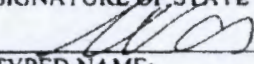
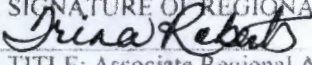


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  13-001	2. STATE  NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  January 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  42 CFR 447.400, 447.410 and 447.415		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$16,040,629 b. FFY 2014 \$21,389,528	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B, Section 5, Page 1a, Attachment 4.19-B, Section 5, Page 1b, Attachment 4.19-B, Section 5, Page 1c, Attachment 4.19-B, Section 5, Page 1d, and Attachment 4.19-B, Section 5, Page 1e		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  N/A	
10. SUBJECT OF AMENDMENT: Increased Primary Care Service Payments			
11. GOVERNOR'S REVIEW (Check One): <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: Aldona Z. Wos, M.D.			
14. TITLE: Secretary			
15. DATE SUBMITTED: March 15, 2013			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/15/13	18. DATE APPROVED: 06-12-13
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/13	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 9 as authorized by State Agency e-mail dated 05/08/13

Blocked #9 changed to read: New