

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER: **2011-003**      2. STATE: **MS**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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  
**May 1, 2011**

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 1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:  
a. FFY **2011**      \$ **0**  
b. FFY **2012**      \$ **0**

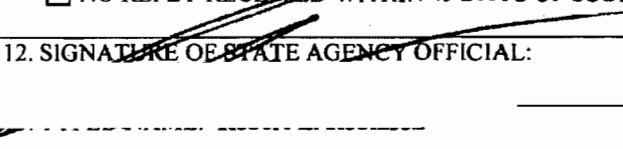
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-B, Page 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):  
Attachment 4.19-B, Page 11

10. SUBJECT OF AMENDMENT: The attached State Plan Amendment is being filed to ensure the financial/reimbursement page for therapy services provided in non-hospital settings is comprehensive and meets all requirements of Section 1902(a)(30)(A) of the Social Security Act. After review of the SPA for expansion of services for adults, it was noted that the corresponding financial/reimbursement page did not meet all necessary federal requirements. This revised SPA is to ensure the Mississippi Medicaid State Plan is in compliance with all federal statutes and regulations and that the State Plan comprehensively and accurately describes payment of these 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:  


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

14. TITLE: **Executive Director**

15. DATE SUBMITTED:

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: 05/17/11

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
05/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Jackie Glaze

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

23. REMARKS: