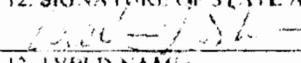


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 10-01	2. STATE Alaska
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: April 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  Section 1902 of the Act 42 CFR 440.130		7. FEDERAL BUDGET IMPACT: a. FFY            10                      \$ 0 b. FFY            11                      \$ 0 Please see Box 10, below	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attached pages to Attachment 3.1-A, pages 4a-6 Attachment 4.19-B, page 4 and 11 (P&I)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attached pages to Attachment 3.1-A, pages 4.5 and 6 Attachment 4.19-B, page 4 and 11 (P&I)	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):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor does not wish to comment. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Alaska Department of Health and Social Services Office of the Commissioner P.O. Box 110601 Juneau, Alaska 99811-0601	
13. TYPED NAME: William J. Streur			
14. TITLE: Deputy Commissioner			
15. DATE SUBMITTED: March 17, 2010			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>MAR 17 2010</b>		18. DATE APPROVED: <b>JUN 10 2010</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR 01 2010</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>CAROL JC PEVERLY</b>		22. TITLE: <b>Associate Regional Administrator</b> <b>Division of Medicaid &amp; Children's Health</b>	
23. REMARKS: 5/06/2010 State authorizes pen and ink changes.			