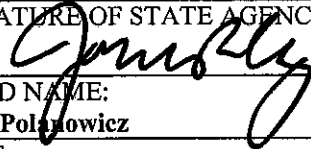



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <div style="text-align: center;"><b>013-015</b></div>	2. STATE  <div style="text-align: center;"><b>MA</b></div>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE 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>07/01/13</b></div>	
6. FEDERAL STATUTE/REGULATION CITATION:  <div style="text-align: center;"><b>42 U.S.C. 1396d(a)(25), 1396a(a)(43), 1396d(r), 1396a(a)(10), 42 CFR 440 and 441</b></div>		7. FEDERAL BUDGET IMPACT:  <div style="text-align: right;">           a. FFY 2014    \$    0            b. FFY 2015    \$    0         </div>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <div style="text-align: center;"><b>Attachment 4.19-B, Page 2A-2</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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  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>Targeted Case Management Services</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 CFR 430.12(b)(2)(ii)</b>			
12. SIGNATURE OF STATE AGENCY 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>John Polanowicz</b>		17. DATE RECEIVED: <b>09/27/13</b>	
14. TITLE: <b>Secretary</b>		18. DATE APPROVED: <b>11/12/13</b>	
15. DATE SUBMITTED: <b>09/30/13</b>		<b>FOR REGIONAL OFFICE USE ONLY</b>	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>07/01/13</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Richard R. McGreal</b>		22. TITLE: <b>Associate Regional Administrator DMCHO - CMS Boston</b>	
23. REMARKS:			