

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-21	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE July 1, 2009 August 18, 2009	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

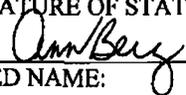
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Sec. 1923, Social Security Act, 42 CFR 447.252	7. FEDERAL BUDGET IMPACT: a. FFY '09 \$ 1,650,246 b. FFY '10 \$ 6,600,246
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-A (Inpatient Hospital) pp. 1-47	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Att. 4.19-A (Inpatient Hospital) pp. 1-47

10. SUBJECT OF AMENDMENT:
Adds Regions hospital as eligible to CPE uncompensated care costs as DSH.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Lisa Knazan Minnesota Department of Human Services Federal Relations Unit P.O. Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Ann Berg	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: September 24, 2009	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 8-25-10
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 18 2009	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS
23. REMARKS: Per a id change to block # 4	