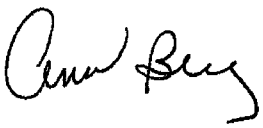


|  |  |   |                           |
|--|--|---|---------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL<br/>FOR: CENTER FOR MEDICARE &amp; MEDICAID SERVICES</b>  |  | 1. TRANSMITTAL NUMBER:<br><br>13-07   | 2. STATE<br><br>Minnesota |
|  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE<br>SOCIAL SECURITY ACT (MEDICAID)   |                           |
| TO: REGIONAL ADMINISTRATOR<br>CENTER FOR MEDICARE & MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br><br>January 1, 2013   |                           |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)          |  |   |                           |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR §440.50  |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY '13 \$0<br>b. FFY '14 \$0   |                           |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Attachment 3.1-A, pages 19 & 23<br>Attachment 3.1-B, pages 18 & 22<br>SPP, Section 3, page 27   |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION<br>OR ATTACHMENT (If Applicable):<br>Same   |                           |
| 10. SUBJECT OF AMENDMENT:<br>Optometrist services  |  |   |                           |
| 11. GOVERNOR'S REVIEW (Check One):<br><input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |   |                           |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br><br>   |  | 16. RETURN TO:<br>Sean Barrett<br>Minnesota Department of Human Services<br>Federal Relations Unit<br>PO Box 64983<br>St. Paul, MN 55164-0983 |                           |
| 13. TYPED NAME:<br>Ann Berg  |  |   |                           |
| 14. TITLE:<br>Deputy Medicaid Director   |  |   |                           |
| 15. DATE SUBMITTED:<br>March 29, 2013  |  |   |                           |
| FOR REGIONAL OFFICE USE ONLY   |  |   |                           |
| 17. DATE RECEIVED:   |  | 18. DATE APPROVED:  |                           |
| PLAN APPROVED - ONE COPY ATTACHED  |  |   |                           |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:   |  | 20. SIGNATURE OF REGIONAL OFFICIAL:   |                           |
| 21. TYPED NAME:  |  | 22. TITLE:  |                           |
| 23. REMARKS:   |  |   |                           |