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: MP 12-004B

2. STATE: CNMI

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: 1/2/13

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:
Title XIX of the Social Security Act, Section 1902(k)(2)/Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 - 0 -
b. FFY 2014 - 0 -

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 4.19B pgs. 7-12
~~Attachment to~~ Supplement 3.1A – pgs. 1, 2, 5, 6, 10, 11, 13, 14, and 16 to Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment to~~ Supplement 3.1A – pgs. 1, 2, 5, 6, 10, 11, 13, 14, and 16 to Attachment

10. SUBJECT OF AMENDMENT:

Reimbursement Methodology for Covered Services

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: Esther S. Fleming

14. TITLE: Special Assistant for Administration

15. DATE SUBMITTED: 10/23/13

16. RETURN TO:
Medicaid Agency
Caller Box 10007
Saipan, MP 96950

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/23/13

18. DATE APPROVED: OCT 30 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/2/13

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and ink changes to Sections 8 and 9.

FORM HCFA-179 (07-92)