DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-030

2. STATE: Minnesota

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
July 1, 2009

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:
§1902(r)(2); §1931; 42 CFR §433.138

7. FEDERAL BUDGET IMPACT:
a. FFY '09: $0
b. FFY '10: $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A, Supplement 8a, page 5
Attachment 2.6-A, Supplement 8b, page 4
Attachment 2.6-A, Supplement 8b, page 4a
Attachment 2.6-A, Supplement 13, pages 2, 3
Attachment 4.22-A, pages 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 8a, page 5 to Attachment 2.6-A
Supplement 8b, page 4 to Attachment 2.6-A
Supplement 13, pages 2 & 3, to Attachment 2.6-A
Attachment 4.22-A, pages 1-2
Attachment 4.22-A, Supplements 1, 2 & 3 (deleted)

10. SUBJECT OF AMENDMENT: More liberal methods; third party liability;

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:
Ann Berg

16. RETURN TO:
Ann Berg, Deputy Medicaid Director
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 25, 2009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
SEP 28 2009
September 25, 2009

18. DATE APPROVED
JUN 07 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Verlon Johnson

22. TITLE
Associate Regional Administrator

FORM HCFA-179 (07-92)