DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2010-001**

2. STATE **MS**

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, 2009

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:
In compliance with Miss. Code Ann. §43-13-117 (39)

7. FEDERAL BUDGET IMPACT:
a. FFY **2010** **$ 36,421,000**
b. FFY **2011** **$ 38,782,800**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 21

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: This State Plan is being filed in order for MS Division of Medicaid to comply with Miss. Code Ann. §43-13-117 (39), which requires "From on and after July 1, 2009, the Division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method." In addition, the SPA is updated to define how the agency is reimbursing all other crossover claims.

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: **Robert L. Robinson**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: January 25, 2010

16. RETURN TO:
Robert L. Robinson
Miss. Division of Medicaid
Attn: Ginnie McCardle
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 01/25/10

18. DATE APPROVED: 08/26/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS: