DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD 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: 012-001	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 01/23/12	

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 USC 1396a (e)(13).	**a. FFY12 $ 1,679,103** **b. FFY13 $ 1,660,058**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section Two, pages 11b, 11c, 11c.1, 11c.2, 11c.3, 11d	**None**

10. SUBJECT OF AMENDMENT:

Express Lane Renewal

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)(i)**

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **JudyAnn Bigby, M. D.**	**Michael P. Coleman** **State Plan Coordinator** **Office of Medicaid** **Executive Office of Health and Human Services** **One Ashburton Place, 11th Floor** **Boston, MA 02108**
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **01/27/12**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 1/27/12	18. DATE APPROVED: 8/2/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/23/12	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office

23. REMARKS:

The State and CMS agreed to the following pen and ink change in an email dated 7/12/12: checked off box 5(a) on plan page 11c.3 to confirm that the State has elected a screening threshold established by the Medicaid agency.

FORM CMS-179 (07-92)