

**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:
09-27

2. STATE
Minnesota

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

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 §§447.53-.55

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY '09: 0
b. FFY '10: 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Pre-print pages 55, 56d

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Same

10. SUBJECT OF AMENDMENT:

Recipient cost sharing and similar charges

11. GOVERNOR'S REVIEW (Check One):

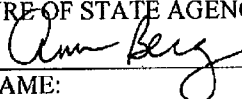
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Ann Berg

14. TITLE:

Deputy Medicaid Director

15. DATE SUBMITTED:

August 31, 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:

August 31, 2009

18. DATE APPROVED:

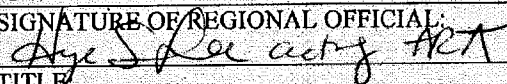
NOV 13 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associated Regional Administrator

23. REMARKS: