

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
11-24

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  
October 1, 2011

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 §§447.53-.55

7. FEDERAL BUDGET IMPACT: (in thousands)  
a. FFY '12: (\$2,072)  
b. FFY '13: (\$2,189)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.18-A, pp. 1, 3  
Att. 4.18-C, pp. 1,3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):  
Att. 4.18-A, p. 1  
Att. 4.18-C, p. 1

10. SUBJECT OF AMENDMENT:

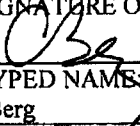
Recipient cost sharing and similar charges

11. GOVERNOR'S REVIEW (*Check One*):

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:

November 7, 2011

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:

November 7, 2011

18. DATE APPROVED:

FEB - 3 2012

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associate Regional Administrator

23. REMARKS: