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: **2009-001**

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
October 1, 2009

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 1913, Title XIX of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2010** **$ 0.00**
b. FFY **2011** **$ 0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Exhibit 1a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Exhibit 1a

10. SUBJECT OF AMENDMENT: This State Plan Amendment is to remove language which addresses the pre-certification requirements for swing bed services. To manage utilization and medical necessity, the Division of Medicaid has always required pre-certification for inpatient days during an admission to swing bed. Utilization will be monitored on a post-payment basis.

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: July 22, 2009

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: 07/21/09

18. DATE APPROVED: 09/29/09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Mary Kaye Justis, RN, MBA

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

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 09-09-09:

Block 8: Attachment 3.1-A, Exhibit 1a changed to read: delete 3.1-A Exhibit 1a from State Plan and Block 9: Attachment 3.1-A, Exhibit 1a changed to read: delete 3.1-A Exhibit 1a from State Plan and