DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 10-01	2. STATE Alaska
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: April 1, 2010	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Section 1902 of the Act 42 CFR 440.130	a. FFY 10 $ 0 b. FFY 11 $ 0 Please see Box 10, below
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attached pages to Attachment 3.1-A, pages 4a-6 ~~Attachment 4.19-B, page 4 and 11~~ (P&I)	Attached pages to Attachment 3.1-A, pages 4.5 and 6 ~~Attachment 4.19-B, page 4 and 11~~ (P&I)

10. SUBJECT OF AMENDMENT:
Behavioral Health Service descriptions and reimbursement methodology updates.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor does not wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: William J. Streur	Alaska Department of Health and Social Services Office of the Commissioner P.O. Box 110601 Juneau, Alaska 99811-0601
14. TITLE: Deputy Commissioner	
15. DATE SUBMITTED: March 17, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 17 2010	18. DATE APPROVED: JUN 10 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2010	20. SIGNATURE OF REGIONAL OFFICIAL: Carol JC Peverly
21. TYPED NAME: CAROL JC PEVERLY	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:
5/06/2010 State authorizes pen and ink changes.

FORM HCFA-179 (07-92)