

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
11-025

2. STATE  
Montana

FOR: HEALTH CARE FINANCING ADMINISTRATION

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  
08/01/2011

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 11 (\$8,276)  
b. FFY 12 (\$49,138)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.19B Methods & Standards for Establishing Payment Rates for  
Service 8 Private Duty Nursing Services.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

4.19B Methods & Standards for Establishing Payment Rates  
for Service 8 Private Duty Nursing Services.

10. SUBJECT OF AMENDMENT:

The purpose of this amendment is to document the revised date the agency's rates were set.

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:

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: JUNE 30, 2011

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:

6/30/11

18. DATE APPROVED:

8/19/11

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

8/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

RICHARD C. ALLEN

22. TITLE:

ARA, DMCHO

23. REMARKS:

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 August 1, 2011 and are effective for services on or after that date. All rates are published on the agency's website, [www.mtmedicaid.org](http://www.mtmedicaid.org). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

TN: 11-025

Approved: \_\_\_\_\_

8/19/11

Effective: 08/01/2011

Supersedes TN: 10-015