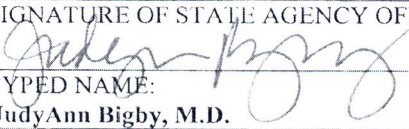


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: <div style="text-align: center;">012-009</div>	2. STATE <div style="text-align: center;">MA</div>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT 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		4. PROPOSED EFFECTIVE DATE <div style="text-align: right;">07/01/12 10/01/12</div>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <div style="text-align: center;">42.CFR 440.167</div>		7. FEDERAL BUDGET IMPACT: <div style="text-align: right;"> a. FFY 2012 13 \$ 1,005,293. 5,021,175. b. FFY 2013 14 \$ 4,021,175. 5,021,175. </div>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <div style="text-align: center;">Attachment 4.19-B, Page 3.2</div>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <div style="text-align: center;">Same</div>	
10. SUBJECT OF AMENDMENT: <div style="text-align: center;">Personal Care Attendant Services Rates</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 Not required under <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 42 CMR 430.12(b)(2)(ii)			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Michael P. Coleman State Plan Coordinator Office of Medicaid Executive Office of Health and Human Services One Ashburton Place, 11 th Floor Boston, MA 02108	
13. TYPED NAME: JudyAnn Bigby, M.D.			
14. TITLE: Secretary			
15. DATE SUBMITTED: 09/28/12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 10/01/2012		18. DATE APPROVED: 03/26/2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2012		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Richard R. McGreal		22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA	
23. REMARKS: <div style="height: 100px;"></div>			