DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Centers for Medicare and Medicaid Services

1. TRANSMITTAL NUMBER: 10-001

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2010~~
October 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:

Section 1916A of the Social Security Act
Section 1916 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
~~FFY 10: $231,726 + $135,522 (Other) = ($367,248)~~
~~FFY 11: $625,962 + $329,637 (Other) = ($955,599)~~
FFY 11: ($683,000)
FFY 12: ($670,700)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.18-F, pages 1, 1(a), 2, 3, 3(a), 4-8
Attachment 4.18-A, pages 1-3
Section 4.18 pages 54-56

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Same~~
Attachment 4.18-A, page 1
Section 4.18 page 54-56

10. SUBJECT OF AMENDMENT:

Implements alternative cost sharing for certain populations as authorized under the Deficit Reduction Act (§1916A of the Social Security Act) and nominal cost sharing under §1916 of the Social Security Act for all other individuals covered under the State Plan not otherwise exempted.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Monica Coury

14. TITLE:
Assistant Director

15. DATE SUBMITTED:
January 11, 2010

16. RETURN TO:

Monica Coury
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 11, 2010

18. DATE APPROVED:
MAY 06 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Gloria Nagle

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:
Boxes 4, 7, 8, 9 and 10 changes made by AZ on 9/28/10 per CMS request. Box 4 changes the effective date. Box 7 updates the Fiscal Impact amounts. Boxes 8 and 9 adds pages 54-56 of Section 4.18. Block 9: Deletes "Same" since only Attachment 4.18-A page 1 is being superseded. Box 10: Adds language to indicate to whom nominal cost sharing applies.

FORM HCFA-179 (07-92)