DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-026

2. STATE: Montana

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
08/01/2011

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:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 11 ($19)
b. FFY 12 ($116)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplements to Attachments 3.1A and 3.1B Service 6(e), Nutrition Services 4.19B Methods & Standards for Establishing Payment Rates for Service 6(e) Nutrition Services.
Attachment 3.1-A, Page 3
Attachment 3.1-B, Page 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, Page 3
Attachment 3.1-B, Page 3

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to add Nutrition Services pages and document the date the agency's rates were set.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: SINGLE AGENCY DIRECTOR REVIEW

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mary E. Dalton

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 6/30/11

16. RETURN TO:
Montana Dept of Public Health and Human Services
Mary E. Dalton, State Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/11

18. DATE APPROVED: 9/27/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 8/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: RICHARD C. ALLEN

22. TITLE: ARA, DNCHO

23. REMARKS:

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Chiropractors' services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Other practitioners' services

/X/ Provided Identified on attached sheet with description of limitations, if any.

/ / Not provided.

e. Nutrition services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S) All Medically Needy

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/x/ Provided: / / No limitations /x/ With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

e. Nutrition services

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

MONTANA

The following limits apply to Nutritionists' Services:

1. Nutrition services for individuals under age 21 (EPSDT) are available for all medically necessary services.

2. Services considered experimental are not a benefit of the Montana Medicaid Program. Experimental services include:

   a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

   b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization

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   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

MONTANA

I. Reimbursement for Nutrition Services shall be the lowest of the following:

A. The provider's usual and customary charge for the service.

B. The Department's fee schedule.

II. The Department's fee schedule is determined using a methodology, based on the current budget in combination with review of past utilization.

IV. The agency's rates were set as of August 1, 2011 and are effective for services on or after that date. All rates are published on the agency's website, www.mtmedicaid.org. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.