

# CMS Rural Health Transformation Program (CMS-RHT-26-001) Response: **State of Alaska**

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## **Project Narrative**

### **A. Rural Health Needs and Target Population**

#### **Alaska's Geography**

Alaska is geographically isolated from the rest of the United States and is exceptional in both its scale and environment. With a total land area spanning over 570,000 square miles, it is the largest U.S. state, accounting for more than 16% of the nation's total territory.<sup>1</sup> Despite this vast expanse, Alaska is the third smallest state by population with approximately 733,000 residents and has by far the lowest population density in the country.<sup>2</sup> If Washington, D.C. had Alaska's population density, it would have about 80 residents, or would need to cover more land than California and Texas combined to be equally sparse.

Alaska's geographic scale, extreme climate, and widely dispersed population pose unique challenges to health care access that are fundamentally different from those faced in the Lower 48 states. Solutions developed for rural areas in other states often presume year-round road access, denser population hubs, and more stable communication networks; assumptions that do not hold true in frontier Alaska. At the same time, these very constraints have cultivated a culture of innovation and self-reliance that defines Alaska's approach to rural health.

#### **Alaska's People**

Alaska has the highest proportion of Alaska Native or American Indian (AN/AI) people (21.9%) of any other state and is home to 229 of the 574 recognized Tribes in the U.S.<sup>3</sup> This population is concentrated in remote and frontier communities where cultural traditions and Indigenous knowledge are central to daily life. Subsistence hunting, fishing, and gathering are integral to AN/AI people's way of life.<sup>4</sup> Wild subsistence foods are healthier and more economical

than processed store-bought foods, which must be shipped into rural communities at great expense.<sup>5,6</sup>

Alaska's 29 boroughs and census areas are organized across six major geographic regions. The majority of Alaskans reside near the Municipality of Anchorage and the Matanuska-Susitna Borough, which together account for over half of the state's population.<sup>7</sup>

Even Juneau, the state's capital, has just 31,500 residents and is considered rural. Overall, more

than 30% of Alaskans live in small, remote villages and hub communities, often fewer than 1,000 people.<sup>8</sup>

Rural Alaskan communities generally experience higher rates of poverty and unemployment, along with lower average education levels compared to Anchorage. Employment rates in rural areas often vary significantly with seasons (commercial fishing, tourism, mining), and population sizes can double or triple during summer.<sup>9,10,11</sup> Major employment sectors in Alaska include health care, Tribal corporations, commercial fishing, transportation, and retail.<sup>12,13</sup> Construction and mining also contribute notably to job growth. The statewide unemployment rate ranges from 1.6% to 19.6%, with greater fluctuation in rural areas.<sup>14</sup> Over the last decade,



**Figure 1. Village Snapshot.** Kivalina (Kivaliniq in Iñupiaq) is a traditional Iñupiat village on Alaska's northwest coast, off the road system, without running water or sewer, and powered by diesel generators. The 400 residents rely on planes and barges for fuel, food, and medical supplies. Building availability is limited, and many homes are overcrowded with multigenerational families. If the village clinic cannot meet a health care need, residents will travel 80 miles to the hub community of Kotzebue by plane, boat, or snowmachine. Kivalina is the only whaling community in the region, with a culture rooted in subsistence activities. The surrounding Chukchi Sea is frozen from November through June.

Alaska’s unemployment rate has been consistently above the national average, and the poverty rate remains elevated at 18.5% in rural areas, compared to 11.2% in urban areas.<sup>15</sup> The cost of living is 24% higher than the national average, driven by Alaska’s geography, extreme weather conditions, and infrastructure challenges.<sup>16</sup> For example, the price of a gallon of milk can reach \$20 in frontier areas in winter months, over four times the national average.<sup>17</sup>

Alaska boasts a remarkably high military-affiliated population; veterans make up about 10% of the adult civilian population in the state, the highest rate among all states.<sup>18</sup> The state also has a strong active military presence, which is likely to grow due to Alaska’s strategic location amid rising geopolitical tensions.

Although Alaska’s population is younger than the U.S. average, the state’s population is aging rapidly.<sup>19</sup> Additionally, Alaska has experienced outmigration for over a decade: the working-age cohort (18–64) has shrunk by 13% or over 34,000 people since its peak in 2013, and these trends are expected to continue.<sup>20</sup> This dual dynamic (fewer working-age people and rapidly growing senior population) has significant implications for the state’s health system.

### Alaska’s Physical Infrastructure

Delivering health care in Alaska’s remote communities requires extensive resources and logistical planning due to geography, weather, and infrastructure limitations.

Approximately 82% of Alaska’s



**Figure 2. Alaska Tribal Health System Referral Patterns.**

communities lack road connections (see *Supporting Document A*), relying on small planes, ferries, or snow machines, with only 35% of roads paved.<sup>21,22,23</sup> Even Juneau, Alaska’s capital city, has no road link to the mainland. Travel across the state often involves multiple flights or transport modes, with routes from villages to hub towns to Anchorage requiring several flights, often with limited frequency.<sup>24</sup> For example, a person traveling from Kobuk to Anchorage may fly 150 miles to Kotzebue on a nine-passenger aircraft, often with multiple weather-dependent stops, before taking one of the two daily 1.5-hour commercial jet flights covering the remaining 547 miles to Anchorage. Utqiagvik, located on the Arctic Ocean, is 725 miles from Anchorage. Limited transport options increase costs for essential items and complicate infrastructure maintenance.<sup>25,26,27</sup> Housing conditions are also strained, with an estimated 7,000 new housing units needed over the next decade to

address overcrowding.<sup>28</sup> Alaska’s rural areas also face some of the most severe infrastructure challenges in the nation.

Over 200 rural communities have inadequate access to basic water and sanitation services, and over 3,300 year-round occupied homes lack piped

water.<sup>29,30,31</sup> In the absence of plumbing, many rural Alaskans rely on “honey buckets,” containers lined with a disposable plastic bag, which are emptied into local sewage lagoons. The lack of adequate water and sewer infrastructure causes significant health issues for rural Alaskans, including severe skin infections.<sup>32</sup> In many communities, communal “washaterias” serve as the



**Figure 3. Village Infrastructure.** Many residents of Stebbins, Alaska use washaterias (left) and honey buckets (right) for water and sanitation needs. This is common infrastructure in remote Alaskan communities.

sole access point to showers, laundry, and potable water. However, these facilities are vulnerable to power outages, funding gaps, and mechanical failures, which can leave rural Alaskans without access to safe water or hygiene for extended periods.

Internet connectivity is costly, limited, and unreliable due to vast distances and weather. Over the past few years, multiple undersea fiber-optic cable breaks have further disrupted internet and cellular service for weeks or months.<sup>33</sup> Satellite internet has recently improved internet access, presenting new opportunities in rural communities, but capacity remains limited.<sup>34</sup>

Alaska’s Tribal Health System

The Alaska Tribal Health System (ATHS) is the backbone of rural health in Alaska. Embodying innovation, resilience, and partnership, the ATHS is a diverse, multifaceted, and statewide network that provides integrated, culturally appropriate care across 229 federally recognized Tribes and 586,000 square miles of predominantly roadless terrain.<sup>35</sup> The table below summarizes the services and facilities within the ATHS network. A full list of Indian Health Service (IHS) facilities in Alaska is in *Supporting Document B*.

**Table 1. The Alaska Tribal Health System (ATHS) Network**

Facilities	Services
<ul style="list-style-type: none"> <li>• 70 regional clinics and health centers</li> <li>• 193 village-based clinics</li> <li>• 93 behavioral health and substance use treatment facilities</li> <li>• 8 hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Primary medical care</li> <li>• Specialty care and professional support services</li> <li>• Dental and oral health</li> <li>• Behavioral health</li> <li>• Preventive wellness programs</li> <li>• Health research</li> <li>• Health education for rural primary care</li> <li>• Public health community infrastructure</li> </ul>

Alaska has long been a national leader in using telehealth and innovative care models to bridge vast distances and maintain continuity of care. In 1999, Alaska established a statewide



**Figure 4. ATHS Telehealth.** Community Health Aide/Practitioner using an Alaska Federal Health Care Access Network telemedicine cart.

Tribal telehealth network, connecting more than 200 sites and setting an early example for the nation.<sup>36</sup> Telehealth expanded substantially during COVID-19, reducing travel burdens and increasing access to care for remote and frontier Alaska communities.<sup>37</sup> Alaska's rural health strategy presents opportunities to build on the state's early innovation and strengthen the state's

capacity to deliver telehealth and virtual care with satellite connectivity.<sup>38</sup>

The strength of Alaska's health system lies in its partnerships and long-standing collaboration across Tribal, state, local, and community entities. Over time, shared planning and integrated service delivery have built a strong foundation for coordinated care across the state. As an example, proven models such as the Community Health Aide/Practitioner (CHA/P), Behavioral Health Aide/Practitioner (BHA/P), and Dental Health Aide Therapist (DHAT) programs were pioneered by ATHS to train local residents to deliver frontline care.<sup>39,40</sup> These models have been successfully replicated in parts of the Lower 48 as models of sustainable, culturally grounded rural health delivery.<sup>41,42</sup>

Alaska is uniquely positioned to design transformative solutions tailored to frontier and rural conditions. If a health innovation works in Alaska, it can succeed anywhere. Alaska's distinctive challenges create opportunities to advance new, scalable models nationwide.

## Alaska's Health Care System

### *Access and Availability Challenges*

- **Rural service reductions:** Over the past two decades, several rural hospitals have discontinued labor and delivery services, leaving only eight of the 13 rural critical access hospitals (CAHs) with such services.<sup>43</sup> Behavioral health programs have also been reduced or are insufficient, forcing patients to travel or temporarily relocate to access care.<sup>44</sup>
- **Geographic and emergency access barriers:** Many residents must travel hundreds of miles to reach the nearest hub hospital to access specialty care, and delays due to weather or transportation often extend travel to multiple days.<sup>45</sup> The “golden hour” standard for emergency response is rarely achievable. Alaska relies heavily on medevac and emergency medical services (EMS), including 69 state-certified and 50 non-certified agencies across seven regions with limited coordination.<sup>46</sup>
- **Limited specialty and inpatient capacity:** Alaska lacks a Level 1 trauma center and a dedicated burn center.<sup>47,48</sup> The state has only one neonatal intensive care unit (NICU), a single stand-alone psychiatric hospital, no intermediate care facilities, and there are no acute dialysis centers off the road system.<sup>49,50,51,52</sup> Organ transplants are not performed in-state, there is no capacity for extracorporeal membrane oxygenation (ECMO), and limited availability of pediatric subspecialists.<sup>53,54,55</sup>
- **Dependence on out-of-state care:** Patients requiring advanced or highly specialized services are often referred to hospitals in the Pacific Northwest, primarily Seattle, WA.<sup>56,57,58</sup>
- **Limited primary care access for seniors:** Many primary care providers limit how many Medicare patients they can accept due to low reimbursement rates.<sup>59</sup>

- **Limited long-term care access:** Long-term services and supports are scarce, particularly in rural areas. Elders often must travel hundreds of miles from their home communities or move to urban centers for care. Alaska has only 20 skilled nursing/long-term care facilities.<sup>60,61</sup>
- **Severe workforce shortages:** All communities in Alaska have one or more Health Professional Shortage Area (HPSA) designations for primary, dental, or behavioral health care, and most rural areas experience high staff turnover and rely on temporary workers.<sup>62,63</sup>

### *Financing and Payment Challenges*

- **Fragmented financing and payment structures:** Alaska’s health system operates under multiple reimbursement models. Tribal hospitals and clinics are largely reimbursed using encounter rates established by IHS and other federal agencies, while most other providers are paid on a Fee-for-Service (FFS) basis.<sup>64</sup> Alaska’s Medicaid program, like most insurance plans in the state, functions entirely under an FFS model with no managed care organizations, state-directed payments, or provider taxes.<sup>65</sup> The FFS payment model is unsustainable for low-volume, low-margin rural and frontier hospitals.
- **Limited adoption of managed care or value-based models:** Alaska’s small population and rural geography limit sustainability of risk-based payments. As a result, adoption of managed care or value-based care models is minimal, with only one Medicare Accountable Care Organization (based in Anchorage) and no Health Maintenance Organizations.<sup>66</sup>
- **No Medicare Advantage (MA) plans:** Alaska is the only state without MA plans, due to a small market, limited infrastructure, and network adequacy challenges.<sup>67</sup>
- **Limited local public health authority:** Alaska has no county-level governments.<sup>68</sup> Only two boroughs (Anchorage and North Slope) exercise very limited health authority.<sup>69</sup> Public health

responsibilities are largely administered by the Alaska Department of Health (DOH) and coordinated with Tribal and regional health entities.

- **Reliance on Medicaid and Tribal care systems:** Alaska's relatively small commercial insurance market means much of the state depends on Medicaid for coverage.<sup>70</sup> Tribal Health Organizations (THOs) deliver much of the direct care for AN/AI people, and often serve all residents in rural areas.<sup>71,72,73</sup>
- **High operating costs and low patient volumes:** Rural hospitals face severe financial strain from low patient volumes and high operating costs, with expenses 58% above the national average and rural hospital occupancy averaging 34 to 36% (national average, 59%).<sup>74,75</sup> Amongst Alaska's 26 hospitals, three are sole community hospitals, 13 are CAHs, and eight are Tribal. Several hospitals operate with negative margins, one has closed since 2015, and three are at risk.<sup>76,77</sup>
- **Aging and outdated infrastructure:** Many health care facilities are aging and require extensive modernization.<sup>78</sup>
- **Dependence on federal and state funding:** Rural hospitals rely heavily on Medicaid and Medicare, which cover over 60% of inpatient discharges (31.4% Medicaid, 30.6% Medicare).<sup>79</sup>

#### Challenges to be Addressed by Alaska's RHTP

- **High burden of chronic disease:** Nearly 75% of adults have chronic conditions, with obesity rates nearly tripling since 1991 and diabetes affecting over 8%, driving disability and high health care costs that necessitate investments in prevention, primary care, and long-term care services.<sup>80,81,82,83</sup>

- **Poor maternal and infant health outcomes:** Maternal and infant health outcomes are below national averages, particularly for AN/AI and rural populations.<sup>84</sup>
- **Mental health crisis and high suicide rates:** Mental health conditions affect about 20% of adults and 75% of youth, 80% of whom have unmet needs.<sup>85</sup> The state’s suicide rate is more than twice the national average, disproportionately impacting AN/AI and rural youth.<sup>86,87</sup>
- **Substance misuse and related harms:** Drug overdose death rates in Alaska are consistently among the highest in the country.<sup>88</sup> Between 2022 and 2023, drug overdose death rates in Alaska increased by 47% overall, and Alaska ranked sixth in the US.<sup>89,90</sup>
- **Severe workforce shortages:** All communities in Alaska have one or more HPSA designations for primary, dental, or behavioral health care. Recruitment and retention difficulties are exacerbated by low patient volumes and high turnover.<sup>91,92,93,94</sup>
- **Infrastructure, broadband, and interoperability gaps:** Infrastructure limitations include aging facilities, poor broadband connectivity, and limited data-sharing capacity, which hamper access and care coordination despite Alaska’s telehealth advancements.<sup>95,96,97</sup>
- **Fragile financial conditions and outdated payment models:** Many rural hospitals and clinics operate with small margins, high fixed costs, and outdated FFS reimbursement.<sup>98</sup>
- **System modernization and transformation needs:** Modernizing Alaska’s health system, strengthening workforce pipelines, expanding technology and data capabilities, and ensuring culturally appropriate care are essential steps to address Alaska’s interconnected challenges.<sup>99</sup>

## Target Populations for Alaska's RHTP

The chart below identifies Alaska's key rural target populations for health system transformation, each characterized by significant gaps in access, prevention, or care. For purposes of Alaska's RHTP, all communities outside Anchorage are considered rural. HRSA's county-based method designates Fairbanks North Star and Matanuska-Susitna Boroughs as non-rural, but this doesn't fit Alaska's geography – Matanuska-Susitna is larger than West Virginia, has 18 times fewer people per square mile, and only one hospital. Because Alaska lacks counties, its boroughs and census areas do not align with HRSA's metrics. However, under an alternative HRSA definition (non-metropolitan statistical areas with populations under 50,000), all of Alaska except the Municipality of Anchorage would qualify as rural.<sup>100</sup> In addition, the HRSA methodology does not adequately take into account the fact that over 80% of Alaska's communities are off the road system. HRSA uses the Road Ruggedness Scale, which merely measures how level or rugged the roads are rather than accounting for the absence of roads altogether.<sup>101</sup> Most parts of California are ranked as more rugged than Alaska (for example, despite not being connected to the road system, and with only 2.8 people per square mile, Nome is ranked equally rugged as Sacramento, with 6,029 people per square mile). For these reasons, Alaska's RHTP designates every community outside of Anchorage as rural. While the focus is on rural communities, improvements in infrastructure, access, and outcomes will benefit all Alaskans statewide.

AN/AI people are a central focus throughout the initiatives due to their unique historical and cultural representation. AN/AI health priorities are integrated as a cross-cutting theme across all population strategies. AN/AI residents face significant health challenges, including high-risk pregnancies; youth lacking access to culturally appropriate screenings, behavioral

health, and Traditional Healing services; and high chronic disease rates among adults with limited disease management and healthy lifestyle support.

Dually eligible Alaskan seniors experience higher institutionalization risk and lower life expectancy with limited culturally appropriate services. Additionally, Alaskans with complex needs experience inconsistent care coordination and scarce wraparound programs, underscoring the need for targeted, culturally appropriate interventions.

**Table 2. Target Populations**

Target Populations for Alaska’s RHTP
<p><b>Pregnant and Postpartum Women in Rural Communities</b></p> <p><u>Population baseline:</u></p> <ul style="list-style-type: none"> <li>• Pregnancy-associated mortality rate in rural Alaska increased by 184% (2012–2021); rural AN/AI women mortality rate is 307 per 100,000 live births versus 55 per 100,000 for white women (2023).<sup>102</sup></li> <li>• Infant mortality rate of 6.1 per 1,000 live births and 64% higher among AN/AI births.<sup>103</sup></li> </ul> <p><u>Population needs:</u></p> <ul style="list-style-type: none"> <li>• Expanded access to comprehensive prenatal and postpartum care in rural, remote, and frontier regions to improve maternal and infant outcomes.</li> <li>• Integrated maternal behavioral health and substance use treatment into family health settings to ensure early identification and management.</li> <li>• Strengthened postpartum support programs to promote healthy infant development and maternal wellness.</li> </ul>
<p><b>Underserved Children and Youth in Rural Alaska</b></p> <p><u>Population baseline:</u></p> <ul style="list-style-type: none"> <li>• Children make up 24% of Alaska’s population.<sup>104</sup></li> <li>• 28% of children live below 200% of the federal poverty level; 13% are uninsured or underinsured.<sup>105</sup></li> <li>• 19% of Alaska children have special health care needs; only 39.9% receive care in a medical home and 19% lack a usual source of care.<sup>106</sup></li> </ul> <p><u>Population needs:</u></p> <ul style="list-style-type: none"> <li>• Improved access to coordinated preventive, dental, and behavioral health services.</li> <li>• Expanded access to consistent care aligned with child development milestones.</li> <li>• Expanded access to nutrition programs addressing food insecurity and teaching healthy eating habits.</li> <li>• Delivered behavioral and preventive services where children and adolescents can easily access them.</li> </ul>
<p><b>Alaskans with Behavioral Health and Substance Use Disorders (BH/SUD) in Rural Communities</b></p> <p><u>Population baseline:</u></p> <ul style="list-style-type: none"> <li>• Less than half of youth ages 12–17 receive needed SUD treatment.<sup>107</sup></li> <li>• Alaska’s suicide rates are among the highest in the U.S.<sup>108</sup></li> <li>• 23% of Alaska youth seriously considered suicide and 19% attempted to commit suicide.<sup>109</sup></li> </ul> <p><u>Population needs:</u></p> <ul style="list-style-type: none"> <li>• Improved access to peer recovery and support programs related to substance use treatment.</li> <li>• Increased availability of early intervention and prevention programs for early identification of needs.</li> <li>• Expanded school and community-based behavioral health supports to address youth mental health and prevent crisis escalation.</li> </ul>

**Adults with or at Risk for Chronic Disease living in Rural Alaska**Population baseline:

- 3 of 4 Alaskans have or are at risk of chronic disease.<sup>110</sup>
- 8% of adults in Alaska live with diabetes.<sup>111</sup>
- 32-35% of adults in Alaska are obese;<sup>112</sup> 21% of adults report no physical activity.<sup>113</sup>

Population needs:

- Improved access to routine primary and preventive care to manage and avoid chronic diseases.
- Improved access to healthy lifestyle programs promoting physical activity, nutrition, and social engagement.
- Improved access to appropriate specialist care locally and via telehealth as needed.

**Rural Older Adults Who are Dually Eligible (Medicare/Medicaid)**Population baseline:

- Alaska has approximately 19,600 full- and partial-benefit duals.<sup>114</sup>
- Nationally, duals face hospitalization rates 2–3x higher than non-duals.<sup>115</sup>

Population needs:

- Expanded comprehensive, integrated management across medical, behavioral, and skilled nursing/long-term care services.
- Improved coordination between acute, post-acute, and community-based services.
- Enhanced primary care, behavioral health, and skilled nursing/long-term care services, including transportation barriers.
- Strengthened support for navigating complex health care programs and clinical decision-making.

**Individuals with Complex Needs in Rural Settings**Population baseline:

- 43% of Alaska Medicaid recipients have at least one chronic condition.<sup>116</sup>
- The state's Complex Care Unit tracks over 700 active complex cases statewide.<sup>117</sup>

Population needs:

- Expanded care coordination and health care system navigation, including integration with social services.
- Expanded community-based services, promoting aging in place and reducing institutionalization.
- Improved direct care workforce capacity and caregiver support programs in rural, remote, and frontier areas.

## B. Goals and Strategies

### Overview of Alaska's Rural Health Transformation Plan

Alaska proposes to use RHTP funding to support three broad goals, comprising six cross-sectional initiatives, designed to strengthen community-led and regionally designed, rural, remote, and frontier health care systems that provide access to a full continuum of care as close to home as possible. Alaska's RHTP reflects our culture of innovation and self-reliance and affirms our commitment to high quality, accessible, and sustainable care.

**Table 3. Alaska’s RHTP Goals**

<b>Goal 1: Promote Lifelong Health and Wellbeing for Rural, Remote, and Frontier Alaskans</b>	
<b>Description</b>	<p>Advance evidence-based interventions that produce measurable improvements in access and health outcomes and launch innovative care models that:</p> <ul style="list-style-type: none"> <li>• Address the root causes of disease in Alaska’s diverse communities.</li> <li>• Improve rural providers’ capacity to engage in strategic partnerships that promote quality improvement and expanded access to care.</li> <li>• Improve the provision of high-quality prevention-focused initiatives, primary care, chronic disease management, emergency services, and specialty care, strengthening the entire continuum of health across the lifespan of all Alaskans.</li> </ul>
<b>RHTP Initiatives</b>	<p>Aligned with Governor Dunleavy’s <i>Healthy Families</i> initiative, this goal will primarily be met via three interrelated initiatives that together promote whole-person and community well-being: #1 <i>Healthy Beginnings</i>, #2 <i>Health Care Access</i>, and #3 <i>Healthy Communities</i>.</p>
<b>Statutory Elements</b>	<ul style="list-style-type: none"> <li>• Improving access</li> <li>• Improving outcomes</li> <li>• Technology use</li> <li>• Partnerships</li> <li>• Workforce</li> </ul>
<b>Strategic Goals</b>	<ul style="list-style-type: none"> <li>• Make rural America healthy again</li> <li>• Innovative care</li> <li>• Sustainable access</li> </ul>
<b>Goal 2: Build Sustainable Outcomes-Driven Health Systems</b>	
<b>Description</b>	<p>Advance sustainable payment models that drive high quality, cost-effective care and financial stability for rural health providers by pursuing a multiphase strategy that:</p> <ul style="list-style-type: none"> <li>• Lays a foundation for provider financial stability by addressing immediate operational and financial risks to ensure continuity of care and essential service delivery. Implements phased and voluntary adoption of innovative payment models, including value-based reimbursement and regional provider partnerships, which incentivize quality, efficiency, and collaboration.</li> <li>• Aligns financial incentives with measurable health outcomes to ensure that fiscal sustainability is achieved through the delivery of higher-quality, cost-effective care and diversified revenue streams.</li> </ul>
<b>RHTP Initiatives</b>	<p>This goal will primarily be met through the implementation of four initiatives: #2 <i>Health Care Access</i>, #3 <i>Healthy Communities</i>, #4 <i>Pay for Value: Fiscal Sustainability</i>, and #6 <i>Spark Technology and Innovation</i>.</p>
<b>Statutory Elements</b>	<ul style="list-style-type: none"> <li>• Improving outcomes</li> <li>• Technology use</li> <li>• Partnerships</li> <li>• Data driven solutions</li> <li>• Financial solvency</li> <li>• Cause identification</li> </ul>
<b>Strategic Goals</b>	<ul style="list-style-type: none"> <li>• Make rural America healthy again</li> <li>• Sustainable access</li> <li>• Innovative care</li> <li>• Technology innovation</li> </ul>
<b>Goal 3: Drive Workforce and Technology Innovation</b>	
<b>Description</b>	<p>Strengthen Alaska’s rural health care systems by advancing a sustainable, high-performing delivery infrastructure, which includes the following strategies:</p> <ul style="list-style-type: none"> <li>• Build, attract and retain a skilled workforce through targeted recruitment, comprehensive training, and evidence-based retention strategies that ensure provider stability and reduce turnover.</li> <li>• Modernize health care facilities to support team-based, integrated models of care that meet current standards and adapt to future needs.</li> <li>• Promote innovative, technology-enabled solutions and expand interoperable health technology and data systems, including through telehealth, remote monitoring, the statewide health information exchange (HIE), and decision-support tools driven by</li> </ul>

	appropriate AI and other advanced technologies to enable seamless collaboration, real-time care coordination, and continuous quality improvement.
<b>RHTP Initiatives</b>	This goal will be primarily met with the implementation of two initiatives: #5 <i>Strengthen Workforce</i> and #6 <i>Spark Technology and Innovation</i> .
<b>Statutory Elements</b>	<ul style="list-style-type: none"> <li>• Improving access</li> <li>• Improving outcomes</li> <li>• Technology use</li> <li>• Partnerships</li> <li>• Workforce</li> <li>• Data driven solutions</li> </ul>
<b>Strategic Goals</b>	<ul style="list-style-type: none"> <li>• Sustainable access</li> <li>• Workforce development</li> <li>• Innovative care</li> <li>• Technology innovation</li> </ul>

Key Performance Objectives

RHTP funds will be used to establish a community-centered, sustainable health care foundation that maximizes care close to home for lifelong health and well-being despite the unique challenges existing across the state. Alaska has developed the following overarching key performance objectives that focus on improving health care access across rural, remote, and frontier Alaskan communities:

- Close the urban-rural gap in infant and maternal mortality and morbidity by 50%.
- Reduce risk factors related to chronic disease by 25%.
- Ensure that 90% of seniors have a usual source of primary care.
- Increase specialty service access in rural hub communities by 25%.
- Reduce vacancy rates for critical health care positions by 25%.
- Shift health care spending from acute care to preventive care by 10%.

These key performance objectives are consistent and complementary to the detailed measures and outcomes described in the Metrics and Evaluation Plan.

Elements of Rural Health Transformation in Alaska

**Table 4. Proposed Strategies and Actions**

Statutory Element	Proposed Strategies and Actions
<b>Improving Access</b>	<ul style="list-style-type: none"> <li>• Invest in consumer-facing technology, remote care services, and telehealth infrastructure to support access to specialty care and maternal and infant health services close to home.</li> <li>• Support workforce initiatives that will recruit, train, and retain health care providers that will commit to rural and frontier settings and strengthen regional itinerant programs.</li> <li>• Invest in programs that ensure the availability of local primary, behavioral, and oral health care services as well as home and community-based residential service options and skilled nursing/long-term care facilities for post-acute care transition programs.</li> <li>• Improve rural providers’ financial sustainability through investment in operational efficiencies and population health clinical infrastructure and support to participate in value-based care arrangements and alternative payment models that reward improved outcomes and reduced costs.</li> </ul> <p><i>Through implementation of Initiatives #1 Healthy Beginnings, #2 Health Care Access, #4 Pay for Value: Fiscal Sustainability, #5 Strengthen Workforce, and #6 Spark Technology and Innovation.</i></p>
<b>Improving Outcomes</b>	<ul style="list-style-type: none"> <li>• Improve rural maternal and infant outcomes through expanded access to prenatal and postpartum care, enhanced infant care, and improved availability of home visits and lactation support.</li> <li>• Decrease the percentage of suicidal youth by increasing access to the full spectrum of behavioral health services including expanded telehealth and crisis intervention services.</li> <li>• Better manage chronic disease by increasing access to services, right-sizing the primary care delivery system, and investing in workforce and facility improvements.</li> <li>• Improve outcomes for dual eligible individuals through increased care coordination.</li> <li>• Reduce reliance on institutional care for individuals with complex needs through expanded support for care coordination, health care system navigation, use of emerging technologies, and integration of health and social services.</li> </ul> <p><i>Through implementation of Initiatives #1 Healthy Beginnings, #2 Health Care Access, and #3 Healthy Communities.</i></p>
<b>Technology Use</b>	<ul style="list-style-type: none"> <li>• Expand and modernize telehealth infrastructure to enhance telehealth-enabled specialty, behavioral health, prevention, and primary care services</li> <li>• Deploy consumer-facing digital health tools (wearables, apps, remote monitoring) and support successful provider and patient adoption</li> <li>• Support provider training for technology adoption and appropriate AI tools</li> <li>• Upgrade interoperable health IT systems and facilitate data sharing across providers</li> <li>• Build population health IT infrastructure for chronic disease management</li> </ul> <p><i>Through implementation of Initiative #6 Spark Technology and Innovation.</i></p>
<b>Partnerships</b>	<ul style="list-style-type: none"> <li>• Four major statewide organizations – the Alaska Native Tribal Health Consortium (ANTHC), Alaska Community Foundation (ACF), Alaska Hospital &amp; Healthcare Association (AHHA), and the Alaska Primary Care Association (APCA) – have met weekly with DOH leadership since August 2025 to guide RHTP planning and structure.</li> <li>• Regional partnerships across rural Alaska will create community-led regional health care delivery plans at the beginning of RHTP implementation. These plans will include data collection, stakeholder engagement, and strategic planning activities enabling local innovation and operations coordination, the buildout of new services, sustainability of existing core and new service lines, and align resources.</li> <li>• Establish a customized accelerator program for health providers (e.g., mentorship, best practices, shared purchasing).</li> <li>• Expand value-based integrated provider networks and shared coordination hubs that enable population health analytics, care-model coaching, and aligned payment systems.</li> </ul>

Statutory Element	Proposed Strategies and Actions
	<ul style="list-style-type: none"> <li>Facilitate public/private partnerships on housing and child care to address unmet workforce needs in rural communities.</li> </ul> <p><i>Through implementation of Initiatives #1 Healthy Beginnings, #2 Health Care Access, and #3 Healthy Communities; minimally through all other initiatives.</i></p>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>Build pipeline “grow our own” programs from high school through graduate levels.</li> <li>Create reskill and upskill programs for adults.</li> <li>Expand physician residency slots, rural internships, rotations and fellowships.</li> <li>Offer structured incentives to certain providers who commit to serving in a rural community.</li> <li>Expand training academies and certification pathways for CHA/Ps, BHA/Ps, DHATs, EMS, doulas, midwives, rehabilitation therapists, and other direct care workers through coordinated Tribal and statewide workforce initiatives so all providers are practicing at the top of their license.</li> </ul> <p><i>Through implementation of Initiative #5 Strengthen Workforce.</i></p>
<b>Data Driven Solutions</b>	<ul style="list-style-type: none"> <li>Deploy appropriate AI-enhanced clinical workflow and decision-support technologies to improve care quality, provider efficiency, and health outcomes in rural settings.</li> <li>Invest in interoperable electronic health records, analytics platforms, and health data systems.</li> <li>Train providers to leverage data for risk stratification, outcome monitoring, and tailored chronic disease management.</li> <li>Provide Technical Assistance (TA) for analytics integration and measurement-informed care practices.</li> </ul> <p><i>Through implementation of Initiative #6 Spark Technology and Innovation.</i></p>
<b>Financial Solvency</b>	<ul style="list-style-type: none"> <li>Test voluntary alternative payment and value-based models focused on cost reduction, outcome improvement, and innovative models of care.</li> <li>Centralize and improve back-office solutions for providers.</li> <li>Enhance provider ability to participate in innovative payment arrangements.</li> <li>Evaluate the Centers for Medicare and Medicaid Innovation (CMMI) AHEAD model.</li> <li>Deliver TA including contract evaluation, financial modeling, and change management to support and incentivize providers’ voluntary participation in innovative and transformative payment models.</li> </ul> <p><i>Through implementation of Initiative #4 Pay for Value: Fiscal Sustainability.</i></p>
<b>Cause Identification</b>	<ul style="list-style-type: none"> <li>Align development and resources through community-led regional health delivery plans.</li> <li>Accelerate technology investments to integrate care and shift to value-based payment.</li> <li>Incentivize the adoption of alternative payment models.</li> <li>Leverage wearable devices and new consumer-facing technology to pilot new care models.</li> <li>Incentivize workforce recruitment and retention.</li> </ul> <p><i>Through implementation of Initiatives #2 Healthcare Access, #4 Pay for Value: Fiscal Sustainability, and #5 Strengthen Workforce.</i></p>

Legislative and Regulatory Action

The chart below describes Alaska’s current state policy and planned policy actions related to the RHTP Notice of Funding Opportunity (NOFO) State Policy Actions Technical Score Factors.

**Table 5. Current State Policies and Planned Policy Actions**

Technical Score Factor	Current State Policy	Commitment to Legislative or Regulatory Action and Timeline
<b>Health and Lifestyle (B.2)</b>	Alaska does not have a requirement for schools to administer the Presidential Fitness Test consistent with Executive Order 14327.	Alaska Department of Education and Early Development will establish this requirement through regulatory action by 12/31/28.
<b>Supplemental Nutrition Assistance Program (SNAP) Waiver (B.3)</b>	Alaska submitted a draft waiver application to USDA on 9/23/25 (the federal government shutdown has delayed the process). Alaska has <a href="#">pending legislation</a> to require a waiver. <sup>118</sup>	DOH will achieve an approved SNAP Food Restriction Waiver by 12/31/27.
<b>Nutrition Continuing Medical Education (CME) (B.4)</b>	Alaska does not currently have a requirement for nutrition to be included in CME for physicians.	The Alaska State Medical Board will establish this requirement through regulatory action by 12/31/28.
<b>Certificate of Need (CON) (C.3)</b>	The NOFO data source classifies Alaska as “moderate” in CON laws. However, Alaska contends that the report does not accurately reflect current state policy ( <b>see note below</b> ).	DOH will promulgate regulations by 12/31/27 to modify CON for ancillary services, making Alaska less restrictive.
<b>Licensure Compacts (D.2)</b>	Alaska is not a member state and does not have any pending legislation for the following licensure compacts: <ul style="list-style-type: none"> <li>• Interstate Medical License Compact</li> <li>• EMS Compact</li> <li>• Psychology Interjurisdictional Compact</li> <li>• Physician Assistants Compact</li> </ul> Alaska has <a href="#">pending legislation</a> to join the following licensure compacts: <sup>119</sup> <ul style="list-style-type: none"> <li>• Nurse Licensure Compact</li> </ul>	Alaska will join all licensure compacts consistent with D.2 by 12/31/27.
<b>Scope of Practice (D.3)</b>	Alaska has the following scope of practice environments: <ul style="list-style-type: none"> <li>• Physician Assistants: Advanced</li> <li>• Nurse Practitioners: Full Practice</li> <li>• Pharmacists: Restricted Authority</li> <li>• Dental Hygienists: <b>Unrestricted (see note)</b></li> </ul>	Alaska will enact policy changes to expand scope of practice for pharmacists by 12/31/27, consistent with full authority. Note that Alaska has <a href="#">pending legislation</a> . <sup>120</sup>
<b>Short-term, Limited-Duration Insurance (STLDI) (E.3)</b>	STLDI plans are not restricted in Alaska beyond the latest federal guidance. Alaska does not have any specific statutes or regulations for STLDI.	No policy commitment; Alaska is already in full alignment with E.3.
<b>Remote Care Services (F.1)</b>	Alaska has state policies that support access to remote care and telehealth services, including for: <ul style="list-style-type: none"> <li>• Medicaid payment for at least one form of live video</li> <li>• Medicaid payment for Store and Forward</li> <li>• In-State licensing requirement exception</li> <li>• Telehealth license/registration process</li> </ul>	Alaska will update Medicaid coverage to include remote patient monitoring by 12/31/2027 and will be in full alignment with F.1.
<p><b>Alaska Notes on Scoring:</b></p> <p><b>C.3:</b> The NOFO data source (Cicero Institute) gives Alaska a score of 55, but does not accurately reflect current state policy. Alaska identified errors in methodology in the “Other” category, which incorrectly attributes regulatory oversight to services not included by Alaska’s CON program. In addition, the Cicero scoring framework does not account for Alaska’s unique Tribal health care landscape, particularly that THOs are exempt from state</p>		

licensing and CON requirements. Therefore, Alaska has substantially less restrictive CON laws than the report reflects. See [AS 18.07.031\(a\)](#); <sup>121</sup>, [AS 18.07.111](#); <sup>122</sup> [7 AAC 07.001](#); <sup>123</sup> [7 AAC 12.611](#).<sup>124</sup>

**D.3:** The NOFO data source (Oral Health Workforce Research Center) does not accurately reflect current state policy. In 2022, Alaska enacted SB 173, establishing an unrestricted scope of practice for advanced practice dental hygienists (now in statute under [AS 08.32.125](#)).<sup>125</sup> In addition, [7 AAC 145.120\(e\)](#) enables Medicaid to pay for services provided by an advanced practice dental hygienist – covered services are included in this fee schedule.<sup>126</sup>

## Notes on Rural Facility and Population Score Factors

**Table 6. Notes on Rural Facility and Population Score Factors**

Technical Score Factor	Notes
<b>Absolute size of rural population in a State (A.1)</b>	HRSA’s methodology for defining rurality does not accurately account for Alaska’s geography. HRSA’s county-based method designates Fairbanks North Star and Matanuska-Susitna Boroughs as non-rural, but this doesn’t fit Alaska’s geography – Matanuska-Susitna is larger than West Virginia, has 18 times fewer people per square mile, and only one hospital. Because Alaska lacks counties, its boroughs and census areas do not align with HRSA’s metrics. However, under an alternative HRSA definition (non-metropolitan statistical areas with populations under 50,000), all of Alaska except the Municipality of Anchorage would qualify as rural. In addition, the HRSA methodology does not adequately take into account the fact that over 80% of Alaska’s communities are off the road system. HRSA uses the Road Ruggedness Scale, which merely measures how level or rugged the roads are rather than accounting for the absence of roads altogether. Most parts of California are ranked as more rugged than Alaska (for example, despite not being connected to the road system, and with only 2.8 people per square mile, Nome is ranked equally rugged as Sacramento, with 6,029 people per square mile). For these reasons, Alaska’s RHTP designates every community outside of Anchorage as rural.
<b>Proportion of Rural Health Facilities in the State (A.2)</b>	<ul style="list-style-type: none"> <li>It is critical that each IHS facility (Tribal clinics and other village facilities) is counted individually for the purposes of determining Alaska’s blended percent of total rural health facility count. A current list of these facilities is included as <i>Supporting Document B</i>. Compared to the NOFO’s data sources there is a discrepancy in the count. Alaska is providing <i>Supporting Document B</i> because it is a data source that CMS has responsibility for maintaining with IHS.</li> <li>Alaska has five Certified Community Behavioral Health Clinics (CCBHCs) (see <i>Supporting Document C</i>). By HRSA’s definition using county-level metrics, only one is rural.<sup>127</sup> However, using Alaska’s RHTP rurality definition (see note above for A.1), four out of five should be designated as rural.<sup>128</sup></li> </ul>
<b>Percentage of hospitals in a State that receive Medicaid DSH payments (A.7)</b>	Alaska has eight Tribally-operated IHS hospitals <sup>129</sup> that are not eligible to receive DSH payments under federal law. These eight hospitals should be excluded from the denominator when calculating the percentage of hospitals that receive Medicaid DSH payments. During State Plan Rate Year 2024, nine hospitals received DSH payments.

### **C. Proposed Initiatives and Use of Funds**

Alaska proposes to use RHTP funding to support six cross-sectional initiatives: *#1 Healthy Beginnings*; *#2 Health Care Access*; *#3 Healthy Communities*; *#4 Pay for Value: Fiscal Sustainability*; *#5 Strengthen Workforce*; and *#6 Spark Technology and Innovation*. The implementation of these initiatives will be driven by community-led regional health care delivery and system plans designed to: (a) enable local innovation, (b) ensure sustainability of existing and new service lines, (c) align resources to most effectively meet regional and statewide health needs, and (d) promote long-term financial and operational sustainability across Alaska's rural health system. Recognizing the diversity in size, capacity, and readiness among Alaska's regions and organizations, these initiatives are flexible, phased, and voluntary, allowing each community and provider to engage at a pace and scale suited to their local priorities and resources. These initiatives will transform Alaska's health system to provide rural, remote, and frontier Alaskans with access to a full continuum of care as close to home as possible.

**Table 7. Proposed Initiatives**

1. Healthy Beginnings	
<b>Description</b>	<p>Alaska’s <i>Healthy Beginnings</i> initiative strengthens maternal and child health as a foundation for healthy families, especially in rural areas. With Alaska’s unique geography, regional and local hospitals provide critical labor and delivery services, NICU, maternal health, and pediatric care across vast distances. Families living off the road system face provider shortages, long travel distances, and unreliable transportation, often requiring pregnant women to leave their communities and temporarily relocate prior to delivery to access facilities equipped for labor, delivery, and high-risk monitoring, which creates emotional, financial, and logistical strain. After birth, mothers and infants often face isolation and limited support for needs such as lactation, nutrition and pediatric needs.</p> <p><u>Potential Uses of Funds:</u></p> <ul style="list-style-type: none"> <li>● <b>Expand technology-enabled maternal care infrastructure:</b> Develop and implement cloud-based maternal health information platforms that leverage proven telehealth and remote monitoring technology, enabling providers to coordinate care using patient data, consult virtually with specialists, and support high-risk pregnancies. Invest in remote fetal monitoring devices, interoperable electronic medical records, coordinated case management systems, and consumer-facing mobile apps aligned with CMS’s Health Technology Ecosystem criteria and Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) criteria, as applicable, for appointment scheduling and patient education. Provide TA and training for clinics in rural communities to maximize the use of new technologies and improve outcomes and patient experience. This effort will involve partnerships with technology vendors, regional health organizations, and THOs to ensure seamless integration and local provider autonomy. <i>(Key Intersection with Initiative #6 Spark Technology and Innovation)</i></li> <li>● <b>Modernize rural maternal care facilities and staffing models:</b> Fund targeted capital improvements, subject to federal limitations, for maternal care facilities including but not limited to labor, delivery, and birthing centers and clinics to achieve high-quality care. Eligible renovations could include converting space into or updating existing labor and delivery suites, installing or enhancing telehealth and fetal monitoring equipment, converting underused patient rooms into family-friendly maternity spaces, and retrofitting entryways and bathrooms for accessibility. These renovations promote the availability of safe, patient-centered care close to home and could include multi-use or mobile spaces to support itinerant health workers or other related needs. Test new staffing and payment models that support specialized standby readiness and other essential maternal care services in low-volume, high-acuity settings. <i>(Key Intersection with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)</i></li> </ul>

- **Strengthen rural maternal health and early childhood development workforce:** Fund and implement comprehensive programs that recruit, expand, train, and retain this workforce to serve in rural, remote and frontier communities. Programs will strengthen and develop skills related, but not limited to, prenatal care, labor and delivery and postpartum care, maternal behavioral health, and developmental screenings for infants and toddlers to ensure providers are practicing at the top of their license and with integrated care at the center. Trainings will encompass remote consultation and monitoring technologies, virtual and in-person training, simulation-based skill-building, and rotations in higher-volume settings to maintain clinical competencies suited for rural, remote and frontier Alaskan practice. Programs will test innovative, evidence-based, and outcomes-driven approaches in remote areas including, for example, peer support for pregnant women and engagement through strategic provider and community partnerships to sustain workforce capacity while preserving local autonomy. *(Key Intersection with Initiative #5 Strengthen Workforce)*
- **Enhance maternal and child health home visiting programs:** Provide funding to establish or expand evidence-based prenatal and postpartum home visiting programs delivered locally in-person and via telehealth services that build on Alaska’s existing health clinic infrastructure. Integrated teams made up of clinical and non-clinical health and community workers will partner with clinics to provide a bundle of culturally appropriate, family-centered integrated care services. Services will include, for example, lactation consultation and support for breastfeeding, screening for prenatal and postpartum depression, maternal and infant nutrition support, education on safe sleep practices, screening for key infant and early childhood developmental milestones, and other health risks and early intervention for families, infants, and toddlers who experience developmental delays. This program will also support the enhancement and expansion of Tribal maternal health programs.
- **Build healthy habits for youth:** Support school districts, home-schooling programs, and community organizations to launch and grow programs that build a foundation of lifelong health that address the root causes of disease and are prevention-focused by increasing physical activity (e.g., Presidential Fitness Test), providing nutritional education, and strengthening mental health resilience. Prioritize communities where access to such programming is limited. Modify space to allow efficient, dual-purpose use for extracurricular recreation and wellness activities, including itinerant programming. Fund evidence-based mental and behavioral health supports, including family engagement practices, to build resilience and positive social connections, core drivers of better long-term health outcomes. Strong partnerships among schools, local organizations, and Tribal entities will facilitate program delivery that respects community priorities and sustains local control. *(Key Intersection with Initiative #3 Healthy Communities)*

	<ul style="list-style-type: none"> <li>● <b>Provide TA to support <i>Healthy Beginnings</i> projects:</b> Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and performance improvement to ensure sustained impact on maternal and child health and early childhood development.</li> </ul>
<b>Alignment</b>	<p><u>Main Strategic Goal:</u> Make Rural America Healthy Again.</p> <p><u>Use of Funds:</u> A, B, C, D, E, F, G, H, J, K.</p> <p><u>Technical Score Factors:</u> B.1, B.2, C.1, D.1, F.1, F.2, F.3.</p>
<b>Key Stakeholders</b>	<p><b>Core health care stakeholders</b> include hospitals, clinics, health centers, birthing and maternal care facilities, ANTHC, and the ATHS and Tribal health facilities, along with physicians, primary care providers, obstetricians, pediatricians, and maternal care providers such as doulas, lactation consultants, and midwives. <b>Educational and workforce partners</b> include universities, training centers, professional associations, and programs such as the Healthcare Workforce Enhancement Program (HWEP). <b>Additional community partners</b> include community-based organizations and THOs offering prenatal and postpartum home visiting services, as well as early childhood services, public schools, charter schools, and home-school programs. <b>Other key partners</b> include patients and families, particularly pregnant and postpartum women, local governments, state agencies overseeing health initiatives, and technology or IT vendors supporting telehealth and data systems.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>● Expanded access to timely, technology-enabled, and evidence-based maternal and child health services, leading to increased early prenatal care, reduced maternal and infant mortality.</li> <li>● Greater numbers of early intervention screenings and home visits.</li> <li>● New facilities supporting connected care infrastructure.</li> <li>● Expanded school district participation in Medicaid School-Based Services.</li> </ul>
<b>Impacted Counties</b>	Statewide
<b>Est. Funding</b>	\$204,100,000 over the five-year grant period.
<b>2. Health Care Access</b>	
<b>Description</b>	<p>The <i>Health Care Access</i> initiative aims to expand and sustain essential health services across Alaska’s road-connected and off-road communities, where geography, severe weather, and workforce shortages limit timely, comprehensive care. This system maximizes care close to home by (a) expanding access to primary, behavioral, and oral health care within integrated systems; (b) increasing access to specialty care through the development of local provider capacity, telehealth, remote monitoring, and mobile specialist teams; (c) strengthening hospital capacity to provide 24/7 urgent, acute, and emergency care, trauma services, labor and delivery, maternity care,</p>

diagnostic, laboratory, and other ancillary services and therapies tailored to rural, remote and frontier needs; (d) supporting seniors and individuals with intellectual and developmental disabilities (IDD) in accessing aging-in-place and home- and community-based services; and (e) aiding healing and transitions through post-acute and recovery care at home or in the community.

Potential Uses of Funds:

- **Improve primary care access by investing in workforce and facility improvements:** Provide funds to recruit, train, and retain a multidisciplinary workforce with the aim of right-sizing the primary care delivery system, including Community Health Aides/Practitioners (CHA/Ps), to deliver high-quality integrated primary care and long-term disease management. Support targeted renovations and IT software, hardware, and equipment upgrades at existing clinics and health centers to improve operability of systems and extend service hours, telehealth capability, and outreach programming. This will leverage partnerships with local clinics, THOs, and community groups to ensure culturally appropriate services while maintaining rural provider autonomy and local care delivery. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)*
- **Increase access to the full spectrum of behavioral health services:** Provide funds to support evidence-based workforce development, recruitment, and training programs that measurably grow the behavioral health workforce. Invest in telehealth capabilities and facility renovations to expand availability of and increase timely access to culturally appropriate behavioral health services for youth and adults including but not limited to: community behavioral health, crisis services, acute inpatient care, partial hospitalization programs, Emergency psychiatric assessment, treatment, and healing (EmPATH), and substance use disorder services in hospitals, rural, remote, and frontier health clinics, and health and wellness centers. Build out expansion of integrated care delivered through Certified Community Behavioral Health Clinics or other care models. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)*
- **Deploy mobile dental clinics and expand access to remote and frontier health options:** Fund the start-up and deployment of mobile dental clinics equipped to provide preventive and basic restorative dental care in partnership with local community organizations and schools. Expand access to primary and specialty dental services through investment in dental staffing, recruitment, retention and training programs, and upgrading existing facilities and equipment to support contemporary dental practices with the adoption of advanced technology. This initiative will also support the enhancement and expansion of existing DHAT programs. Partnering with local institutions ensures sustained rural dental services. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)*

- **Increase access to high-quality, specialized services:** Ensure that specialized care is available as close to home as possible through targeted investments in facility renovations, technology, and strategic staffing models that expand access to specialized services by developing local provider services where possible and extending the reach of specialists. This may include facility upgrades and virtual programs to support time-sensitive events, modern care practices, and new consumer-facing digital health tools aligned with CMS's Health Technology Ecosystem criteria and ASTP/ONC criteria for patient-facing apps, including remote-monitoring technologies, as well as upgrading to new and AI-enabled point of care diagnostic and radiologic equipment. Address key staffing gaps that limit regional specialist care availability. Implement or expand itinerant specialty clinics and pilot service delivery options in remote and frontier communities. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)*
- **Build out care homes and multidisciplinary teams to develop and sustain innovative complex care models:** Fund facility renovations, population health IT infrastructure improvements, and payment incentive mechanisms to test innovative care models serving individuals with cooccurring complex needs, such as IDD, traumatic brain injury, autism spectrum disorder, severe and persistent mental illness, serious medical conditions, and dementia to measurably improve access to high-quality care. Support coordinated care delivery that integrates medical, behavioral, and skilled nursing/long-term services that result in improved access, better care coordination, and improved quality of life. *(Key Intersections with Initiatives #4: Pay for Value: Fiscal Sustainability, #5 Strengthen Workforce, and #6 Spark Technology and Innovation)*
- **Strengthen Tribally led Traditional Healing in care delivery:** Support and expand existing Indigenous Traditional Healing practices within the Tribal health system (including home visits where appropriate), mentorship for traditional healers, and orientation/education for clinic staff and providers to foster culturally appropriate, holistic care.
- **Enhance statewide pharmacy capacity and reach to expand access:** Fund efforts to establish and expand access to pharmacy services including, but not limited to medication management, adherence support, substance use treatment assistance, and disease-specific counseling. Support pharmacist training and licensure to implement test and treat programs, expanding access to point-of-care testing and diagnostic services. Create and test alternative payment models that reimburse pharmacists for these clinical services, incentivizing expanded chronic care roles and improving care continuity outside traditional clinical settings to ensure they are working at the top of their license. Test or expand innovative, technology-driven prescription delivery methods, including but not limited to remote prescription dispensing machines, portable prescription boxes, and the use of Unmanned Aerial Vehicles. This program will also support the enhancement and

expansion of existing Tribal pharmacist networks. *(Key Intersections with Initiatives #4 Pay for Value: Fiscal Sustainability, #5 Strengthen Workforce, and #6 Spark Technology and Innovation)*

- **Pilot technology-enabled care models to serve rural and frontier residents with IDD:** Develop and expand evidence-based targeted care coordination and delivery programs for rural Alaskans with IDD that recruit and train interdisciplinary clinical and non-clinical community and health workers, including Direct Support Professionals, to help individuals and their families connect with IDD specialists, navigate rural health care systems, access health services, and connect to other IDD support programs. This will establish regional partnerships to deliver culturally appropriate, integrated care tailored to community needs and will leverage technologies that support coordinated care across providers and provision of care via telehealth to measurably improve access to care and health outcomes. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)*
- **Drive transformation of the statewide EMS and trauma care systems:** Support the establishment and sustainability of EMS services in underserved rural communities, by upgrading and expanding access to specialized equipment to improve patient assessment, triage, and transport. Fund workforce development and training programs and technologies that support providers to implement best practice protocols and interventions, such as treat-in-place, community paramedicine, mobile integrated health care, and alternate destination transport. Strengthen providers' financial stability by training agencies in accurate billing and piloting alternative payment models that support both existing and newly developed EMS systems to reduce health care costs, improve quality of care, and shift care to lower-cost settings. *(Key Intersections with Initiatives #4 Pay for Value: Fiscal Sustainability, #5 Strengthen Workforce, and #6 Spark Technology and Innovation)*
- **Bolster home and community senior supports:** Fund outcomes-driven programs that support seniors living in rural, remote, and frontier Alaskan communities healthy and independent where they live, including those that offer education on fall prevention, specialized nutrition supports, oral health, and social engagement to improve well-being and delay intensive care needs. Fund the expansion of programs that offer home safety assessments and execution of home modifications that support aging-in-place. In alignment with RHTP requirements, these funds will not duplicate or supplant services already covered by Medicaid but will expand access for individuals who cannot receive them through Medicaid.
- **Expand home and community-based residential services, skilled nursing/long-term care facilities, and post-acute care transition programs:** Expand assisted living, adult host home, and regional skilled nursing /long-term care facility capacity through funding for renovations, equipment, and telehealth upgrades;

	<p>workforce training programs; partnership-building activities between regional health systems and local partners. Fund programs that offer post-discharge home visits to improve recovery outcomes, reduce barriers to discharge, and reduce hospital readmissions. Home visits may include assisting patients with remote monitoring set-up and participation in telehealth visits, medication reconciliation, environmental modifications, and coordinating transportation to or in-home physical therapy. Emphasize collaborative local partnerships and continuity of care. <i>(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)</i></p> <ul style="list-style-type: none"> <li>• <b>Build transportation networks to connect people to care:</b> Identify transportation barriers that limit access to health care, employment, and social supports, and invest in planning and start-up activities necessary to build sustainable mobility networks. Support partnerships with local transit agencies, community organizations, and Tribal entities to design flexible, community-driven solutions that health systems and payers can later integrate and reimburse for ongoing operation.</li> <li>• <b>Conduct a comprehensive provider gap analysis to guide resource allocation and improve rural health access:</b> Fund a systematic assessment of health care provider availability, distribution, and service capacity across Alaska, mapping access points and analyzing provider-to-population ratios by care type to identify access gaps and workforce shortages. Across regions, support collaboration with and among Tribal organizations, local hospitals, clinics and primary care providers and other community leaders to ensure accurate, culturally informed findings, and use the resulting data to prioritize services for strategic investments and expanded rural workforce development programs in regions, and future workforce recruitment and retention program planning.</li> <li>• <b>Provide TA to support Health Care Access projects:</b> Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and performance improvement to ensure sustained impact on improving access to high-quality care that promotes long-term, lifelong health and well-being across Alaska’s rural and most remote frontier communities.</li> </ul>
<b>Alignment</b>	<p><u>Main Strategic Goal:</u> Sustainable Access.  <u>Use of Funds:</u> A, B, C, D, E, G, H, I, J, K.  <u>Technical Score Factors:</u> B.1, B.2, C.1, C.2, D.1, E.1, E.2, F.1, F.3.</p>
<b>Key Stakeholders</b>	<p><b>Core health care stakeholders</b> include hospitals, clinics, health centers, skilled nursing and long-term care facilities, and other facilities serving rural residents, as well as ANTHC and the ATHS. They also include physicians and health care providers offering primary, specialty, and behavioral health care; clinical and non-clinical workers</p>

	such as CHA/Ps, BHA/Ps, and DHATs; EMS providers; and pharmacists. <b>Additional community partners</b> include community-based organizations and THOs that serve older adults and support behavioral health programs, along with home health providers and aging-in-place support services, as well as educational and workforce partners, local governments, and schools. <b>Other key partners</b> include patients and consumers, state agencies that oversee health programs, and technology or IT vendors that enable telehealth and health information systems.
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>Expanded access to continuous, community-based, culturally aligned care, including more adults with a primary care provider, increased follow-up for Medicaid youth after mental health hospitalization, greater availability of Tribal and Traditional Healing services, and greater use of community-based behavioral health care.</li> <li>Reduced drug overdose and suicide mortality.</li> <li>Improved rates of age-appropriate cancer screenings.</li> </ul>
<b>Impacted Counties</b>	Statewide.
<b>Est. Funding</b>	\$241,800,000 over the five-year grant period.
<b>3. Healthy Communities</b>	
<b>Description</b>	<p>The <i>Healthy Communities</i> initiative targets the unique challenges of rural, remote, and frontier Alaska by investing in preventive care and root causes of poor health through: (a) enhancing access to locally tailored preventive and primary care services that enable early chronic disease management, reduce avoidable hospitalizations, and improve long-term health outcomes through evidence-based screenings and coordinated care; (b) expanding consumer-facing digital tools, population health clinical infrastructure and management systems, and community-based workforce capacity to strengthen outreach, self-sufficiency, and care coordination; and (c) promoting healthy lifestyles with culturally appropriate community education focused on nutrition, physical activity, and chronic disease prevention tailored to rural and frontier populations.</p> <p><u>Potential Uses of Funds:</u></p> <ul style="list-style-type: none"> <li><b>Deploy consumer-facing digital tools for chronic disease self-management:</b> Support use of mobile apps, wearable devices, and patient portals aligned with CMS’s Health Technology Ecosystem criteria and ASTP/ONC criteria for patient-facing apps, as applicable, that empower individuals with chronic conditions to track symptoms, access educational resources, and communicate directly with care teams for timely support and medication adjustments. (<i>Key Intersection with Initiative #6 Spark Technology and Innovation</i>)</li> <li><b>Build infrastructure to support population health and care coordination:</b> Invest in and expand existing interoperable data systems and analytics platforms aligned with CMS’s Health Technology Ecosystem criteria</li> </ul>

and ASTP/ONC criteria that aggregate clinical, behavioral, and health-related needs information. Enable care teams, health care providers, and health systems to identify high-risk patients, monitor outcomes in real-time, and tailor interventions for more effective, proactive chronic disease management at the community level. Foster collaborations among regional health systems, Tribal entities, and local providers to maintain local data governance and coordinated care models. *(Key Intersection with Initiative #6 Spark Technology and Innovation)*

- **Launch integrated primary and preventive care units:** Deploy or expand mobile clinics, community paramedicine programs, and unmanned health kiosks to deliver routine screenings, immunizations, chronic disease monitoring, and preventive health products in community settings, schools, and homes. Foster local and regional strategic partnerships with university health programs to use these units as interprofessional training sites for integrated care delivery in remote and frontier areas. Support mobile Medication Assisted Treatment teams to address opioid and alcohol use disorders to reduce overdose rates.
- **Fund evidence-based, outcomes-driven community health programs:** Implement and expand scalable, evidence-based initiatives that deliver health education, increase health literacy, and promote sustained behavior change to prevent and manage chronic disease such as (a) the *National Diabetes Prevention Program* (b) Alaska's *Fresh Start* program that supports Alaskans to improve weight management, blood pressure control, and tobacco cessation, among other health improvement goals, through digitally enabled, coach-supported interventions. Establish or expand Health Aide Academies to expand Tribal outreach and implementation of such programs.
- **Establish wellness centers to promote community health and lifestyle changes:** Invest in infrastructure renovations and equipment in existing workplace facilities, schools, or community centers to offer dedicated space and resources to facilitate physical activity, support local food production and healthy eating initiatives, provide nutrition education and cooking classes focused on nutritious diets, and host other wellness programming. Modify space to allow dual-purpose use for extracurricular recreation and wellness activities, including itinerant programming. Facilitate partnerships with local employers, schools, and Tribal leaders to align programming with community priorities and sustain local control.
- **Develop community-led regional health care delivery plans:** Fund data collection, stakeholder engagement, and strategic planning activities to enable local innovation and operations coordination, coordinate the buildout of new services, ensure sustainability of existing core and new service lines, and align resources to most effectively meet regional and statewide health needs.
- **Improve home environments to support health:** Fund essential home modifications and innovative solutions that ensure access to clean water and sanitation in remote and off-grid homes. Investments will reduce

	<p>infectious disease, improve population health, and avoid higher-acuity care while prioritizing locally-led implementation. (<i>Key Intersection with Initiative #6 Spark Technology and Innovation</i>)</p> <ul style="list-style-type: none"> <li>• <b>Provide TA to support Healthy Communities projects:</b> Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and performance improvement to ensure sustained impact on community-level interventions that support preventive care, chronic disease management, healthier lifestyles and tackling the root causes of poor health.</li> </ul>
<b>Alignment</b>	<p><u>Main Strategic Goal:</u> Make Rural America Healthy Again.</p> <p><u>Use of Funds:</u> A, C, D, F, G, I, J, K.</p> <p><u>Technical Score Factors:</u> B.1, B.2, C.1, E.2, F.1, F.2, F.3.</p>
<b>Key Stakeholders</b>	<p><b>Core health care stakeholders</b> include hospitals, clinics, health centers, skilled nursing/long-term care facilities, and other facilities serving rural residents, as well as the ANTHC and the ATHS. This group also comprises physicians and health care providers offering primary, specialty, and behavioral health care; clinical and non-clinical workers such as CHA/Ps, BHA/Ps and DHATs; EMS providers; and pharmacists. <b>Additional community partners</b> include employers, community-based entities, and THOs that work with children and youth, provide community wellness services and programs, and support home infrastructure improvements in local communities, along with local governments, community centers, libraries, and school districts that engage families and residents. <b>Other key partners</b> include patients and consumers, state agencies that oversee and coordinate health programs, and technology or IT vendors that strengthen telehealth, data infrastructure, and information connectivity.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Increased participation in Alaska’s <i>Fresh Start</i> programs to prevent diabetes and lower blood pressure.</li> <li>• More adults engaging in regular physical activity.</li> <li>• Reduced consumption of sugary drinks.</li> <li>• More schools promoting physical activity through <i>Fresh Start</i> programs and the Presidential Fitness Test.</li> <li>• Expanded use of consumer technologies that support wellness and health monitoring.</li> </ul>
<b>Impacted Counties</b>	Statewide.
<b>Est. Funding</b>	\$249,200,000 over the five-year grant period.
<b>4. Pay for Value: Fiscal Sustainability</b>	
<b>Description</b>	The <i>Pay for Value: Fiscal Sustainability</i> initiative incentivizes a shift from traditional volume-based reimbursement models which are financially unsustainable for rural providers, whose low patient volume, high fixed costs, and

geographic isolation lead to financial strain and limit their ability to generate sufficient revenue under current FFS systems. Building long-term financial stability of rural providers requires a transition to payment models that empower providers and incentivize health care organizations, especially rural providers, to invest in innovative care models to improve coordination among primary and behavioral care providers, strengthen chronic disease management, and maintain access to essential acute care services. Recognizing that providers vary in readiness and face unique challenges, participation is voluntary and supported through flexible approaches, with careful consideration of the unique AHS reimbursement structure.

