduate Medical Education (THCGME) Academic Year 2022-2023 Awardees. Available at https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education/ay2022-2023-awardees
14. State of Alaska Department of Commerce, Community, and Economic Development Division of Corporations, Business and Professional Licensing. Medical or Osteopathic Licensing Application Instructions. Available at https://www.commerce.alaska.gov/web/portals/5/pub/med4105.pdf
15. Heisler EJ, Mendez BHP, Mitchell A, Panangala SV, Villagrana MA. (December 27, 2018). Federal Support for Graduate Medical Education: An Overview. Congressional Research Service. Report R44376.
16. Villagrana MA. (September 29, 2022). Medicare Graduate Medical Education Payments: An Overview. Congressional Research Service. IF10960.
17. Cubanski J, Neuman T. Kaiser Family Foundation. What to Know About Medicare Spending and Financing (January 19, 2023). Available at https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/
18. United States Department of Health and Human Services. Who is Eligible for Medicare? Available at https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html
19. Cosgrove J. (March 2018). Physician Workforce HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding, United States Government Accountability Office. GAO-18-240.
20. Henderson, T. How Accountable to the Public Is Funding for Graduate Medical Education? The Case for State Medicaid GME Payments. American Journal of Public Health. 2021;(111):1216-1219.
21. He K, Whang E, Kristo G. Graduate Medical Education Funding Mechanisms, Challenges, and Solutions: A narrative Review. American Journal of Surgery. 2021;(221):65-71.
22. Iglehart JK. Medicare, Graduate Medical Education, and New Policy Directions. New England Journal of Medicine. 2008 August 7;359(6):643-650.
23. Mullan F, Chen C, Steinmetz E. The Geography of Graduate Medical Education: Imbalances Signal Need for New Distribution Policies. Health Affairs (Millwood). 2013 November:32(11):1914-1921.
24. Regenstein M, Snyder JE, Jewers MM, Nocella K, Mullan F. Comprehensive Revenue and Expense Data Collection Methodology for Teaching Health Centers: A Model for Accountable Graduate Medical Education Financing. Journal of Graduate Medical Education 2018 April;10(2):157-164.
25. RuralGME.org. (Accessed on December 6, 2023). Available at https://portal.ruralgme.org/hospital-analyzer
26. Kaiser Family Foundation (June 2023). Available at https://files.kff.org/attachment/fact-sheet-medicaid-state-AK.
27. Mitchell A, Baumrucker EP, Colello KJ, Napili A, Binder C, Keyser JA. (February 22, 2021). *Medicaid: An Overview*. Congressional Research Service. Report No. R43357.
28. Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map (October 4, 2023). Available at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/#
29. United States Department of Veterans Affairs Office of Academic Affiliations. Available at https://www.va.gov/oaa/medical-and-dental.asp
30. United States Census Bureau. Percent of Veterans by State. Available at
31. https://www.census.gov/library/visualizations/2015/comm/percent-veterans.html
32. United States Census Bureau. Quick Facts Alaska. Available at https://www.census.gov/quickfacts/AK
33. Klink KA, Albanese AP, Bope ET, Sanders KM. Veterans Affairs Graduate Medical Education Expansion Addresses US Physician Workforce Needs. Academic Medicine 2022;97:1144-1150.
34. Cosgrove J. (March 2018). Physician Workforce HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding, United States Government Accountability Office. GAO-18-240.
35. Henderson, T. How Accountable to the Public Is Funding for Graduate Medical Education? The Case for State Medicaid GME Payments. American Journal of Public Health. 2021;(111):1216-1219.
36. He K, Whang E, Kristo G. Graduate Medical Education Funding Mechanisms, Challenges, and Solutions: A narrative Review. American Journal of Surgery. 2021;(221):65-71.
37. Iglehart JK. Medicare, Graduate Medical Education, and New Policy Directions. New England Journal of Medicine. 2008 August 7;359(6):643-650.
38. Mullan F, Chen C, Steinmetz E. The Geography of Graduate Medical Education: Imbalances Signal Need for New Distribution Policies. Health Affairs (Millwood). 2013 November:32(11):1914-1921.
39. Regenstein M, Snyder JE, Jewers MM, Nocella K, Mullan F. Comprehensive Revenue and Expense Data Collection Methodology for Teaching Health Centers: A Model for Accountable Graduate Medical Education Financing. Journal of Graduate Medical Education 2018 April;10(2):157-164.

1. State-by-State Table - References

2. 2021 Medicare Enrollee data from the Kaiser Family Foundation (https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).
3. Medicare GME payment data from the Robert Graham Center (https://www.graham-center.org/maps-data-tools/gme-data-tables.html).
4. 2022 Census data from the United States Census Bureau (https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html)
5. Medicaid GME payment data from Medicaid Graduate Medical Education Payments Results from the 2022 50-State Survey (https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html)
6. 2021-2022 Residents Per 100,000 Population from the Accreditation Council for Graduate Medical Education Data Resource Book Academic Year 2022-2021 (https://www.acgme.org/globalassets/pfassets/publicationsbooks/2021-2022_acgme__databook_document.pdf)

