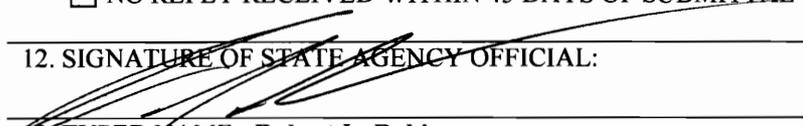
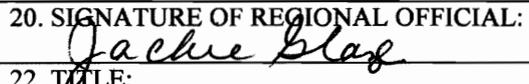


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 2010-004	2. STATE MS
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One): <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1932(a)(1)(A) of the Social Security Act and 42 CFR 438		7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$ 12,729,000 b. FFY 2011 (\$ 16,000,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F, Page 1 through Page 13		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New Section	
10. SUBJECT OF AMENDMENT: This State Plan is being filed in order for MS Division of Medicaid to implement a coordinated care program, entitled MississippiCAN. This program is for a certain targeted, high-cost population (SSI, Foster Care, Working Disabled, Disabled Children Living at Home, Breast and Cervical Cancer waiver participants). The purpose of the program is to improve the health of this population thereby accomplishing a cost savings to the agency			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Robert L. Robinson Miss. Division of Medicaid Attn: Ginnie McCardle 550 High Street, Suite 1000 Jackson, MS 39201-1399	
13. TYPED NAME: Robert L. Robinson			
14. TITLE: Executive Director			
15. DATE SUBMITTED: February 26, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 05/28/10		18. DATE APPROVED: 08/30/10	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/01/10		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS: Approved with the following changes to item 8 as authorized by State Agency on email dated 08/26/10. Block #8 Attachment 3.1-F, Pages 1 through 13 Changed to read: 8 Attachment 3.1-F Pages 1 through 15.			