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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-16-0011

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

September 19, 2016

Mary Dalton, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: SPA MT-16-0011

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-16-0011. This amendment updates the fee schedule and increases the rate by the legislatively appropriated amount, which is reflected on the CMS 179 for MT 16-0009.

Please be informed that this State Plan Amendment was approved today, with an effective date of July 1, 2016. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

[redacted]

Matthew J. Rodriguez, PharmD, Ph.C., BCPS
Acting Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

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: 16-0011	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 7/1/2016	

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: Section 1902(a)(30)	7. FEDERAL BUDGET IMPACT: a. FFY 2016 (9 mos.): $0 b. FFY 2017 (12 mos.): $0 c. FFY 2018 (3 mos.): $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B, Targeted Case Management for Children and Youth with Special Health Care Needs, Page 1 of 1.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19B, Targeted Case Management for Children and Youth with Special Health Care Needs, Page 1 of 1.

10. SUBJECT OF AMENDMENT:

This amendment updates the fee schedule and increases the rate by the legislatively appropriated amount, which is reflected on the CMS 179 for MT 16-0009.

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: [redacted]	16. RETURN TO: Montana Department of Public Health and Human Services Mary E. Dalton Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620
13. TYPED NAME: Mary E. Dalton	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: originally submitted 7-25-16 resubmitted 9-9-16 (MEK)	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 25, 2016	18. DATE APPROVED: September 19, 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Matthew J. Rodriguez	22. TITLE: Acting ARA, DMCHO

23. REMARKS:

Attachment 4.19B
Methods and Standards for
Establishing Payment Rates
Service 19e
Targeted Case Management Services for
Children and Youth with
Special Health Care Needs

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Montana

I. Targeted case management services for Children and Youth with Special Health Care Needs (CYSHCN) will be reimbursed on a fee per unit of service basis. A unit of service is 15 minutes.

II. The Department will pay the lower of the following for targeted case management services for CYSHCN:
   A. The provider's actual submitted charge for the services; or
   B. The Department's fee schedule.

III. Unless otherwise noted in the plan, the department fee schedule rate for both governmental and private providers was set as of the date on the Attachment 4.1B Introduction Page and is effective for services on or after that date. All rates are published on the agency's website at http://medicaidprovider.mt.gov.