EXHIBIT-C
SHARP-3: Program Description

A - Overall

SHARP Components

(a) The Alaska Department of Health & Social Services will operate Alaska's SHARP-3 Program, located within the Office of Healthcare Access, Section of Rural and Community Health Systems, Division of Public Health.

Support for Service

(a) The department will operate the SHARP-3 support-for-service program the purpose of which is to enhance the recruitment or retention of persons working in Alaska's healthcare system. The department will provide the program-admitted person with specified financial payment. These are support-for-service payments, of which there are two types: education loan repayment; and direct incentive. This will be paid in addition to the person's employer-provided wage and benefit.

Recruitment Emphasis

(a) The program will emphasize practitioner recruitment in its selection process. This will be accomplished by use of a prior approval process through which the employer receives a pre-determination of the position's eligibility.

(b) The program is available statewide. Program-eligible employers may be located anywhere in the state. The whole state is defined as an underserved area.

(c) The department will define an underserved person as uninsured; or receives or is eligible to receive medical assistance (Medicaid or Medicare coverage); or receives or is eligible to receive other federal health program benefits (e.g. I.H.S. beneficiaries, VA).

B - Practitioner

Designation of Eligible Practitioner

(a) The department will designate practitioner eligible for SHARP-3 as a United States citizen or National (naturalized citizen), a Permanent Resident, or a person with a current employment visa. Upon request by program, the applicant must provide documentation from the U.S. Citizenship and Immigration Services as to citizenship or residency or employment visa status.

Affiliation

(a) The following stages of program affiliation pertain: (1) interested person; (2) applicant; (3) candidate; (4) participant; and (5) alumnus. All persons affiliated with the program will be termed practitioners regardless of whether they provide direct patient care.

Full-Time and Half-Time Positions

(a) The department will designate either full-time or half-time contract-specified service at an eligible site. Through contract amendment, participation can be changed from full-time to half-time but not from half-time to full-time. There is no further sub-division of position size or prorating of payment. The practitioner may be a full-time employee but have only half-time program participation.

(1) For full-time participation, the practitioner will work at least 40 hours per week in at least one contract-specified site. The 40 hours per week may occur in no less than four days per week, with no more than 12 hours of work to be performed in any 24-hour period.

(2) For half-time participation, the practitioner will work at least 20 hours per week in at least one contract-specified site. The 20 hours per week may occur in no less than two days per week, with no more than 12 hours of work to be performed in any 24-hour period.

(3) The practitioner will provide at least 45 weeks of work in at least one specified location per service year. No more than seven weeks (35 work days) per year may be spent away from the practice for any reason. Absences greater than seven weeks in a contract year will extend the contract's end-date proportionately. Time spent on-call does not count toward the minimum number of hours required per work week. If the practitioner's submitted quarterly work report indicates that less

than the contract-specified service duration occurred during the quarter then that quarter's payment may be prorated. Hours worked in excess of the number of hours required for the minimum work week will not be applied to any other work week.

Position Type

(a) Both regular-fill and very hard-to-fill (VHTF) positions will be considered, and no others. The program provides contracts with higher support-for-service payment to practitioners who occupy VHTF positions than are provided to practitioners in regular-fill positions. The term very hard-to-fill is found in the definitions section.

Occupation Tier and Direct Patient Care

(a) The department will consider program-eligible disciplines as occupations that are direct patient care, not direct patient care, or both. A tier designation establishes the maximum annual payment benefit available for each occupation, which depends in part on the practitioner's delivery of direct patient care. In order for a position to be classified as direct patient care (DPC): (1) if the position is full-time then it must provide DPC at least 32 hours of a minimum 40 hours of work per week; (2) if the position is half-time then it must provide DPC at least 16 hours of a minimum 20 hours of work per week. All positions that are not direct patient care are classified as tier-3 occupations only. The council will periodically review, update and publicly announce the list of eligible occupations and associated tier designations. Those tiers and their maximum levels of benefit are:

(1) Tier-1 Payment

For tier-1 full-time positions, the maximum annual benefit is: Regular-fill, $35,000 per year, and for very hard-to-fill, $47,000 per year. Half-time participation has the maximum annual benefit of half these amounts, that is: Regular-fill positions $17,500; and very hard-to-fill positions $23,750.

(i) Licensed direct patient care physician (MD, DO), or pharmacist.

(ii) Licensed direct patient care dentist (DDS, DMD).

(iii) Licensed direct patient care physician (MD, DO), practicing as psychiatrist.

(2) Tier-2 Payment

For tier-2 full-time positions, the maximum annual benefit is: Regular-Fill, $20,000 per year, and for very hard-to-fill, $27,000 per year. Half-time participation has the maximum annual benefit of half these amounts, that is: Regular-Fill positions $10,000; and very hard-to-fill positions $13,500.

(i) Licensed direct patient care physician assistant, nurse practitioner, nurse midwife, nurse-RN, or physical therapist.

(ii) Licensed direct patient care registered dental hygienist.

(iii) Licensed direct patient care physician assistant, nurse practitioner, or nurse-RN, with psychiatric specialization, psychologist (Ph.D., PsyD, counseling or clinical), clinical social worker (LCSW), licensed professional counselor (LPC), board certified behavior analyst, or marriage and family therapist.

(3) Tier-3 Payment

For tier-3 full-time positions, the maximum annual benefit is: Regular-Fill, $10,000 per year, and for very hard-to-fill, $17,000 per year. Half-time participation has the maximum annual benefit of half these amounts that is: Regular-Fill positions $5,000; and very hard-to-fill positions $8,500.

(i) Other occupations employed in healthcare facilities that are not listed as a medical tier-1 or tier-2 licensed direct care occupations, as well as other non-licensed occupations, and non-direct patient care occupations.

(ii) Other occupations employed in healthcare facilities that are not listed as dental tier-1 or tier-2 licensed direct care occupations, as well as other non-licensed occupations, and non-direct patient care occupations.

(iii) Other occupations employed in healthcare facilities that are not listed as a behavioral health tier-1 or tier-2 licensed direct care occupations, as well as other non-licensed occupations, and non-direct patient care occupations.

Licensure for Tier-1 and Tier-2, and Tier-3

(a) The department will determine that occupational licensure must be issued by the Alaska Department of Commerce, Community and Economic Development, with the exception that if the practitioner works in a tribal health organization then

occupational licensure can be from any other state or territory. To be classified as either a tier-1 or tier-2 practitioner, the individual must hold a full and unencumbered professional license to practice healthcare delivery in that individual's stated discipline.

(b) Licensure for Tier-3

(1) The department will designate a tier-3 practitioner is an individual employed to work at a health-related facility, but for whom licensure is not required. Tier-3 also includes direct patient care occupations (1) that are not licensed, but that do require state-sanctioned certification, and, (2) those direct care occupations that require licensure in disciplines that are not included in tier-1 or tier-2 occupations. If an occupational license is required then the practitioner's license must be full and unencumbered.

Professional credentialing

The employer must conduct its own practitioner background checks by using health care professional credentialing processes including reference review, licensure verification, and a query of the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank. The program does not conduct any background checks, but instead relies on the employer for all vetting of practitioners.

C - Employer

Facility Eligibility

a) The department will designate a program-eligible employer as either a government entity, a private non-profit entity; or a for-profit entity. Solo and group practices will be allowed. Employer type is determined by reference to United States Internal Revenue Service document(s).

Employer Registration

a) For an employer to participate in the program it must register by submitting program-specified forms. The program shall review registration materials and, if approved, the program shall issue written conditional authorization. Upon issuance, the employer becomes an authorized registrant as regards that specified position.

b) In the employer registration form, the employer must present its most recent 12-month billing summary on a program-provided form, which indicates revenue from services to patients who (1) are uninsured; (2) receive or are eligible to receive medical assistance (Medicaid or Medicare coverage); or (3) receive or are eligible to receive other federal health program benefits.

Employer Recruitment Prerogative

a) An employer recruitment prerogative (ERP) exists once the employer is registered. This allows the employer to offer a support-for-service contract to interested persons who may be recruited. In order to receive this benefit, the practitioner must: (1) be identified as program-eligible; and (2) sign the program's standard service contract. The recruitment period concludes when the employer issues a letter of intent to hire dated no later than six months after the registration date. If the employer does not exercise the ERP within six months of registration then the option is canceled and the payment is forfeited.

Employer Location

a) Program-eligible employers may be located anywhere in the state. However, council is at liberty to distribute the opportunity for contracts according to a range of considerations including: (1) region of Alaska; (2) community; and (3) level of rurality. Employer eligibility does not depend on whether the locale has a federal Health Professional Shortage Area (HPSA) designation. However, the SHARP-1 component does require that practice sites do have HPSA designations.

(1) Program-eligible practice settings may include dental, medical or behavioral health facilities, or other facilities that are deemed by program to be entities within the state health system. These include: (A) clinics; (B) hospitals; (C) correctional facilities; (D) education institutions; (E) substance abuse treatment facilities; (F) disability service centers; and (G) community-based healthcare delivery locations such as those for homeless persons.

(2) Eligible employers shall provide services on a sliding fee scale or have a written charity care policy that provides for a free or reduced fee schedule basis to persons whose income is at or below 200 percent of the federal poverty level for Alaska. The definition of federal poverty level for Alaska is provided and updated annually by the United States Department of Health and Human Services and adopted by reference in 7 AAC 24.950. The employer shall submit a copy of its sliding fee schedule or charity care policy.

