


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 2013-004	2. STATE ARKANSAS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2013	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <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 (<i>Separate Transmittal for each amendment</i>)		
6. FEDERAL STATUTE/REGULATION CITATION: 1902(n)(1) through (3)	7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$(6,490,931) b. FFY 2014 \$(25,937,826)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 4.19-B Page 2-3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Supplement 1 to Attachment 4.19-B Page 2-3	
10. SUBJECT OF AMENDMENT: The Arkansas Title XIX State Plan has been amended to change Medicaid Reimbursement for Inpatient and Outpatient Hospital Services Covered by Medicare Part A and Medicare Part B Programs (Medicare Crossover Claims). Effective for all claims and claim adjustments with dates of service on and after July 1, 2013, the Division of Medical Services will implement Medicaid reimbursement for Medicare Part A and Part B coinsurance and deductibles related to inpatient and outpatient hospital services to the lesser of the Medicaid allowed amount minus the Medicare payment or the sum of the Medicare coinsurance and deductible. If the Medicaid allowed amount minus the Medicare paid amount is zero or a negative number, Medicaid's reimbursement will be zero.		
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input 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: Division of Medical Services PO Box 1437, Slot S295 Little Rock, AR 72203-1437 Attention: LeAnn Edwards	
13. TYPED NAME: Andrew Allison, PhD		
14. TITLE: Director, Division of Medical Services		
15. DATE SUBMITTED: March 15, 2013		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: 15 March, 2013	18. DATE APPROVED: 16 May, 2013	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July, 2013	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:		