



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-003	2. STATE Arizona
FOR: Centers for Medicare and Medicaid Services		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 January 1, 2013	
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(a)(13), <u>1902(a)(62)</u> and 1928 42 CFR 447.405, 447.410, 447.415, and 42 CFR 441 Subpart L (Vaccines for Children Program)		7. FEDERAL BUDGET IMPACT: \$ FFY 2013 (1/1/13-9/30/13): \$4,692,931 \$ FFY 2014 (10/1/13-9/30/14): \$6,257,242 \$ FFY 2015 (10/1/14-12/31/14): \$1,689,455	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 5a 5(a) of Attachment 4.19-B Pages 5d-5g 5(d-g) of Attachment 4.19-B		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Page 5a 5(a) of Attachment 4.19-B	
10. SUBJECT OF AMENDMENT: Updates the State Plan to reflect that reimbursements under the Arizona Medicaid Fee Schedule will comply with Section 1902(a)(13), as amended by Section 1202 of the Affordable Care Act and implementing regulations.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <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: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034	
13. TYPED NAME: Monica Coury			
14. TITLE: Assistant Director			
15. DATE SUBMITTED: March 18, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: March 18, 2013		18. DATE APPROVED: JUN 11 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2013		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Gloria Nagle		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Operations	
23. REMARKS: Box 6: Additional citations made by CMS on 6/7/13 via email. Box 7: Budget Impact estimates revised to reflect FFY by State on 4/30/13 per CMS request. Box 8-9: Corrections made to page references made by CMS on 6/7/13 via email.			