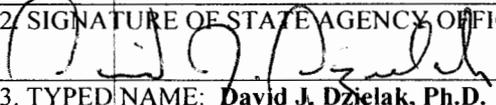
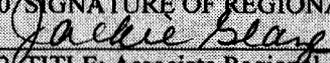


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>2012-009</b>	2. STATE <b>MS</b>
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>September 1, 2012</b>	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input checked="" 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: <b>42 CFR 430; 42 CFR 440.20; 42 CFR 440.230; 42 CFR 447, Subpart A, and B; 42 CFR 455, Subpart A, B, C and D; 42 CFR 482; 42 CFR 489, Subpart A, B, C, D and E</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>2013</b> (\$24.2) million b. FFY <b>2014</b> (\$28) million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 3.1-A pages 2a, 24e Attachment 4.19-B pages 2a.2, 2a.3, 2a.4, 24e.1, 24e.2</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 3.1-A pages 2, 24e Attachment 4.19-B, page 2a</b>	
10. SUBJECT OF AMENDMENT: To implement a Hospital Outpatient Ambulatory Payment Classification (APC) payment methodology replacing the current cost-to-charge ratio (CCR) method, as authorized by HB 421 passed by the MS State Legislature in the 2012 session Also clarifies the six (6) emergency room visits per fiscal year are for non-emergent emergency room visits.			
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:	
13. TYPED NAME: <b>David J. Dzielak, Ph.D.</b>		<b>David J. Dzielak, Ph. D. Miss. Division of Medicaid Attn: Kristi Plotner 550 High Street, Suite 1000 Jackson, MS 39201-1399</b>	
14. TITLE: <b>Executive Director</b>			
15. DATE SUBMITTED:			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>07/23/12</b>		18. DATE APPROVED: <b>10/19/12</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>09/01/12</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:  Approved with the following changes to item 8 as authorized by State Agency email dated 09/20/12 and 08/24/12:  Block #8 changed to read: Attachment 3.1-A page 9; Attachment 3.1-A page 2 to Exhibit 2 and Attachment 4.19-B pages 2a, 2a.2, 2a.3, 2a.4 and 2a.5  Block #9 changed to read: Attachment 3.1-A page 9; Attachment 3.1-A page 2 to Exhibit 2 and Attachment 4.19-B page 2a, 2a.2, 2a.3, 2a.4 and 2a.5(new)  Delete last sentence in block #10 (also clarifies the six (6) emergency room visits per fiscal year are for non-emergent emergency room visits).			