Revision: HCFA-PM-86-20 (BERC)

SEPTEMBER 1986

ATTACHMENT 3.1-B Page 1

OMB No. 0938-0193

State/Territory:	ACABRA	
AMOUNT, DURATION MEDICALLY NEEDY G	AND SCOPE OF SERVICES ROUP(S):	PROVIDED

The following ambulatory services are provided.

*Description provided on attachment.

TN No. 30 30 87-3

Supersedes
TN No. 81-7

Approval Date 6/17/89 Effective Date 1/1/89

HCFA ID: 0140P/0102A

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

ATTACHMENT 3.1-B Page 2 OMÉ No. 0938-

State/Territory: ALASKA
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):
 Inpatient hospital services other than those provided in an institution for mental diseases.
//Provided: //No limitations //With limitations*
2.a.Outpatient hospital services.
//Provided: //No limitations //With limitations*
b.Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.
c.Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA -Pub. 45-4).
Provided No limitations With limitations*
3. Other laboratory and X-ray services.
// Provided // No limitations // With limitations*
4.a.Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.*
Provided No limitations / With limitations*
b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
/_/ Provided
c.Familiy planning services and supplies for individuals of childbearing age.
// Provided // No limitations // With limitations*
*Description provided on attachment
TN No. 91-13 Supersedes Approval date 4/3/25 Effective Date 10/1/21
Supersedes Approval date 4/10/2 Effective Date 70/10/2 TN No. 90-1/2 HCFA ID: 7986E

Revision: HCFA-PM-93-5 (MB)

MAY 1993

ATTACHDER SALEB Page 2a OMB NO:

	State/Territory: ALASKA
	AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s):
5.a.	Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.
	Provided: No limitations With limitations*
b.	Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
	Provided: No limitationsWith limitations:

*Description provided on attachment.

				-	THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.
TN No. 95-005		. / . / .			1.100
Supersedes	Approval Date	4/28/95	Effective	Dare	111195
TN NO. 61-13					

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ATTACHMENT 3.1-B Page 3

		State/Territo	ry:	HLAXA			
*		AMOUNT, MEDICALLY	DURATION NEEDY G	AND SCOPE OF ROUP(S):	SERVIC	ES PROVIDE	D
6.		Medical care and law, furnished by practice as defin	y license	d practitioner	dial cass with	are recogni in the scop	zed under State e of their
	a.	Podiatrists' Ser	vices				
		// Provided:	/_/ No	limitations	<u>/</u> /	With limit	ations*
	b.	Optometrists' Se	rvices				
		// Provided:	<u>/</u> / No	limitations	<u>/_</u> /	With limit	ations*
	c.	Chiropractors' S	ervices				
		// Provided:	/_/ No	limitations		With limit	tations*
	d.	Other Practition	ers' Serv	ices			
		// Provided:	/_/ No	limitations		With limit	tations*
7.		Home Health Serv	ices				
	a.	Intermittent or agency or by a r the area.	part-time egistered	nursing servi	ice pro home	vided by a health age	home health ncy exists in
		// Provided:	/_/ No	limitations	<u>/</u> /	With limi	tations*
	ъ.	Home health aide	services	provided by	a home	health age	ncy.
		// Provided:	<u>/</u> / No	limitations		With limi	tations*
	c.	Medical supplies home.	, equipme	ent, and applia	ances s	suitable fo	r use in the
		// Provided:	<u>/_</u> / No	limitations		With limi	tations*
	đ.	Physical therapy audiology service rehabilitation is	es provid	tional therapy ded by a home b	, or sp health	eech patho agency or	logy and medical
		// Provided:	<u>/</u> / No	o limitations		With limi	tations*
		ription provided (man b			

TN No. (257-)
Supersedes
TN No. (47-7)

Approval Date 1/17/87 Effective Date 1/1/87

HCFA ID: 0140P/0102A

Revision: HCFA-PM-86-20 (BERC)

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ATTACHMENT 3.1-B Page 4

	1	State/Territ	огу:	1	2 HSKH			_
•					AND SCOPE OF DUP(S):			
8.		ate duty nur						
		Provided:	<u></u>	No	limitations		With limitation	s*
9.	Clin	ic services.						
		Provided:		No	limitations		With limitation	s*
10.	Dent	al services.						
		Provided:	<u>/</u> /	No	limitations		With limitation	s*
11.	Phys	sical therapy	and r	elat	ed services.			
a.	Phys	sical therapy						
		Provided:		No	limitations		With limitation	ıs*
b.	Occi	pational the	rapy.					
		Provided:	<u></u>	No	limitations		With limitation	18*
с.	Serv	vices for ind vided by or u	lividus ınder s	ıls w	with speech, wision of a	hearing speech	, and language of pathologist or a	lisorders audiologist.
		Provided:	<u>/</u> /	No	limitations		With limitation	18*
12.	pre	scribed drugs scribed by a ometrist.	s, deni	ure:	s, and prosth skilled in d	etic de iseases	evices; and eyes; s of the eye or	lasses by an
a.	Pre	scribed drug	в.					
		Provided:		No	limitations	<u>/</u> /	With limitation	ns*
b.	Den	tures.						
		Provided:		No	limitations	17	With limitatio	ns*
*Desc	ripti	on provided	on att	achm	ent.			
Super	sedes	-20:57 -	Appro	val	Date 6/17/8	2	Effective Date	1/1/87
TN No	· X/	- 7			- 4			01409/0102/

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ATTACHMENT 3.1-B Page 5

	State/Territory: DIPLIA	
	AMOUNT, DURATION AND SCOPE OF SERVION MEDICALLY NEEDY GROUP(S):	CES PROVIDED
c.	Prosthetic devices.	
	// Provided: // No limitations //	With limitations*
d.	Eyeglasses.	
	// Provided: // No limitations //	With limitations*
13.	Other diagnostic, screening, preventive, and i.e., other than those provided elsewhere in	rehabilitative services, this plan.
a.	Diagnostic services.	IA.
	// Provided: // No limitations //	With limitations*
b.	Screening services.	
	// Provided: // No limitations //	With limitations*
c.	Preventive services.	
	// Provided: // No limitations //	With limitations*
d.	Rehabilitative services.	
	// Provided: // No limitations //	With limitations*
14.	Services for individuals age 65 or older in diseases.	institutions for mental
a.	Inpatient hospital services.	
	// Provided: // No limitations //	With limitations*
ъ.	Skilled nursing facility services.	
Desc	// Provided: // No limitations // ription provided on attachment.	With limitations
Super	. 4-30 7-3 sedes Approval Date	Effective Date 1/1/87
TN No	. 81-7	HCFA ID: 0140P/0102

Revision: HCFA-PM-86-20 (BERC) SEPTEMBER 1986

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ATTACHMENT 3.1-B

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	State/Territory: April P
	AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):
c.	Intermediate care facility services.
	// Provided: // No limitations // With limitations*
15. a.	Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.
	/// Provided: /// No limitations /// With limitations*
b.	Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
	// Provided: // No limitations // With limitations*
16.	Inpatient psychiatric facility services for individuals under 22 years of age.
	// Provided: // No limitations // With limitations*
17.	Nurse-midwife services.
	// Provided: // No limitations // With limitations*
18.	Hospice care (in accordance with section 1905(o) of the Act).
	// Provided: // No limitations // With limitations*
*Descr	iption provided on attachment.
Supers	84-70 51-3 edes
TN No.	8/-) HCFA ID: 0140P/0102

OMB No. 0938-State/Territory: ____ ALASKA AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): 19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act). // Provided: // With limitations // Not provided. 20. Extended services for pregnant women. a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls. // Additional coverage / Provided: b. Services for any other medical conditions that may complicate pregnancy. // Provided: // Additional coverage // Not provided. Certified pediatric or family nurse practitioners' services. 21. // No limitations // With limitations* / / Provided: / / Not provided. + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy. ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only. *Description provided on attachment.

ATTACHMENT 3.1-B

Effective Date _

HCFA ID: 7986E

Page 7

Revision: HCFA-PM-91-4

TN No.

Supersedes TN No.

Approval Date

AUGUST 1991

(BPD)

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Revision: HCFA-PM-87-4 (BERC) **MARCH 1987**

ATTACHMENT 3.1-B

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	State/Territory: ALASKA
	AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):
22.	Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
	// Provided: // No limitations // With limitations*
	// Not provided.
23.	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
а	. Transportation.
	// Provided: // No limitations // With limitations*
b	o. Services of Christian Science nurses.
	// Provided: // No limitations // With limitations*
	c. Care and services provided in Christian Science sanitoria.
	// Provided: // No limitations // With limitations*
(Skilled nursing facility services provided for patients under 21 years of age.
	// Provided: // No limitations // With limitations*
	e. Emergency hospital services.
	// Provided: // No limitations // With limitations*
	f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
	// Provided: // No limitations // With limitations*
Supe	Approval Date 45187 Reflective Date 7187
	HCFA ID: 1042P/001

	STATE	ALASKA		Page 8a Attachment 3.1-8
24. Pediatric or 1905 (a)(21)	family nurse of the Act (a	practitioners' dded by Section	services as def 6405 of OBRA '8	ined in section 39)=
// Provi	ded //	No Limitations	// With	LImitations*
				*
* *				
* .	⁵ es			
*Description prov	ided on attach	nment.		
TN No. 90-1 Supersedes TN No.	Approval	Date	Effective	Date///s,