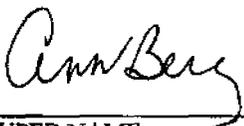


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 13-34	2. STATE Minnesota
TO: REGIONAL ADMINISTRATOR CENTER FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
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)		4. PROPOSED EFFECTIVE DATE January 1, 2014	
6. FEDERAL STATUTE/REGULATION CITATION: § 1902(a)(73) of the Act		7. FEDERAL BUDGET IMPACT: a. FFY '14 (\$ 0) b. FFY '15 (\$ 0)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Pre-print page 9.1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same	
10. SUBJECT OF AMENDMENT: Tribal Consultation			
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: Sean Barrett 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: December 31, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 31, 2013		18. DATE APPROVED: 3/7/14	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	
23. REMARKS:			