

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

**TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:  
09-08

2. STATE  
Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
June 30, 2009

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 447.252

7. FEDERAL BUDGET IMPACT:  
a. FFY '09 \$ 2,932,978  
b. FFY '10 \$ 3,006,304

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Att. 4.19-A (Inpatient Hospital) pp. 1-45

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):  
Att. 4.19-A (Inpatient Hospital) pp. 1-45

10. SUBJECT OF AMENDMENT:  
Implements a new supplement to FFS inpatient hospital payments.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ann Berg

14. TITLE:

Deputy Medicaid Director

15. DATE SUBMITTED:

June 29, 2009

16. RETURN TO:

Lisa Knazan  
Minnesota Department of Human Services  
Federal Relations Unit  
P.O. Box 64983  
St. Paul, MN 55164-0983