## TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: Centers for Medicare and Medicaid Services**

**TO: REGIONAL ADMINISTRATOR**

**PROGRAM IDENTIFICATION:** TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

**STATE:** Arizona

**PROPOSED EFFECTIVE DATE:** July 1, 2016

**TRANSMITTAL NUMBER:** 16-003

**TYPE OF PLAN MATERIAL** (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- **AMENDMENT**

**FEDERAL STATUTE/REGULATION CITATION:**

42 CFR Part 447

**FEDERAL BUDGET IMPACT:**

FFY 16: $0

**PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:**

Att. 4.19-B, page 5(b)

**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):**

Same

**SUBJECT OF AMENDMENT:**

Updates the State Plan to expand the types of vaccines and immunizations administered by pharmacists for AHCCCS members consistent with ARS §32-1974.

**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

**SIGNATURE OF STATE AGENCY OFFICIAL:**

Monica Coury

Assistant Director

**DATE SUBMITTED:** May 12, 2016

**RETURN TO:**

Monica Coury

801 E. Jefferson, MD#4200

Phoenix, Arizona 85034

**DATE RECEIVED:**

**DATE APPROVED:**

PLAN APPROVED – ONE COPY ATTACHED

**EFFECTIVE DATE OF APPROVED MATERIAL:**

**SIGNATURE OF REGIONAL OFFICIAL:**

**TITLE:**

**TYPED NAME:**

**TYPED NAME:**

**TYPED NAME:**

**TYPED NAME:**

**TYPED NAME:**

FORM HCFA-179 (07-92)
23. REMARKS: