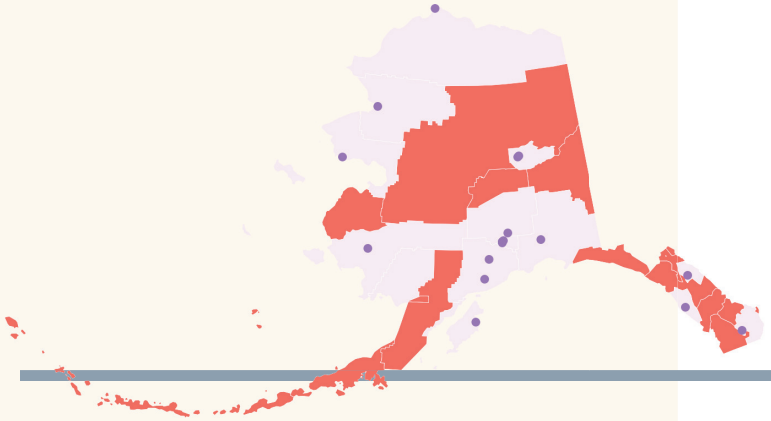
Cross-Cutting Topics in Alaska Maternity Care

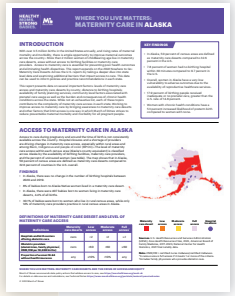
AUGUST 2025



NATIONAL MEASURES OF MATERNITY CARE

Weaknesses of the Maternity Care Desert Model in Alaska

- Alaska has **boroughs and census areas**, not traditional counties, which may affect how well the model represents geographic barriers unique to the state. The maternity care desert measure is dependent on the number and size of counties in a state and fails to account for actual distance to maternity care services.
- The model does not fully capture the unique **transportation challenges** including the impact of long-distance travel, extreme weather, and medevac reliance, which are critical factors in Alaska's maternity care access.
- Many rural Alaskan communities rely on **tribal health facilities, community health aides, and midwifery services**, which may not be fully recognized in the model's classifications.
- Alaska needs **regional solutions** rather than relying on national benchmarks that do not account for the state's geography and demographics. A one-size-fits all solution often does not work for Alaska.
- The model does not consider **alternative strategies** to expand access such as home visits, telehealth services, housing and support in regional hubs, and improved transportation.


WHERE YOU LIVE MATTERS:
MATERNITY CARE IN ALASKA

INTRODUCTION

ACCESS TO MATERNITY CARE IN ALASKA

The Alaska maternity care system has a mix of strengths and weaknesses, shaped by the state's unique geographic and demographic challenges, that can make it difficult to successfully apply nationwide measures of access to maternity care and capture the unique challenges and opportunities present in Alaska. Two of those national measures include the March of Dimes' maternity care desert designation and the Health Resources and Services Administration (HRSA)'s Maternity Care Target Area (MCTA).

MATERNITY CARE DESERTS

In 2024, the March of Dimes released *Nowhere to Go: Maternity Care Deserts Across the US*, a national report on maternity care access in the United States. The report examines how factors like fertility rates, chronic disease, and social drivers of health (SDOH) influence access to care and explores the association between maternity care access and birth outcomes.

The report's maternity care access designations are based on 3 factors: the ratio of obstetric clinicians to births, the availability of birthing facilities, and the proportion of women without health insurance. Each county is classified into 1 of 4 categories: full access, moderate access, low access, or maternity care desert. Maternity care deserts are those counties with no obstetric care facility or obstetric providers, or regions further than 50 miles from critical care obstetric services. The measure also incorporates the proportion of women 18-64 without health insurance.[1]

The maternity care desert model may be a valuable tool for identifying and addressing gaps in maternity care, but Alaska's unique geography, transport barriers, and reliance on tribal health systems mean that local adaptations of the model are necessary to create effective, sustainable solutions. Applying this national methodology in Alaska results in locations being designated either a desert or providing full access and does not tell the whole story about access to maternity care in Alaska.

For example, the access measures assume if an obstetric provider and a hospital exist in a census area, there is full access to care, neglecting to consider the lack of surgical or specialized care and the high percent of people in rural areas who must travel long distances by plane for delivery. Eliminating maternity care deserts would require obstetric care facilities in very small communities without the volume or staffing to make services sustainable.

RECOMMENDATIONS

- **Identify new ways to categorize access to maternity care in Alaska.** For example, a recent study on preterm labor uses the following methodology. "Each residence community was categorized as 'low access' if not connected by road to a birth facility; 'medium access' if on the road system but >1-hour driving distance from a community with a birth facility; and 'high access' if the community contains a birth facility or is on the road system and <1-hour driving distance from a community with a birth facility."[4]

- **A useful metric to track over time could be the percentage of mothers whose births take place outside their community of residence.** According to the study, between 2000 and 2020, 19.3% (n=42 081) of mothers left their residence borough/census area for childbirth and 39.1% (n=85 315) of births took place in communities other than the mother's community of residence.[5] Tracking this in the future could help understand access to care.

- Effective solutions to improve access to care in Alaska will not revolve around building new birthing facilities no matter how access is defined. **Innovations such as telehealth and mobile prenatal care delivery** are needed along with much **stronger social support** for families who must travel outside their community for delivery.

MATERNITY CARE TARGET AREA (MCTA)

The Health Resources and Services Administration (HRSA) provides Maternity Care Target Area scores for communities to designate a shortage of maternity health care professionals. MCTAs are identified as supplementary scores within existing Primary Care Health Professional Shortage Areas (HPSAs) designed to focus specifically on maternity care.[2]

The MCTA designation is intended to:

- Identify areas with shortages of maternity care providers (especially OB-GYNs and family physicians who deliver babies).
- Guide the placement of National Health Service Corps (NHSC) clinicians—particularly those who provide maternity care.
- Support policy decisions and funding allocations to improve access to maternal health services in underserved areas.

HRSA assigns MCTA scores (0–25) based on key maternity care factors[3], including:

- Availability of Obstetric Providers: Number of OB/GYNs and certified nurse-midwives (CNMs) per population.
- Birth Rates: Demand for maternity care services in the area.
- Access Barriers: Distance to the nearest maternity care provider, insurance coverage, and transportation challenges.
- Socioeconomic Factors: Poverty levels, Medicaid reliance, and racial/ethnic disparities in maternal health outcomes.

In Alaska more than 300 locations have been assigned an MCTA score ranging from 6 to 24. Approximately 100 of these locations have a score of 20 or greater and 30 of these locations have a score of 24.

Areas with higher MCTA scores reflect a greater need for maternity care services and are eligible for targeted federal resources, funding, and workforce recruitment. While the MCTA scoring system is intended to support resource planning, in practice, hundreds of communities across Alaska have high scores. The longstanding challenges of providing maternity care in rural and remote parts of the state—such as workforce shortages and financial instability—are well documented. Simply having a high MCTA score does not resolve these complex issues.

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[1] *March of Dimes, Where you live matters: Maternity care access in Alaska, https://www.marchofdimes.org/peristats/reports/alaska/maternity-care-deserts*

[2] *HRSA designated shortage areas data tool. https://data.hrsa.gov/tools/shortage-area*

[3] *Maternity Care Target Areas Scoring ://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring*

[4] *Smith ML, et al. BMJ Public Health 2025;3:e001457. doi:10.1136/bmjph-2024-001457 1*

[5] *ibid*

MATERNITY CARE IN THE TRIBAL HEALTH SYSTEM

Tribal Health Organizations

Alaska Native Tribal Health Consortium
Aleutian Pribilof Islands Association
Arctic Slope Native Association
Bristol Bay Area Health Corporation
Chickaloon Village Traditional Council
Chugachmiut
Copper River Native Association
Council of Athabascan Tribal Governments
Eastern Aleutian Tribes
Karluk IRA Tribal Council
Kenaitze Indian Tribe
Ketchikan Indian Community
Kodiak Area Native Association
Maniilaq Association
Metlakatla Indian Community
Mt. Sanford Tribal Consortium
Native Village of Eklutna
Native Village of Eyak
Native Village of Tyonek
Ninilchik Traditional Council
Norton Sound Health Corporation
Seldovia Village Tribe
Southcentral Foundation
SouthEast Alaska Regional Health Consortium
Tanana Chiefs Conference
Valdez Native Tribe
Yakutat Tlingit Tribe
Yukon Kuskokwim Health Corporation

160,000

Alaska Native and American Indian people cared for by Alaska's Tribal Health System

Alaska's Tribal Health System is a network of 28 Tribal Health Organizations *(left)* delivering culturally appropriate care to over 160,000 Alaska Native and American Indian people statewide. Each organization serves specific regions under the Alaska Tribal Health Compact, which authorizes Tribal management of services formerly run by the Indian Health Service. They operate a range of facilities, including hospitals, health centers, community health aide clinics, and behavioral health services.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM (ANTHC): ANTHC is the largest, most comprehensive Tribal health organization in the United States. In partnership with the Alaska Native and American Indian people and Tribal health organizations across Alaska, ANTHC provides medical services, wellness programs, disease research and prevention, rural provider training and rural water and sanitation systems construction. ANTHC and Southcentral Foundation operate programs and services at the Alaska Native Medical Center under the terms of Public Law 105-83.

ALASKA NATIVE MEDICAL CENTER (ANMC): ANMC manages approximately 1,500 deliveries per year. The hospital works in close partnership with rural health facilities to support high-risk deliveries for tribal health organizations statewide and offers 24/7 obstetric consultation via telehealth, including medevac coordination and commercial transport support for urgent cases.

SOUTHCENTRAL FOUNDATION (SCF): SCF plays a key role in statewide collaboration for maternity care through outpatient consultations, advanced obstetric ultrasound, and antenatal fetal testing. SCF certified nurse-midwives (CNMs) provide primary prenatal care through telehealth and local clinics, ensuring patients in remote areas receive continuous maternity care. SCF OB/GYNs travel to each region for field clinics and develop collaborative relationships with local maternity care teams at tribal organizations.

TRIBAL HEALTH ORGANIZATIONS RURAL HOSPITALS: THOs operate eight rural hospitals including seven critical access hospitals across rural Alaska, six of which provide labor

Access to Prenatal and Delivery Care

Barriers such as childcare challenges, financial concerns, and lack of escorts for travel frequently delay prenatal care. Social support programs aim to connect patients with alternative solutions to help them receive necessary services. However, relocating for delivery can cause significant stress for both the pregnant person and their family. When patients delay travel, the likelihood of emergency medevac transports or unplanned village deliveries increases—both of which pose significant health risks.

- **Referral Patterns:** Nurse case managers play a crucial role in coordinating prenatal and obstetric care, ensuring that patient records, test results, and ultrasounds are properly documented and shared with nurse midwives and OB providers. Their role is essential in tracking high-risk pregnancies, ensuring timely referrals, making transport arrangements, and providing follow-up care.

- **Prematernal Housing**: Housing is available in regional hubs and Anchorage for those receiving prenatal care or relocating for delivery. Medicaid will cover housing and meals for eligible recipients with prior authorization.

- **Telehealth Use:** Telehealth has become an increasingly valuable tool in prenatal care, offering direct-to-patient and direct-to-clinic obstetric consultations. It is especially beneficial for patients in remote areas, allowing them to receive pre-transfer evaluations, follow-up appointments, and fetal monitoring consultations without requiring extensive travel.

and delivery services. These hospitals serve as regional hubs for maternity care and collaborate with ANMC/SCF when a higher level of care is needed.

MIDWIFERY AND DOULA SERVICES:

Certified nurse-midwives (CNMs) are important maternity care providers at THOs. ANMC follows a midwifery-led care model, supported by CNMs with OB physician backup for higher-risk cases. Maniilaq Health Center relies on CNMs for most deliveries. Alaska Native doulas provide culturally centered birth support, strengthening community connections for patients, particularly those traveling from rural areas for delivery. The Alaska Native Birthworker Community is training and supporting doulas.

BEHAVIORAL HEALTH PROVIDERS:

Behavioral health care varies across the state, with access depending on regional THO resources. Some areas lack specialized perinatal mental health services, requiring patients to travel for care. Integrated behavioral health services are available at SCF and ANMC, offering 24-hour inpatient support and screenings for postpartum depression.

SYSTEM OF CARE

Maternity care begins at the village level with Community Health Aides/Practitioners (CHA/Ps) or advanced practice providers offering initial prenatal. Pregnant people often must travel to a regional hub for ultrasound or specialized care. Anchorage serves as Alaska's tertiary care hub for high-risk pregnancies, offering specialized maternal-fetal medicine, neonatal intensive care, and advanced obstetric interventions. ANMC plays a critical role in evaluating and improving rural maternity care practices, ensuring evidence-based guidelines shape policy and process improvements. ANMC also enhances care coordination between rural providers and specialists, optimizing maternal and infant health outcomes statewide.

MEDICAID AND THE TRIBAL HEALTH SYSTEM

Medicaid reimbursement is critical to maintain maternity care services across Alaska. Alaska Native and American Indians qualify for Medicaid coverage based on income, with no copays required at IHS or tribal facilities. Medicaid pays for maternity care services, transportation, housing, and mental health services and substance use treatment. Medicaid expansion in 2015 and postpartum expansion in 2024 expanded the number of Alaskan Natives eligible for Medicaid.

Tribal health organizations bill Medicaid directly for services provided. Reimbursement rates vary depending on the methodology selected by the tribal organization. The state receives 100% federal match for Medicaid services provided by tribal organizations which limits the financial impact of the Medicaid program on the state operating budget.

OPPORTUNITIES FOR IMPROVEMENT

There are opportunities for improvement to enhance maternity care access, improve maternal and infant health outcomes, and strengthen culturally competent care for Alaska Native and American Indian communities.

- **Standardize Electronic Health Records** (EHR): Implementing a unified EHR system across tribal health organizations could streamline referrals, improve care coordination, and reduce delays in transferring patient information.
- **Expand Pediatric Services in Rural Alaska**: Increasing access to pediatric care in rural communities would reduce the need for people to relocate to Anchorage for deliveries involving newborn complications.
- **Increase Inpatient Beds**: Expanding capacity for pregnant people struggling with substance use disorders would provide comprehensive prenatal and addiction care.
- **Enhance Provider Education & Training**: Improving training for rural healthcare professionals would strengthen their ability to manage obstetric emergencies and improve maternal health outcomes.
- **Address Referral Barriers**: Ensuring timely access to higher-level care for non-IHS beneficiaries would prevent gaps in service and improve patient outcomes.

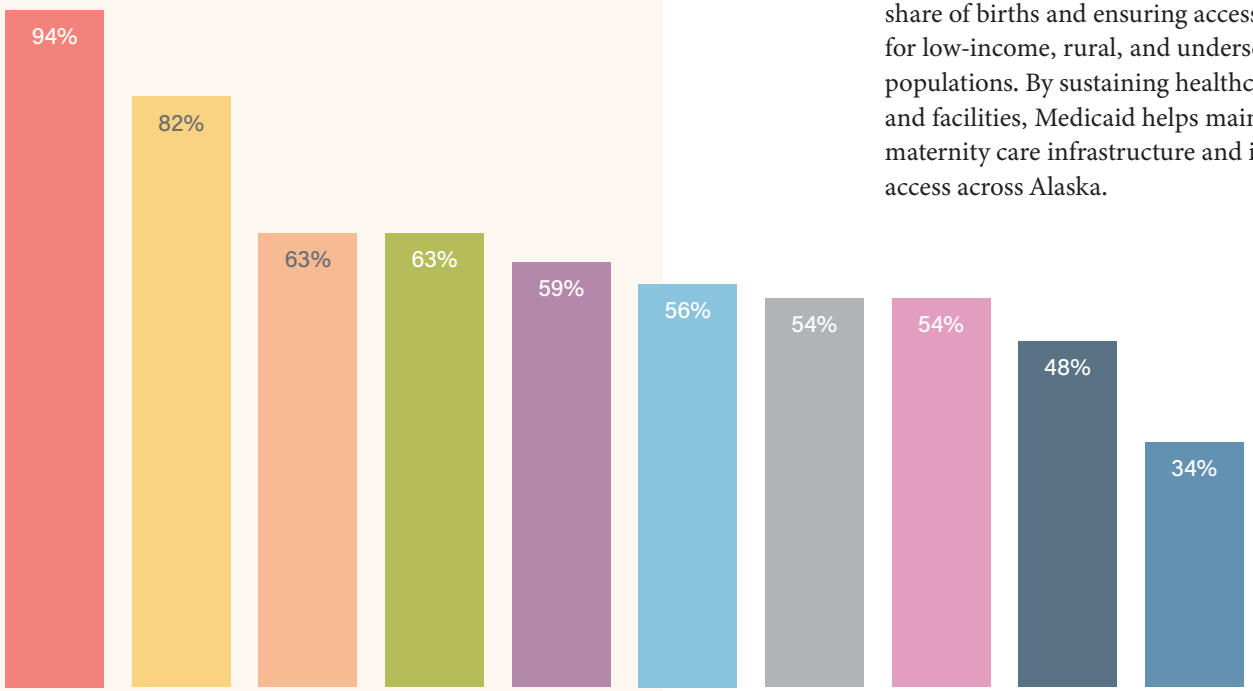
STRENGTHS

- Tribal health organizations provide an integrated care system through self-governance. They offer culturally competent care, advanced specialty services, telehealth use, preventive care, and community health aide services across vast areas of Alaska.
- ANMC leads maternity care improvements through collaborations with tribal health organizations to keep patients in their home communities for as long as possible. Low-volume labor and delivery providers have the opportunity to train at ANMC, enhancing their clinical skills and emergency response capabilities.
- Advanced obstetric life support training includes OB simulation exercises for medevac teams and rural providers, improving coordination between rural and urban care teams.
- Medication-assisted treatment (MAT) programs are integrated into pregnancy care, providing comprehensive addiction support services for pregnant people facing substance use challenges.
- ANMC conducts monthly meetings with partners, discussing safe care planning, service gaps, and opportunities for collaboration.

CHALLENGES

- Medicaid limitations prevent escorts from accompanying pregnant people for prenatal care, delivery, and postpartum care, which can increase stress and isolation for those traveling long distances.
- Communication inefficiencies remain a concern, as some tribal organizations rely on fax-based systems for transferring medical records. This can delay care coordination and referrals, particularly in urgent obstetric cases.
- Field clinics primarily focus on gynecological (GYN) care, with limited obstetric (OB) services available. Because these clinics operate intermittently, they are not equipped to handle time-sensitive pregnancy assessments, leading to delayed diagnostics and intervention for at-risk pregnancies.
- A shortage of community-based suboxone prescribers impacts continuity of care for pregnant patients requiring opioid addiction treatment. There is a need for increased provider availability in rural areas.

MEDICAID AND MATERNITY CARE



Medicaid is a cornerstone of Alaska's maternity care system, covering a significant share of births and ensuring access to care for low-income, rural, and underserved populations. By sustaining healthcare providers and facilities, Medicaid helps maintain the state's maternity care infrastructure and improves access across Alaska.

Rural and tribal communities, where private insurance options are limited, rely especially heavily on Medicaid for essential care. In the area of maternal health, Medicaid plays a critical role in supporting behavioral health services, which are essential for addressing perinatal mental health conditions and substance use disorders. It also provides transportation benefits, helping pregnant individuals in remote areas reach maternity care services.

Medicaid coverage includes pregnancy and childbirth, even if the pregnancy began before enrollment. Babies born to Medicaid enrollees are automatically covered and remain eligible for at least one year.

In February 2024, Alaska implemented a 12-month postpartum Medicaid coverage extension (increased from 60 days) and increased the income eligibility limit from 200% to 225% of the federal poverty level. This expansion, passed overwhelmingly in May 2023 (Senate Bill 58), improves access to postpartum care.

"Without access to Medicaid, my pregnancy would have been much more stressful and I wouldn't have had access to as good of care. Additionally, **without the Alaska Medicaid postpartum care extension, I would be suffering.** I am nearly 13 weeks postpartum and dealing with a perineal tear healing issue for which I still need medical appointments. When I'm healed, I will need physical therapy. Without the extension of my Medicaid to a full year postpartum, my access to this care would be much more limited and stressful on finances."

— Quote from a 2024
Alaska PRAMS survey respondent

MATERNITY CARE SERVICES COVERED BY ALASKA MEDICAID

Prenatal Care	Covered and reimbursed by a variety of healthcare providers.
Dental Services	No preauthorization required.
Prenatal Vitamins	Prescription required.
Ultrasounds	Covered with no prior authorization; No limits on the number of prenatal ultrasounds.
Home Blood Pressure Monitors	Covered when medically necessary, particularly for conditions such as preeclampsia or gestational diabetes.
Nutritional Counseling	Covered for gestational diabetes, though limits may apply to the number of visits or hours.
Certified Nurse-Midwife (CNM) and Direct-Entry Midwife (DEM) Services	Covered for all services within the licensure scope.
Childbirth at Hospital and Licensed Birth Centers	Covered
Postpartum Care	Covered for 12 months of postpartum with no limit on the number of covered visits.
Postpartum Depression Screening and Treatment	Reimbursement available as part of a well baby visit, but the amount is not adequate to cover the cost of implementing screening processes.
First Trimester Genetic Screenings (amniocentesis and Chorionic Villus Sampling)	Covered with prior authorization for high-risk pregnancies or age-related risks. Genetic counseling is included as part of an office visit.
Non-Emergency Medical Transportation (NEMT)	Provides access to care for those who may not have a means of getting to health care appointments. Includes options such as taxis, public transit, air, or ferry and is eligible for federal Medicaid matching funds.
Case Management Services	Limited to high-risk pregnancies.
Prenatal and Postpartum Home Visits	Visits by nurses or clinicians to address medical, social, and child-rearing needs.
Substance Use Disorder Services	Includes most services recommended by the American Society of Addiction Medicine (ASAM) to support treatment and recovery including residential services.

Medicaid Coverage for Long-Acting Reversible Contraception (LARC): LARC is highly effective, fully reversible, and cost-efficient, lasting 3–10 years. Immediate postpartum LARC provision is a clinically recommended intervention that allows patients to receive contraception without the need for additional appointments or travel and is a unique opportunity to optimize provision of health care during a time when all necessary workers and supplies are readily available. Medicaid reimburses postpartum LARC as an add-on payment to the DRG or through separate billing for tribal and critical access hospitals.

MATERNITY CARE SERVICES COVERED BY ALASKA MEDICAID

Breastfeeding Education and Breast Pumps	Electric and manual pumps are covered.
Long-Acting Reversible Contraception (LARC)	Covered, with an add-on payment for hospitals billing through the DRG payment. Critical access and tribal hospitals can bill directly for LARC.
Transportation and Housing Services	
Non-Emergency Medical Transportation	Medicaid covers air, ferry, and train transportation services with a specific eligibility code for pregnant women (11). Requires a service authorization requested by the recipient's referring medical provider.
Pre-Maternal Homes	Housing in licensed pre-maternal homes is covered, offering a critical resource for those traveling for care.
Hotels	Medicaid covers hotels as part of approved travel, however, in many communities there are not enough Medicaid housing providers.

SERVICES NOT COVERED BY ALASKA MEDICAID

(May be covered in other states)

Doula Services	Not covered, despite evidence showing benefits such as lower C-section rates, shorter labor, and improved breastfeeding initiation.
Lactation Consultations	Not covered for inpatient, outpatient, or home settings.
Childbirth and Parenting Education	Group prenatal visits and education classes are not covered. Many states provide separate reimbursement to providers.
Weight Scales for Home Use	Not covered as a pregnancy-related service.
Continuous Glucose Monitors	Not covered for gestational diabetes; covered by 35 other states.

Source: KFF Report on Medicaid Coverage of Pregnancy-Related Services

RECOMMENDATIONS

- **Advocate for Medicaid policy changes to allow travel escorts** for pregnant people who must relocate far from home for care to reduce stress and isolation.
- **Explore options for funding** to support **innovations in maternity care.** The Department of Health could seek funding to support new models of care, such as maternity care coordination, group prenatal care, maternity medical homes, doula services, and prenatal community health workers.
- **Increase Medicaid reimbursement rates for certified nurse-midwives** (CNMs) providing prenatal, labor and delivery, and postpartum care. Providing reimbursement parity with physicians would support the financial sustainability of midwifery-led care models.
- **Educate providers** on Medicaid reimbursement for immediate postpartum LARC placement to improve uptake and access.
- **Provide Medicaid reimbursement for doula services** from prenatal through postpartum. This would require a doula certification process to allow provider enrollment in Medicaid. This could be accomplished in partnership with community-based organizations.

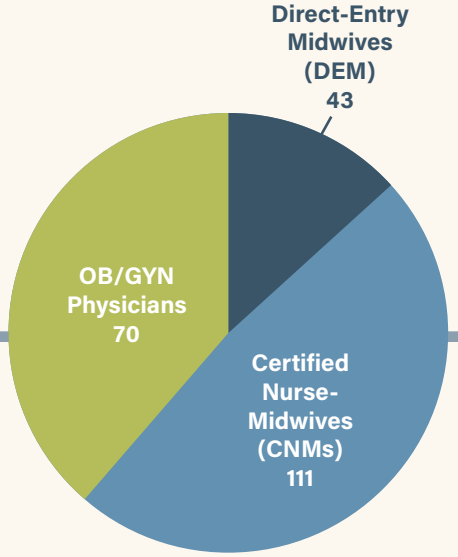
STRENGTHS

- Alaska has a 12-month postpartum Medicaid coverage extension (increased from 60 days) and income eligibility limit of 225% of the federal poverty level (increased from 200%.)

CHALLENGES

- Federal funding opportunities exist to improve maternity care services through Medicaid, but the Alaska Department of Health has had limited capacity to pursue these funds.
- Doula services are not reimbursed by Medicaid, making it difficult to provide services to those most in need.
- Some Medicaid covered services are difficult for providers to bill or receive reimbursement for, and payment rates may be too low. Additionally, certain covered services are not available statewide.
- Delays in Medicaid eligibility determination can postpone the initiation of prenatal care, especially in the first trimester. The travel authorization process can delay access to early prenatal care.
- Many communities lack sufficient Medicaid-approved hotels, particularly during peak tourism and fishing seasons. Hotel reimbursement rates are outdated and fall well below market value.
- Medicaid policies limit support for pregnant people who must relocate for prenatal care or delivery. Escort travel is reimbursed only in limited cases including multiple gestation or for a minor. Many people traveling for delivery are unable to have pregnancy and labor support once transferred, often increasing stress, isolation, and logistical difficulties, particularly for those with children
- Medicaid does not cover housing during hospital stays, requiring patients to check out of their accommodation upon admission for delivery. This can create uncertainty about housing availability post discharge and leave family members without housing.

MATERNITY CARE WORKFORCE



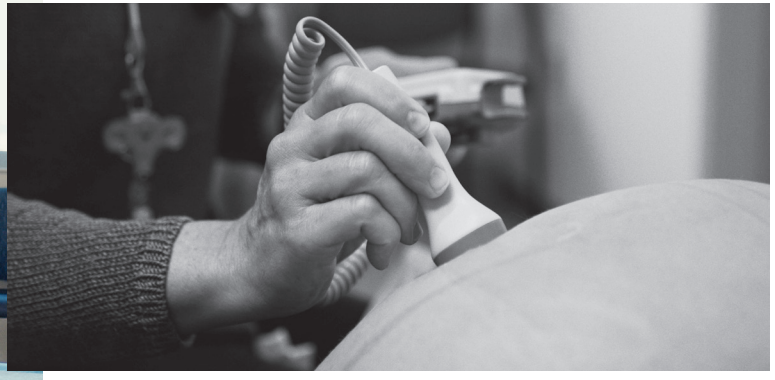
Licensed/Certified Maternity Care providers (2024)

Family Medicine Physicians providing OB services: no data available

There are a number of major workforce challenges in maternity care in Alaska, including:

- A shortage of qualified healthcare providers, particularly in rural areas.
- High burnout rates among existing providers due to demanding work schedules and stress.
- Difficulty recruiting and retaining nurses with specialized obstetric training.
- Limited training opportunities for OB/GYN and certified nurse-midwives (CNMs).
- A lack of diversity within the maternity care workforce that can lead to disparities in care.

Despite these challenges, healthcare providers consult and support each other across the state and are generous with their time and expertise. Alaska relies on strong collaboration between different healthcare professionals involved in maternity care—including OB/GYN, maternal fetal specialists, family medicine physicians, CNMs, OB nurses, community health aides/practitioners (CHA/Ps), and doulas—who are finding creative solutions to meet the needs of Alaskans



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RECOMMENDATIONS

- **Enhance Collaborative Care Models**: Strengthen partnerships between healthcare professionals to maximize their expertise in meeting patient needs.
- **Develop a Community-Based Doula Workforce**: Establish certification programs to enable Medicaid reimbursement for doula services.
- **Expand CNM Services for Low-Risk Deliveries**: Support development of CNM services for low-risk deliveries including payment parity by Medicaid and insurance plans. CNMs can focus on routine prenatal, deliveries, and postpartum care freeing OBs to manage high-risk cases.
- **Support Education and Training**: Expand opportunities for rural maternity care staff to get experience in higher volume facilities to maintain and expand skills. Expand programs to train a diverse workforce of Alaskans as CNMs.

STRENGTHS

- Certified Nurse-Midwives (CNMs): CNMs are licensed in Alaska as Advanced Practice Registered Nurses (APRNs), with full prescriptive authority and one of the strongest scopes of practice in the country. CNMs provide comprehensive women's healthcare, including gynecologic, prenatal, postpartum, and newborn care.
- High Midwife Utilization: Alaska has one of the highest rates of midwife-attended births—both CNM and direct-entry midwife (DEM)—supported by the tribal system, birth centers, and hospitals.
- Financial Incentives for CNMs: The tribal system benefits from Medicaid all-inclusive payment rates, making CNM-led care cost-effective.
- Growing Interest in Doulas: Doulas improve maternity care and often reflect the communities they serve, helping reduce disparities.
- OB Trained Family Medicine Physicians: Family medicine physicians who have completed OB fellowships/residency provide a wider array of services (including c-sections) at rural hospitals.
- Training for Emergency OB Care: The Alaska Hospital & Healthcare Association (AHHA) has developed an online OB Care in the ED training program for hospitals without labor and delivery services, launching for free in 2025.
- Community Health Aides/Practitioners (CHA/Ps): CHA/Ps provide initial prenatal care in villages throughout rural Alaska and connect with higher levels of care when necessary. They serve as eyes and ears on the ground in rural communities. This is a model unique to Alaska.

CHALLENGES

- Declining Family Medicine Physicians in OB Care: Increased specialization and reduced OB training in residency discourage family medicine physicians from pursuing maternity care, leading to provider shortages in rural areas.
- Shift Toward OB/GYN Specialists: Fewer family medicine physicians are being trained in OB. Hospitals are hiring more OB/GYNs due to reduced availability of family medicine along with increasing patient demand for specialty services.
- OB Nurse Shortages in Rural Areas: Low birth volumes make skill retention difficult, complicating recruitment and retention of nurses at rural hospitals.
- Medicaid Reimbursement Disparities: CNMs receive only 80% of the physician reimbursement rate for the same services.
- Lack of Medicaid Coverage for Doulas: Medicaid does not reimburse for doula services, making program sustainability difficult.
- Barriers to 1115 Medicaid Waiver Implementation: Challenges in developing services and securing reimbursement under 1115 waiver contribute to behavioral health workforce shortages.

MAINTAINING MATERNITY CARE IN RURAL HOSPITALS

Labor & Delivery Services Lost

Over the past 30 years, five hospitals in Alaska have discontinued providing birth services and one hospital closed completely. The following hospitals are no longer able to provide labor and delivery services:

- **Petersburg Medical Center**
- **Wrangell Medical Center**
- **Cordova Community Medical Center**
- **Bristol Bay/Kanakanak Hospital in Dillingham**
- **Providence Seward Medical Center**

Labor & Delivery Services Threatened

Currently three birthing hospitals in Alaska have volumes averaging less than 30 births per year. These hospitals work hard to maintain access to care for the pregnant people in their regions where the next nearest OB unit requires air travel or a long drive with winter weather sometimes making travel difficult or impossible.

Across the U.S.—including in Alaska—rural hospitals are increasingly closing their maternity units and discontinuing labor and delivery services. These closures are driven by financial strain, staffing shortages, and declining birth rates. As a result, pregnant individuals in rural areas are often forced to travel long distances for care, increasing the risk of poor maternal and infant health outcomes, including preterm births and emergency deliveries. The loss of local obstetric services also puts added pressure on emergency departments and regional hospitals.

In Alaska, where roughly 20% of the population lives in communities off the primary road system, accessing maternity care often requires travel by plane, boat, or snow machine. For many, childbirth involves weeks away from home in the final months of pregnancy. Maintaining labor and delivery services in low-volume rural hospitals presents a difficult balance between financial and safety concerns and the community's need for accessible maternity care. Hospital leaders face tough decisions: Can the labor and delivery unit continue operating safely, or must it close—knowing the risks that loss of access poses to the health and lives of pregnant individuals and their babies?

Declining birth rates across Alaska are a warning sign that it may get more difficult for small rural hospitals to maintain labor and delivery services in the coming years.

8 of the 13 rural critical access hospitals in Alaska provide labor and delivery services.

6 of these are tribal health organizations.

5 rural critical access hospitals don't provide labor and delivery services.

Why do Rural Hospitals Close OB Units?

There are a variety of reasons why rural hospitals close maternity care units. Key reasons include:

- **Financial Struggles:** Labor and delivery services are costly to maintain, requiring specialized staff and equipment. Many rural hospitals operate on thin margins, and low reimbursement rates make OB units financially fragile.
- **Declining Birth Rates:** The number of births at rural hospitals has declined in many places over the past five years. The population in rural areas is aging with declining birth rates.
- **Workforce Shortages:** Recruiting and retaining family medicine physicians with OB training, OB nurses, and anesthesiologists in rural areas is challenging. Without adequate staffing, hospitals cannot safely provide maternity care.
- **Patient safety concerns:** Maternity care providers may worry about providing safe care in a low birth volume environment and it can be difficult to recruit providers willing to provide the care.
- **Liability and Malpractice Costs:** Obstetric care carries high malpractice insurance costs, which can be prohibitive for small rural hospitals with limited budgets.

WHAT CAN BE DONE IN ALASKA TO SUPPORT RURAL HOSPITALS TO KEEP MATERNITY CARE ACCESSIBLE?

Alaska rural hospitals are working hard to maintain delivery services despite low volumes. Strategies to maintain services at rural hospitals include:

- Develop risk assessment protocols to help determine which people can safely deliver locally and which need to go to a larger facility before labor begins.
- Strengthen provider-to-provider telehealth infrastructure. Build strong connections with the tribal health system and/or other maternity care specialists who can support the hospital to maintain services. The tribal health system is a useful example of Anchorage-based OB providers traveling to rural areas and building strong relationships with rural providers.
- Hospitals can cross-train nurses so they can care for trauma and general medicine patients along with providing OB care.
- Regional partnerships to support OB training and preparedness through simulation training and opportunities for physicians, nurses, and certified nurse-midwives (CNMs) to spend time in higher volume facilities to keep skills current.
- Explore ways to increase reimbursement for rural maternity care by Medicaid and private insurance. Options could include maternity care standby payments or low volume payment adjustments.
- Educate hospital boards and community members on the essential need filled by low volume maternity care units and the need to maintain services through creative solutions and partnerships. Look beyond the bottom line to advocate for maintaining services.

PERINATAL BEHAVIORAL HEALTH

Overcoming Perinatal Behavioral Health Challenges

Key strategies to improve maternal and child outcomes:

- **Normalize perinatal mental health concerns.**
- **Provide compassionate and culturally responsive care.**
- **Expand access to screening, early intervention, and integrated behavioral health services.**
- **Address stigma, train providers, and strengthen referral networks.**

Alaska's Maternal Child Death Review (MCDR) Committee has emphasized these priorities in its recommendations, which include expanding provider training on behavioral assessments, increasing capacity to address interpersonal violence, improving access to safe storage of lethal means, promoting culturally informed crisis response, and reducing stigma around perinatal mental health.

10–20%
Perinatal depression

18–25%
Perinatal anxiety

Precent of birthing people experiencing mental health complications

Perinatal behavioral health includes a range of mental health conditions—such as depression, anxiety, PTSD, and substance use disorders—that occur during pregnancy or within one year after delivery. It also includes preexisting mental health conditions that continue into the perinatal period (AHRQ, 2023).

These disorders are common and represent major complications of pregnancy and postpartum health. In the U.S., 10–20% of women experience perinatal depression (Bauman, Ko, & Cox, 2020), and 18–25% experience perinatal anxiety globally (Dennis, Falah-Hassani, & Shiri, 2017). Mental health risks are heightened during the perinatal period, making psychological care a vital component of maternal and infant health (eClinicalMedicine, 2024).

While anyone can experience perinatal mental health issues, certain risk factors increase vulnerability, including extreme stress, poverty, migration, exposure to violence, conflict or disaster, and low social support (WHO, 2024).

Untreated behavioral health conditions can have serious consequences for both parent and child. Maternal depression can disrupt sleep, nutrition, and caregiving, while also hindering bonding, breastfeeding, and infant care. These challenges increase the risk of adverse outcomes such as preterm birth, stillbirth, and long-term developmental delays in children (WHO, 2024; Bauman, Ko, & Cox, 2020).

Despite growing awareness, there are still many barriers to care. Stigma, fear of judgment or consequences, and feelings of shame or guilt often prevent individuals from seeking help (Nonacs, 2024). Additional barriers include limited resources, lack of trained providers, inadequate referral systems, and the scarcity of perinatal mental health services—especially in remote areas.

The movement to integrate behavioral health into primary and acute care emerged as a best practice in the 1970s. Achieving the goal of a fully integrated system where behavioral health is seamlessly incorporated into all aspects of care with shared records and decision-making has been elusive, but there is broad recognition that the connections between mental, behavioral, and physical health require an integrated and collaborative approach.

MATERNAL HEALTH DISPARITIES

Particular Challenges in Alaska

Historical inequities, historical trauma, and effects of colonization have a significant effect on maternal outcomes for American Indian and Alaska Native (AI/AN) birthing people. (Alexander & Raj, 2025). According to the CDC, AI/AN maternal mortality rates—likeliness to die from pregnancy-related complications—are more than twice that of non-Hispanic, White rates (CDC, 2024). A lack of cultural competence, and cultural insensitivity within health care systems, may also result in a lack of trust for the system of care.

Geographic disparities for rural and underserved areas can also impact maternal health outcomes. Rural and remote communities often face limited access to essential and specialized healthcare services (Smith, Vertigan, Athauda, & Hahn, 2025). In Alaska, geographic comparison is not as simple as rural vs. urban. Unlike the rest of the country, many communities within the state are remote and off the road system which can make timely access to care a potential challenge.

63.4
AI/AN

55.9
Black

18.1
White

Pregnancy-related mortality rates per 100,000 birthing people

Glaring disparities in maternal and infant health persist across the United States. These inequalities are driven by a complex interplay of factors including social determinants of health, systemic racism, historical inequities, and geographic disparities. While each of these factors is significant on its own, they often overlap and interact, creating unique challenges for individuals with multiple marginalized identities.

Social determinants of health have a profound impact on health outcomes, often a greater impact than healthcare or genetics. In the Healthy People 2030 initiative through the US Department of Health and Human Services, social determinants of health (SDOH) are defined as conditions in the environment where people are born, live, learn, work, play, worship, and age that affect health functioning and quality of life outcomes and risks (HealthyPeople2030, 2024).

Nationally, housing security, violence, trauma, and alcohol and substance use, have been identified as key factors in maternal health by numerous national studies and play a significant role in maternal mortality rates. (Wang, Glacer, Howell, & Janevic, 2020). Unsurprisingly, these issues are also important challenges to maternal health in Alaska. Among the cases of maternal death between 2020 and 2022 reviewed by the Alaska Maternal Child Death Review (MCDR) Committee, 5% were attributed to housing insecurity, 2% were attributed to violence, 7% were attributed to trauma, and 15% were attributed to substance use.

Systemic racism, bias, and discrimination within the healthcare system significantly and negatively impact maternal and child health—racial disparities in maternal and infant health outcomes persist (CDC, 2024). Pregnancy-related mortality rates among American Indian and Alaska Native (AI/AN), and Black pregnant people are over three times higher than the rate for White pregnant people in the United States (Hill, Rao, Artiga, & Ranji, 2024). Across the country, mortality rates for infants born to Black, AI/AN, and Native Hawaiian or Pacific Islander (NHPI) people are significantly higher than those born to White people.

ADDRESSING MATERNAL AND CHILD HEALTH DISPARITIES

Addressing maternal and child health disparities requires a comprehensive and multi-pronged approach centered on health equity.

By actively addressing the social determinants of health, we can improve outcomes for all. This includes a concerted effort to improve access to care through initiatives like:

- expanding Medicaid coverage
- ensuring that healthcare is culturally competent and responsive to the diverse needs of communities

To reduce racial and ethnic disparities, it is crucial to:

- reassess outdated protocols
- identify trends and concerns within regions
- recognize the importance of implicit bias training
- increase diversity within the healthcare workforce

Finally, sustained advocacy for policy changes is essential to creating a system that truly supports the well-being of prenant people and children, including:

- expanding healthcare access
- strengthening maternal leave policies
- investing in critical maternal health research

MATERNITY CARE IN THE MILITARY SYSTEM

Differences Among Military Branches

While the Army, Air Force, and Coast Guard all provide maternity care, there are key differences in Alaska:

- **Army:** The Army primarily utilizes Bassett Army Community Hospital in Fort Wainwright and collaborates with civilian providers in remote areas.
- **Air Force:** The Air Force provides maternity care through JBER Hospital in Anchorage. If a service member becomes pregnant while stationed remotely, they may be relocated to an area with maternity services.
- **Coast Guard:** The Coast Guard relies more heavily on civilian healthcare partnerships, as many of its members are stationed in coastal communities without direct access to military hospitals.

Importance of Military Births in Local Hospitals

Military births in community hospitals play a crucial role in maintaining obstetric services in small Alaskan communities like Kodiak, Sitka, Ketchikan, and Juneau because hospitals rely on a minimum number of births to sustain their birthing units. Military families contribute significantly to this volume, helping to ensure the continued availability of these services for both military and civilian populations.

The military provides comprehensive maternity care, through a combination of military treatment facilities (MTFs) and partnerships with civilian healthcare providers including doula care, which is particularly valuable for military families. In some Alaskan communities, military births play a key role in sustaining local obstetric services.

Military maternity care in Alaska is delivered through a mix of on-base facilities and civilian hospitals. The two MTFs that provide birthing services are Joint Base Elmendorf-Richardson (JBER) Hospital in Anchorage and Bassett Army Community Hospital in Fairbanks. Clinics serving service members and dependents are located in Kodiak, Sitka, Ketchikan, and Juneau. Due to Alaska's vast geography and dispersed population, pregnant service members and spouses often travel long distances to access care and may at times relocate temporarily.

THE ROLE OF DOULA CARE

TRICARE covers doula services under the Childbirth and Breastfeeding Support Demonstration (CBSD), which allows TRICARE Prime and TRICARE Select enrollees to receive support from certified labor doulas. As of January 1, 2025, the CBSD covers up to six hours of prenatal and postpartum visits, divided into 15-minute increments, along with continuous support during labor. To qualify, beneficiaries must be at least 20 weeks pregnant and plan to give birth outside a military hospital.

Doula care is an increasingly recognized support service for military families, offering emotional, informational, and physical support before, during, and after childbirth. This service is especially beneficial in remote locations where access to extended family support is limited and costly.

Births in Military Hospitals

	2019	2020	2021	2022	2023	5 year total	5 year average	% change over 5 years
Joint Base Elmendorf-Richardson Hospital	637	604	440	522	474	2,677	535	-25.6%
Bassett Army Hospital	465	443	453	433	339	2,133	427	-27.10%

ALASKA MATERNAL CHILD DEATH REVIEW (MCDR)

Among 57 deaths reviewed during 2016-2022:

88%
Potentially preventable

72%
Drug/alcohol use or substance use disorders were documented

71%
History of being a victim or possible victim of interpersonal violence

44%
Associated with barriers to health care access

The Alaska Maternal and Child Death Review (MCDR) is an initiative that aims to identify causes and factors related to pregnancy-associated and infant deaths. MCDR is a multidisciplinary committee that includes healthcare providers, behavioral health clinicians, social service and violence intervention professionals, and first responders. The MCDR seeks to involve panelists who are Alaska Native, people of color, and who have experience working with rural Alaskans.

The MCDR follows a structured review process that includes identifying cases, collecting medical and social records, analyzing findings to determine risk factors, and formulating actionable recommendations. These recommendations are shared with healthcare providers, policymakers, and community stakeholders to implement and evaluate prevention strategies.

Pregnancy-associated mortality includes all deaths that occur while a birthing person is pregnant or within one year of the end of their pregnancy, due to any cause and regardless of the pregnancy outcome. MCDR determines whether a death is pregnancy-related and, if so, categorizes it based on specific codes for the underlying cause of death.

The review process also highlights systemic and social factors affecting maternal health, including barriers to healthcare access, provider-related issues, perinatal mental health disorders, and the influence of social determinants such as poverty, housing instability, and discrimination.

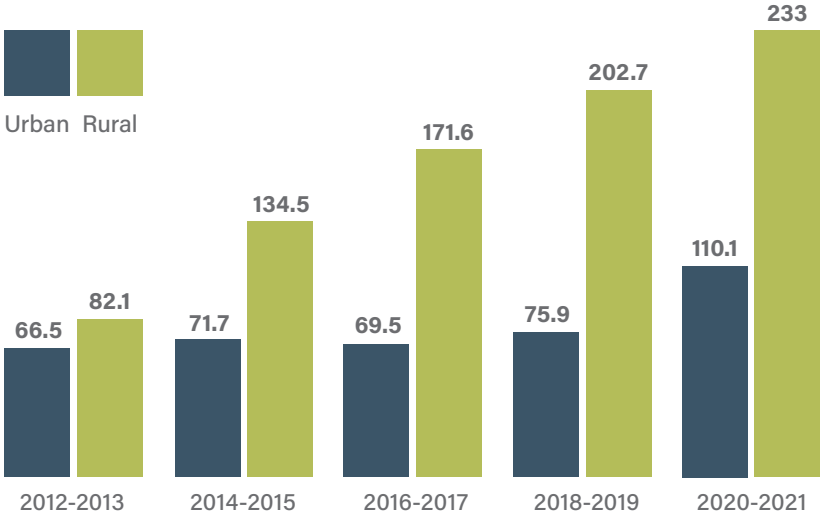
MCDR findings, highlighted in the *Alaska Pregnancy-Associated Mortality Update 2022*, reveal that, from 2012 to 2021, pregnancy-associated deaths rose by 184% in rural areas, compared to a 66% increase in urban areas. The increase in pregnancy-associated deaths in rural areas disproportionately impacts Alaska Native people.

MCDR Recommendations

To improve maternal and infant health, MCDR recommends:

- **Expanding healthcare access, particularly in rural areas**
- **Strengthening community-based programs for maternal and infant care**
- **Enhancing clinical training for providers to manage high-risk conditions**
- **Increasing mental health screenings and support services**
- **Addressing health disparities through culturally competent care**

Death Categorizations, 2015-2019. In addition, there were seven deaths of undetermined causes.



Mortality rates, 2012-2021 (per 100,000 live births)

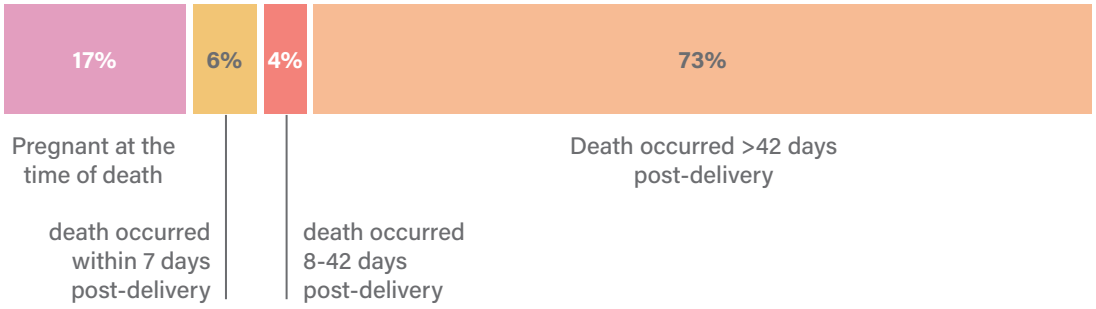
2012	10
2013	6
2014	9
2015	11
2016	12
2017	8
2018	10
2019	14
2020	8
2021	20

Pregnancy associated deaths, 2012-2021

The majority of deaths (73%) occur more than 42 days postpartum. Postpartum care may be limited in rural areas, making it harder to identify and treat complications such as infections, hypertension, or mental health crises.

Substance use disorders (SUDs) are indicated in 72% of deaths which may be a result of limited access to addiction treatment and mental health services in rural areas.

Among deaths in 2015-2019



OUT-OF-HOSPITAL BIRTHS

Geographic Isolation Does Not Drive Out-of-Hospital Births

Despite the rural nature of Alaska, geographic isolation does not appear to be driving the frequency of out-of-hospital births. Mat-Su and Kenai regions, both on the road system, have the highest percentage of community births in the state while the most rural areas have the lowest out-of-hospital births. Low rates in the Northwest region (2.4%) and YK Delta (2.0%) may be due to a lack of home or birth center options as well as the tribal system of regional care and transfer to Anchorage for deliveries. ANMC has a strong midwifery-led maternity care model which supports pregnant people.

7.6%
Alaska

2%
U.S.

Percent of births in community settings 2019-2023

Alaska has one of the highest proportions of out-of-hospital births in the United States—births that occur in locations other than a hospital, including freestanding birth centers, home births (both planned and unplanned), and other locations (clinic, etc.). People may choose to have their babies at home or in a community birth setting for many reasons, including feelings of comfort, control, safety, and trust, a desire for fewer medical interventions and reduced costs.

The Alaska Medicaid program pays for prenatal, delivery, and postpartum care provided by certified nurse-midwives (CNMs) or certified direct-entry midwives (DEMs) at home or in a free-standing birth center, in addition to paying for hospital-based services. This may increase the accessibility of community births compared to states where Medicaid does not pay for care outside a hospital. Uninsured people may choose a community birth to reduce the cost of care.

The Alaska Perinatal Quality Collaborative (AKPQC) has convened a multidisciplinary advisory committee for an initiative focused on improving maternal and neonatal transfers for planned community births. Studies suggest that birth outcomes are improved when community birth providers are integrated into the healthcare system with access to consultation and efficient transfers when escalation of care is needed. The committee has developed transfer guidelines and forms and seeks to support improvement in this area.

	Anchorage	Fairbanks + Interior	Kenai	Mat-Su	Northwest	Southwest	Y-K Delta	Southeast	Alaska statewide
Resident births	18,424	8,311	3,233	6,808	2,288	1,476	3,251	3,323	47,120
Community births	1,227	460	387	1,074	54	101	65	210	3,578
% of resident births	6.7%	5.50%	12.0%	15.8%	2.4%	6.8%	2.0%	6.3%	7.6%
Birthing center	872	251	211	727	25	33	<6	130	2,254
% of resident births	4.7%	3.00%	6.5%	10.7%	1.1%	2.2%	—	3.9%	4.8%
Home births (intended and unintended)	345	193	174	345	9	59	<6	70	1,200
% of resident births	1.9%	2.30%	5.4%	5.1%	*0.4%	4.0%	—	2.1%	2.5%

Data: 2019-2023

ALASKA PERINATAL QUALITY COLLABORATIVE (AKPQC)

Uniquely Structured for Alaska

Perinatal Quality Collaboratives, which exist in most states, are each uniquely structured to meet the needs of the population they serve. Alaska's backdrop necessitates strong collaborative efforts to optimize perinatal care based on its:

- **relatively small population**
- **finite financial resources**
- **vast geographical distances**
- **costly transport**
- **unpredictable weather**
- **scarcity of specialized care**
- **high hospital staff turnover**
- **competing health business entities**

The State of Alaska, Department of Health, Division of Public Health, Section of Women's, Children's and Family Health (WCFH) is the administrative partner to the AKPQC.

The Alaska Perinatal Quality Collaborative (AKPQC) was established to promote high-quality maternal and newborn care across Alaska with an overarching goal to eliminate preventable maternal and neonatal morbidity and mortality.

The AKPQC engages hospitals and birthing facilities in collaborative quality improvement on issues affecting maternal health through participation in the Alliance on Innovation for Maternal Health (AIM) Program. AIM is a national cross-sector commitment designed to support best practices that make birth safer, improve maternal health outcomes, and save lives. AKPQC has adapted AIM's evidence-based bundles of best practices to standardize and enhance care.

The AKPQC focuses on collaboration, data-driven improvement, evidence-based practices, and cultural sensitivity. It engages a diverse range of stakeholders to be inclusive of multiple perspectives and respectful of the varied cultural backgrounds of Alaskan families. Data analysis informs targeted interventions while AIM resources, along with other evidence-based practices, help ensure safe and effective care.

The AKPQC continues to evolve, adapting to Alaska's changing needs. Its future likely involves addressing care disparities, leveraging technology for remote access, and strengthening community partnerships. It is also bringing together key stakeholders to explore funding and partnership opportunities to develop a neonatal branch of the AKPQC and sustain maternal quality improvement efforts.

KEY INITIATIVES

Substance Affected Pregnancies Initiative (SAPI)

Substance-Exposed Newborns Initiative (SENI)

Obstetric Hemorrhage Initiative (OBHI)

Birth Transfer Initiative

Maternal Hypertension Initiative