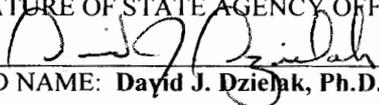
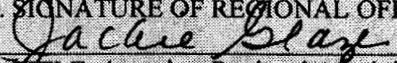


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>2012-004</b>	2. STATE <b>MS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE <b>October 1, 2012</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES			
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: 42 CFR Parts 405, 424, 447, 455, 457, 498 and 1007		7. FEDERAL BUDGET IMPACT: a. FFY <b>2013</b> \$177, 640.00 b. FFY <b>2014</b> \$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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Not applicable	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): <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:  <b>David J. Dzielak, Ph. D. Mississippi Division of Medicaid Attn: Kristi Plotner 550 High Street, Suite 1000 Jackson, MS 39201-1399</b>	
13. TYPED NAME: <b>David J. Dzielak, Ph.D.</b>			
14. TITLE: <b>Executive Director</b>			
15. DATE SUBMITTED: <b>9/25/12</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>09/25/12</b>		18. DATE APPROVED: <b>09/12/12</b>	
<b>PLAN APPROVED -- ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>10/01/12</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Jackie Glaze</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid &amp; Children Health Opns</b>	
23. REMARKS:			