Request for Information (RFI) 26-001 Alaska - Rural Health Transformation Projects

Response Analysis

Background

On July 4, 2025, the One Big Beautiful Bill Act (OBBBA, also known as H.R. 1) was signed into law, establishing the federal $50 billion **Rural Health Transformation Program (RHTP)** to improve rural health care across all fifty states. This landmark investment creates a unique opportunity for Alaska, where the vast majority of communities are rural and providers face significant geographic and operational challenges. The RHTP will be administered at the federal level through the Centers for Medicare and Medicaid Services (CMS). In Alaska, allocated funds will flow through the Department of Health (the Department) to support health system transformation statewide.

To inform its strategic approach to RHTP implementation, the Department published a **Request for Information (RFI) 26-001 – Rural Health Transformation Projects** to gather input from stakeholders. Responses were due on August 22, 2025. The Department invited stakeholders to share on, among other topics:

- Projects with a defined scope and implementation plan that are ready to launch in the near term
- Early-stage ideas that show promise for rural health care transformation
- General input about community needs, regional trends, and recommendations for leveraging RHTP funding

Overarching Summaries of RFI Responses

RFI Respondents

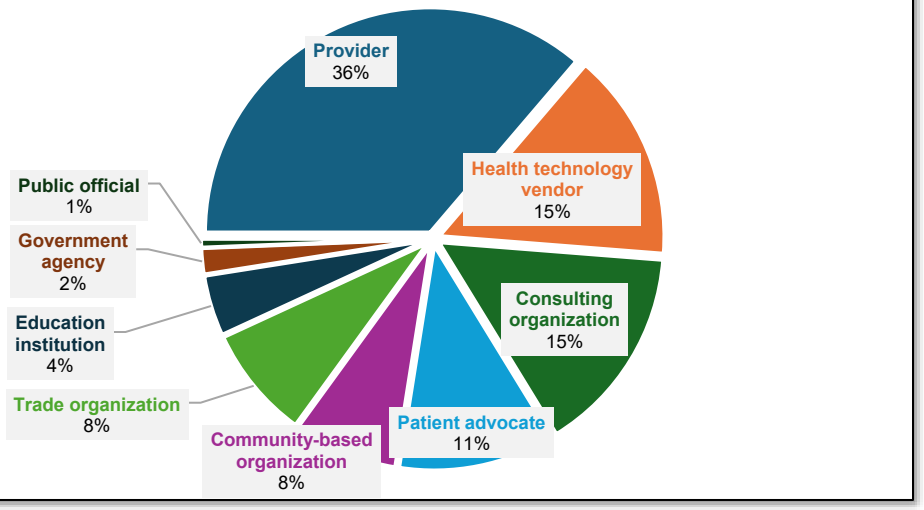
The Department received **159 RFI responses** representing **160 external stakeholders** and **407 projects and recommendations** as of August 22, 2025.[1] *(Note: The Department also received responses from various internal DOH divisions, offices, and advisory boards, which are captured separately.)*

Of the external stakeholders, **77%** are based in or have prior experience in Alaska. Overall, 36% of individuals/entities were **providers** (including Tribal health providers), followed by **health technology vendors** (15%), **health consulting firms** (15%), and **patient advocates** (11%). Other entity types that were less represented include community-based

[1] Some organizations submitted more than one response; other organizations submitted joint responses.

organizations, trade organizations, educational institutions, and other state agencies and public officials.

Figure 1: Responses by Stakeholder Type



Project Proposal Focus Areas

For each project proposal or recommendation, the Department identified a primary focus area.

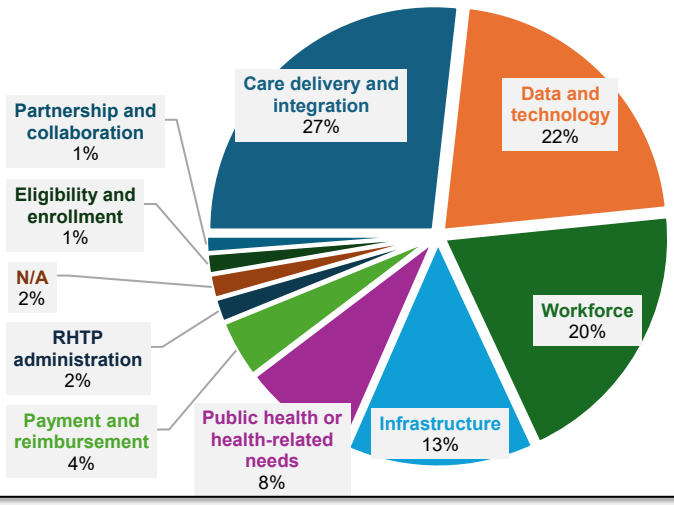
- **Care delivery and integration** (27%) – Recommended investments in new care delivery models and whole-person care delivery, including implementation of new care management and care coordination models, expansion of mobile crisis services and mobile integrated health teams to offer a range of preventive services and health assessments, pilot projects to support expanded access to behavioral health services in school settings, and strategies to enhance access to screenings to identify cancer, hypertension and other clinical conditions. Example projects include:
    - Create a statewide care coordination model that bridges between rural communities, emergency departments, primary care providers and specialists with dedicated care coordinators for patients at discharge, a shared care plan system, and expanded emergency and rapid telehealth availability
    - Develop and implement a model of care for integrating Indigenous Traditional Healing in Alaska Native village clinics, including offering traditional healing house calls, hands-on training for healers, and traditional medicine training for healthcare providers and staff
    - Implement a coordinated child- and youth-focused intake and referral service to centralize and facilitate connections between families and caregivers to

providers, therapists, developmental screenings, and community-based services
    - Establish a community paramedicine service with cross-trained EMS personnel, a mobile crisis responsive team for behavioral health emergencies and a critical care transport team to provide ambulance care rather than medevac care when appropriate
    - Support provider transformation, such as developing a cohort-based Strategic Planning Accelerator program for rural hospitals and health systems to develop and implement data-informed transformation plans; support for rural health centers in achieving patient-centered medical home (PCMH) recognition; and assistance with implementing integrated behavioral health, social services, nutrition, and care coordination
- **Data and technology** (22%) – Proposed investments in health care technologies such as expanding telemedicine to improve rural service delivery, promoting remote patient monitoring technologies to support medication support and chronic disease management, equipping providers with data analytic and artificial intelligence (AI)-enabled tools to improve diagnostic capabilities and coordination across providers, and upgrading electronic medical records and health information technology capabilities. Example projects include:
    - Develop a community-based app and system navigation tool connecting residents with nearby services, connecting to health and benefit systems, with in-person and digital support
    - Expand internet connection in remote areas to improve access to care delivered through telehealth
    - Implement a "Virtual Safe Companion Technology Program," providing remote monitoring for patients at high risk of falls, self-harm, or disruptive behaviors
    - Support providers to purchase and convert to a single electronic health record system
- **Workforce** (20%) – Proposed recruitment, training, and retention strategies aimed at building a stronger and more resilient workforce, particularly in rural areas, such as developing multi-sector coalitions to assess workforce needs and coordinate recruitment efforts, leveraging technology-enabled platforms to expand training, certification, and continuing education opportunities; and implementing loan repayment and forgiveness programs and housing for health care workers. Example projects include:
    - Offer structured retention incentives to certain providers (e.g., dentists, nurses and behavioral health providers) who commit to serving three years or longer in a rural community

    - Curate an online training and workforce development platform for behavioral health care providers in rural areas to offer skill enhancement and peer support
    - Construct a remote simulation lab for training in the provision of care to patients with disabilities and neurodiversity
    - Develop a certificate program for Alaska Native/American Indian Traditional Healers who need university credential to obtain employment in hospital settings
- **Infrastructure** (14%) – Stakeholders emphasized the need for investments in capital infrastructure to expand access to care, improve service delivery, and address critical capacity gaps. Stakeholders identified funding needs for deferred maintenance and facility upgrades, construction of new buildings, including supporting long term services and supports, and expansion of service lines at rural hospitals and health centers. Example projects include:
    - Construct new clinics, including community-based primary care clinics; a clinic to address urgent stroke management, head and spinal trauma and neurosurgical care; and a transitional care clinic for comprehensive post-hospital discharge follow-up care, among others
    - Provide capital for rural hospital deferred maintenance and critical infrastructure improvements
    - Expand a hospital emergency department to include an Emergency Psychiatry Assessment, Treatment, and Healing (EmPATH) unit
- **Public health or health-related needs** (8%) – Proposed investments in upstream solutions addressing health-related needs, including universal screening for health-related needs in health care settings, medically-tailored meals and emergency food assistance, and home modifications for older and disabled Alaskans. Examples projects include:
    - Improve access to transportation, including specifically for preventive cancer screening appointments, for individuals experiencing homelessness, and through gas card or vehicle assistance programs
    - Pursue housing projects, including home modifications to support aging-in-place, additional housing for the provider workforce, and alternative supportive housing for individuals not competent to stand trial and not safe to fully discharge into the community
    - Deliver fresh fruits and vegetables to school lunch programs, while creating vocational opportunities for patients in behavioral health and substance use disorder recovery

- **Other** (10%) – Stakeholders submitted additional project proposals and recommendations focused predominantly on:
    - Improving payment and reimbursement (e.g., establishing an Alaska Medicaid Accountable Care Organization; implementing a coordinated care demonstration project that uses a global budget model that pays participants a fixed rate with ability to earn quality bonus payments; and implementing sustainable payment models for pharmacist services)
    - Establishing partnerships and collaborations (e.g., establishing a statewide collaborative workgroup to develop a plan to address complex care)
    - Facilitating enrollment in Medicaid and public benefits (e.g., hiring additional benefit enrollment agents; enrollment case management system and database improvements)
    - Administering the RHTP program (e.g., grants management support)

Figure 2: Project Proposals by Primary Focus Area



Project Alignment with Department Priorities

Some of the proposals could be categorized into one or more of Alaska's priority health service areas:

- Primary care or chronic condition management (22%), example projects include:
    - Leverage pharmacists to bridge chronic care access gaps, including medication optimization, adherence interventions, substance use treatment support, and disease-specific counseling

        - Invest in Health Information Exchange (HIE) participation and Electronic Health Record (EHR) upgrades to improve care coordination, prevention, and chronic disease management
- Behavioral health (20%) example projects include:
    - Develop an integrated behavioral health and substance use disorder access plan based on statewide service gaps, provider coverage, and treatment modalities
    - Partner with Emergency Medical Service (EMS) to deliver behavioral health crisis services
- Long-term services and support (9%) (including care for individuals with physical, intellectual or developmental disabilities, and elder care) example projects include:
    - Build skilled nursing, assisted living, and long-term care facilities to support growing needs
    - Implement new community-based, technology-enabled care models to facilitate delivery of long-term services and support in rural regions
- Complex care (4%) (co-occurring behavioral, medical, and disability-related needs requiring a multi-disciplinary team and multiple programs), examples include:
    - Construct a complex care residential home in Anchorage
    - Expand complex care supports via the "Community Based Coordination Solutions" program
    - Develop specialized shelters for individuals experiencing homelessness who are elderly or have complex medical needs

Lastly, the Department also flagged proposals for alignment with several other Department priorities:

- Emergency services (8%) example projects include:
    - Develop a statewide emergency transfer center to streamline access to higher level of care and create a formal triage process such that patients with greatest needs are prioritized
    - Provide regional community-based EMS system supports
- Maternal health (2%) example projects include:
    - Establish a state- and provider-funded consortium that supports maternal health providers to practice in their local communities with additional funding targeted towards rural hospital birthing centers and maternal health units
    - Implement postpartum home visits using nurses and peer counselors to provide maternal and infant care
- Needs assessments and strategic plans (2%) example projects include:

        - Conduct regional needs assessments to identify high-priority services and optimize delivery through hub-and-spoke, mobile, and telehealth-supported models
        - Redesign rural referral and access systems by mapping service flows, optimizing telehealth pathways, and creating provider-facing dashboards
- Child care (1%) example projects include:
    - Offer child care subsidies to alleviate workforce shortages in entry-level behavioral healthcare positions

Project Alignment with CMS Priorities

Additionally, most projects can be categorized into one or more of CMS' Strategic Goals:

- **Sustainable access** (32%) projects that help rural providers become long-term access points for care by improving efficiency and sustainability, while facilitating rural facilities working together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services. Example projects include:
    - Develop a community-based primary care clinic to: (a) deliver comprehensive care to underserved community members, and (b) serve as a teaching health center and residency core training site, providing team-based, safety-net care through an integrated care model with primary care, behavioral health and care coordination
    - Deploy a telehealth infrastructure with tablet-based solutions in rural hospitals, Federally Qualified Health Centers (FQHCs), EMS units and clinics to enable real-time consultations, diagnostics and triage support
- **Workforce development** (26%) projects that attract and retain a highly-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities; or help rural providers practice at the top of their license and develop a broader set of providers to serve a rural community's needs, such as community health workers, pharmacists, and individuals trained to help patients navigate the healthcare system. Proposed projects within this category, which align significantly with Alaska's "Workforce" focus area, include:
    - Offer housing support for rural healthcare providers
    - Increase the number of residency positions in the state
    - Develop a certificate program for Traditional Healers who need credentialing to obtain hospital employment
- **Make Rural America Healthy Again** (24%) projects that support rural health innovations and new access points to promote preventative health and address root causes of diseases; and use evidence-based, outcomes-driven interventions to

improve disease prevention, chronic disease management, behavioral health, and prenatal care. Example projects include:
    - Develop visiting specialty clinics to expand chronic disease screening and prevention
    - Improve access to wellness, preventive and sexual health services by deploying health kiosks in rural areas statewide, stocked with supplies such as wellness and testing kits
    - Increase access to healthy foods and nutrition supports in rural areas through partnerships with school districts, vocational programs for food delivery, and nutrition-related education programs
    - Launch a prenatal and postpartum cash prescription program that provides $1,500 at mid-pregnancy and $500 per month for a limited number of months postpartum
- **Tech innovation** (21%) projects that foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients; and support access to remote care, improve data sharing, strengthen cybersecurity, and invest in emerging technologies. Proposed projects within this category, which align significantly with Alaska's "Data and Technology" focus area, include:
    - Provide training and technical assistance to support providers' use of AI tools for care delivery
    - Employ remote monitoring tools to support chronic disease management
    - Deploy new technology to improve in-home and in-community supports, facilitating independent living, safety, and reduced reliance on in-person staff
- **Innovative care** (17%) projects that spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements; and develop and implement payment mechanisms incentivizing providers or Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings. Example projects include:
    - Pursue alternative provider payment models, such as multi-payer global budgets, accountable care organizations, and other specialty care models
    - Develop a coordinated care and navigation hub system that streamlines communication, referrals, and care planning across geographic and institutional boundaries