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: 12-012

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
07/01/2012

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. SFY 13 $0
b. SFY 14 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT.
Pages 1 & 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.d
Clinical Social Worker Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Pages 1 & 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.d
Clinical Social Worker Services

10. SUBJECT OF AMENDMENT:
Update the rate and the date reimbursement rates are set and effective for services provided.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE. State Medicaid Director

15. DATE SUBMITTED: 6/25/12

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/25/12

18. DATE APPROVED: 9/19/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/12

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: RICHARD C ALLEN

22. TITLE: ARA, DMCHO

23. REMARKS: