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**State/Territory Name: Montana** 

State Plan Amendment (SPA) #: 25-0012

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

#### DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 601 E. 12th St., Room 355 Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

December 10, 2025

Rebecca De Camara
State Medicaid Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604
Attention: Carla Rime

Re: Montana State Plan Amendment (SPA) – 25-0012

Dear Director De Camara:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0012. This amendment proposes implementing the mandatory exception to the Medicaid clinic services "four walls" requirement for Indian Health Service (IHS) and Tribal clinics.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Montana's Medicaid SPA TN 25-0012 was approved on December 9, 2025, with an effective date of January 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Montana State Plan.

If you have any questions, please contact Dana Brown at (410) 786-0421 or via email at Dana.Brown@cms.hhs.gov.

Sincerely,

Wendy E. Hill Petras Acting Director, Division of Program Operations

**Enclosures** 

cc: Carla Rime

|    | TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES  | 1. TRANSMITTAL NUMBER<br>25-0012  | 2. STATE<br>Montana |  |  |  |  |
|----|--|---|---------------------|--|--|--|--|
|    |  | 3. PROGRAM IDENTIFICATION: TITLE OF SECURITY ACT  ✓ XIX   | THE SOCIAL XXI      |  |  |  |  |
|    | TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES   | 4. PROPOSED EFFECTIVE DATE 1/1/2025   |                     |  |  |  |  |
|    | 5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 440.90   | 6. FEDERAL BUDGET IMPACT (Amounts   | in WHOLE dollars)   |  |  |  |  |
|    | 1902(a)(30)(A) and 1905(a)(9) of the Social Security Act   | a. FFY 2025- \$0.00 impact (9 months)<br>b. FFY 2026- \$0.00 impact (12 month<br>c. FFY 2027 - \$0.00 impact (3 months)                     | s)                  |  |  |  |  |
|    | 7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT   | 8. PAGE NUMBER OF THE SUPERSEDER ATTACHMENT (If Applicable)   | O PLAN SECTION OR   |  |  |  |  |
|    | Supplement to Attachment 3.1-A, Service 9, Pages 1-6   | Supplement to Attachment 3.1-A, Service   | 9, Pages 1 and 2    |  |  |  |  |
|    |  | Supplement to Attachment 3.1-A, Servi   | ce 9a, Page 1*      |  |  |  |  |
| 9. | SUBJECT OF AMENDMENT: The purpose of this State Plan Amendment is to implement the mandatory exception to the Medicaid clinic services "four walls" requirement for IHS and Tribal clinics in the final rule amending 42 CFR 440.90. |   |                     |  |  |  |  |
|    | GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL A   | OTHER, AS SPECIFIED:  Montana Department of Public Health and Hum  State Medicaid Director  Attn: Carla Rime  PO Box 4210, Helena, MT 59601 | nan Services        |  |  |  |  |
|    | 11. SIGNATURE OF STATE AGENCY OFFICIAL   | 15. RETURN TO:<br>Montana Department of Public Health ar<br>Rebecca de Camara<br>Attn: Carla Rime<br>PO Box 4210                            | nd Human Services   |  |  |  |  |
|    | 12. TYPED NAME: <b>Rebecca de Camara</b>   | Helena MT 59601   |                     |  |  |  |  |
|    | 13. TITLE: Medicaid and Health Services Executive Director/<br>State Medicaid Director   |   |                     |  |  |  |  |
|    | 14. DATE SUBMITTED:<br>March 30, 2025  |   |                     |  |  |  |  |
|    | FOR CMS USE ONLY   |   |                     |  |  |  |  |
|    | 16. DATE RECEIVED:   | 17. DATE APPROVED   |                     |  |  |  |  |
|    | March 30, 2025   | December 9, 202   | 5                   |  |  |  |  |
|    | PLAN APPROVED - C  | ONE COPY ATTACHED   |                     |  |  |  |  |
|    | 18. EFFECTIVE DATE OF APPROVED MATERIAL  | 19. SIGNATURE OF APPROVING OFFICIAL   |                     |  |  |  |  |
|    | January 1, 2025  |   |                     |  |  |  |  |
|    | 20. TYPED NAME OF APPROVING OFFICIAL   | 21. TITLE OF APPROVING OFFICIAL   |                     |  |  |  |  |
|    | Wendy E. Hill Petras 22. REMARKS   | Acting Director, Division of Progra   | m Operations        |  |  |  |  |
|    | ZZ. KEIVIAKNO  |   |                     |  |  |  |  |

Montana revised the following on 12/8/2025:

- Box 7 to reflect Supplement to Attachment 3.1 A and any page number changes to pending pages
- Box 8 to reflect the new pages are replacing Supplement to Attachment 3.1-A, Service 9, Pages 1 and 2

\*The state authorized a pen & ink change on 12/9/25 to add "Supplement to 3.1-A, Service 9a, Page 1" to box 8. FORM CMS-179 (09/24)

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| <b>State Plan</b> | under Title | XIX of the   | Social | Security | / Act         |
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| State/Territory: | Montana    |
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#### Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

#### **General Assurances**

- The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

### Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

| < | Limitations | apply to | all services | within | the be | nefit cate | gory. |
|---|-------------|----------|--------------|--------|--------|------------|-------|

Service must be covered by Montana Healthcare Programs and not be considered cosmetic, experimental, or investigational

