DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL. FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 11-009	2. STATE: MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: 07/01/11	

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:	7. FEDERAL BUDGET IMPACT:
42 U.S.C. 1396d(a)(4)(D), 1396d(a)(12) and 1396d(bb)	**a. FFY 11 $ 00.00** **b. FFY 12 $ 00.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: att. 3.1-A pages 1a (new), 2 att 3.1-B Page 2.1 (new) **Supplement to Attachment 3.1-A, page 3a2** **Supplement to Attachment 3.1-B, page 3a2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~Same~~ att. 3.1-A page 2 Supp to att 3.1A, page 3a2 Supp to att 3.1B, Page 3a2

10. SUBJECT OF AMENDMENT:

Tobacco Cessation Services

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:
Not required under 42 CFR 430.12(b)(2)(ii)

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO:
13. TYPED NAME: **JudyAnn Bigby, M. D**	**Michael P. Coleman** **State Plan Coordinator**
14. TITLE: **Secretary**	**Office of Medicaid** **Executive Office of Health and Human Services**
15. DATE SUBMITTED: **09/20/11**	**One Ashburton Place, 11th Floor** **Boston, MA 02108**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/20/2011	18. DATE APPROVED: 05/24/2012
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/2011	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, DMCHO, Boston

23. REMARKS:

FORM CMS-179 (07-92)