



| | | | |
|--|--|--|--|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: <div style="text-align: center;">11-014</div> | 2. STATE <div style="text-align: center;">NC</div> |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">October 1, 2011</div> | |
| 5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT <div style="text-align: center;">COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)</div> | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.201 | | 7. FEDERAL BUDGET IMPACT: a. FFY 2012 (\$2,480,303) b. FFY 2013 \$ 68,848 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 6, Page 1, Attachment 4.19-B, Section 6, Page 1a, Attachment 4.19-B, Section 6, Page 1b, Attachment 4.19-B, Section 6, Page 1c, Attachment 4.19-B, Section 6, Page 1d, Attachment 4.19-B, Section 6, Page 1e, Attachment 4.19-B, Supplement 3, Page 1d, Attachment 4.19-B, Supplement 3, Page 1e, Attachment 4.19-B, Supplement 3, Page 1f, Attachment 4.19-B, Supplement 3, Page 1g, Attachment 4.19-B, Supplement 3, Page 1h, and Attachment 4.19-B, Supplement 3, Page 1i. | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B, Section 6, Page 1, | |
| 10. SUBJECT OF AMENDMENT: Chiropractic Services, Podiatry Services, Optometry Services, Nurse Practitioner Services, Independent Practitioner Services and Other Licensed Practitioner Services | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: SECRETARY <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001 | |
| 13. TYPED NAME: Lanier M. Cansler | | 16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001 | |
| 14. TITLE: Secretary | | | |
| 15. DATE SUBMITTED: 7/29/11 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 08/02/11 | | 18. DATE APPROVED: 10/31/11 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/11 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Jackie Glaze | | 22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns | |
| 23. REMARKS: Approved with the following changes to item 4 as authorized by State Agency on email dated 10/11/11: Blocked #4 changed to read: November 1, 2011. | | | |