

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

1. TRANSMITTAL NUMBER:  
09-15

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  
August 1, 2009

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 §440.130(d)

7. FEDERAL BUDGET IMPACT:  
a. FFY '09: 0  
b. FFY '10: 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, pages 25, 54b, 54c.1, 54d  
Attachment 3.1-B, pages 24, 53b, 53c.1, 53d  
Attachment 4.19-B, page 16, 45a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

Adult mental health services and rates

11. GOVERNOR'S REVIEW (Check One):

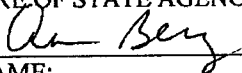
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Ann Berg

14. TITLE:

Deputy Medicaid Director

15. DATE SUBMITTED:

September 14, 2009

16. RETURN TO:

Lisa Knazan  
Minnesota Department of Human Services  
Federal Relations Unit  
P.O. Box 64983  
St. Paul, MN 55164-0983

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

September 14, 2009

18. DATE APPROVED:

DEC 11 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

August 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associate Regional Administrator

23. REMARKS: