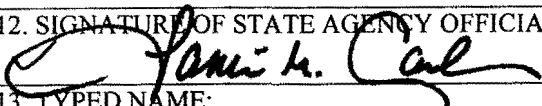



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center;">11-056</div>	2. STATE <div style="text-align: center;">NC</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">January 1, 2012</div>	
5. TYPE OF PLAN MATERIAL (Check One): <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; margin-top: 5px;"> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) </div>			
6. FEDERAL STATUTE/REGULATION CITATION: <div style="text-align: center;">42 CFR 440.20(a)(i)</div>	7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$(13,817,250) b. FFY 2013 \$(23,770,169)		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 7c.13, Attachment 3.1-A.1, Page 15a.16, and Attachment 3.1-A.1, Page 15a.17	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1, Page 7c.13, Attachment 3.1-A.1, Page 15a.16, and Attachment 3.1-A.1, Page 15a.17		
10. SUBJECT OF AMENDMENT: Outpatient Behavioral Health Services			
11. GOVERNOR'S REVIEW (Check One): <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: <div style="text-align: center;">Lanier M. Cansler</div>	14. TITLE: <div style="text-align: center;">Secretary</div>		
15. DATE SUBMITTED: <div style="text-align: center;">11/22/11</div>	17. DATE RECEIVED: <div style="text-align: center;">11/23/11</div>		
FOR REGIONAL OFFICE USE ONLY			
18. DATE APPROVED: 01/29/13		19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center;">01/01/12</div>	
PLAN APPROVED -- ONE COPY ATTACHED			
20. SIGNATURE OF REGIONAL OFFICIAL: 		21. TYPED NAME: <div style="text-align: center;">Jackie Glaze</div>	
22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns		23. REMARKS: Approved with the following changes to item 8 and 9 as authorized by State Agency e-mails dated 12/17/12 and 01/12/13: <u>Blocked #8 changed to read:</u> Attachment 3.1-A.1 pages 7c.13 new, 7c.13a new, 7c.13b new, 7c.13c new, 15a.16, 15a.17, 15a.18 and 15a.18a <u>Blocked #9 changed to read:</u> Attachment 3.1-A.1 pages 7c.13 new, 7c.13a new, 7c.13b new, 7c.13c new, 15a.16, 15a.17, 15a.18 and 15a.18a	