DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-043**

2. STATE: **NC**

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: **August 31, 2011**

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

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 *(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: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/ Lanier M. Cansler

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED: 8/17/11

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/18/11

18. DATE APPROVED: 11/10/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/31/11

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)