

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 013-013	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)

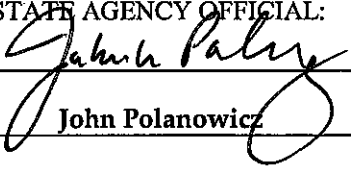
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.120	7. FEDERAL BUDGET IMPACT: a. FFY 2014 \$ 00.00 b. FFY 2015 \$ 00.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement to Attachment 3.1-A, page 3a3. Supplement to Attachment 3.1-B, page 3a3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same

10. SUBJECT OF AMENDMENT:

Coverage Provisions for Dentures, Prosthetics and Eyeglasses

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Not required under
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Michael P. Coleman State Plan Coordinator Executive Office of Health and Human Services Office of Medicaid One Ashburton Place, 11 th Floor Boston, MA 02108
13. TYPED NAME: John Polanowicz	
14. TITLE: Secretary	
15. DATE SUBMITTED: 08/28/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/28/13	18. DATE APPROVED: 10/29/13
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: