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.[1] 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.[2] 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.[3] 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.[4] Wild subsistence foods are healthier and more

economical than processed store-bought foods, which must be shipped into rural communities at great expense.[5,6]

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.[7] 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.[8]

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.

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.[9,10,11] Major employment sectors in Alaska include health care, Tribal corporations, commercial fishing, transportation, and retail.[12,13] 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.[14] Over the last decade, 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.[15] The cost of living is 24% higher than the national average, driven by Alaska's geography, extreme weather conditions, and infrastructure challenges.[16] For example, the price of a gallon of milk can reach $20 in frontier areas in winter months, over four times the national average.[17]

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.[18] 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.[19] 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.[20] 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 communities lack road connections (see *Supporting Document A*), relying on small planes,

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

ferries, or snow machines, with only 35% of roads paved.[21,22,23] 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.[24] 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.[25,26,27] Housing conditions are also strained, with an estimated 7,000 new housing units needed over the next decade to address overcrowding.[28] 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.[29,30,31] 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.[32] In many communities, communal "washaterias" serve as the sole access point to showers, laundry, and potable water. However, these facilities are vulnerable

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

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.[33] Satellite internet has recently improved internet access, presenting new opportunities in rural communities, but capacity remains limited.[34]

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.[35] 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
• 70 regional clinics and health centers • 193 village-based clinics • 93 behavioral health and substance use treatment facilities • 8 hospitals	• Primary medical care • Specialty care and professional support services • Dental and oral health • Behavioral health • Preventive wellness programs • Health research • Health education for rural primary care • Public health community infrastructure

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 Tribal telehealth network, connecting more than 200 sites and setting an early example for the

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

nation.[36] Telehealth expanded substantially during COVID-19, reducing travel burdens and increasing access to care for remote and frontier Alaska communities.[37] 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.[38]

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.[39,40] These models have been successfully replicated in parts of the Lower 48 as models of sustainable, culturally grounded rural health delivery.[41,42]

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.[43] Behavioral health programs have also been reduced or are insufficient, forcing patients to travel or temporarily relocate to access care.[44]

- **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.[45] 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.[46]
- **Limited specialty and inpatient capacity:** Alaska lacks a Level 1 trauma center and a dedicated burn center.[47,48] 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.[49,50,51,52] Organ transplants are not performed in-state, there is no capacity for extracorporeal membrane oxygenation (ECMO), and limited availability of pediatric subspecialists.[53,54,55]
- **Dependence on out-of-state care:** Patients requiring advanced or highly specialized services are routinely referred to hospitals in the Pacific Northwest, primarily Seattle, WA.[56,57,58]
- **Limited primary care access for seniors:** Many primary care providers limit how many Medicare patients they can accept due to low reimbursement rates.[59]
- **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.[60,61]

- **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.[62,63]

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.[64] 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.[65] 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.[66]
- **No Medicare Advantage (MA) plans:** Alaska is the only state without MA plans, due to a small market, limited infrastructure, and network adequacy challenges.[67]
- **Limited local public health authority:** Alaska has no county-level governments.[68] Only two boroughs (Anchorage and North Slope) exercise very limited health authority.[69] 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.[70] Tribal Health

Organizations (THOs) deliver much of the direct care for AN/AI people, and often serve all residents in rural areas.[71,72,73]

- **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%).[74,75] 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.[76,77]
- **Aging and outdated infrastructure:** Many health care facilities are aging and require extensive modernization.[78]
- **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).[79]

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.[80,81,82,83]
- **Poor maternal and infant health outcomes:** Maternal and infant health outcomes are below national averages, particularly for AN/AI and rural populations.[84]
- **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.[85] The state's suicide rate is more than twice the national average, disproportionately impacting AN/AI and rural youth.[86,87]

- **Substance misuse and related harms:** Drug overdose death rates in Alaska are consistently among the highest in the country.[88] Between 2022 and 2023, drug overdose death rates in Alaska increased by 47% overall, and Alaska ranked sixth in the US.[89,90]
- **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.[91,92,93,94]
- **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.[95,96,97]
- **Fragile financial conditions and outdated payment models:** Many rural hospitals and clinics operate with small margins, high fixed costs, and outdated FFS reimbursement.[98]
- **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.[99]

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.[100] 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.[101] 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
Pregnant and Postpartum Women in Rural Communities Population baseline: • 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).[102] • Infant mortality rate of 6.1 per 1,000 live births and 64% higher among AN/AI births.[103] Population needs: • Expanded access to comprehensive prenatal and postpartum care in rural, remote, and frontier regions to improve maternal and infant outcomes. • Integrated maternal behavioral health and substance use treatment into family health settings to ensure early identification and management. • Strengthened postpartum support programs to promote healthy infant development and maternal wellness.
Underserved Children and Youth in Rural Alaska Population baseline: • Children make up 24% of Alaska's population.[104] • 28% of children live below 200% of the federal poverty level; 13% are uninsured or underinsured.[105] • 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.[106] Population needs: • Improved access to coordinated preventive, dental, and behavioral health services. • Expanded access to consistent care aligned with child development milestones. • Expanded access to nutrition programs addressing food insecurity and teaching healthy eating habits. • Delivered behavioral and preventive services where children and adolescents can easily access them.
Alaskans with Behavioral Health and Substance Use Disorders (BH/SUD) in Rural Communities Population baseline: • Less than half of youth ages 12–17 receive needed SUD treatment.[107] • Alaska's suicide rates are among the highest in the U.S.[108] • 23% of Alaska youth seriously considered suicide and 19% attempted to commit suicide.[109] Population needs: • Improved access to peer recovery and support programs related to substance use treatment. • Increased availability of early intervention and prevention programs for early identification of needs. • Expanded school and community-based behavioral health supports to address youth mental health and prevent crisis escalation.
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.[110] • 8% of adults in Alaska live with diabetes.[111] • 32-35% of adults in Alaska are obese;[112] 21% of adults report no physical activity.[113] 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.[114] • Nationally, duals face hospitalization rates 2–3x higher than non-duals.[115]

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.[116] • The state's Complex Care Unit tracks over 700 active complex cases statewide.[117] 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

Goal 1: Promote Lifelong Health and Wellbeing for Rural, Remote, and Frontier Alaskans	
Description	Advance evidence-based interventions that produce measurable improvements in access and health outcomes and launch innovative care models that: • Address the root causes of disease in Alaska's diverse communities. • Improve rural providers' capacity to engage in strategic partnerships that promote quality improvement and expanded access to care. • 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.
RHTP Initiatives	Aligned with Governor Dunleavy's *Healthy Families* initiative, this goal will primarily be met via three interrelated initiatives that together promote whole-person and community well-being: #1 *Healthy Beginnings,* #2 *Health Care Access*, and #3 *Healthy Communities*.
Statutory Elements	• Improving access • Improving outcomes • Technology use • Partnerships • Workforce
Strategic Goals	• Make rural America healthy again • Innovative care • Sustainable access

Goal 2: Build Sustainable Outcomes Driven Health Systems	
Description	Advance sustainable payment models that drive high quality, cost-effective care and financial stability for rural health providers by pursuing a multiphase strategy that: • 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. • 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.
RHTP Initiatives	This goal will primarily be met through the implementation of four initiatives: #2 *Health Care Access,* #3 *Healthy Communities,* #4 *Pay for Value: Fiscal Sustainability,* and #6 *Spark Technology and Innovation*.
Statutory Elements	• Improving outcomes • Technology use • Partnerships • Data driven solutions • Financial solvency • Cause identification
Strategic Goals	• Make rural America healthy again • Sustainable access • Innovative care • Technology innovation
Goal 3: Drive Workforce and Technology Innovation	
Description	Strengthen Alaska's rural health care systems by advancing a sustainable, high-performing delivery infrastructure, which includes the following strategies: • Build, attract and retain a skilled workforce through targeted recruitment, comprehensive training, and evidence-based retention strategies that ensure provider stability and reduce turnover. • Modernize health care facilities to support team-based, integrated models of care that meet current standards and adapt to future needs. • 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 appropriate AI and other advanced technologies to enable seamless collaboration, real-time care coordination, and continuous quality improvement.
RHTP Initiatives	This goal will be primarily met with the implementation of two initiatives: #5 *Strengthen Workforce* and #6 *Spark Technology and Innovation.*
Statutory Elements	• Improving access • Improving outcomes • Technology use • Partnerships • Workforce • Data driven solutions
Strategic Goals	• Sustainable access • Workforce development • Innovative care • Technology innovation

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
Improving Access	• 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. • 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. • 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. • 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. *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.*
Improving Outcomes	• 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. • Decrease the percentage of suicidal youth by increasing access to the full spectrum of behavioral health services including expanded telehealth and crisis intervention services. • Better manage chronic disease by increasing access to services, right-sizing the primary care delivery system, and investing in workforce and facility improvements. • Improve outcomes for dual eligible individuals through increased care coordination. • 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.

Statutory Element	Proposed Strategies and Actions
	Through implementation of Initiatives #1 Healthy Beginnings, #2 Health Care Access, and #3 Healthy Communities.
Technology Use	• Expand and modernize telehealth infrastructure to enhance telehealth-enabled specialty, behavioral health, prevention, and primary care services • Deploy consumer-facing digital health tools (wearables, apps, remote monitoring) and support successful provider and patient adoption • Support provider training for technology adoption and appropriate AI tools • Upgrade interoperable health IT systems and facilitate data sharing across providers • Build population health IT infrastructure for chronic disease management *Through implementation of Initiative #6 Spark Technology and Innovation.*
Partnerships	• Four major statewide organizations – the Alaska Native Tribal Health Consortium (ANTHC), Alaska Community Foundation (ACF), Alaska Hospital & 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. • 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. • Establish a customized accelerator program for health providers (e.g., mentorship, best practices, shared purchasing). • Expand value-based integrated provider networks and shared coordination hubs that enable population health analytics, care-model coaching, and aligned payment systems. • Facilitate public/private partnerships on housing and child care to address unmet workforce needs in rural communities. *Through implementation of Initiatives #1 Healthy Beginnings, #2 Health Care Access, and #3 Healthy Communities; minimally through all other initiatives.*
Workforce	• Build pipeline "grow our own" programs from high school through graduate levels. • Create reskill and upskill programs for adults. • Expand physician residency slots, rural internships, rotations and fellowships. • Offer structured incentives to certain providers who commit to serving in a rural community. • 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. *Through implementation of Initiative #5 Strengthen Workforce.*
Data Driven Solutions	• Deploy appropriate AI-enhanced clinical workflow and decision-support technologies to improve care quality, provider efficiency, and health outcomes in rural settings. • Invest in interoperable electronic health records, analytics platforms, and health data systems. • Train providers to leverage data for risk stratification, outcome monitoring, and tailored chronic disease management. • Provide Technical Assistance (TA) for analytics integration and measurement-informed care practices. *Through implementation of Initiative #6 Spark Technology and Innovation.*
Financial Solvency	• Test voluntary alternative payment and value-based models focused on cost reduction, outcome improvement, and innovative models of care. • Centralize and improve back-office solutions for providers. • Enhance provider ability to participate in innovative payment arrangements. • Evaluate the Centers for Medicare and Medicaid Innovation (CMMI) AHEAD model.

Statutory Element	Proposed Strategies and Actions
	• Deliver TA including contract evaluation, financial modeling, and change management to support and incentivize providers' voluntary participation in innovative and transformative payment models. *Through implementation of Initiative #4 Pay for Value: Fiscal Sustainability.*
Cause Identification	• Align development and resources through community-led regional health delivery plans. • Accelerate technology investments to integrate care and shift to value-based payment. • Incentivize the adoption of alternative payment models. • Leverage wearable devices and new consumer-facing technology to pilot new care models. • Incentivize workforce recruitment and retention. *Through implementation of Initiatives #2 Healthcare Access, #4 Pay for Value: Fiscal Sustainability, and #5 Strengthen Workforce.*

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
Health and Lifestyle (B.2)	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.
Supplemental Nutrition Assistance Program (SNAP) Waiver (B.3)	Alaska submitted a draft waiver application to USDA on 9/23/25 (the federal government shutdown has delayed the process). Alaska has pending legislation to require a waiver.[118]	DOH will achieve an approved SNAP Food Restriction Waiver by 12/31/27.
Nutrition Continuing Medical Education (CME) (B.4)	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.
Certificate of Need (CON) (C.3)	The NOFO data source classifies Alaska as "moderate" in CON laws. However, Alaska contends that the report does not accurately reflect current state policy (**see note below**).	DOH will promulgate regulations by 12/31/27 to modify CON for ancillary services, making Alaska less restrictive.
Licensure Compacts (D.2)	Alaska is not a member state and does not have any pending legislation for the following licensure compacts: • Interstate Medical License Compact • EMS Compact • Psychology Interjurisdictional Compact • Physician Assistants Compact Alaska has pending legislation to join the following licensure compacts:[119] • Nurse Licensure Compact	Alaska will join all licensure compacts consistent with D.2 by 12/31/27.

Scope of Practice (D.3)	Alaska has the following scope of practice environments: • Physician Assistants: Advanced • Nurse Practitioners: Full Practice • Pharmacists: Restricted Authority • Dental Hygienists: **Unrestricted (see note)**	Alaska will enact policy changes to expand scope of practice for pharmacists by 12/31/27, consistent with full authority. Note that Alaska has pending legislation.[120]
Short-term, Limited-Duration Insurance (STLDI) (E.3)	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.
Remote Care Services (F.1)	Alaska has state policies that support access to remote care and telehealth services, including for: • Medicaid payment for at least one form of live video • Medicaid payment for Store and Forward • In-State licensing requirement exception • Telehealth license/registration process	Alaska will update Medicaid coverage to include remote patient monitoring by 12/31/2027 and will be in full alignment with F.1.
Alaska Notes on Scoring: **C.3:** 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 licensing and CON requirements. Therefore, Alaska has substantially less restrictive CON laws than the report reflects. See AS 18.07.031(a);[121] AS 18.07.111;[122] 7 AAC 07.001;[123] 7 AAC 12.611.[124] **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).[125] 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.[126]		

Notes on Rural Facility and Population Score Factors

Table 6. Notes on Rural Facility and Population Score Factors

Technical Score Factor	Notes
Absolute size of rural population in a State (A.1)	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.
Proportion of Rural Health Facilities in the State (A.2)	• 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

	Supporting Document B. Compared to the NOFO's data sources there is a discrepancy in the count. Alaska is providing *Supporting Document B* because it is a data source that CMS has responsibility for maintaining with IHS. • Alaska has five Certified Community Behavioral Health Clinics (CCBHCs) (see *Supporting Document C*). By HRSA's definition using county-level metrics, only one is rural.[127] However, using Alaska's RHTP rurality definition (see note above for A.1), four out of five should be designated as rural. [128]
Percentage of hospitals in a State that receive Medicaid DSH payments (A.7)	Alaska has eight Tribally-operated IHS hospitals[129] 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	
Description	Alaska's *Healthy Beginnings* 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. Potential Uses of Funds: • **Expand technology-enabled maternal care infrastructure:** 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. (*Key Intersection with Initiative #6 Spark Technology and Innovation*) • **Modernize rural maternal care facilities and staffing models:** 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. (*Key Intersection with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation*)

	• **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*) • **Provide TA to support *Healthy Beginnings* 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 performance improvement to ensure sustained impact on maternal and child health and early childhood development.
Alignment	Main Strategic Goal: Make Rural America Healthy Again. Use of Funds: A, B, C, D, E, F, G, H, J, K. Technical Score Factors: B.1, B.2, C.1, D.1, F.1, F.2, F.3.
Key Stakeholders	**Core health care stakeholders** 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. **Educational and workforce partners** include universities, training centers, professional associations, and programs such as the Healthcare Workforce Enhancement Program (HWEP). **Additional community partners** 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. **Other key partners** 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.
Outcomes	• 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. • Greater numbers of early intervention screenings and home visits. • New facilities supporting connected care infrastructure. • Expanded school district participation in Medicaid School-Based Services.
Impacted Counties	Statewide
Est. Funding	$144,444,444 over the five-year grant period.
2. Health Care Access	
Description	The *Health Care Access* 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, 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; 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. *(Key Intersections with Initiatives #5 Strengthen Workforce and #6 Spark Technology and Innovation)* • **Build transportation networks to connect people to care:** 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. • **Conduct a comprehensive provider gap analysis to guide resource allocation and improve rural health access:** 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. • **Provide TA to support *Health Care Access* 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 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.
Alignment	Main Strategic Goal: Sustainable Access. Use of Funds: A, B, C, D, E, G, H, I, J, K. Technical Score Factors: B.1, B.2, C.1, C.2, D.1, E.1, E.2, F.1, F.3.
Key Stakeholders	**Core health care stakeholders** 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 such as CHA/Ps, BHA/Ps, and DHATs; EMS providers; and pharmacists. **Additional community partners** 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. **Other key partners** include patients and consumers, state agencies that oversee health programs, and technology or IT vendors that enable telehealth and health information systems.
Outcomes	• 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. • Reduced drug overdose and suicide mortality. • Improved rates of age-appropriate cancer screenings.

Impacted Counties	Statewide.
Est. Funding	$211,111,111 over the five-year grant period.
3. Healthy Communities	
Description	The *Healthy Communities* 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. Potential Uses of Funds: • **Deploy consumer-facing digital tools for chronic disease self-management:** 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. (*Key Intersection with Initiative #6 Spark Technology and Innovation)* • **Build data infrastructure to support population health clinical infrastructure management:** Invest in and expand existing interoperable data systems and analytics platforms aligned with CMS's Health Technology Ecosystem criteria 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 programing. 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 infectious disease, improve population health, and avoid higher-acuity care while prioritizing locally-led implementation. *(Key Intersection with Initiative #6 Spark Technology and Innovation)* • **Provide TA to support *Healthy Communities* 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 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.
Alignment	Main Strategic Goal: Make Rural America Healthy Again. Use of Funds: A, C, D, F, G, I, J, K. Technical Score Factors: B.1, B.2, C.1, E.2, F.1, F.2, F.3.
Key Stakeholders	**Core health care stakeholders** 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. **Additional community partners** 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. **Other key partners** 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.
Outcomes	• Increased participation in Alaska's *Fresh Start* programs to prevent diabetes and lower blood pressure. • More adults engaging in regular physical activity. • Reduced consumption of sugary drinks. • More schools promoting physical activity through *Fresh Start* programs and the Presidential Fitness Test. • Expanded use of consumer technologies that support wellness and health monitoring.
Impacted Counties	Statewide.
Est. Funding	$116,666,667 over the five-year grant period.
4. Pay for Value: Fiscal Sustainability	
Description	The *Pay for Value: Fiscal Sustainability* initiative incentives 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 ATHS 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 planning 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 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. • **Provide TA to support *Pay for Value: Fiscal Sustainability* 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 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.
Alignment	Main Strategic Goal: Innovative Care. Use of Funds: A, B, D, F, G, H, I, K. Technical Score Factors: B.1, C.1, E.1, F.2.
Key Stakeholders	**Core health care stakeholders** include hospitals, clinics, health centers, skilled nursing/long-term care facilities, and other facilities serving rural residents, along with ANTHC and the ATHS. 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. **Finance partners** include payers such as

	private insurers and public programs including Medicaid and Medicare that support health care financing and service reimbursement. **Additional community partners** include community-based organizations and THOs that track and strengthen the quality of, and access to, health care across regions. **Other key partners** 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.
Outcomes	• Increase in providers completing APM readiness assessments and implementation plans. • Increased providers voluntarily participating in new alternative payment models. • Increase in providers reporting quality measures through HIE. • Increase in dually eligible care coordination. • Increase in days cash on hand for CAHs. • Reduction in potentially avoidable emergency department visits among seniors.
Impacted Counties	Statewide.
Est. Funding	$116,666,667 over the five-year grant period.
5. Strengthen Workforce	
Description	The *Strengthen Workforce* 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. Potential uses of funds: • **Create "grow our own" high school to certification programs:** 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.

	• **Fund or expand training and workforce development and certification programs:** 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. • **Create reskill or upskill programs for adults who may not have considered health care careers:** Programs will offer flexible, accessible training pathways that help new- or mid-career adults (e.g., ages 25–40) transition 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.
Alignment	Main Strategic Goal: Workforce Development. Use of Funds: D, E, K. Technical Score Factors: B.1, D.1, F.1.
Key Stakeholders	**Core health care stakeholders** 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 ATHS. 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. **Education and training partners** 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. **Additional community partners** 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). **Other key partners** include patients and consumers, state agencies that oversee health initiatives, and technology or IT vendors that advance telehealth, workforce platforms, and data systems.
Outcomes	• Increase in physicians per 100,000 residents. • Expanded physician residency opportunities. • Greater participation in RHTP-funded workforce training. • Larger number of certified Community Health Workers and CHA/Ps. • More RHTP-supported initiatives offering recruitment and retention incentives.
Impacted Counties	Statewide.
Est. Funding	$66,666,667 for the five-year grant period.
6. Spark Technology and Innovation	
Description	The *Spark Technology and Innovation* 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 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-effectiveness, and community impact, with the goal of identifying scalable solutions that improve care access and continuity of care in remote, often roadless, settings. • **Integrate advanced analytics across multi-payer health and data systems:** 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. • **Build health IT infrastructure to support provider participation in value-based care:** 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. (*Key Intersection with Initiative #4 Pay for Value: Fiscal Sustainability*) • **Launch rural and frontier health infrastructure fund:** 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 *separately* 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. • **Launch rural technology catalyst fund:** 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. • **Provide TA to support *Spark Technology and Innovation* 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

	performance improvement to ensure sustained impact from investments in innovative tools and systems that facilitate increased access, coordinated care delivery and population health management.
Alignment	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
Key Stakeholders	**Core health care stakeholders** include hospitals, clinics, health centers, skilled nursing/long-term care facilities, and other facilities serving rural residents, as well as ANTHC and the ATHS. 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. **Additional community partners** 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. **Other key partners** 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.
Outcomes	• Increase in hospitals and clinics adopting RHTP-funded AI technologies and remote patient monitoring systems. • Higher percentage of Medicaid providers offering telehealth services. • Greater hospital and organizational participation in the HIE through expanded data sharing and connectivity.
Impacted Counties	Statewide.
Est. Funding	$244,444,444 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. 1. Population health clinical infrastructure	**#1: Healthy Beginnings**	▪ **Expands community-based maternal and child health care,** bringing prenatal, postpartum, and early childhood services closer to home through local programs, home visits, telehealth, and upgraded rural facilities. ▪ **Enhances rural health systems** through technology-enabled care coordination, integration of behavioral and primary care, and workforce development.

		▪ **Promotes collaboration** among clinics, Tribal programs, schools, and community organizations to improve access to preventive, behavioral, and family-centered care across rural and frontier communities.
	#2: Health Care Access	▪ **Expands community-based health care** through local clinic renovations, itinerant specialty clinics, mobile dental units, senior supports, and aging-in-place programs. ▪ **Enhances comprehensive rural care systems** 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. ▪ **Aligns community, THOs, and regional partners** to deliver connected, culturally appropriate, and sustainable care.
	#3: Healthy Communities	▪ **Strengthens community-based preventive and primary care** through mobile clinics, community paramedicine, health kiosks, and wellness centers that deliver screenings, chronic disease management, and health education locally. ▪ **Promotes regional coordination and community planning** by funding data-driven health delivery plans, aligning local stakeholders around shared priorities
B. 2. Health and lifestyle	**#1: Healthy Beginnings**	▪ **Invests in early childhood interventions** that encourage physical activity and have potential to improve long-term child health outcomes. ▪ **Engages local clinics, THOs, schools, families, and community organizations** to deliver coordinated, culturally appropriate services, health education and public health interventions.
	#3: Healthy Communities	▪ **Implements evidence-based lifestyle interventions,** such as diabetes prevention programs, *Fresh Start*, and community wellness centers, all designed to produce measurable improvements in chronic disease management and overall health outcomes. ▪ **Partners with local health, Tribal and community organizations** to deliver programs, coordinate services, and ensure culturally and regionally appropriate interventions. ▪ **Targets root causes of poor health,** such as chronic disease, lack of preventive care, and limited health literacy, through integrated primary care units, health education, and home/community interventions.
C. 1. Rural provider strategic partnerships	**#1: Healthy Beginnings**	▪ **Supports specialized standby readiness** and other essential maternal care services in low-volume, high-acuity settings. ▪ **Develops integrated partnerships** that expand care delivery close to home, including through rural maternal care workforce and mobile and itinerant clinics.
	#2: Health Care Access	▪ **Establishes strategic regional partnerships** between local providers and THOs to exchange best practices and deliver integrated, coordinated care. ▪ **Expands access to specialty services,** including through clinical partnerships that support remote care services, telehealth and itinerant specialty clinics and novel service delivery options in remote and frontier communities.
	#3: Healthy Communities	▪ **Coordinates regional care delivery** 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.
	#4: Pay for Value: Fiscal Sustainability	▪ **Promotes collaboration among rural health providers** to support operational efficiency, creating cost savings and improving overall financial sustainability. ▪ **Implements new alternative payment models and value-based care models** that improve financial sustainability, preserve rural providers' independence, and allow providers to keep care local.

C. 2. EMS	**#2: Health Care Access**	▪ **Expands EMS integration with rural health systems** by upgrading and expanding access to specialized equipment and implementing community paramedicine to improve patient assessment, triage, and transport. ▪ **Develops infrastructure and capacity to implement alternative site of care treatment** (e.g., treat-in-place, mobile integrated health care, and alternate destination transport). ▪ **Strengthens providers' financial stability** by training agencies in accurate billing and testing alternative payment models that support both existing and newly developed EMS systems.
D. 1. Talent recruitment	**#1: Healthy Beginnings** **#2: Health Care Access** **#5: Strengthen Workforce**	▪ **Invests in rural health career education** 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. ▪ **Expands rural residency and fellowship programs** by funding new and expanded training opportunities with multi-year service commitments to strengthen provider retention. ▪ **Provides relocation and retention incentives** such as housing assistance, relocation support, and structured bonuses for clinicians who serve rural and frontier areas for at least five years. ▪ **Strengthens Tribal and IHS-aligned workforce programs**, including for CHA/Ps, BHA/Ps, and DHATs within the ATHS. ▪ **Prioritizes training, certification, and expanded scope of practice** for community-based, non-hospital, and allied health professionals to sustain rural health access.
E. 1. Medicaid provider payment incentives	**#2: Health Care Access** **#4: Pay for Value: Fiscal Sustainability**	▪ **Increases provider capacity and advance implementation of multi-payer alternative payment models** to reduce health care costs, improve patient outcomes, and shift care to lower-cost, high-value settings. ▪ **Supports rural participation in value-based payment models,** including two-sided risk arrangements, that are grounded in evidence to influence provider and patient behavior. ▪ **Transitions rural providers away from unsustainable FFS models** towards new payment paradigms to support financial sustainability.
E. 2. Individuals dually eligible for Medicare and Medicaid	**#2: Health Care Access**	▪ **Assesses current programs and infrastructure** to identify opportunities to improve care coordination and alignment. ▪ **Builds data-sharing capacity, support providers, and engage with beneficiaries and stakeholders** to understand barriers to better integrated care. ▪ **Informs design of potential future integrated care models or plans** that align benefits, improve member experience, and enhance quality and efficiency.
F. 1. Remote care services	**#1: Healthy Beginnings**	▪ **Expands infrastructure and workforce to deliver remote maternal care services,** including renovations to install or enhance telehealth delivery and trainings on remote consultation and monitoring technologies.
	#2: Health Care Access	▪ **Deploys virtual technology infrastructure** to expand access to specialists in remote and frontier areas.
	#6: Spark Technology and Innovation	▪ **Improves remote care infrastructure** by enhancing telehealth infrastructure, deploying remote monitoring devices, and piloting emerging technologies in remote communities (e.g., portable diagnostic tools).
F. 2. Data infrastructure	**#1: Healthy Beginnings**	▪ **Supports cloud-based maternal health information platforms,** which combine interoperable EHRs, case management systems, and other technologies to enable providers to improve outcomes.
	#2 Health Care Access	▪ **Invests in data and IT upgrades,** including software, hardware, and equipment, to improve system interoperability and expand use.

	#3: Healthy Communities	▪ **Invests in interoperable data systems and analytics platforms** that aggregate clinical, behavioral, and health-related needs data.
	#6: Spark Technology and Innovation	▪ **Improves rural health care data infrastructure** through investments in statewide HIE and health care data interoperability, as aligned with national/federal standards. ▪ **Supports rural health providers use of advanced data analytics, platforms, and operational tools** to support care delivery and coordination.
F. 3. Consumer-facing tech	**#1: Healthy Beginnings**	▪ **Develops and deploys consumer-facing digital tools and devices** 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.
	#2: Health Care Access	
	#3: Healthy Communities	
	#6: Spark Technology and Innovation	

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
General Program Setup		
Launch RHTP Program Unit	Q1 2026	Stage 0
Open call for subrecipients across all initiatives	Q2 2026	Stage 0
Launch development of regional health care delivery plans	Q2 2026	Stage 0
Technical Assistance offered to subrecipients	*ongoing*	*ongoing*
Federal reporting	*annual*	*annual*
#1 Healthy Beginnings		
Modify spaces for youth extracurricular recreation and wellness activities	Q2 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
#2 Health Care Access		
Conduct 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	Q3 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
#3 Healthy Communities		
Expand *Fresh Start* program reach	Q2 2026	3
Enter contracts to expand HIE interoperability	Q2 2026	2
Select vendor(s) for consumer-facing tools and technology	Q3 2026	1
Launch program for off-grid sanitation modifications	Q4 2026	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

#4 Pay for Value: Fiscal Sustainability		
Determine participation in CMMI AHEAD model	Q1 2026	0
Design value-based care arrangements, alternative payment methods and methodologies	Q2 2026	1
Contract with technical assistance vendors to support providers' adoption of value-based and alternative payments	Q4 2026	2
Award transitional planning grants to support provider adoption	Q1 2027	2
Invest in IT infrastructure, staffing and equipment for successful participation	Q1 2027	3
Launch value-based care arrangements, alternative payment methods and methodologies	Q3 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
#5 Strengthen Workforce		
Complete statewide health care provider training gap analysis	Q2 2026	0
Create new physician residency program slots	Q3 2026	4
Establish requirement for nutrition to be included in continuing medical education for physicians	Q4 2026	5
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
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
#6 Spark Technology and Innovation		
Expand statewide health information exchange	Q1 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 the rural technology catalyst fund	Q4 2026	5
Launch technical assistance and training programs for providers utilizing AI-powered workflow tools	Q4 2026	1
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

Governance	Role	Description
Final Approval and Decision-maker	Commissioner	Approve all funding decisions, policy guidance, and strategic direction.
Strategic Direction and Oversight	Deputy Commissioner	Align policy and strategic direction across DOH programs (e.g., Medicaid), ensure oversight and compliance.
Program Governance	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.
Operational Management	Senior Program Coordinator	Direct day-to-day program execution, internal communication, and performance tracking.
Initiative Leadership	Program Coordinators	Manage initiative-specific activities, liaise with subrecipients and other state agencies, ensure consistent reporting and compliance.
Fiscal Accountability	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 RTHP 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 and Decision-Making Framework

DOH established a four-member Advisory Council with representatives from the Alaska Native Tribal Health Consortium (ANTHC), the Alaska Hospital and Healthcare Association (AHHA), the Alaska Primary Care Association (APCA), and the Alaska Community Foundation (ACF) to guide funding and program decisions. 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 Advisory Council is responsible for integrating community and provider perspectives and evaluating subrecipient project proposals against federal requirements, state priorities, and a standardized scoring rubric (see *Supporting Document D*). All subrecipient proposals will be reviewed using the process outlined below.

Table 11. Proposal Evaluation Stages

Stages	Description
1. Eligibility Review	The subrecipient administrator screens applications for completeness, eligibility, and cost allowability (e.g., SAM.gov registration, certifications, NOFO compliance).
2. Independent Scoring	Eligible proposals are scored by Advisory Council members using a standardized rubric, with optional subject-matter consultation (see *Supporting Document D*). The rubric will ensure objective, transparent, and consistent decisions that align with the RHTP's statutory purpose. The rubric will be publicly posted and updated annually with public notice.
3. Consensus Discussion	The Council reviews discrepancies and confirms shared evaluation standards. The subrecipient administrator summarizes key findings.
4. Final Recommendation	Members adjust scores as needed and submit a ranked list of recommended projects with rationales to DOH.

To promote fairness and reduce conflict of interest, all scoring and comments will be recorded by DOH for audit and transparency purposes. Proposals submitted by an Advisory Council member will be evaluated separately by DOH using the same rubric. The Commissioner will review the recommendations, confirm compliance, and issue final funding decisions to the subrecipient administrator. Funded projects and evaluation outcomes will be publicly reported. 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 12. Completed Stakeholder Engagement

Engagement	Description	Volume/Frequency	Outcome/Impact
Request for Information (RFI)[130]	Open call for public and organizational input statewide.	160 responses representing over 400 projects and recommendations.[131]	Input and ideas were integrated across all six initiatives.
RHTP Advisory Council	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.
Direct Meetings and Listening Sessions	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 13. Stakeholder Engagement Framework

Partner	Method	Cadence	Purpose
Advisory Council	In-person/virtual meetings	Min: quarterly	Feedback, TA, and project evaluation.
Tribal Entities	In-person/virtual meetings	Min: quarterly	Tribal consultation and feedback.
Regions/Community	Targeted discussions with health care and community leaders	Year 1; Year 3, Year 5	Listening, resource coordination, sharing best practices, and TA.
State Agencies	In-person/virtual	Ongoing	Coordination with subject matter experts in Medicaid, rural health, housing, child care, and corrections to support and inform RHTP efforts.
Public At-Large	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. The four organizations 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 14. 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
#1 Healthy Beginnings (maternal and infant health, childhood health, school programming/child care)					
Percentage of women receiving prenatal care in the first trimester	Alaska Vital Statistics Annual Report[132] and Dashboard[133]	72.3% (2023)	75%	78%	81.1%
Infant mortality rate	Alaska Vital Statistics Annual Report[134] and Dashboard[135]	7.2 (2021-2023)	6.8	6.2	5.6
Pregnancy-associated deaths*	Maternal Child Death Review Committee Annual Report[136]	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	National Home Visiting Resource Center[137]	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
#2 Health Care Access (integrated preventive, primary, behavioral, and oral health; specialty care; emergency services; recovery at home)					
Percentage of adults reporting they have a primary care provider	Alaska Behavioral Risk Factor Surveillance System Dashboard[138]	74.6% (2024)	76%	78%	80%
Percentage of adults with current age-appropriate cancer screenings	Alaska Behavioral Risk Factor Surveillance System Dashboard[139]	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*	CMS Medicaid and CHIP Core Set Data Dashboard[140]	45.7% (2024)	65%	80%	90%
Number of Tribes or THOs offering Traditional Healing services	ANTHC Data[141]	5 (2025)	7	9	11
Drug overdose mortality rate	Alaska Vital Statistics Annual Report[142] and Dashboard[143]	45.5 (2024)	35	25	15

Suicide mortality rate	Alaska Vital Statistics Annual Report[144] and Dashboard[145]	29.9 (2024)	28.5	27	25
#3 Healthy Communities (health promotion and disease prevention, healthy lifestyles, and social connection)					
Percentage of adults reporting recent physical activity outside of work	Alaska Behavioral Risk Factor Surveillance System Dashboard[146]	81.6% (2024)	83%	85%	87%
Percentage of adults consuming one or more sugary drinks per day	Alaska Behavioral Risk Factor Surveillance System Dashboard[147]	25.5% (2024)	24%	22%	20%
Number of participants in Alaska's *Fresh Start* programs	Fresh Start Program Data (annual)[148]	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
#4 Pay for Value: Fiscal Sustainability (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	healthEconnect Alaska[149]	0	0	10	20
Number of non-Tribal CAHs with 273 days or more cash on hand	Health Care Cost Report Information System Medicare Cost Report[150]	1 (2024)	3	5	7
Rate of potentially avoidable emergency department visits for seniors 65+	Commonwealth Scorecard[151]	156.1 (2023)	145	140	135
#5 Strengthen Workforce (health care workforce pipeline and retention, provider training programs)					
Physicians per 100,000 population	HRSA Area Health Resource File[152]	304 (2022)	310	320	330
Number of certified CHA/Ps, BHA/Ps, DHATs, and Community Health Workers*	ANTHC Data[153] 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
#6 Spark Technology and Innovation (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	healthEconnect Alaska[154]	7 (2025)	10	18	26
Number of entities participating in the HIE	healthEconnect Alaska[155]	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 15. Evaluation Plan

Evaluation Activities	Responsible Party	Frequency	Purpose
Project-Level: Regular Assessments			
• Subrecipients submit quarterly progress reports documenting activities, outputs, and key performance indicators. • Reports identify program barriers and emerging needs.	Subrecipients	Quarterly	• Track progress toward project objectives. • Identify implementation challenges and successes. • Support adaptive management and quality improvement.

Evaluation Activities	Responsible Party	Frequency	Purpose
• Subrecipients participate in data verification and site monitoring/visits as requested.			• Identify areas where additional support or collaboration may be beneficial.
Project-Level: Two-Year Subrecipient Impact Evaluation			
• Subrecipients conduct a two-year evaluation assessing the impact of their project on service delivery, outcomes, and system performance. • Evaluation methods may include data analysis, stakeholder interviews, and outcome tracking.	Subrecipients	One-time; Year 2 of subrecipient grant period	• Assess intermediate outcomes and inform mid-course corrections. • Generate preliminary evidence on project effectiveness and replicability. • Support decision-making and strategic refinement of the program.
Project-Level: Progress and Funding Assessment			
• Aggregate and review subrecipient performance against key milestones.	DOH RHTP Unit and Advisory Council	Annual	• Determine if project-level funding should continue. Reallocate funds to existing or new projects, as needed. • Ensure consistency in performance reporting. • Provide TA or corrective guidance based on findings.
Initiative- and State-Level: DOH Monitoring and Evaluation			
• Aggregate and validate performance data across initiatives. • Conduct systematic review and synthesis of quarterly subrecipient data.	DOH RHTP Unit, with support from Advisory Council	Annual	• Develop annual reports based on quarterly submissions and project assessments • Assess impact of funding and trends across initiatives. • Ensure accountability, transparency, and alignment with RHTP objectives. • Support decision-making and strategic refinement of the program.
Initiative- and State-Level: CMS Reporting			
• Analyze data across initiatives to evaluate impact of RHTP in accordance with federal reporting requirements.	DOH RHTP Unit	As required by cooperative agreement	• Execute federal reporting requirements • Assess impact of funding and trends across initiatives. • Ensure accountability, transparency, and alignment with RHTP objectives. • Support decision-making and strategic refinement of the program.
Final Evaluation: Independent Third-Party Evaluation			
• Undertake formal external impact evaluation at the end of the grant period comparing program impacts with baseline and target metrics. • Assess program implementation, outcomes, cost-effectiveness, and scalability.	Independent Evaluator (contracted)	End of RHTP funding period (2031)	• Assess program outcomes. • Inform sustainability planning and future funding strategies.

Evaluation Activities	Responsible Party	Frequency	Purpose
Ongoing CMS Coordination			
• Cooperate fully with CMS-initiated evaluations or monitoring efforts across participating states. • Respond to data requests and participate in learning collaboratives.	DOH RHTP Unit, Subrecipient administrator, Subrecipients	As requested by CMS	• Contribute to federal learning goals. • Share best practices and cross-state implementation insights.

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 assigned a sustainability score 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 16. Sustainability Approach

Example Projects Across RHTP Initiatives	Sustainability Approach
Planning & Technical Assistance (TA)	
• Provide training and TA for technology-enabled maternal care services to equip rural providers with the skills needed to deliver coordinated telehealth-based care. (*Healthy Beginnings*) • Conduct a comprehensive provider gap analysis to identify workforce shortages and inform strategies for improving rural access to maternal and primary care. (*Health Care Access*) • Develop community health plans that align local priorities with statewide health goals, ensuring service coordination and sustainability beyond initial grant funding. (*Healthy Communities*)	**During RHTP:** • Start-up costs to enable coordination, planning, and partnership development. • Establishes frameworks and pathways for successful design and implementation of new policies and programs.

Example Projects Across RHTP Initiatives	Sustainability Approach
• Deliver TA to help providers and health systems participate successfully in value-based care arrangements and compliance with performance metrics. (*Pay for Value: Fiscal Sustainability*) • Design "grow your own" workforce pipeline programs that recruit and train local participants to enter the health care field and serve their home communities. (*Strengthen Workforce*) • Provide training in appropriate artificial intelligence and telehealth technologies for clinical providers and support staff. (*Spark Technology and Innovation*)	• Creates foundational models that become embedded in long-term service delivery systems. **Post-RHTP:** • No ongoing or long-term costs expected.
Capital Improvements	
• Renovate rural maternal care and birthing centers to modernize facilities, expand service capacity, and improve safety for patients and staff. (*Healthy Beginnings*) • Renovate clinics to co-locate primary and behavioral health services. (*Health Care Access*) • Renovate community wellness centers to create dedicated spaces for physical activity, nutrition education, and health promotion programs. (*Healthy Communities*) • Support facility upgrades that enable providers to meet value-based care requirements. (*Pay for Value: Fiscal Sustainability*) • Upgrade training and simulation centers to enhance hands-on learning opportunities for rural health providers. (*Strengthen Workforce*) • Launch a rural health infrastructure catalyst fund to support planning, predevelopment, and one-time renovation projects that expand health care access in remote communities. (*Spark Technology and Innovation*)	**During RHTP:** • 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. • Sustainability ensured through formal grant agreements requiring subrecipient to demonstrate ability to maintain and manage facilities post-award with ongoing revenue streams. **Post RHTP:** • Long-term ongoing costs covered through reimbursement-based revenue when possible, local funds, or operational budgets.
Workforce	
• Recruit and train CHA/Ps and maternal health care workers to expand the capacity of locally available skilled professionals. (*Healthy Beginnings*) • Recruit and retain a diverse primary and behavioral health workforce through relocation incentives and local employment partnerships. (*Health Care Access*) • Use integrated primary and preventive care units as interprofessional training sites where medical, nursing, and behavioral health trainees gain experience serving rural populations. (*Healthy Communities*) • 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. (*Pay for Value: Fiscal Sustainability*) • 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. (*Strengthen Workforce*) • Provide technology-focused training to equip health care workers with the skills to use telehealth platforms, electronic health records, and digital monitoring tools effectively. (*Spark Technology and Innovation*)	**During RHTP:** • One-time costs for trainings, scholarships, and workforce pipeline programs. • Strengthens provider capacity and retention through five-year service agreements. **Post RHTP:** • 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.

Example Projects Across RHTP Initiatives	Sustainability Approach
Technology	
• Fund the development and adoption of interoperable maternal health information technology and mobile applications that improve coordination of care and patient engagement. (*Healthy Beginnings*) • Deploy telehealth platforms across rural and frontier communities to expand virtual access to specialty care, behavioral health consultations, and primary care services. (*Health Care Access*) • Deploy consumer-facing digital health tools such as mobile apps and wearable devices to support chronic disease self-management and encourage healthier behaviors. (*Healthy Communities*) • Invest in providers' IT infrastructure to strengthen their ability to collect and analyze data for value-based payment models and quality improvement initiatives. (*Pay for Value: Fiscal Sustainability*) • Build workforce analytics platforms to monitor workforce distribution, performance, and inform long-term staffing strategies. (*Strengthen Workforce*) • Invest in expanding healthEconnect Alaska by enhancing secure data sharing, integrating electronic medical records, and building interoperable tools and portals. (*Spark Technology and Innovation*)	**During RHTP:** • Start-up costs for equipment, connectivity, and system integration. • Sustainability ensured by requiring recipients to develop maintenance and reimbursement sustainability plans. **Post RHTP:** • 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.
Adding Service Lines	
• Enhance maternal and child health home visiting programs. (*Healthy Beginnings*) • Strengthen Tribal Traditional Healing services by integrating culturally appropriate practices with clinical health care. (*Health Care Access*) • Support programs that offer home environment assessments and implement modifications to improve health and safety for community members aging in place or with disabilities. (*Healthy Communities*) • Enhance care coordination services for dual eligibles. (*Pay for Value: Fiscal Sustainability*) • Provide child care supports for health providers to strengthen workforce in rural and frontier settings. (*Strengthen Workforce*) • Deploy consumer-facing digital tools that support individuals with chronic conditions, behavioral health concerns, and substance use disorders. (*Spark Technology* and *Innovation*)	**During RHTP:** • Start-up costs to establish and/or expand programs and operations and implement care models. • Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans. **Post RHTP:** • 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.
Expanding Access to Services Already Covered	
• Expand access to prenatal and postpartum care through telehealth. (*Healthy Beginnings*) • Deploy mobile dental clinics equipped to provide oral health care in rural and frontier areas. (*Health Care Access*) • Expand access to preventive health screenings within communities to improve early detection and intervention for chronic health conditions. (*Healthy Communities*)	**During RHTP:** • One-time costs to launch, expand or improve innovative, effective services. • Subrecipients required to identify sustainability plans as part of funding request; subrecipients'

Example Projects Across RHTP Initiatives	Sustainability Approach
• Integrate reimbursable value-based health services into new payment models. (*Pay for Value: Fiscal Sustainability*) • Support innovative staffing models. (*Strengthen Workforce*) • Pilot billing and reimbursement models for remote patient monitoring technologies that support care. (*Spark Technology and Innovation*)	proposals evaluated on the quality of their sustainability plans. **Post RHTP:** • Long-term sustainability achieved by ongoing reimbursement under Medicaid and other public/private payers.
Programs	
• Implement youth wellness programs in schools and communities that promote physical activity, nutrition, and mental health resilience. *(Healthy Beginnings*) • Operate mobile dental clinics in partnership with local community organizations and schools that bring essential services directly to rural and frontier populations. (*Health Care Access*) • Support evidence-based chronic disease prevention programs focused on reducing risk factors such as tobacco use and obesity in rural communities. (*Healthy Communities*) • Launch rural health sustainability accelerator programs that assist providers with strategic planning, financial modeling, and operational efficiency improvements to enhance long-term viability. (*Pay for Value: Fiscal Sustainability*) • Develop and expand rural-focused health training academies and residency programs to build a skilled workforce competent in primary, behavioral, and specialty care delivery. (*Strengthen Workforce*) • Create community navigation apps that connect rural residents to critical health and social services. (*Spark Technology and Innovation*)	**During RHTP:** • Start-up costs to launch and test promising programs, models and innovations. • One-time costs to expand evidence-based programs that measurably improve outcomes. • Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans. **Post RHTP:** • 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 of additional service fees, philanthropic support, or public health integration.
Payment Structures	
• Develop payment models that support the expansion of maternal health programs. (*Healthy Beginnings*) • Pilot alternative EMS payment models. (*Health Care Access*) • Implement alternative payment methodologies to support comprehensive health service delivery. (*Pay for Value: Fiscal Sustainability*) • Pilot service-linked incentives for providers to promote recruitment and retention in rural, remote, and frontier areas. (*Strengthen Workforce*)	**During RHTP:** • Start-up costs to develop, implement, and evaluate new payment arrangements. **Post RHTP:** • Sustained through policy changes that align across Medicaid, public health, and private payers.
Statewide System Investments	
• Develop state eligibility and enrollment systems that streamline access to health coverage and services. (*Health Care Access*) • Build population health analytics platforms that integrate health data to drive targeted interventions. (*Healthy Communities*) • Modernize state health data systems to support the state and providers' participation in CMS Innovation Center models. (*Pay for Value: Fiscal Sustainability*)	**During RHTP:** • Start-up costs for system design, installation, and integration. **Post RHTP:** • Continued system maintenance later supported by dedicated, recurring funding streams.

Example Projects Across RHTP Initiatives	Sustainability Approach
• Expand HIE platforms to rural and frontier providers. *(Spark Technology and Innovation)*	• Long-term sustainability ensured by embedding into core state operations and fiscal planning for continued governance and adaptability.
Collaboration and Partnerships	
• 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. (*Healthy Beginnings*) • 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. (*Health Care Access*) • Support partnerships with local transit agencies, community organizations, and Tribal entities to design flexible, community-driven transportation solutions to connect people to care. (*Healthy Communities*) • Facilitate payment and delivery model partnerships that support innovative care coordination and sustainability in rural health systems. (*Pay for Value: Fiscal Sustainability*) • Partner with academic and licensing bodies to standardize workforce certification, reduce barriers, and expand professional development opportunities. (*Strengthen Workforce*) • Cultivate public-private partnerships to accelerate technology adoption and infrastructure development. (*Spark Technology and Innovation*)	**During RHTP:** • Start-up costs to develop collaborative frameworks among Tribal, community, academic, and private partners. • Subrecipients required to identify sustainability plans as part of funding request; subrecipients' proposals evaluated on the quality of their sustainability plans. **Post RHTP:** • Long-term sustainability maintained through shared resource contributions and diversified funding sources. • Reduce continuing/long-term costs by promoting coordinated service delivery and joint workforce or infrastructure initiatives.

Endnotes: Works Cited and Notes

[1] *Note:* State Area Measurements and Internal Point Coordinates. United States Census Bureau. Updated August 2010. Accessed November 3, 2025. https://www.census.gov/geographies/reference-files/2010/geo/state-area.html
[2] *Note:* Alaska's average population density is 1.3 persons per square mile. The U.S. average population density is 93.8 persons per square mile.
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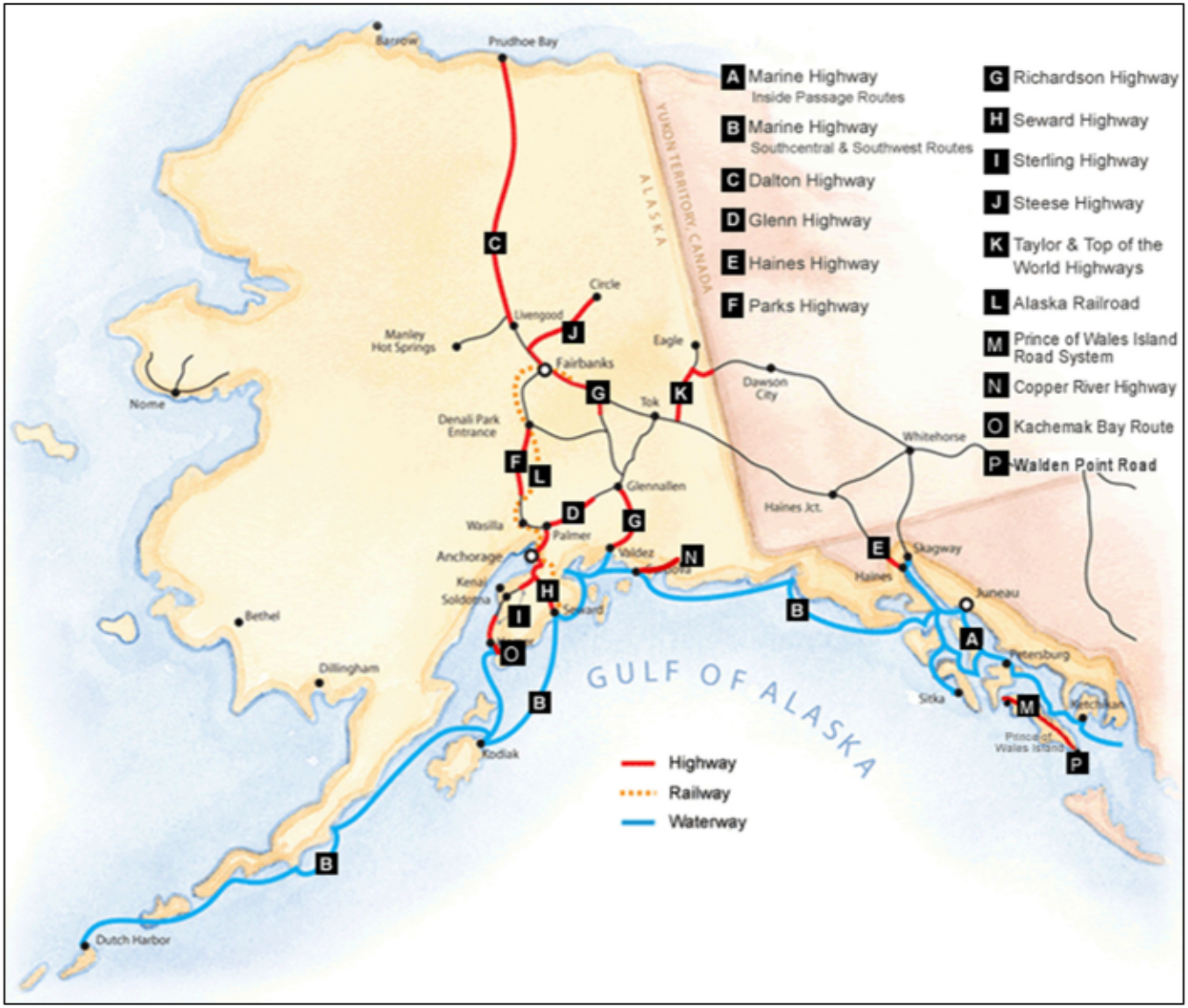
Supporting Document A. Alaska's Road System



Supporting Document B. IHS/CMS Facilities List: Alaska

Generated On: February 22, 2019 at 2:15 PM

Updated As Of: November 18, 2024

	Region / Service Unit	Facility Name	Facility Type
1	ANCHORAGE	Akhiok Village Clinic	Alaska Village Clinic
2	YUKON-KUSKOKWIM	Akiachak Village Clinic	Alaska Village Clinic
3	YUKON-KUSKOKWIM	Akiak Village Clinic	Alaska Village Clinic
4	YUKON-KUSKOKWIM	Alakanuk Village Clinic	Alaska Village Clinic
5	INTERIOR ALASKA	Alatna Village Clinic	Alaska Village Clinic
6	BRISTOL BAY AREA	Aleknagik North Shore Village Clinic	Alaska Village Clinic
7	BRISTOL BAY AREA	Aleknagik South Shore Village Clinic	Alaska Village Clinic
8	INTERIOR ALASKA	Allakaket Village Clinic	Alaska Village Clinic
9	KOTZEBUE	Ambler Village Clinic	Alaska Village Clinic
10	ANCHORAGE	Anesia Anahonak Moonin Health Clinic [Port Graham]	Alaska Village Clinic
11	YUKON-KUSKOKWIM	Anvik Village Clinic	Alaska Village Clinic
12	INTERIOR ALASKA	Arctic Village Clinic	Alaska Village Clinic
13	ANCHORAGE	Atka Village Clinic	Alaska Village Clinic
14	YUKON-KUSKOKWIM	Atmautluak Community Health Clinic	Alaska Village Clinic
15	INTERIOR ALASKA	Beaver Village Clinic	Alaska Village Clinic
16	INTERIOR ALASKA	Birch Creek Village Clinic	Alaska Village Clinic
17	KOTZEBUE	Buckland [Tigautchiaq Amainiq Health Clinic]	Alaska Village Clinic
18	ANCHORAGE	Cantwell Health Clinic	Alaska Village Clinic
19	INTERIOR ALASKA	Chalkyitsik Village Clinic	Alaska Village Clinic
20	YUKON-KUSKOKWIM	Chefornak Community Health Clinic	Alaska Village Clinic
21	ANCHORAGE	Chenega Bay Health Clinic	Alaska Village Clinic
22	BRISTOL BAY AREA	Chignik Lagoon Village Clinic	Alaska Village Clinic
23	BRISTOL BAY AREA	Chignik Lake Village Clinic	Alaska Village Clinic
24	ANCHORAGE	Chistochina Village Clinic	Alaska Village Clinic
25	ANCHORAGE	Chitina Village Clinic	Alaska Village Clinic
26	YUKON-KUSKOKWIM	Chuathbulak Health Clinic	Alaska Village Clinic
27	INTERIOR ALASKA	Circle Village Clinic	Alaska Village Clinic
28	BRISTOL BAY AREA	Clarks Point Village Clinic	Alaska Village Clinic
29	YUKON-KUSKOKWIM	Crooked Creek Village Clinic	Alaska Village Clinic
30	KOTZEBUE	Deering [Pauline Aliitchaq Barr Health Clinic]	Alaska Village Clinic
31	INTERIOR ALASKA	Dot Lake Village Clinic	Alaska Village Clinic
32	INTERIOR ALASKA	Eagle Village Clinic	Alaska Village Clinic
33	YUKON-KUSKOKWIM	Eek Community Health Clinic	Alaska Village Clinic
34	BRISTOL BAY AREA	Egegik Village Clinic	Alaska Village Clinic
35	BRISTOL BAY AREA	Ekuk Village Clinic	Alaska Village Clinic

Supporting Document B. IHS/CMS Facilities List: Alaska

36	BRISTOL BAY AREA	Ekwok Village Clinic	Alaska Village Clinic
37	INTERIOR ALASKA	Evansville Village Clinic	Alaska Village Clinic
38	ANCHORAGE	Gakona Health Clinic	Alaska Village Clinic
39	BRISTOL BAY AREA	Goodnews Bay Village Clinic	Alaska Village Clinic
40	YUKON-KUSKOKWIM	Grayling Village Clinic	Alaska Village Clinic
41	ANCHORAGE	Gulkana Health Clinic	Alaska Village Clinic
42	INTERIOR ALASKA	Healy Lake Village Clinic	Alaska Village Clinic
43	YUKON-KUSKOKWIM	Holy Cross Village Clinic	Alaska Village Clinic
44	INTERIOR ALASKA	Hughes Village Clinic	Alaska Village Clinic
45	INTERIOR ALASKA	Huslia Village Clinic	Alaska Village Clinic
46	ANCHORAGE	Igiugig Village Clinic	Alaska Village Clinic
47	BRISTOL BAY AREA	Iliamna Village Clinic	Alaska Village Clinic
48	ANCHORAGE	Indian Creek Health Clinic Tyonek	Alaska Village Clinic
49	BRISTOL BAY AREA	Ivanof Bay Village Clinic	Alaska Village Clinic
50	YUKON-KUSKOKWIM	Kalskag/Catherine Alexie Clinic	Alaska Village Clinic
51	INTERIOR ALASKA	Kaltag Village Clinic	Alaska Village Clinic
52	ANCHORAGE	Karluk Village Clinic	Alaska Village Clinic
53	YUKON-KUSKOKWIM	Kasigluk Community Health Clinic	Alaska Village Clinic
54	KOTZEBUE	Kiana Village Clinic	Alaska Village Clinic
55	BRISTOL BAY AREA	King Salmon Village Clinic	Alaska Village Clinic
56	YUKON-KUSKOKWIM	Kipnuk Community Health Clinic	Alaska Village Clinic
57	KOTZEBUE	Kivalina Village Clinic	Alaska Village Clinic
58	ANCHORAGE	Kluti-Kaah Health Clinic [Copper Center]	Alaska Village Clinic
59	KOTZEBUE	Kobuk Village Clinic	Alaska Village Clinic
60	ANCHORAGE	Kokhanok Village Clinic	Alaska Village Clinic
61	BRISTOL BAY AREA	Koliganek Village Clinic	Alaska Village Clinic
62	YUKON-KUSKOKWIM	Kotlik Community Health Clinic	Alaska Village Clinic
63	INTERIOR ALASKA	Koyukuk Village Clinic	Alaska Village Clinic
64	YUKON-KUSKOKWIM	Kwigillingok Community Health Clinic	Alaska Village Clinic
65	ANCHORAGE	Larsen Bay Village Clinic	Alaska Village Clinic
66	BRISTOL BAY AREA	Levelock Village Clinic	Alaska Village Clinic
67	YUKON-KUSKOKWIM	Lillian E Jimmy Memorial Clinic Kongiganak	Alaska Village Clinic
68	YUKON-KUSKOKWIM	Lime Village Clinic	Alaska Village Clinic
69	YUKON-KUSKOKWIM	Lower Kalskag/Crimet Phillips Sr. Clinic	Alaska Village Clinic
70	INTERIOR ALASKA	Manley Hot Springs Village Clinic	Alaska Village Clinic
71	BRISTOL BAY AREA	Manokotak Village Clinic	Alaska Village Clinic
72	YUKON-KUSKOKWIM	Marshall Theresa Eli Memorial Village Clinic	Alaska Village Clinic
73	INTERIOR ALASKA	Mary C. Demientieff Health Clinic [Nenana]	Alaska Village Clinic

Supporting Document B. IHS/CMS Facilities List: Alaska

74	YUKON-KUSKOKWIM	Mekoryuk Village Clinic	Alaska Village Clinic
75	ANCHORAGE	Mentasta Village Clinic	Alaska Village Clinic
76	INTERIOR ALASKA	Minto Village Clinic	Alaska Village Clinic
77	YUKON-KUSKOKWIM	Mountain Village Clinic	Alaska Village Clinic
78	INTERIOR ALASKA	Myra Roberts Village Clinic [Venetie]	Alaska Village Clinic
79	BRISTOL BAY AREA	Naknek Village Clinic	Alaska Village Clinic
80	ANCHORAGE	Nanwalek Health Clinic	Alaska Village Clinic
81	YUKON-KUSKOKWIM	Napakiak Village Clinic	Alaska Village Clinic
82	YUKON-KUSKOKWIM	Napaskiak Village Clinic	Alaska Village Clinic
83	BRISTOL BAY AREA	New Stuyahok Village Clinic	Alaska Village Clinic
84	ANCHORAGE	Newhalen Health Clinic	Alaska Village Clinic
85	YUKON-KUSKOKWIM	Newtok Village Clinic	Alaska Village Clinic
86	YUKON-KUSKOKWIM	Nightmute Village Clinic	Alaska Village Clinic
87	ANCHORAGE	Nikolai Health Clinic	Alaska Village Clinic
88	ANCHORAGE	Nikolski Village Clinic	Alaska Village Clinic
89	KOTZEBUE	Noatak [Esther Barger Memorial Health Clinic]	Alaska Village Clinic
90	ANCHORAGE	Nondalton Health Clinic	Alaska Village Clinic
91	KOTZEBUE	Noorvik Village Clinic [Esther Barger Memorial Health Clinic]	Alaska Village Clinic
92	INTERIOR ALASKA	Northway Village Clinic	Alaska Village Clinic
93	INTERIOR ALASKA	Nulato Village Clinic	Alaska Village Clinic
94	YUKON-KUSKOKWIM	Nunam Iqua Village Clinic [formerly Sheldon Pt]	Alaska Village Clinic
95	YUKON-KUSKOKWIM	Nunapitchuk Village Clinic	Alaska Village Clinic
96	ANCHORAGE	Old Harbor Village Clinic	Alaska Village Clinic
97	YUKON-KUSKOKWIM	Oscarville Village Clinic	Alaska Village Clinic
98	ANCHORAGE	Ouzinkie Village Clinic	Alaska Village Clinic
99	ANCHORAGE	Pedro Bay Health Clinic	Alaska Village Clinic
100	BRISTOL BAY AREA	Perryville Village Clinic	Alaska Village Clinic
101	BRISTOL BAY AREA	Pilot Point Village Clinic	Alaska Village Clinic
102	YUKON-KUSKOKWIM	Pilot Station Village Clinic	Alaska Village Clinic
103	YUKON-KUSKOKWIM	Pitkas Point Village Clinic	Alaska Village Clinic
104	BRISTOL BAY AREA	Platinum Village Clinic	Alaska Village Clinic
105	KOTZEBUE	Point Hope Village Clinic CHA/P Services	Alaska Village Clinic
106	ANCHORAGE	Port Alsworth Health Center	Alaska Village Clinic
107	BRISTOL BAY AREA	Port Heiden Village Clinic	Alaska Village Clinic
108	ANCHORAGE	Port Lions Village Clinic	Alaska Village Clinic
109	BRISTOL BAY AREA	Portage Creek Village Clinic	Alaska Village Clinic
110	YUKON-KUSKOKWIM	Quinhagak Village Clinic	Alaska Village Clinic
111	INTERIOR ALASKA	Rampart Village Clinic	Alaska Village Clinic

Supporting Document B. IHS/CMS Facilities List: Alaska

112	YUKON-KUSKOKWIM	Red Devil Village Clinic	Alaska Village Clinic
113	INTERIOR ALASKA	Ruby Village Clinic	Alaska Village Clinic
114	YUKON-KUSKOKWIM	Russian Mission Yukon Village Clinic	Alaska Village Clinic
115	ANCHORAGE	Saint George Health Center	Alaska Village Clinic
116	YUKON-KUSKOKWIM	Sarah S. Nicholai Memorial Clinic Kwethluk	Alaska Village Clinic
117	YUKON-KUSKOKWIM	Scammon Bay Village Clinic	Alaska Village Clinic
118	MOUNT EDGECUMBE	SEARHC Craig Express Care Clinic	Alaska Village Clinic
119	KOTZEBUE	Selawik Village Clinic	Alaska Village Clinic
120	ANCHORAGE	Seldovia Health & Wellness in Seldovia	Alaska Village Clinic
121	YUKON-KUSKOKWIM	Shageluk Village Clinic	Alaska Village Clinic
122	NORTON SOUND	Shaktoolik Village Clinic	Alaska Village Clinic
123	KOTZEBUE	Shungnak Village Clinic	Alaska Village Clinic
124	YUKON-KUSKOKWIM	Sleetmute Village Clinic	Alaska Village Clinic
125	BRISTOL BAY AREA	South Naknek Village Clinic	Alaska Village Clinic
126	INTERIOR ALASKA	Stevens Village Clinic	Alaska Village Clinic
127	YUKON-KUSKOKWIM	Stony River Village Clinic	Alaska Village Clinic
128	ANCHORAGE	Takotna Health Clinic	Alaska Village Clinic
129	INTERIOR ALASKA	Tanacross Village Clinic	Alaska Village Clinic
130	ANCHORAGE	Tatitlek Health Center	Alaska Village Clinic
131	INTERIOR ALASKA	Tetlin Village Clinic	Alaska Village Clinic
132	YUKON-KUSKOKWIM	Thecla Friday-Tuluk Health Clinic [CHEVAK]	Alaska Village Clinic
133	INTERIOR ALASKA	Tok Community Clinic	Alaska Village Clinic
134	YUKON-KUSKOKWIM	Tuluksak Village Clinic	Alaska Village Clinic
135	YUKON-KUSKOKWIM	Tuntutuliak/Kathleen Daniel Memorial Clinic	Alaska Village Clinic
136	YUKON-KUSKOKWIM	Tununak Village Clinic	Alaska Village Clinic
137	BRISTOL BAY AREA	Twin Hills Village Clinic	Alaska Village Clinic
138	BRISTOL BAY AREA	Ugashik Village Clinic	Alaska Village Clinic
139	ANCHORAGE	Valdez Clinic	Alaska Village Clinic
140	YUKON-KUSKOKWIM	Alakanuk Substance Awareness Program	Alcohol Substance Abuse Treatment
141	ANCHORAGE	Alaska Native Alcoholism Recovery Center [Anch]	Alcohol Substance Abuse Treatment
142	YUKON-KUSKOKWIM	Atmautluak Substance Awareness Program	Alcohol Substance Abuse Treatment
143	YUKON-KUSKOKWIM	Bethel Sobering Center	Alcohol Substance Abuse Treatment
144	INTERIOR ALASKA	CATG After Care Center/Shelter	Alcohol Substance Abuse Treatment
145	YUKON-KUSKOKWIM	Chefornak Substance Awareness Program	Alcohol Substance Abuse Treatment
146	YUKON-KUSKOKWIM	Chevak Chemical Misuse Treatment and Recovery Center	Alcohol Substance Abuse Treatment
147	ANCHORAGE	Copper River Substance Abuse	Alcohol Substance Abuse Treatment
148	ANCHORAGE	Dena A. Coy - Adolescent Residential Treatment	Alcohol Substance Abuse Treatment
149	ANCHORAGE	Dena A. Coy - Outpatient	Alcohol Substance Abuse Treatment

Supporting Document B. IHS/CMS Facilities List: Alaska

150	INTERIOR ALASKA	Dot Lake Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment
151	INTERIOR ALASKA	Eagle Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment
152	INTERIOR ALASKA	Gateway to Recovery Detox 650 Younker Court	Alcohol Substance Abuse Treatment
153	INTERIOR ALASKA	Graf Rheenerhanjii Adolescent Alcohol Treatment Center 2550	Alcohol Substance Abuse Treatment
154	YUKON-KUSKOKWIM	Grayling Substance Awareness Program	Alcohol Substance Abuse Treatment
155	INTERIOR ALASKA	Healy Lake Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment
156	YUKON-KUSKOKWIM	Holy Cross Substance Abuse Program	Alcohol Substance Abuse Treatment
157	YUKON-KUSKOKWIM	Hooper Bay Chemical Misuse Treatment and Recovery Ctr.	Alcohol Substance Abuse Treatment
158	YUKON-KUSKOKWIM	Ikayurviat Canlinermiut [Kongiganak]	Alcohol Substance Abuse Treatment
159	BRISTOL BAY AREA	Jake's Place Detox [Freddie Ilutsik Social Detox Unit]	Alcohol Substance Abuse Treatment
160	YUKON-KUSKOKWIM	Kotlik Substance Awareness Program	Alcohol Substance Abuse Treatment
161	NORTON SOUND	Kusqi House [Nome]	Alcohol Substance Abuse Treatment
162	YUKON-KUSKOKWIM	Kwethluk Substance Awareness Program	Alcohol Substance Abuse Treatment
163	YUKON-KUSKOKWIM	Lower Kalskag Substance Awareness Program	Alcohol Substance Abuse Treatment
164	YUKON-KUSKOKWIM	Malone Home, Bethel	Alcohol Substance Abuse Treatment
165	KOTZEBUE	Maniilaq Detox Center	Alcohol Substance Abuse Treatment
166	KOTZEBUE	Mavsigviq Recovery Camp [Kotzebue]	Alcohol Substance Abuse Treatment
167	YUKON-KUSKOKWIM	McCann Treatment Center [Tundra Swan & Boys Group Home]	Alcohol Substance Abuse Treatment
168	YUKON-KUSKOKWIM	Mountain Village Substance Awareness Program	Alcohol Substance Abuse Treatment
169	ANCHORAGE	Nanwalek Alcohol Services	Alcohol Substance Abuse Treatment
170	YUKON-KUSKOKWIM	Napaskiak Alcohol Program	Alcohol Substance Abuse Treatment
171	YUKON-KUSKOKWIM	Napiakiak Substance Awareness Program	Alcohol Substance Abuse Treatment
172	INTERIOR ALASKA	Northway Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment
173	YUKON-KUSKOKWIM	Nunapitchuk Substance Awareness Program	Alcohol Substance Abuse Treatment
174	INTERIOR ALASKA	Old Minto Recovery Camp	Alcohol Substance Abuse Treatment
175	YUKON-KUSKOKWIM	Pilot Station Alcohol Program	Alcohol Substance Abuse Treatment
176	ANCHORAGE	Port Graham Alcohol Services	Alcohol Substance Abuse Treatment
177	YUKON-KUSKOKWIM	Quinhagak Substance Awareness Program	Alcohol Substance Abuse Treatment
178	INTERIOR ALASKA	Ralph Perdue Center 3100 Cushman	Alcohol Substance Abuse Treatment
179	YUKON-KUSKOKWIM	Scammon Bay Chemical Misuse Treatment and Recovery Ctr.	Alcohol Substance Abuse Treatment
180	ANCHORAGE	SCF Bldg. Four Directions	Alcohol Substance Abuse Treatment
181	ANCHORAGE	SCF Detox	Alcohol Substance Abuse Treatment
182	MOUNT EDGECUMBE	SEARHC Raven's Way Facilities	Alcohol Substance Abuse Treatment
183	YUKON-KUSKOKWIM	Substance Awareness Program [Akiak]	Alcohol Substance Abuse Treatment
184	YUKON-KUSKOKWIM	Substance Awareness Program [Sleetmute]	Alcohol Substance Abuse Treatment
185	INTERIOR ALASKA	Tanacross Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment
186	INTERIOR ALASKA	Tetlin UT Alcohol Program	Alcohol Substance Abuse Treatment
187	INTERIOR ALASKA	Tok Upper Tanana Alcohol Program	Alcohol Substance Abuse Treatment

Supporting Document B. IHS/CMS Facilities List: Alaska

188	INTERIOR ALASKA	Women and Child Ctr for Inner Healing 3100 South Cushman	Alcohol Substance Abuse Treatment
189	INTERIOR ALASKA	Yukon Tanana Mental Health and Alcohol Services 1302 21st	Alcohol Substance Abuse Treatment
190	MOUNT EDGECUMBE	Haines Assisted Living	Assisted Living Center
191	KOTZEBUE	Kotzebue Senior Cultural Center Assisted Living	Assisted Living Center
192	KOTZEBUE	Lake Street House [Kotzebue]	Assisted Living Center
193	KOTZEBUE	Maniilaq Prematernal Home	Assisted Living Center
194	BRISTOL BAY AREA	Marrulut Eniit [Grandma's House - Dillingham]	Assisted Living Center
195	BARROW	Prematernal Home	Assisted Living Center
196	INTERIOR ALASKA	Tanana Regional Elder's Residence [Dina' Dilna' Kka'Ya]	Assisted Living Center
197	INTERIOR ALASKA	Yukon Koyukuk Elder Assisted Living Facility	Assisted Living Center
198	INTERIOR ALASKA	Allakaket Counseling Center	Behavioral Health Facilities
199	ANNETTE ISLAND	Arnie Christiansen Crisis Intervention Center	Behavioral Health Facilities
200	YUKON-KUSKOKWIM	Bautista House Adult Rehab [Bethel]	Behavioral Health Facilities
201	BRISTOL BAY AREA	BBAHC Counseling Center	Behavioral Health Facilities
202	INTERIOR ALASKA	CATG Family Recovery Camp	Behavioral Health Facilities
203	ANCHORAGE	Chugachmiut Behavioral Health and Community and Family	Behavioral Health Facilities
204	ANCHORAGE	Cleveland House Adolescent Residential Treatment	Behavioral Health Facilities
205	ANCHORAGE	Cottonwoord House Adolescent Residential Treatment	Behavioral Health Facilities
206	YUKON-KUSKOKWIM	Crisis Respite Center [Bethel]	Behavioral Health Facilities
207	ANCHORAGE	Cultural Treatment Camp Hudson Lake	Behavioral Health Facilities
208	KOTZEBUE	F.R. Ferguson Building	Behavioral Health Facilities
209	KOTZEBUE	Family Resources Center [Kotzebue]	Behavioral Health Facilities
210	ANCHORAGE	Fireweed Mountain Bldg. - BH	Behavioral Health Facilities
211	INTERIOR ALASKA	Galena Mental Health	Behavioral Health Facilities
212	YUKON-KUSKOKWIM	Hooper Bay Mental Health Clinic	Behavioral Health Facilities
213	YUKON-KUSKOKWIM	Integrated Outpatient Program [HRSA CMHC Bethel]	Behavioral Health Facilities
214	BRISTOL BAY AREA	Jake's Place Residence	Behavioral Health Facilities
215	YUKON-KUSKOKWIM	KNA Community Counseling Center [Aniak]	Behavioral Health Facilities
216	YUKON-KUSKOKWIM	Kwigillingok Behavioral Health Clinic	Behavioral Health Facilities
217	MOUNT EDGECUMBE	Lynn Canal Counseling Services [Haines]	Behavioral Health Facilities
218	INTERIOR ALASKA	Minto Counseling Center	Behavioral Health Facilities
219	YUKON-KUSKOKWIM	Morgan Transitional Living [Bethel]	Behavioral Health Facilities
220	ANCHORAGE	Nakenu Family Center [Kenai]	Behavioral Health Facilities
221	BRISTOL BAY AREA	Our House [Dillingham]	Behavioral Health Facilities
222	ANCHORAGE	Pathway Home	Behavioral Health Facilities
223	YUKON-KUSKOKWIM	Phillips Ayagnirvik Residential Treatment [Bethel]	Behavioral Health Facilities
224	KOTZEBUE	Putyuk Childrens Home [Kotzebue]	Behavioral Health Facilities
225	ANCHORAGE	Quyana Club House	Behavioral Health Facilities

Supporting Document B. IHS/CMS Facilities List: Alaska

226	ANCHORAGE	Rendezvous House Adolescent Residential Treatment	Behavioral Health Facilities
227	INTERIOR ALASKA	Ruby Behavioral Health	Behavioral Health Facilities
228	MOUNT EDGECUMBE	SEARHC AICS Behavioral Health	Behavioral Health Facilities
229	MOUNT EDGECUMBE	SEARHC AICS Behavioral Health/Crossings	Behavioral Health Facilities
230	MOUNT EDGECUMBE	SEARHC AICS Community Behavioral Health & Substance	Behavioral Health Facilities
231	MOUNT EDGECUMBE	SEARHC Behavioral Health	Behavioral Health Facilities
232	MOUNT EDGECUMBE	SEARHC Community Health Center [Haa Toowoo Naakw Hit]	Behavioral Health Facilities
233	MOUNT EDGECUMBE	SEARHC Craig Behavioral Health	Behavioral Health Facilities
234	ANCHORAGE	Silver Salmon Training and Retreat [Anchorage]	Behavioral Health Facilities
235	INTERIOR ALASKA	Tanana Chiefs Conf. Paul Williams House	Behavioral Health Facilities
236	YUKON-KUSKOKWIM	Toksook Bay Behavioral Health Clinic	Behavioral Health Facilities
237	ANCHORAGE	Willa's Way Safe Home [Anchorage]	Behavioral Health Facilities
238	ANNETTE ISLAND	WINGS Safe House [Metlakatla]	Behavioral Health Facilities
239	KOTZEBUE	Womens Crisis Center	Behavioral Health Facilities
240	INTERIOR ALASKA	Yukon Flats CARE Center	Behavioral Health Facilities
241	ANCHORAGE	Dena'ina Dental Clinic	Dental Clinic
242	BRISTOL BAY AREA	Dental Clinic Dillingham	Dental Clinic
243	ANCHORAGE	Fireweed Mountain Building Dental	Dental Clinic
244	MOUNT EDGECUMBE	Haines Dental Clinic	Dental Clinic
245	MOUNT EDGECUMBE	SEARHC AICS Dental Clinic Wrangell	Dental Clinic
246	MOUNT EDGECUMBE	SEARHC Dental Clinic	Dental Clinic
247	INTERIOR ALASKA	Tanana Chiefs Conference Dental Clinic	Dental Clinic
248	ANCHORAGE	Wrangell Mountain Dental Clinic	Dental Clinic
249	ANCHORAGE	Adak Medical Center	Health Center
250	MOUNT EDGECUMBE	Alicia Roberts Medical Center [Klawock]	Health Center
251	ANCHORAGE	Alutiiq Enwia Health Center	Health Center
252	ANCHORAGE	Anchorage Primary Care Center	Health Center
253	ANCHORAGE	Anesia Kudrin Memorial Clinic [Akutan]	Health Center
254	MOUNT EDGECUMBE	Angoon Health Center	Health Center
255	YUKON-KUSKOKWIM	Aniak Subregional Clinic	Health Center
256	NORTON SOUND	Anikkan Inuit Iluaqutaat Subregional Clinic [Unalakleet]	Health Center
257	ANCHORAGE	Anna Hoblet Memorial Village Clinic	Health Center
258	ANCHORAGE	Anna Livingston Memorial Clinic	Health Center
259	ANNETTE ISLAND	Annette Island SU Health Center [Metlakatla]	Health Center
260	ANCHORAGE	Bentch Nuutah Valley Native Primary Care Center, SCF	Health Center
261	NORTON SOUND	Bessie Kaningok Village Clinic Gambell	Health Center
262	NORTON SOUND	Brevig Mission Village Clinic	Health Center
263	ANCHORAGE	C'eyiits' Hwnax Life House Community HC	Health Center

Supporting Document B. IHS/CMS Facilities List: Alaska

264	INTERIOR ALASKA	Chief Andrew Isaac Health Center [Fairbanks]	Health Center
265	BRISTOL BAY AREA	Chignik Bay Subregional Clinic	Health Center
266	MOUNT EDGECUMBE	Dahl Memorial Medical Clinic	Health Center
267	ANCHORAGE	Dena'ina Wellness Center [Kenaitze]	Health Center
268	INTERIOR ALASKA	Edgar Nollner Health Center [Galena]	Health Center
269	ANCHORAGE	Eklutna Village Clinic	Health Center
270	NORTON SOUND	Elim Yukuniaraq Yunqcarvik Village Clinic	Health Center
271	YUKON-KUSKOKWIM	Emmonak Mental Health Clinic	Health Center
272	MOUNT EDGECUMBE	Ethel Lund Medical Center [Juneau]	Health Center
273	MOUNT EDGECUMBE	FRONT STREET COMMUNITY HEALTH CENTER	Health Center
274	NORTON SOUND	Golovin Irene L Aukongak Dagumaaq Health Clinic	Health Center
275	ANCHORAGE	Gundersen Memorial Clinic	Health Center
276	MOUNT EDGECUMBE	Haines Health Center	Health Center
277	MOUNT EDGECUMBE	Hoonah Health Center	Health Center
278	YUKON-KUSKOKWIM	Hooper Bay Sub-Regional Clinic	Health Center
279	MOUNT EDGECUMBE	Hydaburg Alma Cook Health Center	Health Center
280	ANCHORAGE	Ilanka Community Health Center	Health Center
281	MOUNT EDGECUMBE	Kake Health Center	Health Center
282	MOUNT EDGECUMBE	Kasaan Health Center	Health Center
283	MOUNT EDGECUMBE	KIC Tribal Health Center [Ketchikan]	Health Center
284	ANCHORAGE	King Cove Medical Clinic	Health Center
285	MOUNT EDGECUMBE	Klukwan Health Center	Health Center
286	NORTON SOUND	Koyuk Ruth Qumiiggan Henry Memorial Clinic	Health Center
287	NORTON SOUND	Little Diomede Clinic	Health Center
288	ANCHORAGE	McGrath Subregional Health Center	Health Center
289	ANCHORAGE	Nilavena Subregional Clinic [Iliamna]	Health Center
290	ANCHORAGE	Ninilchik Traditional Council Community Clinic	Health Center
291	ANCHORAGE	North Star Health Clinic [Seward]	Health Center
292	ANCHORAGE	Oonalaska Wellness Center	Health Center
293	YUKON-KUSKOKWIM	Pearl E. Johnson Sub-Regional Clinic [Emmonak]	Health Center
294	MOUNT EDGECUMBE	Pelican Health Center	Health Center
295	ANCHORAGE	Robert Marshall Building [Health & Wellness]	Health Center
296	YUKON-KUSKOKWIM	Saint Marys Sub-Regional Clinic	Health Center
297	ANCHORAGE	Sand Point Health Center	Health Center
298	NORTON SOUND	Savoonga Village Clinic	Health Center
299	MOUNT EDGECUMBE	SEARHC AICS Gustavus Community Clinic	Health Center
300	MOUNT EDGECUMBE	SEARHC AICS Medical Clinic	Health Center
301	MOUNT EDGECUMBE	SEARHC Sitka Medical Center	Health Center

Supporting Document B. IHS/CMS Facilities List: Alaska

302	ANCHORAGE	Seldovia Health & Wellness in Homer	Health Center
303	NORTON SOUND	Shishmaref Katherine Miksruaq Olanna Memorial Clinic	Health Center
304	MOUNT EDGECUMBE	Sitka Medical Center Express Care Clinic	Health Center
305	NORTON SOUND	St. Michael [Kathleen L. Kobuk Memorial Clinic]	Health Center
306	ANCHORAGE	St. Paul Health Center	Health Center
307	NORTON SOUND	Stebbins Taprarmiut Yungcarviat Village Clinic	Health Center
308	INTERIOR ALASKA	Tanana Health Center	Health Center
309	NORTON SOUND	Teller Clinic	Health Center
310	MOUNT EDGECUMBE	Tenakee Springs Health Center	Health Center
311	MOUNT EDGECUMBE	Thorne Bay Health Center	Health Center
312	BRISTOL BAY AREA	Togiak Subregional Clinic	Health Center
313	YUKON-KUSKOKWIM	Toksook Bay Sub-Regional Clinic	Health Center
314	NORTON SOUND	Wales Toby Anungazuk Sr. Memorial Clinic	Health Center
315	NORTON SOUND	White Mountain Natchirsvik Health Clinic	Health Center
316	ANCHORAGE	Whittier Community Health Center	Health Center
317	MOUNT EDGECUMBE	Yakutat Community Health Center	Health Center
318	INTERIOR ALASKA	Yukon Flats Health Center	Health Center
319	MOUNT EDGECUMBE	SEARHC AICS Coffman Cove	Health Location
320	MOUNT EDGECUMBE	SEARHC AICS Edna Bay	Health Location
321	MOUNT EDGECUMBE	SEARHC AICS Excursion Inlet	Health Location
322	MOUNT EDGECUMBE	SEARHC AICS Naukati Clinic	Health Location
323	MOUNT EDGECUMBE	SEARHC AICS Point Baker Clinic	Health Location
324	MOUNT EDGECUMBE	SEARHC AICS Port Protection Clinic	Health Location
325	MOUNT EDGECUMBE	SEARHC AICS Whale Pass Clinic	Health Location
326	ANCHORAGE	Children's Speech Therapy - Northway Mall	Health Station
327	ANCHORAGE	Alaska Native Medical Center	Hospital
328	BRISTOL BAY AREA	Kanakanak Hospital	Hospital
329	KOTZEBUE	Maniilaq Health Center [Hospital]	Hospital
330	NORTON SOUND	Norton Sound Regional Hospital	Hospital
331	BARROW	Samuel Simmonds Memorial Hospital	Hospital
332	MOUNT EDGECUMBE	SEARHC Mt. Edgecumbe Hospital	Hospital
333	MOUNT EDGECUMBE	SEARHC Wrangell Health Center	Hospital
334	YUKON-KUSKOKWIM	Yukon-Kuskokwim-Delta Regional Hospital [Bethel]	Hospital
335	NORTON SOUND	Quyanna Care Center [aka Nome Nursing Home]	Long Term Care
336	INTERIOR ALASKA	Al Ketzler Senior Building	Other
337	YUKON-KUSKOKWIM	Alakanuk Community Youth Advocates	Other
338	ANCHORAGE	ANMC Ophthalmology, Audiology & ENT at 3801 University	Other
339	ANCHORAGE	ANMC Travel Management Office	Other

Supporting Document B. IHS/CMS Facilities List: Alaska

340	ANNETTE ISLAND	Annette Island Dental Clinic	Other
341	ANCHORAGE	ANTHC Sleep Lab & Pulmonology	Other
342	ANCHORAGE	Brother Francis Shelter	Other
343	INTERIOR ALASKA	Chief Peter John Tribal Building	Other
344	ANCHORAGE	Child Development Center	Other
345	NORTON SOUND	Community Health Service/Behavioral Health Services	Other
346	ANCHORAGE	Cook Inlet Tribal Council Home Health [T-I Contract]	Other
347	ANCHORAGE	Covenant House	Other
348	ANCHORAGE	Cuya Qyut-anen Head Start - Kenai	Other
349	BRISTOL BAY AREA	Division of Family & Youth Services Bldg. [Dillingham]	Other
350	ANCHORAGE	Family Wellness – 3130 Lark	Other
351	ANCHORAGE	Family Wellness – 3140 Lark	Other
352	ANCHORAGE	Family Wellness – 3210 Lark	Other
353	ANCHORAGE	Family Wellness Warriors - 4510 Grumman	Other
354	ANCHORAGE	Family Wellness Warriors – 4530 Grumman	Other
355	ANCHORAGE	Fireweed Mountain Bldg Ophthalmology	Other
356	ANCHORAGE	Fireweed Mountain Bldg. Speech	Other
357	YUKON-KUSKOKWIM	Girl's Group Home [Bethel]	Other
358	ANCHORAGE	Head Start Speech Therapy - Chugach Square	Other
359	ANCHORAGE	Healthy Communities Building	Other
360	ANCHORAGE	Home Health	Other
361	KOTZEBUE	Ililgaat Tupgat Childrens House	Other
362	ANCHORAGE	K'Beq Cultural Heritage Site	Other
363	BRISTOL BAY AREA	Kanakanak House	Other
364	ANCHORAGE	Karluk Behavioral Health Clinic	Other
365	ANCHORAGE	Katherine & Kevin Gottlieb Building	Other
366	YUKON-KUSKOKWIM	Kuskokwim Emergency Youth Services [KEYS, Bethel]	Other
367	YUKON-KUSKOKWIM	Kwethluk Community Youth Advocates	Other
368	NORTON SOUND	Old Norton Sound Regional Hospital Building	Other
369	ANCHORAGE	Physical Therapy/Wellness Center [Anchorage]	Other
370	NORTON SOUND	Prematernal Home [Nome]	Other
371	BARROW	Prematernal Home Utqiagvik	Other
372	BRISTOL BAY AREA	Safe and Free Environment Building [Dillingham]	Other
373	MOUNT EDGECUMBE	SEARHC Administration Building	Other
374	MOUNT EDGECUMBE	SEARHC AICS Home & Community Waiver Services	Other
375	MOUNT EDGECUMBE	SEARHC Medevac/Air Medical Services Program	Other
376	MOUNT EDGECUMBE	SEARHC Prince of Wales Eye Clinic	Other
377	ANCHORAGE	Spirit Lake Camp	Other

Supporting Document B. IHS/CMS Facilities List: Alaska

378	BARROW	SSMH Tribal Clinic	Other
379	INTERIOR ALASKA	TCC Bertha Moses Patient Hostel	Other
380	INTERIOR ALASKA	TCC Bertha Moses Patient Hostel	Other
381	INTERIOR ALASKA	TCC Eye Clinic	Other
382	INTERIOR ALASKA	TCC Housing First	Other
383	INTERIOR ALASKA	TCC Willow House Hotel	Other
384	YUKON-KUSKOKWIM	Tununak Community Youth Advocates	Other
385	ANCHORAGE	Tyotkas Elders Center	Other
386	YUKON-KUSKOKWIM	Women's Care & Support Center	Other
387	MOUNT EDGECUMBE	Wrangell SEARHC Office – Bennett St	Other
388	MOUNT EDGECUMBE	Wrangell SEARHC Office – Front St	Other
389	YUKON-KUSKOKWIM	Youth and Elders Conference [Toksook Bay]	Other
390	ANCHORAGE	Youth Services - Kenaitze	Other
391	MOUNT EDGECUMBE	Juneau Douglas HS Teen Health Center	School Health Center
392	MOUNT EDGECUMBE	Mt Edgecumbe High School	School Health Center

Supporting Document C. List of Certified Community Behavioral Health Clinics (CCBHCs) in Alaska

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Alaska Behavioral Health – Fairbanks	1423 Peger Road	Fairbanks	AK	99709	Alaska Behavioral Health – Fairbanks			Y	N*
Alaska Behavioral Health – Wasilla	351 W Parks Highway, Suite 200	Wasilla	AK	99654-6920	Alaska Behavioral Health – Wasilla			Y	N*
Alaska Behavioral Health – Anchorage	4020 Folker St.	Anchorage	AK	99508	Alaska Behavioral Health – Anchorage			Y	N
JAMHI Health & Wellness, Incorporated	3406 Glacier Hwy., Ste. A	Juneau	AK	99801	JAMHI Health & Wellness, Incorporated			Y	Y
Fairbanks Native Association	3100 S Cushman St	Fairbanks	AK	99701-7516	Fairbanks Native Association			Y	N*

* By HRSA's definition using county-level metrics, only one is rural. However, using Alaska's RHTP rurality definition, four out of five should be designated as rural. 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.[1] In addition, the HRSA methodology does not adequately take into account the fact that 80% 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.[2] 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.

[1] Alaska Department of Labor and Workforce Development. Alaska Population Estimates by Borough, Census Area, City, and Census Designated Place 2020 to 2024 [Excel spreadsheet]. Published 2025.https://live.laborstats.alaska.gov/pop/estimates/data/TotalPopulationPlace.xlsx

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy. Federal Office of Rural Health Policy (FORHP) Data Files. Published 2025. https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files

Supporting Document D. Example Advisory Council Scoring Rubric

	1 (Poor)	2	3	4	5 (Excellent)
Strategy (30%)	Investments would not lead to change or are at risk of producing negative changes to existing rural health care delivery system and facilities.	Investments would lead to small, incremental changes to existing rural health care delivery system and facilities.	Investments would modestly support measurable changes to rural health care delivery.	Major investments with significant transformative potential for rural health care delivery.	Robust investment plan to structurally transform rural health care delivery, particularly projects that align with or amplify other awarded projects.
Outcomes (15%)	No concrete outcomes are identified.	Outcomes to be tracked are vague, cannot be readily measured, and/or do not support improvement of patient outcomes, access to care, and/or reduction of healthcare costs.	Outcomes are reasonable and specific, can be reliably measured, and/or support improvement of patient outcomes, access to care, and/or reduction of healthcare costs.	Outcomes are well-supported by credible literature, are specific, and can be reliably measured. They directly relate to State RHTP targeted outcomes and metrics.	Outcomes are ambitious, well-supported by credible literature, and specific. They can be reliably measured. They directly relate to State RHTP targeted outcomes and metrics.
Rural Impact (15%)	Unclear how the initiative and outcomes impact rural residents.	Impact on rural residents is limited.	Impact on rural residents is fair. Feasible how initiative and outcomes impact rural residents, but the explanation is not substantiated or clear.	Impact on rural residents is significant. Clear explanation on how initiative and outcomes directly impact rural residents.	Projected Impact aligns with State RHTP goals. Clear explanation on how initiatives and outcomes directly impact rural residents across the State, and how the scale of impact is transformative.
Sustainability (5%)	Sustainability is not sufficiently supported or plausible.	Sustainability is somewhat plausible, but without a detailed plan.	Sustainability is clearly plausible, but without a detailed plan.	Sustainability is planned in detail or is not needed, given the nature of the initiative.	Project is not only sustainable in and of itself, but supports the sustainability of other projects and organizations.
Workplan and Monitoring* (10%)	Timeline, milestones, and budget breakdown are not clear, feasible, or directly linked to initiative.	Timeline, milestones, and budget are clear and well-thought out but present inherent risks to spending federal funds on time.	Detailed workplan that reflects serious thought about obstacles and potential delays.	Workplan reflects a considered, thoughtful operating and strategic framework with clear and feasible timelines, milestones, and budget breakdown.	In addition to prior points categories, workplan includes creative and clear approaches to maximizing the immediate impact of the five-year additional federal funds.
Readiness* (20%)	Significant systems, staffing, necessary partnerships, and structures are needed before implementation can begin.	Some systems, staffing, necessary partnerships, and structures are needed before implementation can begin.	Most systems, staffing, partnerships, and structures necessary for initial implementation are already in place.	Systems, staffing, partnerships, and structure for majority of implementation in place.	Systems, staffing, partnerships, and structure for full implementation in place.

* If "Work Plan and Monitoring" and/or "Readiness" is weak, reviewers will indicate one of two readiness decisions:

1. Project Development Support Recommended: The concept is strong, but additional project planning, systems, staffing, or structures are needed before full implementation.

– Advisory Committee will recommend a Technical Assistance Award in lieu of an immediate Project Award. Once the Technical Assistance provider recommends the project is ready, an updated proposal will be submitted to the next round of funding.

– This pre-Project-Award Technical Assistance will be provided by consultants not associated with the Advisory Committee members to avoid future conflicts of interest when re-assessing the proposal in future rounds.

2. Not Recommended: The proposal is not feasible even with additional support.

Supporting Document F. Letters of Support for Alaska's RHTP Submission

Below is a full list of Letters of Support received for Alaska's RHTP. The letters from the Alaska Community Foundation, Alaska Primary Care Association, Alaska Hospital and Healthcare Association, and Alaska Native Tribal Health Consortium are included in their entirety below.

1. Alaska Hospital & Healthcare Association
2. Alaska Native Tribal Health Consortium
3. Alaska Primary Care Association
4. Alaska Community Foundation
5. 100% Communities Alaska
6. Alaska Academy of Family Physicians
7. Alaska Association of Developmental Disabilities
8. Alaska Behavioral Health
9. Alaska Behavioral Health Association
10. Alaska Caregivers Union SEIU 775
11. Alaska Center for Rural Health & Health Workforce
12. Alaska Children's Trust
13. Alaska Commission on Aging
14. Alaska Emergency Medical Services Advisory Council
15. Alaska Impact Alliance
16. Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse
17. Alaska Mental Health Trust Authority
18. Alaska Municipal League
19. Alaska Native Health Board
20. Alaska Pharmacy Association
21. Alaska Psychiatric Institute
22. Alaska Speech-Language-Hearing Association
23. Alaska State Medical Association
24. Aleutian Pribiloff Island Association, Inc.
25. All Alaska Pediatric Partnership
26. American Association of Retired Persons - Alaska
27. Anchorage Coalition to End Homelessness
28. Anchorage Neighborhood Health Center
29. Anchorage Project Access
30. Anchorage Speech-Language-Cognitive Clinic
31. Assets Inc.
32. Bartlett Hospital
33. Bristol Bay Area Health Corporation
34. Careline Crisis Services
35. Chugachmiut
36. Copper River Native Association
37. Cordova Community Medical Center
38. Council of Athabascan Tribal Governments
39. Cross Road Health Ministries Inc.
40. Department of Family and Community Services
41. Envoy
42. Eric L Gurley, DMgt
43. Food Bank of Alaska
44. Foundation Health Partners
45. Frontier Speech Therapy
46. Girdwood Health Clinic, Inc.
47. Governor's Council on Disabilities and Special Education
48. healthEconnect
49. Iliuliuk Family and Health Services, Inc.
50. Interior Community Health Center
51. JAMHI Health and Wellness
52. John Gunnill Cabinetry
53. Ketchikan Indian Community
54. Kodiak Area Native Association
55. Kodiak Community Health Center
56. Maniilaq Association
57. Maple Springs of Palmer
58. Maple Springs of Wasilla
59. Mat-Su Health Foundation
60. Mat-Su Regional Medical Center
61. Mt. Sanford Tribal Consortium
62. National Alliance on Mental Illness Alaska
63. National Association of Social Workers (AK)
64. Native Village of Eyak
65. Ninilchik Community Clinics
66. NorthStar Behavioral Health
67. Norton Sound Health Corporation
68. Pacific Pediatrics
69. PeaceHealth Ketchikan Medical Center
70. Peninsula Community Health Services
71. Petersburg Medical Center
72. Providence Kodiak Island Medical Center Physician
73. Polaris Transitional and Extended Care
74. Protzman Consulting
75. Providence Alaska
76. Providence Alaska Medical Center
77. Providence Seward
78. Providence St. Elias Specialty Hospital
79. Providence Valdez Medical Center
80. Rasmusen Foundation
81. REACH, Inc.
82. Recover Alaska
83. Set Free Alaska
84. Seward Community Health Center
85. South Peninsula Hospital
86. Southcentral Foundation
87. Southeast Alaska Independent Living
88. Statewide Independent Living Council of Alaska
89. Statewide Suicide Prevention Council
90. TalkAbout Inc
91. Tanana Chiefs Conference
92. thread
93. True North Recovery
94. VOA Alaska
95. Yukon-Kuskokwim Health Corporation

ALASKA COMMUNITY
FOUNDATION

October 21, 2025

U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Support for – State of Alaska Rural Health Transformation Program (RHTP) Application

Dear Review Committee,

On behalf of The Alaska Community Foundation (ACF), I am pleased to express our strong support for the creation of the Rural Health Transformation Fund (RHTF). This initiative represents an important step toward ensuring that Alaskans in rural and remote communities have sustained access to high-quality, locally informed health care.

As Alaska's statewide community foundation, ACF manages more than 2,600 philanthropic funds and partners with local, tribal, and regional leaders to advance community-driven solutions across the state. Through our administration of CARES Act and ARPA funds, we have supported hundreds of nonprofit and community partners working to meet urgent needs while strengthening long-term capacity. These experiences have shown how well-coordinated investments can align state, federal, and local resources to create lasting change.

The RHTF builds on that progress by investing in systems that make care more coordinated, sustainable, and responsive to rural realities. We commend the Department of Health for designing a structure that centers collaboration, accountability, and rural voice while advancing data-informed learning and innovation.

As a member of the Advisory Council, ACF is committed to helping ensure the success of this program through the same thoughtful stewardship and partnership that guide our statewide grantmaking. We look forward to working alongside the Department of Health and others to translate this opportunity into lasting improvements for Alaska's rural health systems.

Sincerely,

Alexandra McKay, President & CEO
The Alaska Community Foundation

APCA
ALASKA PRIMARY CARE ASSOCIATION

October 21, 2025

Centers for Medicare and Medicaid Services (CMS)
Rural Health Transformation Program

As Chief Executive Officer of Alaska Primary Care Association (APCA), I am pleased to offer my full support for Alaska's Rural Health Transformation Program (RHTP) application. This initiative represents a vital opportunity to strengthen the health and well-being of rural Alaskans through sustainable, innovative, and community-driven approaches to care.

APCA is the statewide training & technical assistance and membership association for Alaska's Community Health Centers (or Federally Qualified Health Centers – FQHC's). CHCs play a pivotal role in advancing the goals of the RHTP. As trusted, mission-driven providers embedded in rural communities, CHCs deliver comprehensive, culturally appropriate care to underserved populations regardless of an individual's ability to pay. Our organization is proud to be part of this system and actively contributes to the following RHTP priorities:

- **Improving access to quality health care services** by maintaining a strong rural presence, offering integrated primary and behavioral health care, and expanding telehealth capabilities.
- **Enhancing health outcomes** through preventive care, chronic disease management, and community-based health education tailored to local needs.
- **Advancing technology and innovation** by adopting electronic health records, remote patient monitoring, and digital tools that improve care coordination and patient engagement.
- **Strengthening partnerships** with Tribal Health organizations, local governments, schools, and social service agencies to address the non-medical factors of health.
- **Developing and sustaining the rural health workforce** through recruitment pipelines, training programs, and retention strategies that support local talent and build community capacity.
- **Implementing data-driven solutions** to monitor performance, identify gaps, and guide strategic improvements in service delivery.
- **Promoting financial sustainability** by leveraging Alaska-relevant and -appropriate value-based care models, optimizing operational efficiencies, & supporting policies that promote long-term viability.

APCA is honored to serve on the RHTP Advisory Council and remain committed to supporting this transformative effort. Community Health Centers are uniquely positioned to help realize the vision of a healthier, more equitable rural Alaska, and we look forward to continuing our collaboration to achieve lasting impact.

Sincerely,

Nancy Merriman
Chief Executive Officer
Alaska Primary Care Association

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

October 20, 2025

U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Support for – State of Alaska Rural Health Transformation Program (RHTP) Application

Dear Review Committee,

For over 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and a growing number of healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska.

We write today to express our support for the RHTP application submitted by the Alaska Department of Health. AHHA's work to improve healthcare across the state has traditionally included focus areas such as workforce development, maternal health, quality improvement, support for rural facilities, behavioral health, and health information technology. Our work in these areas utilizes three main methods. These are advocacy around healthcare system needs, collaboration and bringing together our members and community partners to share and learn from one another, and lastly development and distribution of resources such as the maternal landscape report or funding to support facility needs.

Given our background working on these focus areas, the RHTP goals to improve access to quality healthcare services, improve health outcomes for rural residents, advancing technology and innovation to enhance care delivery, strengthening partnerships and community systems, developing and sustaining health workforce, implementing data-driven solutions to inform decision-making and improve performance, as well as developing strategies for financial sustainability are a good fit. These goals clearly align well with AHHA's strategic initiatives and overarching mission to build an innovative, sustainable system of care for all Alaskans. AHHA is glad to partner with the State of Alaska, Department of Health to help support this important work.

Thank you for your consideration of this matter and your support for Alaska healthcare.

Sincerely,

Jared C. Kosin, JD, MBA
President & CEO

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

October 21, 2025

U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Support for State of Alaska Rural Health Transformation Program (RHTP) Application

Dear Review Committee,

On behalf of the Alaska Native Tribal Health Consortium (ANTHC), I write in support of the State of Alaska Department of Health proposal in response to the Centers for Medicare and Medicaid Services Notice of Funding Opportunity for the Rural Health Transformation Program.

ANTHC is a statewide Tribal health organization serving all 229 tribes and all Alask Native and American Indian (AN/AI) people in Alaska. ANTHC provides a wide range of statewide public health, community health, environmental health, and other programs and services for Alaska Native people and their communities. ANTHC operates programs at the Alaska Native Medical Center, the statewide tertiary care hospital for all AN/AI people in Alaska, under the terms of Public Law 105-83.

The Alaska Tribal Health System is unique in the nation, representing a collective effort that is remarkably effective in delivering high-quality, culturally appropriate care across vast and remote regions, leveraging tribal self-governance and hub-and-spoke healthcare delivery models.

Due to multi-generational adverse impacts, Alaska Native people face profound health disparities—such as higher rates of chronic disease, limited access to preventive care, and mental health challenges—that are deeply intertwined with the rural and remote nature of the state, where geographic isolation, harsh weather, and limited infrastructure that result in having to travel great distances and leave home communities to access care.

The Rural Health Transformation Program is a unique and potentially catalytic opportunity to address these disparities, support Tribes and Tribal Health Organization that operate in remote, often roadless, and extraordinary circumstances, and realize the outcomes for some of the country's most rural residents as intended in the authorizing legislation.

ANTHC supports the Department of Health's focus on promoting Healthy Beginnings (Families), Healthy Communities, and Health Care Access. ANTHC supports the effort to create fiscal sustainability, strengthen the workforce and to ensure that rural Alaska has equal access to innovative technology. We look forward to ongoing engagement with the Department as implementation of the Rural Health Transformation Program begins.

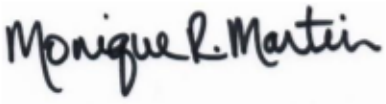
Through our continued partnership, we can develop a program to support improved patient outcomes for residents in the most rural, remote, and frontier communities of Alaska -- if not the entire United States. Acknowledging the unique challenges, opportunities, and perspectives from healthcare providers that

Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, Alaska 99508
Main: (907) 729-1900 | Fax: (907) 729-1901 | **anthc.org**

endeavor to provide high quality care in some of the country's most rural communities will help ensure we develop meaningful application opportunities and support throughout the program's time horizon.

Please do not hesitate to reach out with any questions or if I can provide additional information.

Sincerely,



Monique R. Martin,
Vice President Intergovernmental Affairs

Supporting Document E. Organizations Engaged Pre-NOFO Release

Alaska Native Health Board	Alaska Native Tribal Health Consortium
Alaska Hospital & Healthcare Association	Alaska Primary Care Association
Alaska Behavioral Health Association	Alaska Mental Health Trust Authority
Alaska Association on Developmental Disabilities	Alaska Children's Trust
Food Bank of Alaska	American Association of Retired Persons Alaska
Anchorage Neighborhood Health Clinic	Alaska Community Foundation
Alaska Municipal League	Mat-Su Health Foundation
Rasmuson Foundation	Envoy Integrated Health
Alaska Council of Emergency Medical Services	healthEconnect Alaska
Catholic Social Services	Alaska Association on Developmental Disabilities
Governor's Council on Disabilities and Special Education	thread
Southcentral Foundation	Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse