DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12-18

2. STATE: Minnesota

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

TO: REGIONAL ADMINISTRATOR
CENTER FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§1916 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY $ 0
b. FFY $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
State Plan pre-print pages 54 and 56b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
State Plan pre-print pages 54 and 56b

10. SUBJECT OF AMENDMENT:
Exemption for American Indians from premium, enrollment fee or similar charge

11. GOVERNOR'S REVIEW (Check One):
x 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:
[redacted]

16. RETURN TO:
Ann Berg
Minnesota Department of Human Services
540 Cedar Street, PO Box 64983
St. Paul, MN 55164-0983

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
September 28, 2012

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 28, 2012

18. DATE APPROVED:
12/21/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2012

20. SIGNAT[redacted]

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07-92)