

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 10-001	2. STATE Arizona
<b>FOR: Centers for Medicare and Medicaid Services</b>	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
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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)
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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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Same Attachment 4.18-A, page 1 Section 4.18 page 54-56
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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):

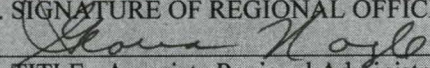
GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:  	16. RETURN TO:  Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Monica Coury	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: January 11, 2010	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: January 11, 2010	18. DATE APPROVED: MAY 06 2011
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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.