



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>11-021</b>	2. STATE <b>North Dakota</b>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: <b>July 1, 2011</b>	
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: <b>42 CFR 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2011</u> \$ <u>699,814</u> b. FFY <u>2012</u> \$ <u>2,099,442</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B, Page A and Page B (new)</b>		9. PAGE NUMBER OF THE SUPERSDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: <b>Amends the State Plan to provide an inflationary increase for services rendered by Medicaid providers.</b>			
11. GOVERNOR'S REVIEW (Check One): <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		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <b>Maggie D. Anderson, Director, Medical Services Division</b>	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Maggie D. Anderson, Director Division of Medical Services ND Department of Human Services 600 East Boulevard Avenue Dept 325 Bismarck ND 58505-0250</b>	
13. TYPED NAME: <b>Maggie D. Anderson</b>			
14. TITLE: <b>Director, Division of Medical Services</b>			
15. DATE SUBMITTED: <b>9-30-2011</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>9/30/11</b>		18. DATE APPROVED: <b>11/21/11</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>7/1/11</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>RICHARD C. ALLEN</b>		22. TITLE: <b>ARA, D.MCHO</b>	
23. REMARKS:			