State	Medicare 2021			Medicaid 2022			2021-2022
	Enrollees	Total GME Payments (millions of dollars)	Payments Per Enrollee (dollars/enrollee)	Census	Total GME Payments (millions of dollars)	Payments Per Population (dollars/person)	GME Trainees Per 100,000 Population
Alabama	1,070,474.00	$129.70	$121.16	5,073,187.00	-	-	34.60
Alaska	108,116.00	$3.06	$28.32	738,023.00	-	-	4.91
Arizona	1,400,160.00	$173.50	$123.91	7,303,398.00	$386.80	$52.96	29.59
Arkansas	653,277.00	$79.80	$122.15	3,030,646.00	$10.50	$3.46	37.18
California	6,499,203.00	$1,055.77	$162.45	39,995,077.00	$415.10	$10.38	36.27
Colorado	961,593.00	$105.67	$109.89	5,922,618.00	$13.70	$2.31	30.23
Connecticut	702,439.00	$391.86	$557.86	3,612,314.00	$164.50	$45.54	71.44
Delaware	222,814.00	$34.91	$156.66	1,008,350.00	$15.00	$14.88	40.76
District of Columbia	94,055.00	$161.69	$1,719.10	707,109.00	$75.40	$106.63	268.34
Florida	4,803,848.00	$705.88	$146.94	22,085,563.00	$797.90	$36.13	37.03
Georgia	1,808,944.00	$202.04	$111.69	10,916,760.00	$55.00	$5.04	29.46
Hawaii	288,450.00	$20.24	$70.17	1,474,265.00	$0.08	$0.05	32.19
Idaho	361,623.00	$15.84	$43.82	1,893,410.00	$3.00	$1.58	10.10
Illinois	2,287,329.00	$527.05	$230.42	12,808,884.00	$158.50	$12.37	55.57
Indiana	1,301,309.00	$82.48	$63.39	6,845,874.00	$39.00	$5.70	24.21
Iowa	646,874.00	$60.78	$93.96	3,219,171.00	$75.60	$23.48	32.60
Kansas	555,807.00	$81.48	$146.60	2,954,832.00	$23.80	$8.05	31.52
Kentucky	952,197.00	$86.14	$90.47	4,539,130.00	$116.30	$25.62	35.57
Louisiana	893,631.00	$170.04	$190.28	4,682,633.00	$23.90	$5.10	51.04
Maine	356,229.00	$52.08	$146.21	1,369,159.00	$16.60	$12.12	26.60
Maryland	1,075,070.00	$274.59	$255.41	6,257,958.00	$59.80	$9.56	55.10
Massachusetts	1,374,243.00	$885.91	$644.66	7,126,375.00	-	-	87.02
Michigan	2,130,074.00	$861.58	$404.49	10,116,069.00	$162.90	$16.10	75.38
Minnesota	1,068,551.00	$228.48	$213.83	5,787,008.00	$78.50	$13.56	42.87
Mississippi	614,598.00	$55.01	$89.50	2,960,075.00	$39.90	$13.48	31.46
Missouri	1,263,819.00	$271.60	$214.90	6,188,111.00	$179.40	$28.99	53.03
Montana	244,107.00	$13.13	$53.78	1,103,187.00	$6.40	$5.80	7.52
Nebraska	360,404.00	$4.89	$13.57	1,988,536.00	$20.10	$10.11	45.78
Nevada	561,939.00	$105.50	$187.75	3,185,426.00	$33.70	$10.58	29.42
New Hampshire	316,557.00	$70.45	$222.56	1,389,741.00	-	-	35.28
New Jersey	1,656,791.00	$527.26	$318.24	9,388,414.00	$242.00	$25.78	45.14
New Mexico	439,390.00	$39.10	$88.99	2,129,190.00	$188.70	$88.63	34.64
New York	3,705,610.00	$2,680.69	$723.41	20,365,879.00	$1,919.00	$94.23	96.87
North Carolina	2,077,983.00	$215.23	$103.58	10,620,168.00	$308.20	$29.02	39.60
North Dakota	137,155.00	$17.37	$126.62	800,394.00	-	-	23.36
Ohio	2,407,792.00	$717.77	$298.10	11,852,036.00	$305.50	$25.78	64.97
Oklahoma	763,654.00	$65.50	$85.77	4,000,953.00	$46.60	$11.65	31.88
Oregon	901,861.00	$96.53	$107.04	4,318,492.00	$151.00	$34.97	26.54
Pennsylvania	2,805,431.00	$485.66	$173.12	13,062,764.00	$111.40	$8.53	75.15
Rhode Island	228,146.00	$113.26	$496.44	1,106,341.00	-	-	84.52
South Carolina	1,133,973.00	$152.85	$134.79	5,217,037.00	$296.60	$56.85	34.89
South Dakota	184,567.00	$10.11	$54.75	901,165.00	$3.10	$3.44	18.20
Tennessee	1,406,240.00	$166.86	$118.65	7,023,788.00	$48.08	$6.85	39.20
Texas	4,386,864.00	$320.30	$73.01	29,945,493.00	$226.60	$7.57	34.99
Utah	427,555.00	$49.18	$115.04	3,373,162.00	$7.00	$2.08	27.44
Vermont	155,077.00	$37.91	$244.44	646,545.00	$30.00	$46.40	52.82
Virginia	1,575,523.00	$206.22	$130.89	8,757,467.00	$449.90	$51.37	35.42
Washington	1,431,948.00	$160.88	$112.35	7,901,429.00	Unavailable	Unavailable	29.80
West Virginia	444,287.00	$98.40	$221.48	1,781,860.00	$13.80	$7.74	57.04
Wisconsin	1,225,485.00	$194.88	$159.02	5,939,064.00	$69.20	$11.65	36.14
Wyoming	117,393.00	$1.89	$16.06	579,495.00	-	-	7.43
Totals*	**63,400,459.00**	**$13,404.45**	**$211.43**	**335,994,025.00**	**$7,388.06**	**$21.99**	**45.90**

* Totals include 810,000 Medicare Enrollees in Puerto Rico, $18,976,063 Medicare GME for Puerto Rico, and $116,468,868 of unspecified IME.

Table Notes:

1. 2021 Medicare Enrollee data from the Kaiser Family Foundation.

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