

ADDITIONAL REGULATION NOTICE INFORMATION
(AS 44.62.190(d))

1. Adopting agency: Department of Health.
2. General subject of regulation: Tribal health programs, Certified Health Provider Encounter Rate.
3. Citation of regulation (may be grouped): 7 AAC 155.040, 7 AAC 160.900.
4. Department of Law file number, if any: 2024200480.
5. Reason for the proposed action:
 - () Compliance with federal law or action (identify): _____
 - () Compliance with new or changed state statute.
 - () Compliance with federal or state court decision (identify): _____
 - () Development of program standards.
 - (X) Other (identify): To add more detail about the rate setting process and increase alignment with the Medicaid State Plan pertaining to this provider type.
6. Appropriation/Allocation: Medicaid Services/Medicaid Services; OMB Component Number: 3234.
7. Estimated annual cost to comply with the proposed action to:
 - A private person: \$0
 - Another state agency: \$0
 - A municipality: \$0
8. Cost of implementation to the state agency and available funding (in thousands of dollars): None.

	Initial Year	Subsequent
	FY _____	Years
Operating Cost	\$0 _____	\$0 _____
Capital Cost	\$0 _____	\$0 _____
1002 Federal receipts	\$0 _____	\$0 _____
1003 General fund match	\$0 _____	\$0 _____
1004 General fund	\$0 _____	\$0 _____
1005 General fund/ program	\$0 _____	\$0 _____
Other (identify)	\$0 _____	\$0 _____
9. The name of the contact person for the regulation:
 - Name: Ms. Mattie Dawson.
 - Title: Program Coordinator I.
 - Address: 3601 C St., Suite 978, Anchorage, Alaska 99503.
 - Telephone: (907) 334-2465.
 - E-mail address: mattie.dawson@alaska.gov

10. The origin of the proposed action:
 Staff of state agency.
 Federal government.
 General public.
 Petition for regulation change.⁷
 Other (identify): _____

11. Date & DOH Division Project Lead: _____

[e-signature]

Name (printed): Mattie Dawson.

Title (printed): Program Coordinator I.

Telephone: (907) 334-2465.