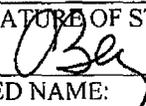


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 12-07	2. STATE Minnesota
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2012	
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)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.200		7. FEDERAL BUDGET IMPACT (in thousands) a. FFY '12: 0 b. FFY '13: 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B pages 3a, 8, 10a, 10e, 10h, 10i		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same	
10. SUBJECT OF AMENDMENT: Mental health rate changes			
11. GOVERNOR'S REVIEW (Check One):			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENTS <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: Lisa Knazan Minnesota Department of Human Services Federal Relations Unit P.O. Box 64983 St. Paul, MN 55164-0983	
13. TYPED NAME: Ann Berg			
14. TITLE: Deputy Medicaid Director			
15. DATE SUBMITTED: March 30, 2012			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

January 1, 2012  
 Verlon Johnson  
 Associate Regional Administrator  
 March 30, 2012  
 11-15-12