

**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:  
10-15

2. STATE  
Minnesota

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

4. PROPOSED EFFECTIVE DATE  
August 1, 2010

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

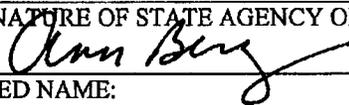
7. FEDERAL BUDGET IMPACT (in thousands)  
a. FFY '10: 0  
b. FFY '11: (\$857,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Att. 4.19-D (Non-State Government-Owned or Operated NF), pp.1-179

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

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       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  
PO Box 64983  
St. Paul, MN 55164-0983

13. TYPED NAME:  
Ann Berg

14. TITLE:  
Deputy Medicaid Director

15. DATE SUBMITTED:  
August 13 2010

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:  
02-09-11

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
AUG - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:  


21. TYPED NAME:  
William Lasowski

22. TITLE:  
Deputy Director, CMCS

23. REMARKS: