

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

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 2012 \$0
b. FFY 2013 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Page(s) 1 of 1 and 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 11.c
Speech Therapy and Audiology Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)
Page(s) 1 of 1 and 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 11.c
Speech Therapy and Audiology Services

10. SUBJECT OF AMENDMENT

Amend Services 11.c. Speech Therapy and Audiology Services to update the date and rates on the fee schedule.

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. 6/22/12

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

6/22/12

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

[Signature]

21. TYPED NAME

RICHARD C. ALLEN

22. TITLE

ARA, DMCHO

23. REMARKS: