Rural Health Transformation Grant Guide — Alaska

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Alaska's scale, remoteness, and Tribal-led delivery system present a distinctive fit for the CMS Rural Health Transformation (RHT) Program's model-and-infrastructure focus. CMS has posted Opportunity No. CMS-RHT-26-001 and the program overview; applications are due November 5, 2025, with awards by December 31, 2025. Only the 50 states are eligible, and funding runs FY26–FY30. (cms.gov)

The Rural Health Transformation (RHT) Collaborative can support Alaska with deployable capabilities across virtual acute support (tele-ER/ICU/hospitalist), consumer and community screening, continuous remote physiologic monitoring, pharmacy-enabled chronic care, High Value Networks (HVNs) of independent rural providers, cybersecurity and interoperable data platforms, and program management/evaluation toolsets. These offerings are described in the Collaborative's consensus document and align to the RHT Program pillars of prevention, access, workforce, care innovation, and technology.

Priority near-term impact areas for Alaska include: 24/7 virtual specialty back-up for CAHs and frontier clinics (Avel eCare), statewide continuous monitoring for high-risk patients (BioIntelliSense), pharmacy-enabled cardiometabolic control in rural towns (Walgreens/CVS), and a provider-owned HVN governance scaffold (Cibolo Health) to coordinate investments and value-based contracts. These capabilities are described with evidence of prior deployments, financing models, and data/reporting readiness in the Collaborative portfolio.

The approach is explicitly conditional on contracting, integration with Alaska's Medicaid and public health systems, alignment with healtheConnect (the state HIE), and compliance with CMS NOFO limits (e.g., provider payment shares) and state policy. Alaska's existing Section 1115 Behavioral Health Reform demonstration through 12/31/2028 provides a foundation for behavioral-health and SUD integration within RHT initiatives. (healtheconnectak.org)

One-page printable summary

- Program window and eligibility (CMS): States only; application due Nov 5, 2025; awards by Dec 31, 2025; FY26–FY30 funding with equal "baseline" and point-based "workload" components. (cms.gov)
- Alaska context (selected 2025 metrics): rural population ≈35.1% (ACS 2023); 13 CAHs; 31 FQHCs; 0 RHCs; substantial HPSA designations; far-frontier geography per USDA ERS FAR. (americashealthrankings.org)
- Collaborative alignment: virtual acute support (Avel eCare), continuous RPM (BioIntelliSense), pharmacy-enabled chronic care (Walgreens/CVS), AI-enabled analytics and documentation (Microsoft, Pangaea Data), HVN scaffolding (Cibolo), telehealth at scale (Teladoc), TEFCA-connected EHR/HIE capabilities.
- Initial outcomes Alaska can target: fewer transfers and avoidable readmissions; improved blood pressure/diabetes control rates; faster time-to-psychiatric consults; frontier EMS support; improved cybersecurity posture; measurable savings via avoided transports and right-sizing service lines.

Assumptions and Open Questions

- CMS has posted the funding opportunity (CMS-RHT-26-001) and program overview on CMS.gov; however, the full NOFO PDF was not accessible during this review. This guide cites CMS's program pages and national organizations' NOFO summaries for specifics (deadlines, caps). Alaska should verify final sections and page citations upon retrieving the grants.gov NOFO package. (cms.gov)
- DSH hospital counts: available national analyses indicate Alaska directs DSH largely to IMDs rather than general hospitals in recent years; the most recent state DSH audit should confirm the number of hospitals receiving DSH in the latest SPRY. (congress.gov)
- Some internal Collaborative claims (e.g., exact deployment counts) reflect member-submitted materials and should be validated in contracting due diligence.

2. Eligibility and RFP Fit

2.1 Program synopsis and deadlines

- Eligibility: Only the 50 states may apply; DC and territories are ineligible. (cms.gov)
- Timeline: NOFO posted, submissions due Nov 5, 2025; anticipated awards Dec 31, 2025; program spans FY26–FY30. (cms.gov)

- Distribution: 50% baseline/equal split among approved states; 50% points-based workload funding recalculated annually from state reporting. (cms.gov)
- Uses of funds: prevention/chronic disease; technology/cyber; behavioral health & SUD; innovative care/payment models; other Administrator-approved uses. (cms.gov)

2.2 Key NOFO compliance features (as summarized by national organizations; verify against CMS NOFO)

- Provider-payment cap: ≤15% of a state's annual award; EHR replacement (if HITECH-certified) cap at 5%. (bipartisanpolicy.org)
- One application per state; cooperative agreement structure; strong CMS involvement in monitoring. (cms.gov)
- Optional LOI and applicant webinars in late September 2025 (industry notices). (ruralhealth.us)

2.3 Requirement-to-Capability map (illustrative)

- Evidence-based prevention/chronic disease projects → consumer kiosks (Higi/Topcon), pharmacy-enabled hypertension/diabetes management (Walgreens/CVS), RPM (BioIntelliSense). Evidence of program designs and adherence metrics included in member materials.
- Rural access and acute support → 24/7 tele-ER/ICU/hospitalist, tele-pharmacy, and EMS consults (Avel eCare) for CAHs/frontier clinics.
- Data interoperability and analytics → secure cloud, AI, and QHIN-connected exchange (Microsoft; eClinicalWorks PRISMA/TEFCA referenced in member profiles), plus population analytics (Pangaea Data; Humetrix).
- Workforce development and burnout reduction → ambient documentation tools and multilingual intake to reduce cognitive load; structured training at FQHCs/clinics.
- Governance and payment innovation → provider-owned High Value Networks (Cibolo) to coordinate shared services and value-based contracts statewide.

3. Alaska Context Snapshot

3.1 Population, geography, and frontier status

- Rural population: 35.1% of Alaskans lived in rural areas in 2023 (ACS 1-year). (americashealthrankings.org)
- Frontier/remoteness: USDA ERS reports Alaska has the highest share of FAR level-1 land area (97.9%) and is among the highest in FAR population share. This underscores the need for remote-care models and aviation-supported networks. (ers.usda.gov)
- Broadband gaps: As of May 7, 2025 update (reflecting FCC 12/31/2022 base), ~64,801 Alaska locations were unserved and ~21,661 underserved; ~197,405 served. (broadbandexpanded.com)

3.2 Facility and network mix

- Rural healthcare inventory (outside urban areas ≥50k): 13 CAHs; 31 FQHCs; 0 RHCs (HRSA data, July 2025 snapshot). (ruralhealthinfo.org)
- Alaska HIE: healtheConnect Alaska convenes statewide HIE stakeholders and supports public-health and care-coordination use cases (summit/program descriptions, Aug 2025). (healtheconnectak.org)

3.3 Workforce and shortage areas

- HPSA indicators (HRSA, as summarized from 3/31/2025): Primary care HPSAs in AK numbered 343 with a shortfall of ~71 practitioners; mental health HPSAs showed ~343 designations with smaller shortfall counts due to population. (commentary.healthguideusa.org)
- Nurse Licensure Compact: Alaska is not an NLC member as of 2025; legislation (HB 131/SB 124) has been introduced. This creates a policy lever under NOFO "licensure compacts" scoring. (ncsbn.org)

3.4 Medicaid structure and waivers

- Delivery system: Alaska is among five states without comprehensive Medicaid managed care as of July 1, 2024; program is predominantly FFS with selective carve-outs/vendors. (kff.org)
- 1115 Behavioral Health Reform demonstration: approved through 12/31/2028; SUD/SMI/SED coverage expansions and monitoring protocols are active. (medicaid.gov)

3.5 Telehealth and EMS

- Alaska Medicaid reimburses synchronous audio-video, audio-only, and store-and-forward telehealth modalities under 7 AAC 110.625 et seq.; exclusions are specified at 7 AAC 110.635; provider and payment conditions at 7 AAC 110.630. (regulations.justia.com)
- EMS and remote care pipeline: statewide licensure and training infrastructure supports rural EMS, with continuing education and symposium programming in 2025. (health.alaska.gov)

