

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:
09-32

2. STATE
Minnesota

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

4. PROPOSED EFFECTIVE DATE
October 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 §447.201(b)

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY '10: \$ (181)
b. FFY '11: \$ (215)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, p.10

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Same

10. SUBJECT OF AMENDMENT:

Provider rate reduction

11. GOVERNOR'S REVIEW (Check One):

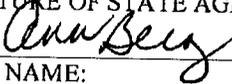
GOVERNOR'S OFFICE REPORTED NO COMMENT

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:

December 23, 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:

December 23, 2009

18. DATE APPROVED:

July 8, 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE:

Associate Regional Administrator

21. TYPED NAME:

Verlon Johnson

23. REMARKS: