| TRANSMITTAL AND NOTICE OF APPROVAL OF | 1. TRANSMITTAL NUMBER: | 2. STATE |
|--|---|--|
| STATE PLAN MATERIAL | 10-16 | Minnesota |
| | | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR | 4. PROPOSED EFFECTIVE DATE | |
| HEALTH CARE FINANCING ADMINISTRATION | July 1, 2010 | |
| DEPARTMENT OF HEALTH AND HUMAN SERVICES | 7, 2010 | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | |
| The state of the s | | |
| ☐ 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 the | nousands) |
| 42 CFR §440.60 | a. FFY '10: \$ 0 | iousuiius) |
| · | b. FFY '11: \$ 0 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERSE | EDED BLAN CECTION |
| Att. 3.1-A, page 24 | | DED PLAN SECTION |
| Att. 3.1-B, pages 23 | OR ATTACHMENT (If Applicable): Same | |
| 74tt 5.1-D, pages 25 | Same | |
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| 10. SUBJECT OF AMENDMENT: | | |
| Chiropractors' Services | | |
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| 44 GOVERNOONS TO THE STATE OF T | | |
| 11. GOVERNOR'S REVIEW (Check One): | | |
| X 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: | |
| Una Berg | TO REPORT TO. | |
| | Lisa Knazan | |
| 13. TYPED NAME: U | Minnesota Department of Human Service | |
| Ann Berg | Federal Relations Unit | 58 |
| 14. TITLE: | PO Box 64983 | |
| Deputy Medicaid Director | | |
| 15. DATE SUBMITTED: | St. Paul, MN 55164-0983 | |
| Avaust 4,2010 | | |
| FOR REGIONAL OFFICE USE ONLY | | |
| 17, DATE RECEIVED: | 18. DATE APPROVED: | |
| August 4, 2010 | SEP 1 5 | 2010 |
| PLAN APPROVED ONE COPY ATTACHED | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFI | CIAI |
| 07=01=10 | Shelley in Circle | |
| 21. TYPED NAME: | 22. TITLE: | |
| | | |
| 23. REMARKS: | Associate Regi c onal Adm | inistrator |
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