3.6 Maternal and behavioral health signals

- Alaska's Maternal & Child Death Review (MCDR) and partners report substance use and interpersonal violence feature prominently in maternal mortality/morbidity reviews (2016–2022), highlighting integrated behavioral health needs. (alaskahha.org)
- Overdose trends: National provisional CDC data showed a 3% U.S. decline in 2023, with Alaska among states posting increases that year; 2024 provisional estimates indicate a large national decline, while Alaska law-enforcement seizures of fentanyl/meth rose sharply in 2024—reinforcing the case for analytics-enabled prevention and treatment access. (cdc.gov)

3.7 SNAP policy levers (NOFO technical scoring)

- Broad-Based Categorical Eligibility: Alaska uses BBCE (200% FPL; no asset limit) per USDA FNS. ABAWD waiver criteria and guidance were updated in 2025; Alaska historically has qualified for broad time-limit waivers in many areas. (fns.usda.gov)

3.8 Selected Alaska metrics and matching Collaborative capabilities

- Rural/nonmetro population (2023 ACS): 32.5% nonmetro; 35.1% rural (share) → match to tele-ER/ICU and RPM to reach remote households. (ruralhealthinfo.org)
- CAHs=13; FQHCs=31; RHCs=0 → emphasize CAH virtual support, FQHC-pharmacy linkages. (ruralhealthinfo.org)
- Broadband unserved locations ~64.8k (2025 update of 2022 base) → prioritize offline-tolerant RPM, store-and-forward, and vendor cellular backhaul kits. (broadbandexpanded.com)
- FAR Level-1 land ≈98% → logistics and aviation-aware service design; local CHAP/EMS integration. (ers.usda.gov)
- 1115 BH Reform through 2028 → integrate tele-behavioral and crisis support; align evaluation metrics. (medicaid.gov)

4. Strategy Aligned to RFP

4.1 Transformation model for Alaska

- Acute and emergency support: Avel eCare's virtual ER/ICU/hospitalist and tele-pharmacy can support CAHs and frontier clinics to stabilize patients locally, reduce avoidable transfers, and mentor rural clinicians.
- Continuous community management: BioIntelliSense's FDA-cleared patch plus exception-based dashboards to monitor cardiopulmonary status; pairing with nurse/CHW digital navigators.
- Pharmacy-enabled prevention and control: Walgreens/CVS programs for medication management, BP checks, adherence, and virtual care linkage; evidence cited for improved adherence and readmission reduction in retail-pharmacy models.

- Data/cyber platform: Microsoft cloud, security, and AI services; population analytics (Pangaea Data) and consumer apps (Humetrix).
- Governance: Cibolo-enabled, member-owned High Value Networks to coordinate shared services, track funds, and support value-based arrangements.

4.2 Equity for rural and Tribal communities

- Solutions can be configured to support Alaska's village-based care (e.g., CHAP/EMS consult lines, store-and-forward imaging, multilingual intake tools) and routed via healtheConnect for continuity and public-health feeds.

4.3 Data use and privacy

- TEFCA-aligned exchange, ONC-certified interface connectors, and Azure-based governance, with PHI handling consistent with HIPAA and Alaska telehealth regs (7 AAC 110.625–.639). (regulations.justia.com)

5. Program Design Options (Alaska-tuned)

Option A. Virtual Critical Care and Transfer-Avoidance Network

- Target: Patients presenting to CAHs/frontier clinics with time-sensitive conditions; EMS field consults.
- Problem: Distance, weather, and limited on-site specialists drive transfers/costs; staffing volatility.
- Collaborative components: Avel eCare tele-ER/ICU/hospitalist + tele-pharmacy; BioIntelliSense post-discharge RPM; Humetrix multilingual triage for intake; Microsoft cyber hardening.
- Payment logic: Global service fees via subawards; constrained "provider payments" for direct care within the NOFO ≤15% cap; savings captured via avoided transports and readmissions. (bipartisanpolicy.org)
- Policy enablers: Telehealth/audio-only allowed; EMS consult documentation via 7 AAC 110.625; alignment with CAH Conditions of Participation. (regulations.justia.com)
- Pros/risks: Rapid clinical impact; dependency on connectivity; needs credentialing and cross-facility protocols.

Option B. Cardiometabolic Control Through Rural Pharmacies + FQHCs

- Target: Adults with hypertension/diabetes in frontier towns with pharmacy presence.
- Problem: Gaps in chronic-disease control; travel barriers; limited primary care appointment supply.
- Components: Pharmacy BP/diabetes programs (Walgreens/CVS) linked to FQHCs; AHA/ASA community screening events; remote monitoring; adherence support; digital nudges (Humetrix).
- Payment logic: Subawards for screening/devices/clinical services; outcomes-based pharmacy agreements; provider payment share within NOFO cap. (bipartisanpolicy.org)
- Pros/risks: High reach; measurable control metrics; requires data-sharing agreements and scope-of-practice alignment.

Option C. Behavioral Health & Crisis Virtual Network (BH-Crisis-Link)

- Target: SUD/SMI/SED populations; perinatal behavioral health patients under 1115 BH Reform.
- Problem: Long waits for psychiatric consults; crisis transports; high overdose risk seasons.
- Components: 24/7 tele-behavioral consults (Avel eCare/Teladoc), virtual crisis response support, analytics to flag risk from claims/EHR (Pangaea Data; Humetrix).
- Payment logic: Subawards to crisis hubs and FQHCs; coordinate with 1115 BH services and Medicaid FFS. (medicaid.gov)
- Pros/risks: Addresses high-burden need; requires data-use agreements, 988 coordination.

Option D. Provider-Owned High Value Network (HVN) for Shared Services

- Target: Independent rural hospitals/clinics.
- Problem: Fragmented purchasing, uneven cyber posture, limited negotiating leverage.
- Components: Cibolo-facilitated HVN to pool procurement (telehealth, RPM, cyber), track funds, and structure value-based contracts with payers.

- Payment logic: Program management subaward; state-level dashboards; technical assistance to bring providers into shared models.

6. Governance and Collaborative Roles

6.1 Partner map (text diagram)

- State of Alaska (Lead/AOR) → program authority, policy, and subaward oversight.
- Alaska Medicaid (Division of Health Care Services) → SPA/wavier alignment; claims/data feeds.
- healtheConnect Alaska (HIE) → data exchange services; consent frameworks; dashboards integration. (healtheconnectak.org)
- Rural providers (CAHs, FQHCs) → implementation sites; data/reporting; local workforce.
- Collaborative members → clinical virtual services (Avel eCare), RPM (BioIntelliSense), pharmacy programs (Walgreens/CVS), analytics (Pangaea Data/Humetrix), cloud/cyber (Microsoft), HVN scaffolding (Cibolo), PMO support (Accenture/KPMG/PwC/AVIA).

6.2 RACI (selected deliverables)

- Tele-ER/ICU operations: Responsible—Avel eCare; Accountable—participating CAHs; Consult—State PMO; Informed—HIE.
- RPM program: Responsible—BioIntelliSense + FQHC clinical leads; Accountable—site medical directors; Consult—State PMO; Informed—HIE/public health.
- HVN formation: Responsible—Cibolo; Accountable—provider board; Consult—State PMO; Informed—payers.
- Cyber posture uplift: Responsible—Microsoft; Accountable—site CIOs; Consult—State CISO/HIE; Informed—CMS.

7. Payment and Funding

- Planning anchor: CMS indicates equal baseline + point-based workload funding across FY26–FY30; program is a cooperative agreement with CMS oversight. (cms.gov)
- NOFO policy limits to observe during budgeting (confirm against final NOFO PDF):
    - Provider payments (direct care) ≤15% of annual award. (bipartisanpolicy.org)
    - EHR replacement (HITECH-certified installed) ≤5%. (bipartisanpolicy.org)
- Example ROM cost table (illustrative; subject to procurement):
    - Tele-ER/ICU hub and spoke activation; RPM kits and monitoring; pharmacy chronic care; HIE integration; cyber uplift; PMO/evaluation. Collaborative deliverables include clinical staffing matrices, device inventories, integration runbooks, and KPI dashboards.

8. Data, Measurement, and Evaluation

- Sources: Medicaid FFS claims; HIE encounter summaries; EHR problem/medication/allergy lists; EMS run sheets; RPM telemetry; pharmacy dispensing and MTM encounters; public-health registries. healtheConnect can serve as a broker. (healtheconnectak.org)
- Core measures (examples): transfer-avoidance rate; 30-day readmissions; ED utilization; BP control (<140/90) and A1c control; time-to-psychiatric consult; SUD engagement (initiation/continuation); cyber incident metrics; program implementation milestones.
- Evaluation cadence: quarterly operational dashboards; annual statewide impact reports for CMS. Collaborative analytics tools (Humetrix, Pangaea Data) support risk stratification and gap closure analyses.

9. Implementation Plan (12–24 months; illustrative)

Gantt-style table (quarters)

Workstream	Start	End	Owner	Outputs
Tele-ER/ICU onboarding (3 CAHs, 5 clinics)	Q1	Q3	Avel eCare + CAHs	24/7 coverage, protocols, credentialing
RPM pilot (CHF/COPD/diabetes; 500 pts)	Q1	Q4	BioIntelliSense + FQHCs	Devices, monitoring team, exception workflows
Pharmacy HTN/DM program (10 towns)	Q2	Q4	Walgreens/CVS + FQHCs	BP checks, MTM visits, closed-loop referrals
HVN formation and bylaws	Q1	Q2	Cibolo + Provider Board	Governance charter, shared-services plan
Cloud/cyber uplift & HIE connectors	Q1	Q4	Microsoft + HIE	Identity, logging, MDR, APIs
Evaluation & dashboards	Q1	Q4	State PMO + SI (Accenture/KPMG/PwC/AVIA)	KPI suite, quarterly reports

Critical milestones: first virtual response live; first 100 RPM patients on service; first pharmacy cohort with documented BP control; HVN board seated; CMS Q1 report accepted.

Procurement/legal: BAAs and DPAs; telemedicine credentialing by proxy agreements; subrecipient monitoring plans; HIE participation agreements (healtheConnect). (healtheconnectak.org)

10. Risk Register (selected)

- Connectivity gaps in frontier villages → Mitigation: store-and-forward, dual-SIM kits, satellite fallbacks; Owner: SI + HIE. (broadbandexpanded.com)
- Workforce burnout or turnover → Mitigation: ambient documentation; tele-mentoring; Owner: provider HR + Microsoft/Avel.
- Cyber incidents → Mitigation: MDR, identity hardening, tabletop exercises; Owner: CIOs + Microsoft.
- Policy misalignment (e.g., NLC not enacted) → Mitigation: leverage audio-only/telehealth flexibilities; pursue compact legislation for scoring; Owner: State/Medicaid. (regulations.justia.com)
- Pharmacy data-sharing barriers → Mitigation: consent management (Humetrix), BAAs; Owner: FQHCs/pharmacies.
- DSH/finance assumptions mismatch → Mitigation: confirm hospital DSH recipients; align funds to non-duplicative services; Owner: Medicaid finance. (congress.gov)
- EMS participation variability → Mitigation: phased onboarding; training grants; Owner: OEMS + Avel. (health.alaska.gov)
- Telehealth billing friction → Mitigation: align to 7 AAC 110.625–.639 and fee schedule updates; Owner: Medicaid + providers. (regulations.justia.com)
- Overdose surge pockets despite national decline → Mitigation: targeted analytics outreach and pharmacy naloxone integration; Owner: Public Health + Pharmacies. (cdc.gov)
- Schedule/cost creep → Mitigation: PMO with earned-value tracking and CMS check-ins; Owner: State PMO + SI.

11. Draft RFP Response Language (paste-ready, to be tailored by Alaska)

11.1 Goals & Strategies

"Alaska proposes to advance a frontier-ready model that integrates 24/7 virtual acute support, continuous remote monitoring for high-risk patients, pharmacy-enabled chronic-disease control, and provider-owned shared services. We will align these

initiatives to the CMS Rural Health Transformation Program's prevention, access, workforce, care innovation, and technology pillars and report quarterly on transfer avoidance, chronic-disease control, behavioral-health engagement, cybersecurity, and implementation milestones."

11.2 Use of Funds and Compliance

"Requested funds will be subawarded to rural hospitals, clinics, pharmacies, and statewide infrastructure partners to execute initiatives in prevention/chronic disease, technology advancement, behavioral health, and innovative care models. Direct provider payments funded under RHT will not exceed the NOFO's 15% annual cap, and any EHR replacement will be limited consistent with the NOFO's 5% limit for replacement of HITECH-certified systems. We will avoid duplication with existing funding streams and comply with federal grant requirements." (bipartisanpolicy.org)

11.3 Data, Privacy, and Evaluation

"Data flows will leverage healtheConnect Alaska and TEFCA-aligned exchange, combined with Medicaid claims, EMS reports, pharmacy data, and RPM telemetry. We will implement HIPAA-compliant governance and consent tooling; dashboards will support quarterly reporting to CMS and public transparency." (healtheconnectak.org)

11.4 Sustainability

"By creating a provider-owned High Value Network to steward shared services and value-based arrangements, and by embedding workforce-sparing technologies, Alaska will position participating organizations to sustain services beyond FY31 through negotiated payer contracts and operational savings."

12. References

Internal (Collaborative) sources

1. Rural Health Transformation Collaborative. R1. 10-11-25 (PDF). Member capabilities, example outcomes, and governance constructs. Accessed Oct 13, 2025.
2. Avel eCare profile and virtual hospital services (in #1), pp. 15–16. Accessed Oct 13, 2025.
3. BioIntelliSense RPM platform (in #1), pp. 16–17. Accessed Oct 13, 2025.
4. Walgreens/CVS pharmacy-enabled chronic care (in #1), pp. 21–22. Accessed Oct 13, 2025.
5. Cibolo Health High Value Networks (in #1), p. 23. Accessed Oct 13, 2025.
6. Microsoft cloud/cyber/AI capabilities (in #1), p. 17. Accessed Oct 13, 2025.
7. Pangaea Data and Humetrix analytics/consumer tools (in #1), pp. 16–17. Accessed Oct 13, 2025.

External sources 8) Rural Health Transformation (RHT) Program overview, CMS. https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview. Accessed Oct 13, 2025. (cms.gov) 9) Current CMS Grants Program Funding Opportunities (listing CMS-RHT-26-001). Centers for Medicare & Medicaid Services. Accessed Oct 13, 2025. (cms.gov) 10) National Association of Counties. "CMS releases details on Rural Health Transformation Program." Sept 2025. Accessed Oct 13, 2025. (naco.org) 11) National Rural Health Association (NRHA). "Rural Health Transformation Program — NOFO summary and dates." Sept 2025. Accessed Oct 13, 2025. (ruralhealth.us) 12) Bipartisan Policy Center. "Rural Health Transformation Program: Notice of Funding Opportunity (Explainer)." Sept 2025. Accessed Oct 13, 2025. (bipartisanpolicy.org) 13) America's Health Rankings. "Rural Population — Alaska (2023)." United Health Foundation. Accessed Oct 13, 2025. (americashealthrankings.org) 14) Rural Health Information Hub — Alaska State Profile (facilities). Updated Sept 11, 2025. Accessed Oct 13, 2025. https://www.ruralhealthinfo.org/states/alaska. (ruralhealthinfo.org) 15) HRSA — Rural Health Clinic COVID-19 testing allocations (Alaska=0 RHCs). U.S. HHS/HRSA. Accessed Oct 13, 2025. (hrsa.gov) 16) healtheConnect Alaska — HIE Summit (program and stakeholders). Aug 2025. Accessed Oct 13, 2025. https://healtheconnectak.org/summit/ (healtheconnectak.org) 17) HRSA/State HPSA summaries (as of 3/31/2025) — Alaska excerpts summarized (primary and mental HPSAs). Accessed Oct 13, 2025. (commentary.healthguideusa.org) 18) KFF 50-state Medicaid budget survey FY2024-2025 — managed care models (Alaska among five without comprehensive managed care). Accessed Oct 13, 2025. (kff.org) 19) Medicaid.gov — Alaska Behavioral Health Reform (1115) approval and dates. Accessed Oct 13, 2025. (medicaid.gov) 20) Alaska Administrative Code — Medicaid Telehealth: 7 AAC 110.625, .630, .635. Current through 2025. Accessed Oct 13, 2025. (regulations.justia.com) 21) USDA ERS — Frontier and Remote Area Codes (documentation; FAR land

share, state ranking). Updated May 8, 2025. Accessed Oct 13, 2025. (ers.usda.gov) 22) Broadband Expanded (FCC National Broadband Map derived; updated May 7, 2025): Alaska served/underserved/unserved location counts. Accessed Oct 13, 2025. (broadbandexpanded.com) 23) Alaska Board of Nursing — NLC information and 2025 legislation (HB 131/SB 124). State of Alaska. Accessed Oct 13, 2025. (commerce.alaska.gov) 24) NCSBN — NLC status (non-member list including Alaska). Accessed Oct 13, 2025. (ncsbn.org) 25) Alaska Department of Health — EMS program overview/licensing. Accessed Oct 13, 2025. (health.alaska.gov) 26) Alaska Behavioral Health Association — MCDR partner data points (maternal review findings). Accessed Oct 13, 2025. (alaskahha.org) 27) CDC/NCHS — Provisional overdose trends 2023 (states with increases include Alaska); 2024 national decline. Accessed Oct 13, 2025. (cdc.gov) 28) Alaska Dept. of Public Safety — 2024 drug seizure report highlights. Accessed Oct 13, 2025. (dps.alaska.gov) 29) USDA FNS — Broad-Based Categorical Eligibility (state parameters including Alaska). Accessed Oct 13, 2025. (fns.usda.gov) 30) USDA FNS — ABAWD waivers hub (FY2025–2029 materials and updates). Accessed Oct 13, 2025. (fns.usda.gov) 31) CRS (via Congress.gov) — Medicaid DSH (IMD DSH limits; Alaska use toward IMDs noted). Accessed Oct 13, 2025. (congress.gov)

Checklist — CMS RHT Application (evidence and alignment)

- Eligibility and deadline confirmed (state applicant; Nov 5, 2025). (cms.gov)
- Minimum three use-of-funds categories addressed (prevention, technology/cyber, BH/SUD, innovative care). (cms.gov)
- Budget respects NOFO caps (≤15% provider payments; ≤5% EHR replacement). (bipartisanpolicy.org)
- Reporting/evaluation plan and cooperative agreement readiness described (monthly/quarterly cadence). (cms.gov)
- Program duplication safeguards and HIE/claims data integration path identified. (healtheconnectak.org)

13. AI Generation Notice

This guide was generated by an AI model (gpt-5) on 2025-10-13 using internal collaborative materials and authoritative public sources cited inline. All facts, figures, and citations must be independently validated against the final CMS NOFO package and current Alaska policies prior to use in planning or submission.