

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 10-08	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE April 1, 2010	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

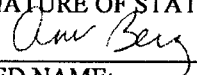
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §§431.11	7. FEDERAL BUDGET IMPACT (in thousands): a. FFY '10: \$ 0 b. FFY '11: \$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 1.2-A Attachment 1.2-B, pages 1-30 P	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 1.2-A Attachment 1.2-B, pages 1-26

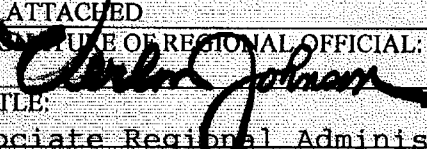
10. SUBJECT OF AMENDMENT:
Organization for administration of the Medicaid agency and state plan

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: 	16. RETURN TO: Lisa Knazan 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: May 19, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 19, 2010	18. DATE APPROVED: August 17, 2010
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2010	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator

23. REMARKS: