DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

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TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **013-015**

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: **07/01/13**

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 U.S.C. 1396d(a)(25), 1396a(a)(43), 1396d(r), 1396a(a)(10), 42 CFR 440 and 441

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ 0
b. FFY 2015 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 2A-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Targeted Case Management Services

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 CFR 430.12(b)(2)(ii)

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
John Polanowicz

14. TITLE:
Secretary

15. DATE SUBMITTED:
09/30/13

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **09/27/13**

18. DATE APPROVED: **11/12/13**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **07/01/13**

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: **Richard R. McGreal**

22. TITLE: **Associate Regional Administrator**
DMCHO - CMS Boston

23. REMARKS:

FORM CMS-179 (07-92)