

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

1. TRANSMITTAL NUMBER:
09-26

2. STATE
Minnesota

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
July 1, 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 (in thousands)
a. FFY '09: (\$8)
b. FFY '10: (\$9286)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-D (Non-State Government-Owned or Operated NF), pp. 1-181^{RP}
175

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Att. 4.19-D (Non State Government-Owned or Operated NF),
pp. 1-170^{RP}
179

10. SUBJECT OF AMENDMENT:
Methods and Standards for Determining Payment Rates for Services Provided by Nursing Facilities

11. GOVERNOR'S REVIEW (Check One):

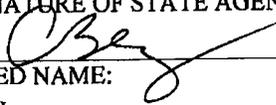
GOVERNOR'S OFFICE REPORTED NO COMMENT

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:
September 1, 2009

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
5-13-10

PLAN APPROVED -- ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

PEN AND INK CHANGE - BOXES 8 AND 9 - PER MAY 13, 2010
REQUEST VIA STATE EMAIL