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: 10-29

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
October 1, 2011

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 §§440.70; 440.120

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY '12: 0
b. FFY '13: 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B, page 27a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-B, item 7.c.

10. SUBJECT OF AMENDMENT:
Home infusion therapy services

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:

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
December 23, 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:
12-23-10

18. DATE APPROVED:
AUG 05 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)