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: 08-030

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
07/01/2008

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 09 $35,716
FFY 10 $40,006

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 1 of 1
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 8
Private Duty Nursing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page 1 of 1
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 8
Private Duty Nursing

10. SUBJECT OF AMENDMENT:
To clarify where the current fee schedule can be obtained. We are striking language that refers to a specific date.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Mary E. Dalton

14. TITLE: Acting State Medicaid Director

15. DATE SUBMITTED: 5/20/09 9/30/08

16. RETURN TO:
Montana Dept of Public Health and Human Services
Mary E. Dalton, Acting State Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/08

18. DATE APPROVED: JUN 2 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/08

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

MONTANA

I. Reimbursement for Private Duty Nursing Services shall be the lowest of the following:

A. The provider's usual and customary charge for the service.

B. The Department's fee schedule.

II. A reimbursable unit of service is up to 15 minutes.

III. The Department's fee schedule is determined using a methodology, based on an evaluation of the prevailing wages for Nurses in combination with review of past utilization.

IV. The agency's rates were set as of July 17, 2008 and are effective for services on or after that date. All rates are published on the agency's website, www.mtmedicaid.org. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.