Employer Eligibility

a) Program-eligible practice settings may include dental, medical or behavioral health facilities, or other facilities that are deemed by program to be entities within the state health system. These include: (1) clinics; (2) hospitals; (3) correctional facilities; (4) education institutions; (5) substance abuse treatment facilities; (6) disability service centers; and (7) community-based healthcare delivery locations such as those for homeless persons.

b) For any employer to be program-eligible a minimum percentage [___] of its caseload must consist of underserved persons. That minimum percentage will be defined and announced annually by council during a publicly noticed meeting. An appeal process will be available for any employer who alleges that it has been erroneously excluded from program participation.

c) Eligible employers shall provide services on a sliding fee scale or have a written charity care policy that provides for a free or reduced fee schedule basis to persons whose income is at or below 200 percent of the federal poverty level for Alaska. The definition of federal poverty level for Alaska is provided and updated annually by the United States Department of Health and Human Services and adopted by reference in 7 AAC 24.950. The employer shall submit a copy of its sliding fee schedule or charity care policy.

d) The participating employer that provides healthcare services must accept patients covered by Medicare (section 1842(b) (3) (B) (ii) of the Social Security Act) for all services for which payment may be made under Part B of Title XVIII, and Medicaid. The employer will have established an appropriate agreement with the department to provide service to individuals entitled to receive Medicaid and Medicare benefits.

e) Participating employers will ensure that the practitioner charges for provided services at the usual and customary prevailing rates in the employer's area, except that if a service recipient is unable to pay such fee, that individual will be charged at a reduced rate (i.e., discounted sliding fee scale) or not charged any fee.

f) Non-tribal health entities will provide health services to any individual seeking care. The site shall ensure that the practitioner does not discriminate on the basis of the patient's ability to pay for such care or on the basis that payment for such care will be made pursuant to Medicare (established in Title XVIII of Social Security Act), or Medicaid (Title XIX of such Act).

g) Participating tribal health organizations shall ensure that the practitioner provides services to any individual seeking care that is also deemed eligible for services at the site under 25. U.S.C. 1680c. The site shall ensure that the practitioner will not discriminate on the basis that payment for care will be made pursuant to Medicare (established in Title XVIII of the Social Security Act), or Medicaid (Title XIX of the Social Security Act).

Site Representative

a) Each participating employer must designate one site representative who will serve as the principal point-of-contact between program and employer, and one person who can serve as an alternate representative as needed.

Recruitment and Retention Plan

a) Each participating employer must: (1) develop and maintain a practitioner recruitment and retention plan (R&R plan); (2) submit a copy of its R&R plan as part of employer registration; (3) update that plan as needed; (4) actively collaborate with program to improve the plan upon request; and (5) ensure that the plan includes policies and processes that the employer will use to recruit and retain staff.

b) The employer will state in writing that it is committed to practitioner retention for purposes of: (1) continuity of patient care; (2) retention of institutional memory; (3) stabilization of provider networks; and (4) continuity of healthcare practices. The employer must assert that there are virtually no reason(s) countenanced for the practitioner to change employers. The employer will agree that any change of employer by the practitioner must be approved in advance via signed contract amendment. If a practitioner departs from the employer, the program has no obligation to place another practitioner to have a replacement or any other contract(s).

D - Contributor

Employer Registration Statement

a) The employer will state on the registration form its commitment to: (1) submit any required payments to the specified fiscal agent; (2) participate in requesting funds from specified contributor(s); and (3) identify the amount of contributor funds required to fully resource the requested practitioner contract.

Contributor Types

a) Contributors may include: (1) private contributors; and (2) public contributors including federal, state and local governments. These may include: (1) hospital foundations; (2) private philanthropy; (3) regional Native for-profit entities; (4) trade associations; (5) labor unions; (6) program alumni and other individual donors; (7) universities; (8) community and advocacy groups and (9) other entities that council may deem eligible.

Contributor Funding

a) The amount of contributor payment is stated in contract, and specified quarterly payments are due upon receipt of invoice net 30 days. The contributor sends this payment directly to the fiscal agent.

Waiver of Contributor Payment

a) All contracts must be jointly resourced by the employer and another contributor to address total contract expense. All employers shall be asked to have another contributor pay at least 20 percent of total contract cost. However, the employer may submit a request for waiver, in which the employer asks to pay 100 percent of the total contract cost for expedience or other factors.

E – Fiscal Agent

Fiscal Agent

a) The fiscal agent (agent) will be a specified private non-profit entity that operates and maintains a specified funding account known as the multi-year operations fund (MYOF).

b) The fiscal agent (agent) will:

1) Be a 501(c3) non-profit organization;
2) Have a governing board of directors;
3) Entered into a memorandum of agreement with the department that establishes the duties of both parties;
4) Receive all employer payments and contributor payments to then be held in the specified MYOF account;
5) Receive and hold contributions for use in more than one fiscal year as needed;
6) Charge for its fiduciary work, which will consist of being a repository for and manager of funds received;
7) Draw its payment for the specified quarterly fiscal agent cost from the fund account, as specified by program;
8) Send to the program a monthly statement of available funds (SAFE), which will certify the sources, amounts and dates of all funds received; and
9) Pay the program the amount specified on the quarterly invoice.

c) The program will:

1) Receive the monthly SAFE statement of available fund. Funding is encumbered in an amount to allow issuance of service contract. This amount must include at least one full quarter's worth of total contract cost, and will be provided prospectively to the program by the employer and contributor(s). Council will refer to the SAFE statement making decisions as regards practitioner admittances.
2) Assess the capacity to issue new contract(s) based in part on the funds available;
3) Send a summary invoice to the fiscal agent each quarter, itemize charges on a per practitioner basis;
4) Send a single quarterly invoice to the agent for the assessed total contract cost, which is itemized by each participant;
5) Send endorsement of the specified quarterly total fiscal agent amount; and
6) Pay out the quarterly support-for-service benefit either directly to, or on behalf of, each participant depending on contract specification.

F - SHARP Council

Council Functions

a) Alaska's SHARP Council (council) shall provide guidance regarding any aspects of program including programmatic, budgetary, visibility or managerial consideration(s). Members may introduce any topic for agenda consideration. Council may issue formal recommendations about (1) policy or procedure; or (2) any practitioner-specific program admittance and participation. Council must formally review and recommend any and all practitioner(s) for admittance to program. The commissioner shall accept a recommendation of the advisory body on a matter pertaining to the identification and monitoring of healthcare shortages, eligible employers, payment priorities, program development or alteration, or program evaluation unless the commissioner finds, in writing, that the recommendation cannot be financially or otherwise supported by the department.

Membership

a) Council will have membership composed of up to 15 member organizations. A member organization can be any organization other than the department or its subunits. If there is a vacancy for any reason, the commissioner may appoint another organization to serve as member. Nominations for membership can be provided by any source. Each member organization shall appoint one representative and one alternate. In the event that a representative cannot participate then the member will assign its alternate to do so.

Officers

a) Council shall vote to select a chair and a vice-chair from within its voting membership. The chair and vice-chair shall continue to serve until a next election is held. Each officer's term of service is for one year. However, there are no term limits for the chair or vice-chair officer positions. Upon council vote, any officer can again fill the seat of chair or vice-chair. The council is at liberty to hold a vote of no confidence at any publicly noticed meeting, and if such a vote passes then the officer is removed from office.

Ex-Officio

a) Council may have any number of ex-officio seats, which are selected to help provide a greater understanding of healthcare system issues. Ex-officio members support the goals of the program and the work of council. Ex-officios are not voting

members, and must not participate in council votes regardless of issue. There can be no more than one ex-officio from any given organization, and in the case of the department this means from any given division.

Quarterly Business Meeting

a) Council shall meet at least quarterly in a business meeting, which is publicly noticed and is open to the public. Council is at liberty to meet more often than quarterly as determined by council consensus. All council business meetings that are conducted as committee of the whole will be publicly noticed. Business may include decisions to recommend given applicant(s) for receipt of service contract(s). Meeting notices will be served via at least the following routes: (1) the department public notices website; (2) the SHARP website's homepage; and (3) email notification to (a) all council representatives and alternates, and (b) all employer site representatives.

Council Retreat

a) Council may also choose to meet in retreat for extended, in-depth discussion of broad issues having possible longer-term consequences. These may be strategic planning sessions, and are not business meetings, and thus no formal actions are taken and no public notices will be issued.

Quorum

a) Each representative shall be in attendance at all publicly noticed council meetings, and at sub-committee meetings as called upon. Quorum is defined as two-thirds of the voting members or their respective alternates. A quorum is required to formally convene the council and conduct business. Council votes are determined by simple majority. Members who attend and vote via teleconference must identify themselves. Proxy voting is not allowed.

Committees

a) Council may establish component committees by council vote. Each committee will: (1) be tasked with a charter of duties; (2) be chaired by a council voting member; (3) be composed of individuals as determined by council vote, and can include persons who are not council members; (4) report findings and accomplishments to council through council chair; (5) have a sunset date, but can be re-initiated by council resolution.

Terms & Continuation

a) Council members will be appointed for staggered three-year terms. All members shall serve until a successor is appointed. An appointment to fill a vacancy will be for the remainder of an unexpired term. There are no term limits for the member organizations or for their representatives or alternates. The commissioner may terminate a member's service for the member's misconduct, bias, subverting the purposes of the program while representing the council; taking positions in the name of the council or program without the support of the council, or promising, without the support of the council, to support the positions or programs of other entities in the name of the council or program; failure to disclose a conflict of interest as specified here; or missing three consecutive meetings.

Conflict of Interest

a) A representative or alternate with a substantial financial interest in an official action must declare the financial interest and request to be excused from voting. The chair will make a final determination on a request by the individual to be excused from voting due to a conflict of interest. Council may override a ruling by the chair on a majority vote. If the chair determines that the individual has a conflict of interest, the individual must file a written disclosure form with the department describing the matter. Any such individual shall inform the chair of potential conflicts of interest valued at more than $5,000 annually if the interest is related to health care system income affecting the member or member's immediate family.

G - Program Process

Sequence

a) Program applications forms as provided by the department will remain continuously available. Completed applications will be accepted on an ongoing basis.

b) To be admitted the interested person will: (1) become an applicant by submitting program-specified application materials; (2) be endorsed by the respective current or prospective eligible employer; (3) be determined as eligible to participate; (4) become a candidate by being reviewed and recommended by council through a defined, publicly noticed, competitive process; (5) become a participant by being offered, and then fully signing the program's service contract; and (6) become an alumnus by successfully completing the terms of the service contract.

Application

a) In order to be admitted to program the practitioner must have submitted an application that is approved following initial program review. The review must ascertain that the practitioner has: (1) completed education or training requirements for the contract-specified occupation; (2) received occupational licensure or certification, if necessary, for the practitioner's occupation; and (3) either be currently employed at a program-eligible healthcare facility, or have received a program-eligible employment-offer. However, any individual may apply to program before these attributes are attained.

Prioritization and Selection

a) For an employer that has submitted more than one practitioner application for review, the program shall require the employer to provide a rank-ordered listing of its applicants according to preference for admission. Council shall use this rank ordering as one of the factors in its recommendations process. However, council decisions are not bound to the employer's rank-orderings since council may also consider other factors.

b) Council shall exercise its collective judgement as to applicant prioritization by taking into account a broad range of system and candidate features, as it determines relevant. Council may consider any of several factors in its deliberation including: (1) degree of rurality; (2) whether position serves clientele statewide; (3) size of position's anticipated workload; (4) candidate specialty; (5) occupation-mix of cohort; (6) practice-type and setting; (7) employer type; (8) type of facility; (9) level of social and medical need in catchment area(s); (10) number of participants at given sites; (11) whether applicants are new recruits or

retention candidates; or (12) other factors including (a) remoteness of site; (b) the percentage of underserved patients served; or (c) a combination of these.

c) Council shall review all applicants through a competitive process, conducted by the use of blind case-code in an open, publicly noticed council meeting. Review of applicants will yield rank-ordering of extant applications, and the positively reviewed applicants will be compared to available funds as indicated in the monthly statement of adequate funds.

d) Thereafter the council may issue recommendation(s), which it does so by conducting an on-record public vote. Council shall present its selection recommendation(s) as a final rank-ordered list of applicants via blind case code. The program will use this list to identify applicants who will then be offered a contract. Council will then issue its prioritized admittance recommendations. The department reserves the right to not accept any or all applications received and may solicit again for more applicants.

Contract

a) The applicant becomes a program participant by fully signing the program-offered service contract. The contract commits the practitioner to provide specified health-related services at specified site(s) for a stated duration of at least two years (24 consecutive months).

Quarterly Cycle

a) The participant shall fulfill specified quarterly requirements including:

(1) provision of specified services at specified healthcare location(s); and
(2) submission of a required quarterly work report (QWR) forms that document contract-specified services.

b) The program will perform the following quarterly requirements:

(1) issue a practitioner-specific payment voucher based on the practitioner's service contract and received quarterly work report. The voucher will state (a) issuance date, (b) practitioner's name and other identifiers, (c) specified quarter, and service dates, (d) regular full quarterly support-for-service payment, (e) calculated final amount to be paid, (f) paid to whom, and (g) from which funding source(s) the funds are drawn;

(2) submit an itemized quarterly invoice to the fiscal agent for payment to the program for calculated quarterly support-for-service payment, and related cost(s). The fiscal agent reviews and pays the invoiced amount to program;
(3) once the program receives the single quarterly payment sent by the fiscal agent, the program issues each specified practitioner payment.

H – Budget Process

Program Revenue

a) There are two types of revenue: (1) employer payment; and (2) contributor payment.

Program Expense

a) Total contract cost will be assessed for each practitioner's contract. Without exception, each total contract cost will have two components, and is the sum of: (support-for-service payment) and (total operating cost). Total contract cost for each practitioner will be resourced by: (1) the employer payment, which must not exceed 80 percent to total; and (2) the contributor payment, which must be at least 20 percent of total. Exceptions to this are granted, if at all, only on a per-case review basis, and upon written approval of the program. On the employer registration form, the employer will specify one or more contributor(s) that will make payments on its behalf.

Support-for-Service Payment

a) The support-for-service payment is the first of two components of the total contract cost. Support-for-service payments are paid by the program either directly to, or on behalf of, the practitioner, for the contract-specified amounts. The total possible support-for-service benefit is calculated as: (maximum annual support-for-service benefit) times (number of contract-specified years). The maximum annual support-for-service payment is determined by: (1) practitioner's occupation categorized as tier-1, tier-2 or tier-3; (2) whether participation is full-time or half-time; and (3) whether position is regular fill or very hard-to-fill.

b) The program issues support-for-service payments only once per quarter. Each payment occurs only after receipt of the practitioner's approved quarterly work report. The maximum quarterly benefit is equal to (maximum annual support-for-service payment) divided by (the number of contract-quarters.) If the quarterly work report shows that the practitioner served less than the contractually agreed upon full work-quarter, then the practitioner's quarterly payment will be prorated.

Benefit Type

a) There are two types of support-for-service benefit payments available: (1) education loan repayment (LRP); (2) direct incentive; or (3) both loan repayment and direct incentive. If the benefit-type is LRP then the payment is sent on behalf of the practitioner directly to the lender or loan holder. If the benefit is direct incentive, then payment is sent directly to the practitioner.

b) If the contract specifies the benefit type as LRP only, and the total amount of eligible debt is less that the total possible support-for-service, then the program will pay up to only the total amount of eligible debt owed, as presented by the practitioner in initial application. If the contract specifies that the benefit is to consist of both the LRP and direct incentive, then the program may pay up to the total possible support-for-service payment benefit. The sum of loan repayment and direct incentive must not surpass the established total possible support-for-service benefit.

Total Operating Cost

a) The total operating cost is the second of two components of each practitioner's total contract cost. For each contract, the total operating cost is equal to 6.5 percent or less of the support-for-service payment. The total operating cost has two components: (1) the program management cost; and (2) the fiscal agent cost. The program management cost is equal to 5 percent or less of the support-for-service payment. The fiscal agent cost is equal to 1.5 percent of the support-for-service payment. The council will re-determine and announce the amount of total operating cost at least annually.

Employer and Contributor Payments

a) The amount of employer payment is stated in contract, and specified quarterly payments are due upon receipt of invoice net 30 days. The employer sends this payment directly to the fiscal agent. The amount of contributor payment is stated in contract, and specified quarterly payments are due upon receipt of invoice net 30 days. The contributor sends this payment directly to the fiscal agent.

Level of Employer Payment

a) There are three levels of employer payment allowed and each one has an associated inverse level of contributor payment. The assigned level of employer payment depends on: (1) employer type; (2) employer's size; and (3) the employer's annual revenue. These levels are:

    1) Contract-A is available to all healthcare employer types and is the default expectation, and it is the only option for for-profit entities. In contract-A, the employer pays 80 percent and the contributor pays 20 percent.

    2) Contract-B is available only to employers: (a) that are either a public or private non-profit entity; and (b) that submit a request for partial waiver of employer payment portion, which is approved; and (c) that employer-provided documentation

shows that: (i) more than 50 percent of the entity's patients are underserved, or at least 50 percent of the agency's revenue comes from patients who are underserved; and (ii) the entity has under $5 million in annual revenue or (ii) less than 15 percent of the total of annual reimbursements and revenue to the entity is from insurance, philanthropic grant money, private payers, or other private sources. In contract-B, the employer pays 50 percent and the contributor pays 50 percent.

3) Contract-C is available only to an employer that: (a) fulfills the requirements described for contract-B; (b) demonstrates an inability to pay 50 percent cost of specified in contract-B; and (c) submits a request for partial waiver of employer payment, which is approved in writing by the commissioner. In contract-C, the employer pays 20 percent and the contributor pays 80 percent.

Other Stipulations

a) Other financial and budget stipulations include:

1) Quarterly Invoice: The quarterly invoice will specify employer payment amount, and contributor payment amounts.

2) Quarterly or Bulk Payments: Both employers and other contributors may submit payments on a quarterly invoice, either as invoiced quarterly or in advance via bulk payment.

3) Payment is Not Refundable: Payments from either employers or other contributors are not refundable.

4) In-Kind Payment Disallowed: Employer payments and contributor payments must be paid in cash. In-kind donations will not serve in lieu of specified cash.

5) Employer and Contributor Payments: All employer and contributor payments shall be sent directly to the fiscal agent, which will duly account for all received funds and provide monthly statement of such to program.

6) Breach due to Non-Payment: The program will not make further payments to, or on behalf of, the practitioner until the contributor pays previously invoiced amount(s). Repeated late payment or non-payment will constitute breach of contract, and the employer will then be classified as not eligible for further program participation.

7) Program Receipt of Funds from Fiscal Agent: The program shall send a quarterly invoice to the fiscal agent that specifies the employer and contributor amounts to be sent to program.

8) Quarterly Payment Required: The program must first receive invoiced quarterly payment from the fiscal agent before the program will issue quarterly practitioner payment(s). Participation is disallowed if the employer or the contributor cannot or will not pay specified portion(s) of the practitioner's total contract cost. If these payment(s) do not occur, then this may constitute a breach of contract.

9) Reduction of Wage and Benefit: The employer will not reduce any portion of the practitioner's wage and employer-provided benefit because of either: (1) the practitioner's receipt of program benefit, or (2) the employer payment to program. If said disallowed reduction does occur, then both the site representative and practitioner must immediately report this reduction to the program. Evidence of such reduction may constitute a breach of contract.

10) Tax Exemption of Benefit: Only loan repayment is exempted from federal personal income taxation, whereas direct incentive is considered taxable income.

11) Practitioner Payment Schedule: The department may not make a support-for-service or direct incentive payment before the completion of a calendar quarter for which the support-for-service or incentive payment is made. Under no circumstances will payment be made for service that has yet to occur.

12) Funds Not Available: If sufficient funds are not available, then specified service contract awards will not be issued. If service contract(s) have been issued, but there then occurs insufficient funding, the program is at liberty to cancel those contract(s), making them void. Cancellation of contract occurs with 30-days written notice. Alternatively, payments may be prorated to adjust to the amount of funding which is still available.

13) Budget Monitor: The department will establish and maintain a budget monitoring system for all extant and projected revenues and expenditures. The department will provide periodic budget reports including those requested by Council and any funder entities. Budget monitoring will separately identify any funds received to resource program administration.

I - Contract

Service Contract

a) The program shall provide a standard service contract, which is the formal agreement between the practitioner, employer, contributor and program. In order to actuate the agreement, all specified parties must sign the service contract, which will set an effective date.

Contract Period and Contract Amendment

a) The service contract will specify its duration, which will be no less than two years (24 consecutive months). If there is a break in service due to an approved suspension then the remaining required service time is resumed upon the practitioner's return to full-time or half-time program-eligible work. In that case, the contract's service end-date is extended to compensate for the break in full-time or half-time service. Only the contract amendment process provides approval for any service suspension. Amendments do not cancel the contract, but rather only revise by stating newly agreed upon terms.

Concurrent Service Obligation

a) The participant must not have any other support-for-service obligation such as education loan repayment or service option loan(s) at any time during the contract period. The exceptions to disallowance of concurrent service obligation include: (1) the reserves of the United States Army, Navy, Air Force, Marine Corps, or Coast Guard; (2) the National Guard; or (3) the Commissioned Corps of the United States Department of Health and Human Services, Office of the Surgeon General, Public Health Service.

b) The program does allow for the employer to provide to the practitioner various other ancillary employment benefits, such as signing bonuses, service-option loan(s), moving expense agreement(s), productivity bonuses or similar financial benefit(s) that entail a service obligation. This does not include education loan repayment from any source except that which is specified above, which is concurrent with program's contract benefit.

c) The participant must accurately and immediately report if there is a concurrent service obligation. If incurred, the participant and the employer must each immediately declare in writing to program the occurrence of the concurrent service obligation. Regarding the concurrent non-program service obligation, the practitioner may seek either (1) written release of that service obligation, or (2) deferral of that service obligation. If release or deferral is not accomplished, then having the concurrent service obligation(s) will constitute breach of contract and default.

Miscellaneous Provisions

a) Governing Law: The contract will be made and entered into in the State of Alaska and will in all respects be interpreted, enforced, and governed by and according to the laws of the State of Alaska.

b) Non-Party Beneficiaries: The service contract is not intended to confer any benefits on any non-party.

c) Severability: If any portion of the service contract is found to be invalid by a court of competent jurisdiction, such invalidity shall not affect the remainder of the contract.

d) Complete Agreement: The service contract constitutes the entire agreement between the parties. The service contract may be amended or terminated only pursuant to terms stated in the contract.

e) Force Majeure: No party shall be liable or have the right to terminate the contract for any delay or default in performing hereunder if such delay or default is caused by conditions beyond the party's control including, but not limited to Acts of God, government-imposed restrictions, wars, insurrections or any other cause beyond the reasonable control of the party whose performance is affected**.**

f) Retention Commitment: The practitioner and the employer will formally assert that each understands that one of the main public policy reasons for the program is to enhance practitioner retention. The purpose is to increase: (a) continuity of patient care, (b) retained institutional memory, (c) stabilization of provider networks, and (d) continuity of healthcare practices. The practitioner will recognize that there are virtually no reason(s) countenanced by SHARP for the Practitioner to change from working at one site to working at another, and will agree that the duration of commitment to practice at the site is for at least two years.

g) Change of Employer: Any potential change-of-employer by the practitioner must be approved in advance, via a fully-signed contract amendment. If the change of employer occurs with an authorized contract amendment then that may constitute a breach of contract, which is one of the grounds for default.

h) Contract Amendment: Amendment is the formal revision of a previously executed service contract. Such revisions can be made for varied reasons (e.g., Family Medical Leave, military service call-up, continuing education training, etc.).

i) Dependent Upon Available Funds: The contract shall remain in effect for two years (24 months), dependent upon the availability of funds. If funds cease to be available to program, as determined by the fiscal agent's statement of adequate funds (SAFE), then the program will void the practitioner contract upon 30-days' written notice.

j) Practitioner Conduct or Death: If the practitioner engages in unethical or illegal conduct inconsistent with the standards governing the practitioner's occupation, the department will have grounds for immediate termination of this agreement. This is one of the types of breach of contract that causes default. In addition, the contract may be terminated immediately upon the death of the practitioner.

k) Default & Damages: A practitioner who fails to begin or complete his or her program service obligation or otherwise breaches the terms and conditions of the contract will be in default of this contract and liable for damages. In addition, the remaining planned but yet-to–be-distributed balance of contract's funds will not be paid to or on behalf of the Practitioner. The following will also occur: (1) the practitioner will be recorded as having left program in the status of "not in good standing;" (2) the practitioner will be recorded as having defaulted on the contract; (3) the program may report this contractual default status to future or potential employer(s) or other support-for-service program(s) regardless of whether those program(s) are state, federal, private or blended; and (4) the practitioner will be barred from future participation in the program or any similar department program.

l) Suspension: A suspension of the practitioner's contract obligation may be granted, with a typical duration of either one or three months, but no more than one year. In order to qualify for a suspension (also known as hiatus), the practitioner must document a medical condition or personal situation that makes compliance with the obligation temporarily impossible or an extreme hardship such that enforcement would be against equity and good conscience. Granting of a suspension is wholly at the discretion of the program. Suspension is granted through issuance of a jointly signed contract amendment.

m) Waiver: In order to qualify for a contract waivers (also known as cancellations), the practitioner must document a medical condition or a personal situation that makes compliance with the obligation permanently impossible or an extreme hardship such that enforcement would be against equity and good conscience.

n) Termination in Best Interests of State: The department, by written 30-day notice, may terminate the contract for convenience, in whole or in part, when it is in the best interests of the State. The State is liable only for support-for-service in accordance with the repayment provisions of the contract for services rendered before the effective date of termination.

o) Notice-to-Quit: The employer must immediately provide written notification to the program if the practitioner's employment at the employer has ended and (1) state the last date of full-time or half-time clinical work, and (2) clearly and succinctly state the specific reason(s) as to why the employment has ended. The program has no obligation whatsoever to fill or re-fill that position, or any position at the vacated site.

p) No-Quit Clause: Once the contract is executed, the practitioner must provide specified healthcare service through to agreed-upon end-of-contract. Pre-mature departures from contract-specified service or unauthorized transfer to another employer are disallowed, and are identified as breach-of-contract, and thus grounds determination of default.

q) Continuation Award: Continuation contracts (also known as renewals) are allowed for a practitioner to be awarded an ensuing service contract after the first contract is completed. However, the receipt of an ensuing contract only occurs through the standard competitive council process. In order to receive an ensuing contract, the practitioner must again apply to program, and the application will then be reviewed along with any others, including new applicants.

r) Federal & State Law: The employer will agree to comply with all applicable federal and state law.

Monitoring and Records

a) The program will conduct ongoing program monitoring and periodic evaluation, dependent upon available funds. The employer will maintain clinical and employment documentation for audit purposes, and upon each and any request, will actively cooperate with, and directly discuss presented issues with, program staff or designee(s) in program evaluation.

b) Participating employers and practitioners will submit quarterly work reports (QWRs) on program-specified forms. The QWR details the practitioner's service during the specified contract quarter. The QWR documents that: (1) the service actually occurred; (2) at the specified location(s); (3) for the specified populations; and (4) in what quantity. The provided data must not contain any information that identifies individual service recipients.

c) The program may use varied approaches to assessing the occurrence, magnitude, productivity, quality and endurance of the program's impact on healthcare practitioner supply, capacity, distribution, recruitment, retention, and turnover.

J - Loan and Lender

Loan Eligibility

a) For the participant to receive the loan repayment benefit: The loan(s) and lenders (or loan holders) of such loan(s) must (1) meet eligibility and priority criteria established here; and (2) the loan(s) must not be (a) consolidated with any other loan that is ineligible for repayment; or (b) refinanced as a loan that is not eligible for repayment. The participant must have a verifiable unpaid balance on one or more eligible education loans described in this section.

Payment to Lender

a) Program loan repayments will be sent directly to eligible lenders or holders of eligible education loan debt, which are paid on behalf of the participant in exchange for documented delivery of eligible health-related services.

Federal Tax Exemption

a) Program-provided loan repayments are exempt from federal personal income taxation. Federal law (PL 111-148, Sec 10908) indicates that in the case of an individual, gross income shall not include any amount received under any state loan repayment program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by such State). Loan repayment is exempt from federal personal income tax; however, direct incentive payment is considered taxable income.

Qualifying Loan

a) Education loans that are eligible for potential repayment by program include only commercial and government loans. These are loans made to the practitioner for the actual costs paid for tuition and reasonable educational and living expenses related to education of the practitioner leading to a degree in an occupation in which the practitioner will satisfy the service commitment.

Loan Consolidation

a) Consolidation of eligible education debt is allowed, and typically occurs when the individual has several education loan debts, wherein some of those have high interest rates. To be program-eligible, the education loan debt must not be consolidated or combined with any other expenses or loans that are disallowed.