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

| TN:    | 25-0012 Approv |     |   | Approval D | ate: | 12/09/2025 |  |
|--------|----------------|-----|---|------------|------|------------|--|
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| Supplement | to | <b>Attachment</b> | 2  | 1 A |
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| Service | 9 | Page | 2 |
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|            | State Plan under   | Title 2            | XIX of the Social Secu   | rity Act                   |   |                 |
|------------|--|--------------------|--|----------------------------|---|-----------------|
|            | State/Territory:   | Mont               | ana  |                            |   |                 |
|            | Section  | 1905(a             | a)(9) Clinic Services  |                            |   |                 |
|            | Types of Clinics and Services:   |                    |  |                            |   |                 |
|            | Select all that apply and describe   | oelow              | as applicable]   |                            |   |                 |
|            | Behavioral Health Clinics [I   |                    |  | oral heal                  | th  |                 |
|            |  |                    |  |                            |   |                 |
|            | [Describe below an   | d indi             | is clinic type within the b<br>cate if limits may be ex<br>edical necessity criter | ceeded l                   | 0 ,   |                 |
|            |  |                    |  |                            |   |                 |
|            | X IHS and Tribal Clinics <b>[Sel</b>   | ect be             | low if applicable.]:   |                            |   |                 |
|            | [describe below an   | d indi             | is clinic type within the b<br>cate if limits may be ex<br>I necessity criteria].  |                            | • •   |                 |
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| TN:        | 25-0012  |                    | Appro  | oval Date:                 | 12/09/2025                                  |                 |
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|   |  |   | State/Territo  | <b>უ</b> ։ [                            | Montana  |  | ]   |   |   |
|   |  |   | Sect   | ion 1                                   | 1905(a)(9) Cli   | nic Services   | -   |   |   |
|   | X  | Rena  | l Dialysis Clinics   | [Sel                                    | ect below if a   | applicable.]:  |   |   |   |
|   |  | X   |  | w an                                    | d indicate if  | type within the limits may be esity criteria.]   |   | 0 ,   | on  |
|   |  |   | Patient must (ESRD) by a   |   |  | end-stage renal  | disease   |   |   |
|   | X  |   | Clinics [Descri<br>elect below if a  |   | • •  | inics, if any lim  | itations a  | ıpply,  |   |
|   |  |   | bulatory Surgica<br>ral Emergency H  |   |  |  |   |   |   |
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|                  |                              | Supplement to Attachment 3.1 A |
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|                  |                              | Service 9 Page 4               |
| State Plan unde  | r Title XIX of the Social Se | curity Act                     |
| State/Territory: | Montana                      |                                |
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# **Four Walls Exceptions**

| rne stat  | e assures that the following services may be lumished outside of the clinic. <b>[Select</b>   |
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| the first | and second checkbox; Do not select the second checkbox if the state does  |
| not enro  | oll IHS or Tribal facilities as providers of clinic services.]:   |
| X         | Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b). |

Section 1905(a)(9) Clinic Services

Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic [Select all that apply.]:

| Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) [Describe the types of behavioral health clinics such exception applies to below.]: |
|---|
|   |

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

| TN:   | 25-0012   |     | Approval Dat  | e: 12/09/2025 |   |
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|  |   |  | State Plan un  | der Title )  | XIX of the Social Secur  | rity Act  |  |   |
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|  |   |  | State/Territor   | y: Mont  | ana  |   |  |   |
| Section 1905(a)(9) Clinic Services                       |   |  |  |  |  |   |  |   |
|  |   | rural h<br>C.F.R<br>physic<br>check                          | ealth clinic (as re<br>. 440.20(b) of this<br>ian in accordanc   | eferenced i<br>s subpart)<br>e with 42 (   | linic that is located in a rin section §1905(a)(2)(B<br>by clinic personnel under<br>C.F.R. 440.90(e) [Selection of a runder   | s) of the A<br>er the dire<br>t one of t  | ct and 42<br>ction of a<br><b>he</b>   |   |
|  |   |  |  | •  | used by a federal governes [Describe below.]:  | ımental aç  | gency  |   |
|  |   |  |  |  | state governmental age<br>policy <b>[Describe below.]</b>  | •   | role in  |   |
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|   |   | Supplement to Attachment 3.1-A   |
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|   |   | Service 9 Page 6   |
| State Plan under  | Title XIX of the Social Secur   | ity Act  |
| State/Territory:  | Montana   |  |
| Section   | 1905(a)(9) Clinic Services  |  |
| The state attests that [Select the control of a clinic that is located  |   | o cover services   |
| rural individuals that m  | n of a rural area best captures the neets more of the four criteria the experienced by individuals wh   | nat mirror the needs   |
| diagnoses or diff  The population e transportation;   | experiences high rates of behaviculty accessing behavioral head experiences issues accessing s  | alth services;<br>ervices due to lack of   |
| system; and   | experiences a historical mistrus experiences high rates of poor h   |  |
| Additional Benefit Description (  | Optional)   |  |
| At its option the state may provide benefit, beyond what is included in and descriptions. [Describe below   | the federal statutory and regul   |  |
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and barriers to access experienced by individuals The population experiences high rates of be diagnoses or difficulty accessing behavioral The population experiences issues accessing transportation; The population experiences a historical mist system; and The population experiences high rates of pomortality. Additional Benefit Description (Optional) At its option the state may provide additional descriptive inform benefit, beyond what is included in the federal statutory and re and descriptions. [Describe below.]: PRA Disclosure Statement - This use of this form is mandatory and the info Centers for Medicare & Medicaid Services in implementing section §1905(a the Privacy Act of 1974, any personally identifying information obtained wil law. An agency may not conduct or sponsor, and a person is not required unless it displays a currently valid Office of Management and Budget (OM number for this project is 0938-1148 (CMS-10398 #91). Public burden for a requirements under this control number is estimated to take about 25 hours regarding this burden estimate or any other aspect of this collection of info reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. TN: 25-0012 Approval Date: 12/09/2025 01/01/2025 Supersedes TN: New Effective: |