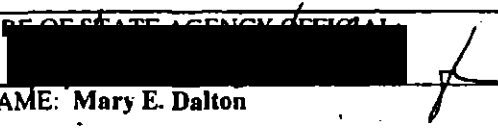



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-015	2. STATE Montana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 01/01/2001 2012-04-5	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT. (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1902 (a)(10) and 1902(a)(30) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 12: \$ 0 c. FFY 13 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 4.19B, Payments of Medicare Part A and Part B Deductibles/Coinsurance, Pages 3 of 3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 1 to Attachment 4.19B, Payments of Medicare Part A and Part B Deductibles/Coinsurance, Pages 3 of 3	
10. SUBJECT OF AMENDMENT: Clarification of Supplement 1 to Attachment 4.19-B reflecting Montana's method of reimbursing Deductible and Coinsurance for Medicare Part B services provided by institutional outpatient providers (those billing on CMS-1450 billing form or electronic equivalent)			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Single Agency Director Review. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		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	
13. TYPED NAME: Mary E. Dalton			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 3-30-12			

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: March 30, 2012	18. DATE APPROVED: May 30, 2012
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Richard C. Allen	22. TITLE: Associate Regional Administrator
23. REMARKS: Pen and ink changes to effective date requested by the State.	