DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **2012-004**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 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 Parts 405, 424, 447, 455, 457, 498 and 1007

7. FEDERAL BUDGET IMPACT:
a. FFY **2013** $177, 640.00
b. FFY **2014** $177, 640.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Pages 35a, 35b, 35c

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Not applicable

10. SUBJECT OF AMENDMENT: SPA 2012-004 Provider Screening and Enrollment is submitted as a new State Plan to establish requirements necessary to prevent or combat fraud, waste and abuse under the Medicare, Medicaid programs and Children's Health Insurance Program (CHIP). The State Plan Amendment (SPA) is required by Centers for Medicare & Medicaid Services (CMS) according to federal regulations set forth from provisions of the Affordable Care Act Section 6401(a) and (b) and 42 CFR Parts 405, 424, 447, 455, 457, 498 and 1007.

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:
David J. Dzielak

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

14. TITLE: **Executive Director**

15. DATE SUBMITTED: 9/25/12

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/25/12

18. DATE APPROVED: 09/12/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/12

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

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

23. REMARKS: