TO ANOMICOLAY AND NOTICE OF A DEPOSIT OF	1 mp 13 m 17 m	OMB NO. 0938-0193
TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	10-04	Minnesota
EOD. HE ALTH CADE EINANGING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE	
FOR: HEALTH CARE FINANCING ADMINISTRATION	SOCIAL SECURITY ACT (MEDICAID)	
	Social Below The Cale Cale Cale Cale Cale Cale Cale Cal	ALD)
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	And the second s
HEALTH CARE FINANCING ADMINISTRATION	January 1, 2010	
DEPARTMENT OF HEALTH AND HUMAN SERVICES	Junuary 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One):		
3. THE OFFICIAL (CRECK ORE).		
□ 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:	7. FEDERAL BUDGET IMPACT: (in t	
42 CFR §440.100	a. FFY '10: \$ (7,132,077)	inousanus)
12 Olik 9 110.100		
O DACTAUL ADED OF THE BLANCE OTHER LONG OF A STOLEN	b. FFY '11: \$ (12,526,780)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	
Att. 3.1-A, pages 40, 40a, 40b, 40c, 40d, 40e, 47	OR ATTACHMENT (If Applicable):	
Att. 3.1-B, pages 39, 39a, 39b, 39c, 39d, 39e, 46	Same	
Att. 4.19-B, page 31, 31a		
,		
10. SUBJECT OF AMENDMENT:		
Dental Services and rates		
		ı
11. GOVERNOR'S REVIEW (Check One):		
X GOVERNOR'S OFFICE REPORTED NO COMMENT	OTHER, AS SPECIA	FIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
_		
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:	
12. SIGNAL OF STATE ACENCY OFFICIAL.	TO. RETORN TO.	
U2/2	T. T.	
13. TYPED NAME:	Lisa Knazan	
Ann Berg	Minnesota Department of Human Services	
14. TITLE:	Federal Relations Unit	
	PO Box 64983	
Deputy Medicaid Director	St. Paul, MN 55164-0983	
15. DATE SUBMITTED:	,	
March 31,2010		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED;	18. DATE APPROVED: JUN	2 9 2010
03-31-10		
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SICNATURE OF REGIONAL OFF	ICIAL:
01-01-10	The x	
21. TYPED NAME:	22. TITLE:/	
Verlon Johnson	Asociate Regional Admi	nietrator
The second secon	ASSOCIATE WANT	HISCIACUL
23. REMARKS:		
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