

## **Table of Contents**

**State/Territory Name: Mississippi**

**State Plan Amendment (SPA)#: 24-0019**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Form CMS-179
- 3) Approved SPA Page

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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December 30, 2024

Cindy H. Bradshaw  
Executive Director  
Mississippi Division of Medicaid  
550 High Street, Suite 1000  
Jackson, MS 39201

Re: Mississippi State Plan Amendment (SPA) 24-0019

Dear Executive Director Bradshaw:

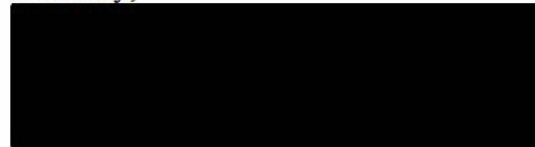
The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0019. This proposed amendment grants authority to the appointed Executive Director to submit state plans on behalf of the Division of Medicaid, Office of the Governor, the single state agency.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 430.12(b). This letter informs you that Mississippi's Medicaid SPA TN 24-0019 was approved on December 30, 2024, with an effective date of October 11, 2024.

Enclosed are copies of Form CMS-179 and the approved SPA Page to be incorporated into the Mississippi State Plan.

If you have any questions, please contact Tandra Hodges at (404) 562-7409 or via email at [Tandra.Hodges@cms.hhs.gov](mailto:Tandra.Hodges@cms.hhs.gov).

Sincerely,



James G. Scott, Director  
Division of Program Operations

Enclosures

cc: Robin Bradshaw  
Sarah Tadlock  
Trip Polles

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER 2 4 — 0 0 1 9	2. STATE MS
		3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 11, 2024	
5. FEDERAL STATUTE/REGULATION CITATION 42 C.F.R. § 430.12(b)		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2025 \$ 0 b. FFY 2026 \$ 0	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Section 7 page 89		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Section 7 page 89	
9. SUBJECT OF AMENDMENT State Plan Amendment (SPA) 24-0019 is being submitted to allow the Division of Medicaid (DOM) to update the appointed Executive Director authorized to submit the State Plan on behalf of the Division of Medicaid, Office of the Governor, the single state agency effective October 11, 2024.			
10. GOVERNOR'S REVIEW (Check One) <input checked="" type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input type="radio"/> OTHER, AS SPECIFIED:			
12. TYPED NAME Cindy H. Bradshaw		15. RETURN TO Cindy H. Bradshaw Miss. Division of Medicaid Attn: Robin Bradshaw 550 High Street, Suite 1000 Jackson, MS 39201-1399	
13. TITLE Executive Director			
14. DATE SUBMITTED DEC 20 2024			
FOR CMS USE ONLY			
16. DATE RECEIVED December 20, 2024		17. DATE APPROVED December 30, 2024	
PLAN APPROVED - ONE COPY ATTACHED			
18. EFFECTIVE DATE OF APPROVED MATERIAL October 11, 2024		19. SIGNATURE [Redacted Signature]	
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott		21. TITLE Director, Division of Program Operations	
22. REMARKS			

Revision: HCFA-PM-91-4  
August 1991

(BPD)

OMB No. : 0938-

State/Territory: Mississippi

Citation                      7.4      State Governor's Review

42 CFR 430.12(b)


The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services (CMS) with such documents.

- ☐ Not applicable. The Governor –
- ☐ Does not wish to review any plan material.
- ☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Division of Medicaid, Office of the Governor  
(Designated Single State Agency)

10-31-24  
DATE

  
Signature

Executive Director  
Title