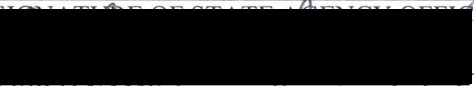


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <b>012-008</b>	2. STATE  <b>MA</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  <b>07/01/12</b>	
		5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <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 ( <i>Separate Transmittal for each amendment</i> )	
6. FEDERAL STATUTE/REGULATION CITATION:  <b>42 USC 1395 qq and 42 USC 1396j</b>		7. FEDERAL BUDGET IMPACT:  a. FFY12      \$ 2,000 b. FFY13      \$ 60,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B, pages 1a &amp; 1aa</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B, page 1a and 1aa</b>	
10. SUBJECT OF AMENDMENT:  <b>Indian Health Services Facilities</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <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 REGIONAL OFFICIAL: 		16. RETURN TO:  <b>Michael P. Coleman State Plan Coordinator Office of Medicaid Executive Office of Health and Human Services One Ashburton Place, 11<sup>th</sup> Floor Boston, MA 02108</b>	
13. TYPED NAME: <b>Judy Ann Bigby, M.D.</b>			
14. TITLE: <b>Secretary</b>			
15. DATE SUBMITTED: <b>09/28/12</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>09/28/2012</b>		18. DATE APPROVED: <b>12/12/2012</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>07/01/2012</b>		20. SIGNATURE OF REGIONAL OFFICIAL: <b>/s/</b>	
21. TYPED NAME: <b>Richard R. McGreal</b>		22. TITLE: <b>Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston, MA</b>	
23. REMARKS:  <b>CMS and State agreed by phone to pen&amp;ink change to box #8 to correct superseded page numbers.</b>			