
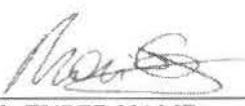
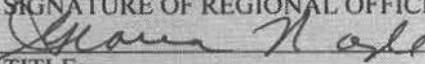


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-003- B	2. STATE Arizona
FOR: Centers for Medicare and Medicaid Services		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2009	
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: 42 CFR 447, Subpart F; 42 CFR 440.17; 42 CFR 440.167		7. FEDERAL BUDGET IMPACT: (\$7.73) million in 2010 	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 2; Attachment 4.19-B		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Same	
10. SUBJECT OF AMENDMENT: An update of the outpatient hospital reimbursement rates for rate year beginning October 1, 2009 to September 30, 2010 to reflect a rate freeze such that inflation factors would not be applied.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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: September 15, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: September 15, 2009		18. DATE APPROVED: DEC 04 2009	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Gloria Nagle, Ph.D., M.P.A.		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Operations	
23. REMARKS: Pen & ink request to change Box 7 received on 10/2/09 via email from State.			