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: **2012-003**

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 **07/01/2012**

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: **42 CFR 440.130**

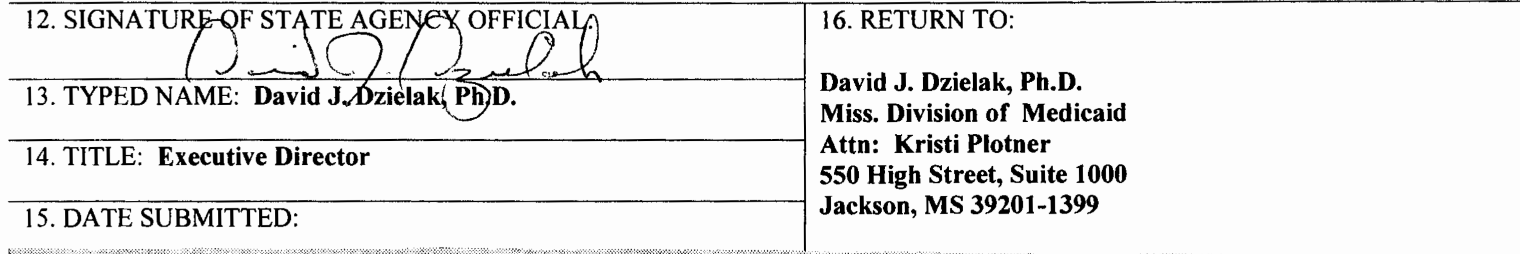
7. FEDERAL BUDGET IMPACT:
a. FFY **2012** **$ $2,073,975**
b. FFY **2013** **$ $2,930,993**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
3.1-A Exhibit 13d, pages 1-13
4.19-B page 13
4.23, page 71

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
3.1-A Exhibit 13d pages 1-2
4.19-B, page 13
3.1-A, Exhibit 13c, pages 2,3,4,5 deleted
4.23, page 71

10. SUBJECT OF AMENDMENT: Revisions to Rehabilitation Option (Community Mental Health Services) Amount, Duration and Scope and corresponding Reimbursement Methodology and to remove disease management which is no longer being provided from all related pages.

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:



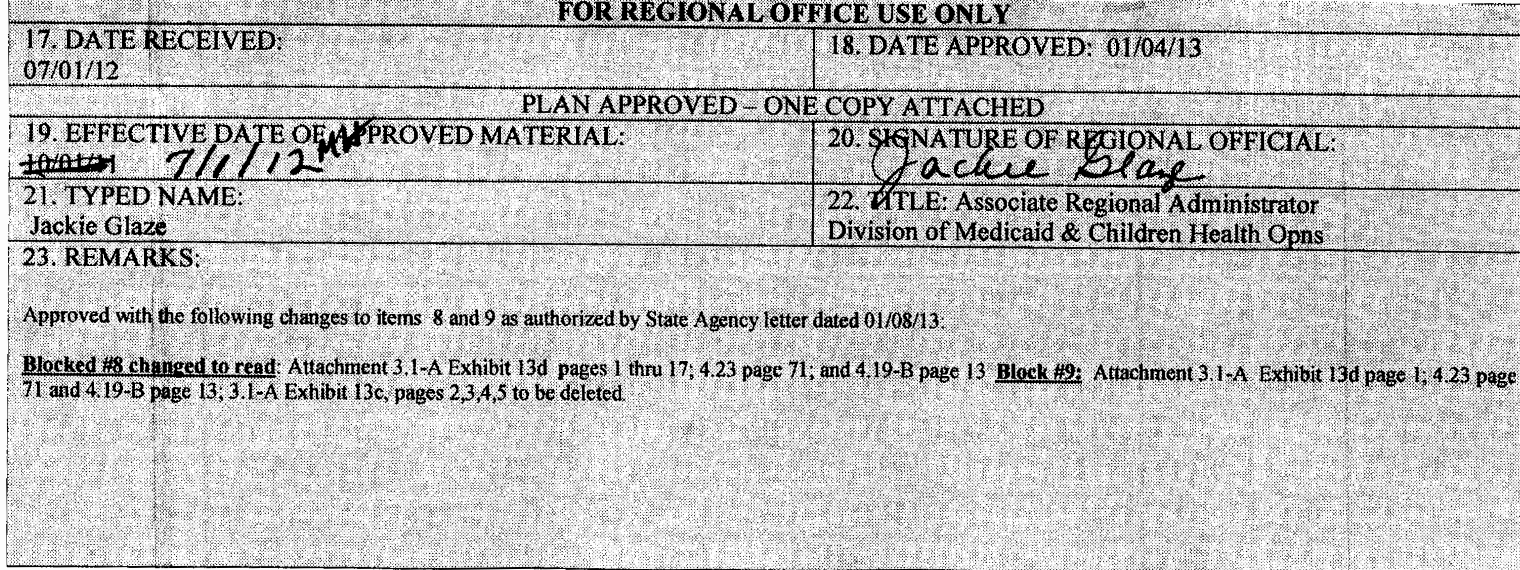
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **David J. Dzielak, Ph.D.**

14. TITLE: **Executive Director**

15. DATE SUBMITTED:

16. RETURN TO:
David J. Dzielak, Ph.D.
Miss. Division of Medicaid
Attn: Kristi Plotner
550 High Street, Suite 1000
Jackson, MS 39201-1399



FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07/01/12

18. DATE APPROVED: 01/04/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: ~~10/01/11~~ 7/1/12

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

Approved with the following changes to items 8 and 9 as authorized by State Agency letter dated 01/08/13:

Blocked #8 changed to read: Attachment 3.1-A Exhibit 13d pages 1 thru 17; 4.23 page 71; and 4.19-B page 13 **Block #9:** Attachment 3.1-A Exhibit 13d page 1; 4.23 page 71 and 4.19-B page 13; 3.1-A Exhibit 13c, pages 2,3,4,5 to be deleted.

FORM HCFA-179 (07-92)