Potential Uses of Funds:

- **Deliver TA for successful value-based care participation:** Provide targeted support for providers and practices to build or expand core competencies required for participation in value-based care arrangements, support for contract evaluation and negotiation, implementation planning, change management, performance benchmarking, patient attribution, and financial modeling. Specific targeted support will be provided to primary care providers to ensure they can effectively participate in value-based care arrangements, including TA to simplify administrative and billing processes. Deliver a customized accelerator program for rural health providers to build partnership and information sharing.
- **Support value-based care and alternative payment model infrastructure:** Invest funding in IT infrastructure, staffing, and equipment to build or expand providers capacity to participate and succeed in value-based payment arrangements, including implementation of modern, interoperable data infrastructure, training to utilize population health analytics platforms, design of team-based care workflows, and integration of physical, behavioral, and social care services. The goal is to reduce health care costs, improve quality of care, and shift care to lower-cost settings while ensuring providers work at the top of their license. *(Key Intersection with Initiative #6 Spark Technology and Innovation)*
- **Centralize and improve back-office solutions for providers:** Centralize or streamline back-office functions and support group purchasing options to create cost savings and reduce administrative burden for participating primary care, behavioral health, and specialty care providers in rural and frontier areas. Develop shared services for billing, scheduling, claims processing, eligibility, and compliance to support operational efficiency and independence and to improve the financial viability of rural providers and simplify administrative processes.
- **Establish alternative payment methods for prevention and chronic disease management:** Design, test, and scale new payment models for primary and preventive care, care coordination for dually eligible populations, maternal, behavioral, oral, specialty care, and chronic disease management. These models provide financial

incentives for provider collaboration, quality metric reporting, and measurable patient outcome improvements. Examples include capitated payments and shared savings (one- and two-sided risk). This approach could also include expanded Tribal case management.

- **Establish innovative care models to support regional care coordination:** Design, test, and scale regional value-based care arrangements that incorporate, for example, pay-for-performance incentives, quality withholds, shared savings programs with upside risk only, shared risk (two-sided), bundled/episode payments, and accountable care organization-like demonstrations with participating hospitals and providers. These evidence-based models will support primary care providers and aim to change patient and provider behavior and increase primary care utilization to drive further improvements in quality of care and reductions in health care costs.
- **Establish alternative payment methodologies for hospitals:** Design, test, and scale new payment models offering incentives to hospitals for collaboration, actionable quality metric submission, and measurable improvements in patient outcomes. Models may include voluntary, multi-payer, prospective capitated payments that are risk adjusted for key population or other characteristics and vary by participating payer. Ultimately, these models will reduce health care costs, improve quality of care, and shift care to lower-cost settings while supporting the fiscal viability of rural providers to meet communities' acute, critical needs.
- **Explore participation in CMMI's AHEAD model:** If feasible, incentivize and support providers' voluntary participation in the CMMI AHEAD payment model. Fund uses may support up-front costs for planning and financial modeling, risk assessments, new partnerships, and measurement and reporting requirements.
- **Develop foundational capabilities for integrated care for dually-eligible Alaskans:** Assess current programs and infrastructure serving dually eligible beneficiaries to identify opportunities to improve care coordination and alignment across Medicare and Medicaid. Activities include: ensuring capacity to identify dual eligibles and support enrollment and awareness of covered benefits, building data-sharing capacity, supporting providers in intentional care coordination and management for this population and engaging with beneficiaries and stakeholders to understand barriers to better integrated care. Assessment results will inform design of potential future integrated care models or plans that align, benefits, improve member experience, and enhance quality and efficiency.
- **Launch transitional grants to support adoption of value-based payment arrangements and alternative payment models:** Offer a time-limited financial transition mechanism to offset potential financial losses for providers participating in early-stage, value-based payment arrangements. The program would serve as a financial bridge, allowing essential community providers to innovate in care delivery while maintaining solvency

	<p>and service access as they build out the resources, data capacity, and care management systems needed to succeed under value-based models. This initiative will reduce short-term financial risk, promote innovation in care delivery, and encourage broader participation in value-based arrangements to reduce health care costs, improve quality of care, and shift care to lower-cost settings, while supporting fiscal viability of rural providers to meet communities' acute, critical needs.</p> <ul style="list-style-type: none"> <li>• <b>Provide TA to support <i>Pay for Value: Fiscal Sustainability</i> projects:</b> Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and performance improvement to ensure sustained impact on transitions to payment models that empower providers and incentivize health care organizations to provide care in innovative ways that improve health outcomes and lower costs.</li> </ul>
<b>Alignment</b>	<p><u>Main Strategic Goal:</u> Innovative Care.  <u>Use of Funds:</u> A, B, D, F, G, H, I, J, K.  <u>Technical Score Factors:</u> B.1, C.1, E.1, F.2.</p>
<b>Key Stakeholders</b>	<p><b>Core health care stakeholders</b> include hospitals, clinics, health centers, skilled nursing/long-term care facilities, and other facilities serving rural residents, along with ANTHC and the AHS. This group also encompasses physicians and health care providers, clinical and non-clinical health and community workers such as CHA/Ps, BHA/Ps, and DHATs, as well as EMS providers and pharmacists. <b>Finance partners</b> include payers such as private insurers and public programs including Medicaid and Medicare that support health care financing and service reimbursement.</p> <p><b>Additional community partners</b> include community-based organizations and THOs that track and strengthen the quality of, and access to, health care across regions. <b>Other key partners</b> include patients and consumers, consulting, analytic, and TA partners, state agencies responsible for health oversight and coordination, and technology or IT vendors that enable telehealth and data interoperability across systems.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Increase in providers completing APM readiness assessments and implementation plans.</li> <li>• Increased providers voluntarily participating in new alternative payment models.</li> <li>• Increase in providers reporting quality measures through HIE.</li> <li>• Increase in dually eligible care coordination.</li> <li>• Increase in days cash on hand for CAHs.</li> <li>• Reduction in potentially avoidable emergency department visits among seniors.</li> </ul>

<b>Impacted Counties</b>	Statewide.
<b>Est. Funding</b>	\$158,712,100 over the five-year grant period.
<b>5. Strengthen Workforce</b>	
<b>Description</b>	<p>The <i>Strengthen Workforce</i> initiative aims to build a resilient rural health care workforce by focusing on (a) developing rural workforce pipelines and recruitment pathways such as high school-to-career programs, certification and graduate pathways, reskill/upskill programs, and enhanced rural internships, rotations, and residencies, especially in primary care and family medicine; (b) targeted signing and retention bonuses tied to five-year service commitments in remote communities; and (c) enhancing retention and provider support through structured mentoring, continuing education opportunities, and incentive programs linked to long-term service, alongside wraparound supports, time-limited housing assistance, and child care partnerships to help providers remain in rural communities. Consistent with federal requirements, individuals who receive RHTP-funded financial assistance and complete a certification supported with RHTP funds will be required to commit five years of service in rural communities.</p> <p><u>Potential uses of funds:</u></p> <ul style="list-style-type: none"> <li>• <b>Create “grow our own” high school to certification programs:</b> Fund the development of online and in-person local training programs for high school students or recent graduates pursuing health care careers such as certification as paramedics, nursing assistants, medical coders/billers, behavioral health technicians, community health workers, CHA/Ps, BHA/Ps, pharmacy technicians, and DHATs, advanced practitioners, and medical laboratory personnel, among others. Training opportunities would include stipends, distance learning options so students can stay in their communities, and career coaching.</li> <li>• <b>Fund or expand training and workforce development and certification programs:</b> Create sustainable career pathways to address health care gaps through the implementation of flexible, virtual and in-person training programs. Programs will include community health workers, CHA/Ps, BHA/Ps, and DHATs, direct care workers, family caregivers, home health aides, care navigators, peer behavioral health specialists, doulas, care coordinators, and developmental specialists. Programs may also include rehabilitation, therapists, Emergency Medical Technicians, paramedics, advanced practitioners, and medical laboratory personnel, mobile integrated health teams, and others.</li> <li>• <b>Create reskill or upskill programs for adults who may not have considered health care careers:</b> Programs will offer flexible, accessible training pathways that help new- or mid-career adults (e.g., ages 25–40) transition</li> </ul>

into high-demand health care roles such as direct care workers, family caregivers, and community care practitioners.

- **Support development and expansion of residency programs:** Develop and expand residency programs in Alaska including primary care and high demand rural specialties. Support the development of residency and internship programs in community outpatient settings in rural, remote, and frontier communities. Explore fellowships, rotations, and stipends to increase the number of providers accepting medical residents. Leverage simulation-based skill-building, and rotations in higher-volume settings to maintain clinical competencies suited for rural Alaskan practice.
- **Implement recruitment and retention strategies:** Provide funding for TA and grants to implement recruiting and retention strategies within and outside of Alaska. Efforts will be targeted to meet community needs and gaps in care with an emphasis on remote and frontier communities.
- **Offer structured incentives to certain providers who commit to serving in a rural community:** Fund structured incentives for high-need providers (such as physicians, nurses, dentists, midwives, pharmacists, behavioral health professionals and other clinical and non-clinical community and health professionals) through upfront bonuses tied to five-year service commitments with incentives weighted towards later years and repayment requirements if the obligation is not fulfilled. To further support provider stability in rural communities, provide housing placement coordination with local partners and time-limited housing and child care stipends.
- **Expand scope of practice:** Invest in training, resources, and collaborative models to increase clinical competencies that support providers and pharmacists in practicing at the top of their licensure.
- **Launch housing placement resources for health care providers and students:** Fund an integrated housing program that promotes strategies to increase housing placement and support for health care providers and students completing clinical rotations in rural, remote, and frontier areas and provides TA and resources to communities with significant housing shortages.
- **Provide child care supports to enhance provider retention:** Support the creation of onsite, or near-site child care centers or partnership agreements with local child care providers. These child care supports are designed to address a primary barrier to recruitment and long-term retention in remote communities.
- **Provide TA to support *Strengthen Workforce* projects:** Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and developing effective recruitment and training programs to ensure sustained impact.

<b>Alignment</b>	<p><u>Main Strategic Goal:</u> Workforce Development.</p> <p><u>Use of Funds:</u> D, E, J, K.</p> <p><u>Technical Score Factors:</u> B.1, D.1, F.1.</p>
<b>Key Stakeholders</b>	<p><b>Core health care stakeholders</b> include hospitals, clinics, health centers, skilled nursing/long-term care facilities, behavioral health centers, and other facilities serving rural residents, along with ANTHC and the AHS. They also include physicians and health care providers, clinical and non-clinical health and community workers such as CHA/Ps, BHA/Ps, and DHATs, as well as EMS providers and pharmacists. <b>Education and training partners</b> include the University of Alaska system, other universities, community and technical colleges, and training centers, together with medical students, residents, and trainees engaged in workforce development. <b>Additional community partners</b> include community-based organizations and THOs that support health care training, apprenticeships, and internship programs to expand and sustain the health workforce, as well as professional associations and workforce development programs (including HWEP). <b>Other key partners</b> include patients and consumers, state agencies that oversee health initiatives, and technology or IT vendors that advance telehealth, workforce platforms, and data systems.</p>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Increase in physicians per 100,000 residents.</li> <li>• Expanded physician residency opportunities.</li> <li>• Greater participation in RHTP-funded workforce training.</li> <li>• Larger number of certified Community Health Workers and CHA/Ps.</li> <li>• More RHTP-supported initiatives offering recruitment and retention incentives.</li> </ul>
<b>Impacted Counties</b>	Statewide.
<b>Est. Funding</b>	\$158,600,000 for the five-year grant period.
<b>6. Spark Technology and Innovation</b>	
<b>Description</b>	<p>The <i>Spark Technology and Innovation</i> initiative harnesses data and technology to enable rural, remote, and frontier providers to deliver secure, efficient, high-quality care. It develops reliable, interoperable, data-driven tools to support community-based, patient-centered care across Alaska’s most remote areas. This initiative empowers providers with innovative digital health tools to enhance access, coordinated care, and population health management by (a) expanding use of consumer wearables and digital devices with provider training and technical support; (b) increasing telehealth, appropriate AI, and cybersecurity through improved IT and remote monitoring; (c) facilitating data sharing and system interoperability by upgrading electronic health records, supporting the</p>

statewide HIE, and advancing workforce training and workflow redesign; and (d) testing new delivery modalities using emerging technologies like unmanned aerial systems and kiosks.

Potential Uses of Funds:

- **Deploy consumer-facing digital tools:** Invest in the development of mobile apps, remote monitoring devices, and patient portals aligned with CMS’s Health Technology Ecosystem criteria and ASTP/ONC criteria for patient-facing apps, as applicable. These tools can support symptom tracking and management, direct communication with care teams for timely support, medication adjustments, and access to personalized health education materials and will focus on people with chronic conditions, BH/SUD, pregnant women, and patients at risk of falls or other harms. Provide TA to train and support providers and support staff in the use of digital solutions. *(Key Intersection with Initiative #2 Health Care Access)*
- **Empower providers’ use of appropriate AI tools for care delivery:** Provide start-up funding for training and TA for a wide range of clinical providers and support staff to leverage or expand AI-powered documentation, workflows, and back-office function and resource tools. Ensure interoperability with existing and developing regional, statewide, and CMS data systems and necessary upgrades or updates.
- **Develop community-based system navigation applications:** Invest in community-based applications that connect rural and frontier community members with nearby clinical and social services, in-person supports, provide scheduling assistance, care navigation, care coordination, and digital support.
- **Invest in standards-based platforms that integrate and store patient health data in the single statewide HIE:** Expand HIE platforms to rural, remote, and frontier providers to integrate patient health data from remote monitoring devices and other clinical data systems, enabling real-time monitoring, provider/patient alerts, and seamless exchange to inform care delivery and improve health outcomes.
- **Create telehealth-enabled specialty care access programs:** Invest in, expand, and update telehealth infrastructure supported by reliable internet access and hospital and clinic IT upgrades. Develop protocols that connect rural and frontier primary care sites with specialty providers such as cardiologists, endocrinologists, oncologists, psychiatrists, and OB/GYN providers. Provide training and TA to educate and support rural providers and specialist teams to maintain best practices, create common workflows, and build collaboration.
- **Evaluate and pilot emerging health technologies to strengthen health care delivery in remote communities.** This effort will assess the viability of unmanned aerial systems (e.g., drones), remote pharmacy dispensing units, portable diagnostic tools, or other emerging technologies in expanding access to essential health services. Where feasible, pilot projects will be implemented to test operational performance, cost-

	<p>effectiveness, and community impact, with the goal of identifying scalable solutions that improve care access and continuity of care in remote, often roadless, settings.</p> <ul style="list-style-type: none"> <li>● <b>Integrate advanced analytics across multi-payer health and data systems:</b> Apply and expand technology-enabled tools that draw from Medicaid, commercial, and public health data to strengthen analytics, improve program integrity, enhance care coordination, and support informed clinical decision-making. Uses may include modeling to detect fraud, waste, and abuse; identify critical incidents; conduct advanced claims and utilization analyses; and perform population-level risk stratification to guide care management and resource allocation.</li> <li>● <b>Build health IT infrastructure to support provider participation in value-based care:</b> Provide targeted investments in interoperable electronic health record systems, shared data infrastructure, and tools that enable providers to routinely measure, report, and act on clinical and functional outcomes will strengthen value-based payment readiness. These systems will be aligned with ASTP/ONC criteria, as applicable, and allow for integrated tracking across service types supporting performance measurement and improved population health outcomes. <i>(Key Intersection with Initiative #4 Pay for Value: Fiscal Sustainability)</i></li> <li>● <b>Launch rural and frontier health infrastructure fund:</b> Leverage public-private partnerships to stack resources and address the acute lack of adequate health care facilities in rural, remote and frontier Alaska. RHTP funds will be leveraged for pre-development costs, renovations within existing spaces, and one-time start-up costs for new facilities, while private partner organization funds will <i>separately</i> fund new construction needs, major expansion of capital projects, and long-term financing sustainability. Projects that will be considered include renovating or modifying multi-use or mobile spaces to address temporary or itinerant staffing needs. Infrastructure funding is subject to restrictions outlined in the NOFO.</li> <li>● <b>Launch rural technology catalyst fund:</b> Establish a competitive grant or procurement program intended to encourage the adoption of emerging health technology innovation focused on rural populations that improve quality, expand access, and reduce cost of care. Funds will prioritize scalable solutions, aligned with CMS’s Health Technology Ecosystem and ASTP/ONC criteria, as applicable, with plans for sustainability.</li> <li>● <b>Provide TA to support <i>Spark Technology and Innovation</i> projects:</b> Offer TA and training to help eligible entities develop strong funding applications and successfully implement funded projects. Support may include guidance on application development, financial analysis, project planning, data collection, reporting, and performance improvement to ensure sustained impact from investments in innovative tools and systems that facilitate increased access, coordinated care delivery and population health management.</li> </ul>
<b>Alignment</b>	Main Strategic Goal: Tech Innovation

	Use of Funds: A, C, D, F, G, I, J, K Technical Score Factors: B.1, B.2, C.1, F.1, F.2, F.3
<b>Key Stakeholders</b>	<b>Core health care stakeholders</b> include hospitals, clinics, health centers, skilled nursing/long-term care facilities, and other facilities serving rural residents, as well as ANTHC and the AHS. This group also includes physicians and health care providers, clinical and non-clinical health and community workers such as CHA/Ps, BHA/Ps, and DHATs, along with EMS providers and pharmacists. <b>Additional community partners</b> include community-based organizations and THOs that promote internet connectivity and access, provide technology education, and offer social service navigation assistance to improve care coordination and digital inclusion, as well as universities, workforce alliances, and training entities. <b>Other key partners</b> include patients and consumers, state agencies such as the State Office of Rural Health, and the statewide HIE (healthEconnect), as well as technology, IT, and cybersecurity vendors that support telehealth, data sharing, and system interoperability.
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Increase in hospitals and clinics adopting RHTP-funded AI technologies and remote patient monitoring systems.</li> <li>• Higher percentage of Medicaid providers offering telehealth services.</li> <li>• Greater hospital and organizational participation in the HIE through expanded data sharing and connectivity.</li> </ul>
<b>Impacted Counties</b>	Statewide.
<b>Est. Funding</b>	\$246,700,000 for the five-year grant period.

The following chart demonstrates how Alaska’s six proposed initiatives and potential uses of funds align with each of the NOFO’s Initiative-Based Technical Score Factors.

**Table 8. Initiatives and Potential Use of Funds by Initiative-Based Technical Score Factors**

Technical Score Factor	Initiatives	Alignment
<b>B. 1. Population health clinical infrastructure</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Expands community-based maternal and child health care</b>, bringing prenatal, postpartum, and early childhood services closer to home through local programs, home visits, telehealth, and upgraded rural facilities.</li> <li>▪ <b>Enhances rural health systems</b> through technology-enabled care coordination, integration of behavioral and primary care, and workforce development.</li> </ul>

		<ul style="list-style-type: none"> <li>▪ <b>Promotes collaboration</b> among clinics, Tribal programs, schools, and community organizations to improve access to preventive, behavioral, and family-centered care across rural and frontier communities.</li> </ul>
	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Expands community-based health care</b> through local clinic renovations, itinerant specialty clinics, mobile dental units, senior supports, and aging-in-place programs.</li> <li>▪ <b>Enhances comprehensive rural care systems</b> through expansion of telehealth, remote monitoring, and digital infrastructure upgrades across primary, behavioral, dental, and specialty care; workforce and facility investments in primary and preventive care; and expansions of the rural workforce’s scope and sustainability.</li> <li>▪ <b>Aligns community, THOs, and regional partners</b> to deliver connected, culturally appropriate, and sustainable care.</li> </ul>
	<b>#3: Healthy Communities</b>	<ul style="list-style-type: none"> <li>▪ <b>Strengthens community-based preventive and primary care</b> through mobile clinics, community paramedicine, health kiosks, and wellness centers that deliver screenings, chronic disease management, and health education locally.</li> <li>▪ <b>Promotes regional coordination and community planning</b> by funding data-driven health delivery plans, aligning local stakeholders around shared priorities</li> </ul>
<b>B. 2. Health and lifestyle</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Invests in early childhood interventions</b> that encourage physical activity and have potential to improve long-term child health outcomes.</li> <li>▪ <b>Engages local clinics, THOs, schools, families, and community organizations</b> to deliver coordinated, culturally appropriate services, health education and public health interventions.</li> </ul>
	<b>#3: Healthy Communities</b>	<ul style="list-style-type: none"> <li>▪ <b>Implements evidence-based lifestyle interventions</b>, such as diabetes prevention programs, <i>Fresh Start</i>, and community wellness centers, all designed to produce measurable improvements in chronic disease management and overall health outcomes.</li> <li>▪ <b>Partners with local health, Tribal and community organizations</b> to deliver programs, coordinate services, and ensure culturally and regionally appropriate interventions.</li> <li>▪ <b>Targets root causes of poor health</b>, such as chronic disease, lack of preventive care, and limited health literacy, through integrated primary care units, health education, and home/community interventions.</li> </ul>
<b>C. 1. Rural provider strategic partnerships</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Supports specialized standby readiness</b> and other essential maternal care services in low-volume, high-acuity settings.</li> <li>▪ <b>Develops integrated partnerships</b> that expand care delivery close to home, including through rural maternal care workforce and mobile and itinerant clinics.</li> </ul>
	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Establishes strategic regional partnerships</b> between local providers and THOs to exchange best practices and deliver integrated, coordinated care.</li> <li>▪ <b>Expands access to specialty services</b>, including through clinical partnerships that support remote care services, telehealth and itinerant specialty clinics and novel service delivery options in remote and frontier communities.</li> </ul>
	<b>#3: Healthy Communities</b>	<ul style="list-style-type: none"> <li>▪ <b>Coordinates regional care delivery</b> to strategically plan activities that will enhance local innovation, expand needed services, and ensure their sustainability to most effectively meet regional and statewide health needs.</li> </ul>

	<b>#4: Pay for Value: Fiscal Sustainability</b>	<ul style="list-style-type: none"> <li>▪ <b>Promotes collaboration among rural health providers</b> to support operational efficiency, creating cost savings and improving overall financial sustainability.</li> <li>▪ <b>Implements new alternative payment models and value-based care models</b> that improve financial sustainability, preserve rural providers' independence, and allow providers to keep care local.</li> </ul>
<b>C. 2. EMS</b>	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Expands EMS integration with rural health systems</b> by upgrading and expanding access to specialized equipment and implementing community paramedicine to improve patient assessment, triage, and transport.</li> <li>▪ <b>Develops infrastructure and capacity to implement alternative site of care treatment</b> (e.g., treat-in-place, mobile integrated health care, and alternate destination transport).</li> <li>▪ <b>Strengthens providers' financial stability</b> by training agencies in accurate billing and testing alternative payment models that support both existing and newly developed EMS systems.</li> </ul>
<b>D. 1. Talent recruitment</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Invests in rural health career education</b> by supporting high school-to-career pathway programs, develop new upskill/reskill training opportunities, and expand local training infrastructure to grow the rural health workforce from within communities.</li> <li>▪ <b>Expands rural residency and fellowship programs</b> by funding new and expanded training opportunities with multi-year service commitments to strengthen provider retention.</li> <li>▪ <b>Provides relocation and retention incentives</b> such as housing assistance, relocation support, and structured bonuses for clinicians who serve rural and frontier areas for at least five years.</li> <li>▪ <b>Strengthens Tribal and IHS-aligned workforce programs</b>, including for CHA/Ps, BHA/Ps, and DHATs within the ATHS.</li> <li>▪ <b>Prioritizes training, certification, and expanded scope of practice</b> for community-based, non-hospital, and allied health professionals to sustain rural health access.</li> </ul>
	<b>#2: Health Care Access</b>	
	<b>#5: Strengthen Workforce</b>	
<b>E. 1. Medicaid provider payment incentives</b>	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Increases provider capacity and advance implementation of multi-payer alternative payment models</b> to reduce health care costs, improve patient outcomes, and shift care to lower-cost, high-value settings.</li> <li>▪ <b>Supports rural participation in value-based payment models</b>, including two-sided risk arrangements, that are grounded in evidence to influence provider and patient behavior.</li> <li>▪ <b>Transitions rural providers away from unsustainable FFS models</b> towards new payment paradigms to support financial sustainability.</li> </ul>
	<b>#4: Pay for Value: Fiscal Sustainability</b>	
<b>E. 2. Individuals dually eligible for Medicare and Medicaid</b>	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Assesses current programs and infrastructure</b> to identify opportunities to improve care coordination and alignment.</li> <li>▪ <b>Builds data-sharing capacity, support providers, and engage with beneficiaries and stakeholders</b> to understand barriers to better integrated care.</li> <li>▪ <b>Informs design of potential future integrated care models or plans</b> that align benefits, improve member experience, and enhance quality and efficiency.</li> </ul>
<b>F. 1. Remote care services</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Expands infrastructure and workforce to deliver remote maternal care services</b>, including renovations to install or enhance telehealth delivery and trainings on remote consultation and monitoring technologies.</li> </ul>
	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Deploys virtual technology infrastructure</b> to expand access to specialists in remote and frontier areas.</li> </ul>

	<b>#6: Spark Technology and Innovation</b>	<ul style="list-style-type: none"> <li>▪ <b>Improves remote care infrastructure</b> by enhancing telehealth infrastructure, deploying remote monitoring devices, and piloting emerging technologies in remote communities (e.g., portable diagnostic tools).</li> </ul>
<b>F. 2. Data infrastructure</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Supports cloud-based maternal health information platforms</b>, which combine interoperable EHRs, case management systems, and other technologies to enable providers to improve outcomes.</li> </ul>
	<b>#2: Health Care Access</b>	<ul style="list-style-type: none"> <li>▪ <b>Invests in data and IT upgrades</b>, including software, hardware, and equipment, to improve system interoperability and expand use.</li> </ul>
	<b>#3: Healthy Communities</b>	<ul style="list-style-type: none"> <li>▪ <b>Invests in interoperable data systems and analytics platforms</b> that aggregate clinical, behavioral, and health-related needs data.</li> </ul>
	<b>#6: Spark Technology and Innovation</b>	<ul style="list-style-type: none"> <li>▪ <b>Improves rural health care data infrastructure</b> through investments in statewide HIE and health care data interoperability, as aligned with national/federal standards.</li> <li>▪ <b>Supports rural health providers use of advanced data analytics, platforms, and operational tools</b> to support care delivery and coordination.</li> </ul>
<b>F. 3. Consumer-facing tech</b>	<b>#1: Healthy Beginnings</b>	<ul style="list-style-type: none"> <li>▪ <b>Develops and deploys consumer-facing digital tools and devices</b> to support maternal and child health, rural access to specialty services, and health prevention and chronic disease management, including mobile applications, patient portals, and remote monitoring devices.</li> </ul>
	<b>#2: Health Care Access</b>	
	<b>#3: Healthy Communities</b>	
	<b>#6: Spark Technology and Innovation</b>	

## D. Implementation Plan and Timeline

### Initiative Milestones

The following chart describes key implementation milestones across each of Alaska’s six RHTP initiatives. Each milestone is described briefly along with a timeline for implementation and assigned a stage corresponding to the NOFO phases.

**Table 9. Anticipated Milestones by Initiative**

Milestone	Timeline	Stage
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<b>General Program Setup</b>		
Launch RHTP Program Unit	Q1 2026	Stage 0
Open call for subrecipients across all initiatives	Q2 2026	Stage 0
Launch regional RHTP planning sessions	Q2 2026	Stage 0
Technical Assistance offered to subrecipients	<i>ongoing</i>	<i>ongoing</i>
Federal reporting	<i>annual</i>	<i>annual</i>
<b>#1 Healthy Beginnings</b>		
Modify spaces for youth extracurricular recreation and wellness activities	Q4 2026	2
Select maternal telehealth and remote monitoring vendor(s)	Q4 2026	1
Expand maternal workforce recruitment programs	Q1 2027	1
Launch new home visiting programs	Q1 2027	2
Deploy remote fetal monitoring devices	Q2 2027	1
Implement Presidential Fitness Test requirement for all schools	Q3 2027	5
Expand maternal workforce training programs	Q1 2028	3
Complete maternal care facility upgrades	Q4 2030	5
Establish reimbursement strategy for ongoing service delivery	Q4 2030	5
<b>#2 Health Care Access</b>		
Launch comprehensive provider gap analysis	Q2 2026	1
Begin CMS CCBHC demonstration program	Q3 2026	3
Upgrade and expand access to specialized EMS equipment	Q4 2026	0
Identify and prioritize rural facility renovation needs	Q4 2026	0
Enter contract(s) for expanded telehealth capabilities	Q1 2027	1
Launch expanded use of Tribally-led Traditional Healing	Q2 2027	3
Update Medicaid coverage to include remote patient monitoring	Q4 2027	5
Launch expanded itinerant specialty clinics	Q4 2027	4
Launch technology-driven prescription delivery methods	Q4 2027	4
Enact policy change to remove CON requirements for ancillary services	Q4 2027	5
Deploy/expand mobile dental clinic services	Q2 2028	3
Complete rural health facility upgrades	Q4 2030	5
<b>#3 Healthy Communities</b>		
Expand <i>Fresh Start</i> program reach	Q2 2026	3
Enter contracts to expand HIE interoperability	Q3 2026	2
Select vendor(s) for consumer-facing tools and technology	Q3 2026	1

Launch program for off-grid sanitation modifications	Q2 2027	2
Deploy consumer-facing tools and technology	Q2 2027	2
Finalize Supplemental Nutrition Assistance Program (SNAP) Food Restriction Waiver	Q4 2027	5
Develop staffing plans and equipment for new/expanded mobile and itinerant service lines	Q3 2028	4
Establish community wellness centers and improved nutrition education and resources	Q3 2028	5
Deploy new/expanded mobile and itinerant service lines	Q1 2029	3
<b>#4 Pay for Value: Fiscal Sustainability</b>		
Determine participation in CMMI AHEAD model	Q4 2026	0
Design value-based care arrangements, alternative payment methods and methodologies	Q2 2027	1
Contract with technical assistance vendors to support providers' adoption of value-based and alternative payments	Q2 2027	2
Launch value-based care arrangements, alternative payment methods and methodologies	Q3 2027	3
Launch transitional grants to support provider adoption	Q4 2027	2
Invest in IT infrastructure, staffing and equipment for successful participation	Q4 2027	3
Complete assessment of impact of value-based care arrangements, alternative payment methods and methodologies	Q3 2029	4
Adopt successful value-based care arrangements, alternative payment methods and methodologies	Q2 2030	5
<b>#5 Strengthen Workforce</b>		
Launch statewide health care provider training gap analysis	Q4 2026	0
Enter contracts with organizations to launch new programs	Q1 2027	1
Launch recruitment and retention incentives	Q1 2027	2
Establish statewide community health worker certification	Q1 2027	3
Finalize slots and number of new workforce programs	Q2 2027	2
Create new physician residency program slots	Q3 2027	4
First cohort of new/expanded workforce programs starts	Q3 2027	3
Expand scope of practice for pharmacists	Q4 2027	5
Join licensure compacts for physicians, nurses, EMS, psychologists, and physician assistants	Q4 2027	5
Launch new/expanded career pathway programs	Q1 2028	3
Establish requirement for nutrition to be included in continuing medical education for physicians	Q4 2028	5
<b>#6 Spark Technology and Innovation</b>		
Expand statewide health information exchange	Q2 2026	1
Provide targeted investments for participating in interoperable electronic health record system	Q3 2026	2
Select vendors for developing community-based care navigation and scheduling assistance applications	Q4 2026	5
Launch technical assistance and training programs for providers utilizing AI-powered workflow tools	Q4 2026	1

Launch the rural technology catalyst fund	Q2 2027	5
Deploy remote monitoring devices to providers	Q3 2027	2
Implement technology-enabled tools to perform population-level risk stratification	Q4 2029	3

## Governance and Project Management Structure

The Alaska DOH will lead the RHTP, providing overall administration, fiscal oversight, and compliance. Governance and project management will follow a tiered decision-making structure to ensure efficiency, accountability, and transparency, with clear lines of responsibility from strategic oversight to operational execution:

**Table 10. Governance Structure**

<b>Governance</b>	<b>Role</b>	<b>Description</b>
<b>Final Approval and Decision-maker</b>	Commissioner	Approve all funding decisions, policy guidance, and strategic direction.
<b>Strategic Direction and Oversight</b>	Deputy Commissioner	Align policy and strategic direction across DOH programs (e.g., Medicaid), ensure oversight and compliance.
<b>Program Governance</b>	Office of Health Savings (OHS) Director	Direct the RHTP Unit, manage interagency coordination, and act as primary liaison to the Commissioner’s Office and federal partners.
<b>Operational Management</b>	Senior Program Coordinator	Direct day-to-day program execution, internal communication, and performance tracking.
<b>Initiative Leadership</b>	Program Coordinators	Manage initiative-specific activities, liaise with subrecipients and other state agencies, ensure consistent reporting and compliance.
<b>Fiscal Accountability</b>	Administrative Operations Manager & Accounting Staff	Oversee fiscal controls, payment processing, and compliance with federal financial requirements.

To operationalize this structure, DOH will establish a dedicated RHTP Unit within the Office of Health Savings (OHS) in Q4 CY2025, with hiring and onboarding in Q1 CY2026 to align with federal funding. The RHTP Unit will include four new positions: one senior program coordinator and three program coordinators, responsible for program management, monitoring, and milestone achievement. Additionally, two new project coordinators in OHS will focus on advancing long-term sustainability and financing strategies for RHTP-supported initiatives (see *Budget Narrative*). Fully funded by the RHTP, the new positions will coordinate implementation across the six program initiatives, manage subgrants and contracts, support interagency and

stakeholder engagement, ensure federal compliance, and implement strategies to sustain RHTP activities beyond the performance period.

Fiscal and administrative support will be provided by two dedicated accountant positions within the Office of the Assistant Commissioner, reporting to the Administrative Operations Manager (see *Budget Narrative*). These positions will exclusively support RHTP fiscal and reporting activities, developing standardized workflows with the RHTP Unit and subgrant administrator to ensure timely, compliant fund distribution. Together, this cross-functional team integrates policy, fiscal, and programmatic oversight to deliver a unified, accountable management structure for the RHTP.

#### External Subrecipient Administrator

To efficiently distribute funds statewide, DOH will contract with a community-based subgrant administrator in Q4 CY2025, with award and onboarding in Q1 CY2026. Operating under a formal agreement and federal requirements, the subrecipient administrator will:

- Manage outreach, application, and award processes for subrecipient;
- Provide targeted TA for application and reporting;
- Track expenditures and collect fiscal and program reports;
- Monitor compliance and coordinate with DOH on performance reporting; and
- Maintain an accessible, transparent application and award system.

This model builds on DOH's successful COVID-19 relief funds distribution plan, which significantly improved efficiency and accountability.

## Advisory Council Framework

DOH established an RHTP Advisory Council comprising organizations spanning Alaska's health system, including representatives from Tribal health, hospitals, and primary care. Other entities may be added as necessary. The Advisory Council will meet at least quarterly, supported by a program officer from the RHTP Unit who will provide administrative support and maintain archived records. The purpose of the Advisory Council is to provide informed, structured, and practical input so that rural health transformation efforts are implemented effectively, sustainably, and in alignment with the approved program framework. Responsibilities may include:

- Providing feedback on implementation approaches consistent with the approved RHTP application
- Advising on operational considerations, risks, and opportunities identified during implementation
- Offering rural, Tribal, provider, and community perspectives to inform DOH planning
- Identifying emerging challenges or gaps that may affect program success

DOH will review the Advisory Council input and recommendations throughout the lifetime of the program. The Advisory Council will submit annual recommendations on program improvement, emerging priorities, and systemic barriers to inform future program adjustments and cross-agency system planning.

## E. Stakeholder Engagement

### Alaska’s Collaborative Approach

Partnership is Alaska’s greatest strength and the foundation for transforming care and improving rural health. Collaboration is not new to Alaska; it is how health care has always been delivered in a state where distance, weather, and small populations demand partnership at every level. Alaska's RHTP builds on this, with stakeholder engagement defining our approach.

### Stakeholder Consultation

Alaska has engaged a broad and representative group of stakeholders in developing its RHTP plan. Engagement has been continuous and layered, combining structured Advisory Council meetings, public input, and targeted outreach to specific sectors and regions. Collectively, these efforts have shaped every major element of the state’s application. They include hospital leaders, private primary care practitioners, multi-disciplinary specialty organizations, Tribal health officials, legislators, seniors, EMS providers, pharmacists, the Alaska Municipal League, local philanthropy groups, other state agencies, disability councils, advocacy organizations, subject-matter experts, and university leadership.

**Table 11. Completed Stakeholder Engagement**

Engagement	Description	Volume/Frequency	Outcome/Impact
<a href="#">Request for Information (RFI)</a> <sup>130</sup>	Open call for public and organizational input statewide.	<a href="#">160 responses representing over 400 projects and recommendations.</a> <sup>131</sup>	Input and ideas were integrated across all six initiatives.
<b>RHTP Advisory Council</b>	Comprised of four statewide organizations co-designing Alaska’s RHTP.	Meeting weekly since August 2025.	Supported RHTP application and will serve as an ongoing advisory body post-award.
<b>Direct Meetings and Listening Sessions</b>	Targeted discussions with health care and community leaders.	20+ meetings since August 2025.	Shaped program design, identified priorities, and generated widespread support.

**RFI Engagement.** Upon release of the NOFO, Alaska issued one of the earliest RFIs in the nation, inviting ideas and recommendations for rural transformation. Of the 160 respondents, 77% were Alaska-based or experienced in Alaska. Approximately 36% were providers (including THOs), 15% each were health technology vendors and consulting firms, and 11% were patient advocates. Other respondents included patients, community organizations, educational institutions, trade associations, and public officials. This breadth of participation ensured that both service providers and public perspectives were represented from the outset.

**RHTP Advisory Council.** The Advisory Council has met weekly with DOH leadership since August 2025 to guide RHTP planning and structure; each has submitted a letter of support.

**Direct Meetings and Listening Sessions.** In addition to the RFI, DOH has convened more than 20 meetings with stakeholders. These meetings were instrumental in shaping RHTP strategy and building broad support for Alaska's approach (see *Supporting Document E* for a comprehensive list of organizations engaged prior to NOFO release).

In addition to organizational engagement and the RFI process, DOH posted the proposed initiatives and fund uses online for multiple rounds of public review and feedback, which has been incorporated into this application. This process was open to individuals and organizations, enabling direct input from the public, caregivers, and individual providers.

### *Engagement Framework*

Alaska's stakeholder engagement is designed as a continuous feedback cycle rather than a top-down process with 1) the Advisory Council; 2) Tribal engagement and consultation; 3) community-led, regional development plans; and 4) public engagement. This robust engagement framework allows DOH to create an ongoing process aimed at enhancing operational efficiency

and identifying areas of improvement. This process will inform the reallocation of resources to ensure that Alaska directs funds towards the areas of greatest impact and need.

**Table 12. Stakeholder Engagement Framework**

<b>Partner</b>	<b>Method</b>	<b>Cadence</b>	<b>Purpose</b>
<b>Advisory Council</b>	In-person/virtual meetings	Min: quarterly	Provide input, feedback, and TA.
<b>Tribal Entities</b>	In-person/virtual meetings	Min: quarterly	Tribal consultation and feedback.
<b>Regions/Community</b>	Targeted discussions with health care and community leaders	Year 1; Year 3, Year 5	Listening, resource coordination, sharing best practices, and TA.
<b>State Agencies</b>	In-person/virtual	Ongoing	Coordination with subject matter experts in Medicaid, rural health, housing, child care, and corrections to support and inform RHTP efforts.
<b>Public At-Large</b>	Website, online materials, annual reports, project status, surveys, dedicated email	Ongoing	Education, public awareness, and promotion of engagement and opportunities.

Evidence of Support

To date, DOH has received letters of support from 95 entities statewide from hospitals, THOs, behavioral health providers, community partners, private primary care practitioners, federally qualified health centers, pediatric providers, multi-disciplinary specialty organizations, senior groups, EMS providers, pharmacists, the Alaska Municipal League, unions, non-profits, associations, local philanthropy groups, other state agencies, disability councils, advocacy organizations, and individual Alaskans. All organizations currently serving on the Advisory Council have also each submitted formal letters of support. These are included in *Supporting Document F*

and demonstrate a shared commitment to collaboration and to advancing Alaska’s strategic goals.

## **F. Metrics and Evaluation Plan**

### Performance Metrics

To evaluate the effectiveness of each initiative, Alaska has developed a comprehensive set of quantifiable performance metrics. These measures will be tracked using data submitted by participating entities, supplemented with information from existing state health data systems, national surveys, and data reported by partners. All metrics will be analyzed and reported on an annual basis, with progress published to ensure transparency and accountability. For metrics not derived directly from RHTP program data, Alaska already maintains established data collection, analysis, and reporting processes. Baseline values are provided using the most recently available data. The table below presents Alaska’s proposed performance metrics for each RHTP initiative.

**Table 13. Alaska’s RHTP Performance Metrics**

*Note: Data for all metrics, except for four identified with an asterisk (\*), are available on a community level.*

Outcome Metric	Data Source	Baseline (Year)	Target 1: FFY 2027	Target 2: FFY 2029	Target 3: FFY 2031
<b>#1 Healthy Beginnings</b> (maternal and infant health, childhood health, school programming/child care)					
Percentage of women receiving prenatal care in the first trimester	<a href="#">Alaska Vital Statistics Annual Report</a> <sup>132</sup> and <a href="#">Dashboard</a> <sup>133</sup>	72.3% (2023)	75%	78%	81.1%
Infant mortality rate	<a href="#">Alaska Vital Statistics Annual Report</a> <sup>134</sup> and <a href="#">Dashboard</a> <sup>135</sup>	7.2 (2021-2023)	6.8	6.2	5.6
Pregnancy-associated deaths*	<a href="#">Maternal Child Death Review Committee Annual Report</a> <sup>136</sup>	66 (2019-2023)	63	59	55
Number of early intervention and infant learning program screenings performed in the past year	Alaska Infant Learning Program Screening Hub	5,829 (2024)	6,020	6,220	6,420
Number of home visits provided by evidence-based programs	<a href="#">National Home Visiting Resource Center</a> <sup>137</sup>	8,152 (2024)	8,500	9,000	9,500
Number of school districts participating in Medicaid School-Based Services programs	Alaska Medicaid program data	6 (2025)	7	9	10
Number of new facilities supporting technology-enabled maternal care infrastructure	RHTP reporting	N/A	4	10	20
<b>#2 Health Care Access</b> (integrated preventive, primary, behavioral, and oral health; specialty care; emergency services; recovery at home)					
Percentage of adults reporting they have a primary care provider	<a href="#">Alaska Behavioral Risk Factor Surveillance System Dashboard</a> <sup>138</sup>	74.6% (2024)	76%	78%	80%
Percentage of adults with current age-appropriate cancer screenings	<a href="#">Alaska Behavioral Risk Factor Surveillance System Dashboard</a> <sup>139</sup>	61% (2023)	65%	68%	70%
Percentage of Medicaid recipients receiving community-based behavioral health services in the past year	Alaska Medicaid claims data	7.6% (2025)	9%	11%	13%
Percent of Medicaid youth with follow-up care within 30-days after hospitalization for mental illness*	<a href="#">CMS Medicaid and CHIP Core Set Data Dashboard</a> <sup>140</sup>	45.7% (2024)	65%	80%	90%
Number of Tribes or THOs offering Traditional Healing services	<a href="#">ANTHC Data</a> <sup>141</sup>	5 (2025)	7	9	11

Drug overdose mortality rate	<a href="#">Alaska Vital Statistics Annual Report</a> <sup>142</sup> and <a href="#">Dashboard</a> <sup>143</sup>	45.5 (2024)	35	25	15
Suicide mortality rate	<a href="#">Alaska Vital Statistics Annual Report</a> <sup>144</sup> and <a href="#">Dashboard</a> <sup>145</sup>	29.9 (2024)	28.5	27	25
<b>#3 Healthy Communities</b> (health promotion and disease prevention, healthy lifestyles, and social connection)					
Percentage of adults reporting recent physical activity outside of work	<a href="#">Alaska Behavioral Risk Factor Surveillance System Dashboard</a> <sup>146</sup>	81.6% (2024)	83%	85%	87%
Percentage of adults consuming one or more sugary drinks per day	<a href="#">Alaska Behavioral Risk Factor Surveillance System Dashboard</a> <sup>147</sup>	25.5% (2024)	24%	22%	20%
Number of participants in Alaska's <i>Fresh Start</i> programs	<a href="#">Fresh Start Program Data</a> (annual) <sup>148</sup>	2,000 (2025)	3,300	4,600	5,000
Number of schools administering the Presidential Fitness Test in alignment with Executive Order 14327	Alaska Department of Education and Early Development	0 (2025)	100	300	493
Number of programs deploying RHTP-funded consumer-facing technologies (e.g., wearables, remote-monitoring, app-based technologies)	RHTP reporting	N/A	5	15	30
<b>#4 Pay for Value: Fiscal Sustainability</b> (alternative payment methods (APMs), value-based care, operational and systems efficiency)					
Number of providers that engage in APM readiness assessments and/or develop APM implementation plans	RHTP reporting	N/A	10	15	20
Number of providers voluntarily participating in new APMs	Alaska Medicaid and CMMI Program data	N/A	0	10	20
Number of providers reporting quality measures for value-based care participation via HIE	<a href="#">healthEconnect Alaska</a> <sup>149</sup>	0	0	10	20
Number of non-Tribal CAHs with 273 days or more cash on hand	<a href="#">Health Care Cost Report Information System Medicare Cost Report</a> <sup>150</sup>	1 (2024)	3	5	7
Rate of potentially avoidable emergency department visits for seniors 65+	<a href="#">Commonwealth Scorecard</a> <sup>151</sup>	156.1 (2023)	145	140	135
<b>#5 Strengthen Workforce</b> (health care workforce pipeline and retention, provider training programs)					
Physicians per 100,000 population	<a href="#">HRSA Area Health Resource File</a> <sup>152</sup>	304 (2022)	310	320	330

Number of certified CHA/Ps, BHA/Ps, DHATs, and Community Health Workers*	<a href="#">ANTHC Data</a> <sup>153</sup> and Alaska Community Health Worker Network	549 (2025)	580	615	650
Number of physician residency slots*	Hospital reporting	12 (2025)	16	25	32
Number of participants in RHTP-funded workforce programs	RHTP reporting	N/A	50	150	300
Number of RHTP-funded programs for recruitment and retention incentives and supports	RHTP reporting	N/A	5	10	20
<b>#6 Spark Technology and Innovation</b> (wearables, telehealth, data sharing and systems)					
Number of hospitals and clinics using RHTP-funded AI technologies and tools	RHTP reporting	N/A	0	3 hospitals 10 clinics	7 hospitals 20 clinics
Number of hospitals and clinics with RHTP-funded remote patient monitoring capabilities	RHTP reporting	N/A	0	3 hospitals 10 clinics	7 hospitals 20 clinics
Percentage of eligible Medicaid providers delivering telehealth services	Alaska Medicaid claims data	32.8% (2024)	36%	38%	40%
Number of hospitals sharing full clinical data with the HIE	<a href="#">healthEconnect Alaska</a> <sup>154</sup>	7 (2025)	10	18	26
Number of entities participating in the HIE	<a href="#">healthEconnect Alaska</a> <sup>155</sup>	92 (2024)	100	110	120

### Evaluation Plan

Alaska will implement a structured, multi-tiered evaluation and monitoring approach to ensure transparency, accountability, and continuous improvement throughout the cooperative agreement. As further described below, evaluation activities will occur at the project, initiative, and statewide levels, supported by subrecipient reporting, two-year project impact evaluations, and third-party and state oversight.

**Table 14. Evaluation Plan**

Evaluation Activities	Responsible Party	Frequency	Purpose
<b>Project-Level: Regular Assessments</b>			
<ul style="list-style-type: none"> <li>Subrecipients submit quarterly progress reports documenting activities, outputs, and key performance indicators.</li> <li>Reports identify program barriers and emerging needs.</li> <li>Subrecipients participate in data verification and site monitoring/visits as requested.</li> </ul>	Subrecipients	Quarterly	<ul style="list-style-type: none"> <li>Track progress toward project objectives.</li> <li>Identify implementation challenges and successes.</li> <li>Support adaptive management and quality improvement.</li> <li>Identify areas where additional support or collaboration may be beneficial.</li> </ul>
<b>Project-Level: Two-Year Subrecipient Impact Evaluation</b>			
<ul style="list-style-type: none"> <li>Subrecipients conduct a two-year evaluation assessing the impact of their project on service delivery, outcomes, and system performance.</li> <li>Evaluation methods may include data analysis, stakeholder interviews, and outcome tracking.</li> </ul>	Subrecipients	One-time; Year 2 of subrecipient grant period	<ul style="list-style-type: none"> <li>Assess intermediate outcomes and inform mid-course corrections.</li> <li>Generate preliminary evidence on project effectiveness and replicability.</li> <li>Support decision-making and strategic refinement of the program.</li> </ul>
<b>Project-Level: Progress and Funding Assessment</b>			
<ul style="list-style-type: none"> <li>Aggregate and review subrecipient performance against key milestones.</li> </ul>	DOH RHTP Unit and Advisory Council	Annual	<ul style="list-style-type: none"> <li>Determine if project-level funding should continue. Reallocate funds to existing or new projects, as needed.</li> <li>Ensure consistency in performance reporting.</li> <li>Provide TA or corrective guidance based on findings.</li> </ul>
<b>Initiative- and State-Level: DOH Monitoring and Evaluation</b>			
<ul style="list-style-type: none"> <li>Aggregate and validate performance data across initiatives.</li> <li>Conduct systematic review and synthesis of quarterly subrecipient data.</li> </ul>	DOH RHTP Unit, with support from Advisory Council	Annual	<ul style="list-style-type: none"> <li>Develop annual reports based on quarterly submissions and project assessments</li> <li>Assess impact of funding and trends across initiatives.</li> <li>Ensure accountability, transparency, and alignment with RHTP objectives.</li> <li>Support decision-making and strategic refinement of the program.</li> </ul>
<b>Initiative- and State-Level: CMS Reporting</b>			
<ul style="list-style-type: none"> <li>Analyze data across initiatives to evaluate impact of RHTP in accordance with federal reporting requirements.</li> </ul>	DOH RHTP Unit	As required by	<ul style="list-style-type: none"> <li>Execute federal reporting requirements</li> <li>Assess impact of funding and trends across initiatives.</li> </ul>

Evaluation Activities	Responsible Party	Frequency	Purpose
		cooperative agreement	<ul style="list-style-type: none"> <li>• Ensure accountability, transparency, and alignment with RHTP objectives.</li> <li>• Support decision-making and strategic refinement of the program.</li> </ul>
<b>Final Evaluation:</b> Independent Third-Party Evaluation			
<ul style="list-style-type: none"> <li>• Undertake formal external impact evaluation at the end of the grant period comparing program impacts with baseline and target metrics.</li> <li>• Assess program implementation, outcomes, cost-effectiveness, and scalability.</li> </ul>	Independent Evaluator (contracted)	End of RHTP funding period (2031)	<ul style="list-style-type: none"> <li>• Assess program outcomes.</li> <li>• Inform sustainability planning and future funding strategies.</li> </ul>
<b>Ongoing CMS Coordination</b>			
<ul style="list-style-type: none"> <li>• Cooperate fully with CMS-initiated evaluations or monitoring efforts across participating states.</li> <li>• Respond to data requests and participate in learning collaboratives.</li> </ul>	DOH RHTP Unit, Subrecipient administrator, Subrecipients	As requested by CMS	<ul style="list-style-type: none"> <li>• Contribute to federal learning goals.</li> <li>• Share best practices and cross-state implementation insights.</li> </ul>

## G. Sustainability Plan

Through the RHTP, Alaska will make investments that serve as a basis for lasting transformation. In the first year, DOH and its partners will launch statewide planning efforts to identify priority projects, solicit proposals, and begin targeted investments. Each subrecipient proposal will be assessed on sustainability plans as part of the evaluation process (see *Supporting Document D*), ensuring early alignment between near-term implementation and long-term viability.

The chart below outlines ten project type categories to be implemented across Alaska’s six RHTP initiatives and the sustainability approaches planned for each category. The example projects below collectively demonstrate how RHTP funds will

advance the state’s goals to improve access, quality, and fiscal stability across the state while ensuring that every RHTP dollar continues to deliver measurable benefits well beyond the grant period.

**Table 15. Sustainability Approach**

Example Projects Across RHTP Initiatives	Sustainability Approach
<b>Planning &amp; Technical Assistance (TA)</b>	
<ul style="list-style-type: none"> <li>• Provide training and TA for technology-enabled maternal care services to equip rural providers with the skills needed to deliver coordinated telehealth-based care. (<i>Healthy Beginnings</i>)</li> <li>• Conduct a comprehensive provider gap analysis to identify workforce shortages and inform strategies for improving rural access to maternal and primary care. (<i>Health Care Access</i>)</li> <li>• Develop community health plans that align local priorities with statewide health goals, ensuring service coordination and sustainability beyond initial grant funding. (<i>Healthy Communities</i>)</li> <li>• Deliver TA to help providers and health systems participate successfully in value-based care arrangements and compliance with performance metrics. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>• Design “grow your own” workforce pipeline programs that recruit and train local participants to enter the health care field and serve their home communities. (<i>Strengthen Workforce</i>)</li> <li>• Provide training in appropriate artificial intelligence and telehealth technologies for clinical providers and support staff. (<i>Spark Technology and Innovation</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>• Start-up costs to enable coordination, planning, and partnership development.</li> <li>• Establishes frameworks and pathways for successful design and implementation of new policies and programs.</li> <li>• Creates foundational models that become embedded in long-term service delivery systems.</li> </ul> <p><b>Post-RHTP:</b></p> <ul style="list-style-type: none"> <li>• No ongoing or long-term costs expected.</li> </ul>
<b>Capital Improvements</b>	
<ul style="list-style-type: none"> <li>• Renovate rural maternal care and birthing centers to modernize facilities, expand service capacity, and improve safety for patients and staff. (<i>Healthy Beginnings</i>)</li> <li>• Renovate clinics to co-locate primary and behavioral health services. (<i>Health Care Access</i>)</li> <li>• Renovate community wellness centers to create dedicated spaces for physical activity, nutrition education, and health promotion programs. (<i>Healthy Communities</i>)</li> <li>• Support facility upgrades that enable providers to meet value-based care requirements. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>• Upgrade training and simulation centers to enhance hands-on learning opportunities for rural health providers. (<i>Strengthen Workforce</i>)</li> <li>• Launch a rural health infrastructure catalyst fund to support planning, predevelopment, and one-time renovation projects that expand health care access in remote communities. (<i>Spark Technology and Innovation</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>• One-time funding to improve the safety, efficiency, and capacity of existing health care and rural community infrastructure to provide high-quality services to members, aligned with RHTP goals.</li> <li>• Sustainability ensured through formal grant agreements requiring subrecipient to demonstrate ability to maintain and manage facilities post-award with ongoing revenue streams.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>• Long-term ongoing costs covered through reimbursement-based revenue when possible, local funds, or operational budgets.</li> </ul>
<b>Workforce</b>	

Example Projects Across RHTP Initiatives	Sustainability Approach
<ul style="list-style-type: none"> <li>Recruit and train CHA/Ps and maternal health care workers to expand the capacity of locally available skilled professionals. (<i>Healthy Beginnings</i>)</li> <li>Recruit and retain a diverse primary and behavioral health workforce through relocation incentives and local employment partnerships. (<i>Health Care Access</i>)</li> <li>Use integrated primary and preventive care units as interprofessional training sites where medical, nursing, and behavioral health trainees gain experience serving rural populations. (<i>Healthy Communities</i>)</li> <li>Support and train providers to participate in new CMS innovation models by helping them build the infrastructure and data systems needed for value-based reimbursement. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>Implement targeted recruitment and retention incentives, such as stipends, career advancement opportunities, and housing assistance, for health care professionals in high-need rural and frontier areas. (<i>Strengthen Workforce</i>)</li> <li>Provide technology-focused training to equip health care workers with the skills to use telehealth platforms, electronic health records, and digital monitoring tools effectively. (<i>Spark Technology and Innovation</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>One-time costs for trainings, scholarships, and workforce pipeline programs.</li> <li>Strengthens provider capacity and retention through five-year service agreements.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>Long-term sustainability maintained through amendments to the Medicaid program when possible, ongoing collaboration with universities and community-based programs, and public-private partnerships that sustain effective workforce programs.</li> </ul>
<b>Technology</b>	
<ul style="list-style-type: none"> <li>Fund the development and adoption of interoperable maternal health information technology and mobile applications that improve coordination of care and patient engagement. (<i>Healthy Beginnings</i>)</li> <li>Deploy telehealth platforms across rural and frontier communities to expand virtual access to specialty care, behavioral health consultations, and primary care services. (<i>Health Care Access</i>)</li> <li>Deploy consumer-facing digital health tools such as mobile apps and wearable devices to support chronic disease self-management and encourage healthier behaviors. (<i>Healthy Communities</i>)</li> <li>Invest in providers' IT infrastructure to strengthen their ability to collect and analyze data for value-based payment models and quality improvement initiatives. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>Build workforce analytics platforms to monitor workforce distribution, performance, and inform long-term staffing strategies. (<i>Strengthen Workforce</i>)</li> <li>Invest in expanding healthEconnect Alaska by enhancing secure data sharing, integrating electronic medical records, and building interoperable tools and portals. (<i>Spark Technology and Innovation</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>Start-up costs for equipment, connectivity, and system integration.</li> <li>Sustainability ensured by requiring recipients to develop maintenance and reimbursement sustainability plans.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>Long-term sustainability supported via amendments to the Medicaid program as appropriate, collaboration with the Division of Insurance for third party reimbursement pathways, user fees for platform use, and vendor agreements.</li> </ul>
<b>Adding Service Lines</b>	
<ul style="list-style-type: none"> <li>Enhance maternal and child health home visiting programs. (<i>Healthy Beginnings</i>)</li> </ul>	<p><b>During RHTP:</b></p>

Example Projects Across RHTP Initiatives	Sustainability Approach
<ul style="list-style-type: none"> <li>Strengthen Tribal Traditional Healing services by integrating culturally appropriate practices with clinical health care. (<i>Health Care Access</i>)</li> <li>Support programs that offer home environment assessments and implement modifications to improve health and safety for community members aging in place or with disabilities. (<i>Healthy Communities</i>)</li> <li>Enhance care coordination services for dual eligibles. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>Provide child care supports for health providers to strengthen workforce in rural and frontier settings. (<i>Strengthen Workforce</i>)</li> <li>Deploy consumer-facing digital tools that support individuals with chronic conditions, behavioral health concerns, and substance use disorders. (<i>Spark Technology and Innovation</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Start-up costs to establish and/or expand programs and operations and implement care models.</li> <li>Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>Long-term support achieved via amendments to the Medicaid program as appropriate, collaboration with the Division of Insurance for third party reimbursement pathways, and incorporation into value-based payment models.</li> </ul>
<b>Expanding Access to Services Already Covered</b>	
<ul style="list-style-type: none"> <li>Expand access to prenatal and postpartum care through telehealth. (<i>Healthy Beginnings</i>)</li> <li>Deploy mobile dental clinics equipped to provide oral health care in rural and frontier areas. (<i>Health Care Access</i>)</li> <li>Expand access to preventive health screenings within communities to improve early detection and intervention for chronic health conditions. (<i>Healthy Communities</i>)</li> <li>Integrate reimbursable value-based health services into new payment models. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>Support innovative staffing models. (<i>Strengthen Workforce</i>)</li> <li>Pilot billing and reimbursement models for remote patient monitoring technologies that support care. (<i>Spark Technology and Innovation</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>One-time costs to launch, expand or improve innovative, effective services.</li> <li>Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>Long-term sustainability achieved by ongoing reimbursement under Medicaid and other public/private payers.</li> </ul>
<b>Programs</b>	
<ul style="list-style-type: none"> <li>Implement youth wellness programs in schools and communities that promote physical activity, nutrition, and mental health resilience. (<i>Healthy Beginnings</i>)</li> <li>Operate mobile dental clinics in partnership with local community organizations and schools that bring essential services directly to rural and frontier populations. (<i>Health Care Access</i>)</li> <li>Support evidence-based chronic disease prevention programs focused on reducing risk factors such as tobacco use and obesity in rural communities. (<i>Healthy Communities</i>)</li> <li>Launch rural health sustainability accelerator programs that assist providers with strategic planning, financial modeling, and operational efficiency improvements to enhance long-term viability. (<i>Pay for Value: Fiscal Sustainability</i>)</li> <li>Develop and expand rural-focused health training academies and residency programs to build a skilled workforce competent in primary, behavioral, and specialty care delivery. (<i>Strengthen Workforce</i>)</li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>Start-up costs to launch and test promising programs, models and innovations.</li> <li>One-time costs to expand evidence-based programs that measurably improve outcomes.</li> <li>Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>Long-term sustainability achieved via amendments to the Medicaid program as appropriate, collaboration with the Division of Insurance for third party reimbursement pathways, and a combination</li> </ul>

Example Projects Across RHTP Initiatives	Sustainability Approach
<ul style="list-style-type: none"> <li>• Create community navigation apps that connect rural residents to critical health and social services. <i>(Spark Technology and Innovation)</i></li> </ul>	<p>of additional service fees, philanthropic support, or public health integration.</p>
<b>Payment Structures</b>	
<ul style="list-style-type: none"> <li>• Develop payment models that support the expansion of maternal health programs. <i>(Healthy Beginnings)</i></li> <li>• Pilot alternative EMS payment models. <i>(Health Care Access)</i></li> <li>• Implement alternative payment methodologies to support comprehensive health service delivery. <i>(Pay for Value: Fiscal Sustainability)</i></li> <li>• Pilot service-linked incentives for providers to promote recruitment and retention in rural, remote, and frontier areas. <i>(Strengthen Workforce)</i></li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>• Start-up costs to develop, implement, and evaluate new payment arrangements.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>• Sustained through policy changes that align across Medicaid, public health, and private payers.</li> </ul>
<b>Statewide System Investments</b>	
<ul style="list-style-type: none"> <li>• Develop state eligibility and enrollment systems that streamline access to health coverage and services. <i>(Health Care Access)</i></li> <li>• Build population health analytics platforms that integrate health data to drive targeted interventions. <i>(Healthy Communities)</i></li> <li>• Modernize state health data systems to support the state and providers’ participation in CMS Innovation Center models. <i>(Pay for Value: Fiscal Sustainability)</i></li> <li>• Expand HIE platforms to rural and frontier providers. <i>(Spark Technology and Innovation)</i></li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>• Start-up costs for system design, installation, and integration.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>• Continued system maintenance later supported by dedicated, recurring funding streams.</li> <li>• Long-term sustainability ensured by embedding into core state operations and fiscal planning for continued governance and adaptability.</li> </ul>
<b>Collaboration and Partnerships</b>	
<ul style="list-style-type: none"> <li>• Establish partnerships between rural schools, THOs, and community service providers to implement school-based wellness programs, coordinating resources and expertise to deliver physical activity, nutrition education, and mental health support. <i>(Healthy Beginnings)</i></li> <li>• As part of a comprehensive provider gap analysis, support collaboration with and among THOs, local hospitals, clinics and primary care providers and other community leaders to ensure accurate and culturally appropriate findings. <i>(Health Care Access)</i></li> <li>• Support partnerships with local transit agencies, community organizations, and Tribal entities to design flexible, community-driven transportation solutions to connect people to care. <i>(Healthy Communities)</i></li> <li>• Facilitate payment and delivery model partnerships that support innovative care coordination and sustainability in rural health systems. <i>(Pay for Value: Fiscal Sustainability)</i></li> <li>• Partner with academic and licensing bodies to standardize workforce certification, reduce barriers, and expand professional development opportunities. <i>(Strengthen Workforce)</i></li> <li>• Cultivate public-private partnerships to accelerate technology adoption and infrastructure development. <i>(Spark Technology and Innovation)</i></li> </ul>	<p><b>During RHTP:</b></p> <ul style="list-style-type: none"> <li>• Start-up costs to develop collaborative frameworks among Tribal, community, academic, and private partners.</li> <li>• Subrecipients required to identify sustainability plans as part of funding request; subrecipients’ proposals evaluated on the quality of their sustainability plans.</li> </ul> <p><b>Post RHTP:</b></p> <ul style="list-style-type: none"> <li>• Long-term sustainability maintained through shared resource contributions and diversified funding sources.</li> <li>• Reduce continuing/long-term costs by promoting coordinated service delivery and joint workforce or infrastructure initiatives.</li> </ul>

## Endnotes: Works Cited and Notes

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