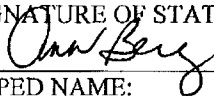



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-14b	2. STATE Minnesota
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.100		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY '10: \$ (1,375,613) b. FFY '11: \$ (4,694,594)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 3.1-A, pages 40, 40a, 40b, 40c, 40d Att. 3.1-B, pages 39, 39a, 39b, 39c, 39d		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same	
10. SUBJECT OF AMENDMENT: Dental Services			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> 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: August 11, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 08-11-10		18. DATE APPROVED: 10-07-10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2010		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	
23. REMARKS:			