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: **2011-003**
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
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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:

14. TITLE: **Executive Director**

15. DATE SUBMITTED:

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

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: