

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

1. TRANSMITTAL NUMBER:  
10-22

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  
July 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: (\$31)  
b. FFY '11: (\$263)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-B, page 45e

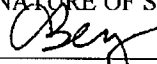
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
Same

10. SUBJECT OF AMENDMENT:  
Chemical dependency treatment 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:  
August 11, 2010

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**

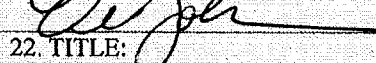
17. DATE RECEIVED:  
08-11-10

18. DATE APPROVED:  
10-07-10

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
07-01-10

20. SIGNATURE OF REGIONAL OFFICIAL:



22. TITLE:  
Associate Regional Administrator

21. TYPED NAME:  
Verlon Johnson

23. REMARKS: