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: **013-001**

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: **01/22/13**

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: **42 CFR 430.12(b)**

7. FEDERAL BUDGET IMPACT: **N/A**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Section 7, Page 89**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Section 7, Page 89**

10. SUBJECT OF AMENDMENT:

Authorization to Submit Plan on Behalf of the Single State Agency

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 CMR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL: John Polanowicz

13. TYPED NAME: **John Polanowicz**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **03/06/13**

16. RETURN TO:
Michael P. Coleman
State Plan Coordinator
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/06/2013

18. DATE APPROVED: 03/13/2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/22/2013

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: