

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0193

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 10-28	2. STATE Minnesota
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 January 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §5447.53-.55		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY '11: 0 b. FFY '12: 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Att. 4.18-A, p. 1 Att. 4.18-C, p. 1		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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  same	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: <i>Ann Berg</i>	16. RETURN TO: Lisa Knutson 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: December 20, 2010	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: <i>12/20/10</i>	18. DATE APPROVED: <i>5/18/2011</i>
19. EFFECTIVE DATE OF APPROVED MATERIAL: <i>1/1/2011</i>	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Alan ...</i>
21. TYPED NAME: <i>Alan ...</i>	22. TITLE: <i>Regional Administrator</i>
23. REMARKS:	