

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  <b>09-006</b>	2. STATE  <b>NC</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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  <b>April 1, 2009</b>	
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 COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 438</b>		7. FEDERAL BUDGET IMPACT: a. FFY 2009                      (\$6,909,867) b. FFY 2010                      (\$17,126,552)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 3.1-F, Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13,</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 3.1-F, Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13</b>	
10. SUBJECT OF AMENDMENT:  PCCM Program			
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:  <i>[Signature]</i>		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			
14. TITLE: Secretary			
15. DATE SUBMITTED: <b>6/24/09</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 06/25/09		18. DATE APPROVED: 09/11/09	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/09		20. SIGNATURE OF REGIONAL OFFICIAL:  <i>[Signature]</i>	
21. TYPED NAME: Mary Kaye Justis, RN, MBA		22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:  Approved with following changes as authorized by State Agency on email dated 09/02/09:  Block # 8 Attachment 3.1-F, pages 1,2,3,4,5,6,7,8,9,10,11,12,13,14 change to read Attachment 3.1-F, pages 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15 and 16. Block # 9 Attachment 3.1-F, pages 1,2,3,4,5,6,7,8,9,10,11,12,13 change to read Attachment 3.1-F, pages 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15 and 16.			