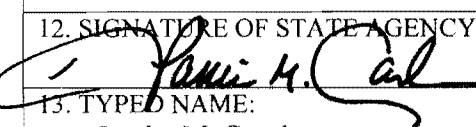
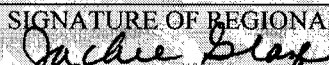


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center;">11-043</div>	2. STATE <div style="text-align: center;">NC</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">August 31, 2011</div>	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> : <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT </div> <div style="text-align: center; font-size: small;">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 Part 440.70		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$ 0 b. FFY 2013 \$ 0	
8. PAGE NUMBER OF THE PLAN, SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 13a.3 and Attachment 4.19-B, Section 7, Page 11		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 3.1-A.1, Page 13a.3 and Attachment 4.19-B, Section 7, Page 11	
10. SUBJECT OF AMENDMENT: Tocolytic Infusion Therapy			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: SECRETARY </div> </div>			
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		17. DATE RECEIVED: 08/18/11	
14. TITLE: Secretary		18. DATE APPROVED: 11/10/11	
15. DATE SUBMITTED: 8/17/11		FOR REGIONAL OFFICE USE ONLY	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/31/11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			