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: **2010-004**

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, 2010

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:
Section 1932(a)(1)(A) of the Social Security Act and 42 CFR 438

7. FEDERAL BUDGET IMPACT:
a. FFY **2010** **$ 12,729,000**
b. FFY **2011** **($16,000,000)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Page 1 through Page 13

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT: This State Plan is being filed in order for MS Division of Medicaid to implement a coordinated care program, entitled MississippiCAN. This program is for a certain targeted, high-cost population (SSI, Foster Care, Working Disabled, Disabled Children Living at Home, Breast and Cervical Cancer waiver participants). The purpose of the program is to improve the health of this population thereby accomplishing a cost savings to the agency

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: February 26, 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:
05/28/10

18. DATE APPROVED:
08/30/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Approved with the following changes to item 8 as authorized by State Agency on email dated 08/26/10.

Block #8 Attachment 3.1-F, Pages 1 through 13 **Changed to read**: 8 Attachment 3.1-F Pages 1 through 15.