

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:
09-18

2. STATE
Minnesota

**3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)**

4. PROPOSED EFFECTIVE DATE
January 1, 2010

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 '10: \$69,889

b. FFY '11: \$111,776

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, pages 25, 54b
Attachment 3.1-B, pages 24, 53b

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Same

10. SUBJECT OF AMENDMENT:

Licensed professional clinical counselors

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:

August 19, 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:

August 19, 2009

18. DATE APPROVED:

OCT 29 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

January 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Verlon Johnson

22. TITLE:

Associate Regional Administrator

23. REMARKS: