

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <div style="text-align: center;"><b>012-004</b></div>	2. STATE  <div style="text-align: center;"><b>MA</b></div>						
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)							
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		4. PROPOSED EFFECTIVE DATE  <div style="text-align: center;"><b>04/01/12</b></div>							
6. FEDERAL STATUTE/REGULATION CITATION:  <div style="text-align: center;"><b>42 CFR 435.232</b></div>	7. FEDERAL BUDGET IMPACT:  <table style="width: 100%; border: none;"> <tr> <td style="width: 40%;">a. FFY12</td> <td style="width: 10%; text-align: center;">\$</td> <td style="width: 50%; text-align: right;">530,000</td> </tr> <tr> <td>b. FFY13</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">00</td> </tr> </table>			a. FFY12	\$	530,000	b. FFY13	\$	00
a. FFY12	\$	530,000							
b. FFY13	\$	00							
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <div style="text-align: center;"><b>Attachment 2.2-A, pages 15 and 17</b></div>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <div style="text-align: center;"><b>Same</b></div>								
10. SUBJECT OF AMENDMENT:  <div style="text-align: center;"><b>Termination of 1616 Agreement</b></div>									
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>Not required under</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <b>42 CMR 430.12(b)(2)(ii)</b>									
12. SIGNATURE OF STATE AGENCY OFFICIAL:  <div style="text-align: center;">/s/ </div>		16. RETURN TO:  <b>Michael P. Coleman State Plan Coordinator Executive Office of Health and Human Services Office of Medicaid One Ashburton Place, 11<sup>th</sup> Floor Boston, MA 02108</b>							
13. TYPED NAME: <b>JudyAnn Bigby</b>									
14. TITLE: <b>Secretary</b>									
15. DATE SUBMITTED: <b>06/20/12</b>									
<b>FOR REGIONAL OFFICE USE ONLY</b>									
17. DATE RECEIVED: <b>6/20/12</b>		18. DATE APPROVED: <b>9/18/12</b>							
<b>PLAN APPROVED - ONE COPY ATTACHED</b>									
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>4/1/12</b>		20. SIGNATURE OF REGIONAL OFFICIAL:  <div style="text-align: center;">/s/ </div>							
21. TYPED NAME: <b>Richard R. McGreal</b>		22. TITLE: <b>Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office</b>							
23. REMARKS: The Commonwealth and CMS agreed to the following pen and ink changes to Attachment 2.2-A, Page 15 in an email dated 9/7/12: <ul style="list-style-type: none"> <li>The regulation citation in the upper left-hand column was changed from 42 CFR 345.230 to 42 CFR 435.230.</li> <li>The TN number in the footer was changed from 004-012 to 12-004 and the effective date was changed from 10/1/96 to 4/1/12.</li> </ul>									