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: 10-15

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
August 1, 2010

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:
42 CFR §447.252

7. FEDERAL BUDGET IMPACT (in thousands)
a. FFY '10: 0
b. FFY '11: ($857,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-D (Non-State Government-Owned or Operated NF), pp.1-179

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
Methods and Standards for Determining Payment Rates for Services Provided by Nursing Facilities

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

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
August 13 2010

16. RETURN TO:

Lisa Knazan
Minnesota Department of Human Services
Federal Relations Unit
PO Box 64983
St. Paul, MN 55164-0983

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
02-09-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Lasowski

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)