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: 13-036

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
7/1/13

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:
Deficit Reduction Act of 2005, modified effective 10/1/10 through the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY13 (3 months): $8,654
b. FFY14 (12 months): $49,697
c. FFY15 (9 months): $70,677

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement to Attachment 3.1-I; Attachment 4.19B, 1915(i) HCBS State Plan Services for High Needs Youth with Serious Emotional Disturbance

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement to Attachment 3.1-I; Attachment 4.19B, 1915(i) HCBS State Plan Services for High Needs Youth with Serious Emotional Disturbance

10. SUBJECT OF AMENDMENT:

Increase most fees in the 1915i by 2% (some fees held at the current rate), update the date of the fee schedule for the 1915(i) Home and Community Based Services State Plan Program for Youth with Serious Emotional Disturbance, and in the absence of the Utilization Review Contractor, the Regional Manager completes the needs-based eligibility criteria, face-to-face assessment, and the service plan.

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: 6-27-13

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: 6/27/13

18. DATE APPROVED: 9/20/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/13

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: RICHARD C. ALLEN

22. TITLE: ARA, DMCHO