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: TN 10 - 034	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 10/01/10	

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: 42 CFR 431.800 (c) 50 FR 21839 1903 (u)(1)(D) of the Act, P.L. 99-509 (section 9407)	7. FEDERAL BUDGET IMPACT: a. FFY $0 b. FFY $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Citation 4.4, Page 35	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Citation 4.4, Page 35

10. SUBJECT OF AMENDMENT:
The purpose of this will be to substitute the Program Error Rate Measurement (PERM) reviews for the Traditional Medicaid MEQC reviews starting in Federal Fiscal Year 2011 and in every third year thereafter (2014, 2017 etc).

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:	16. RETURN TO: **Montana Dept. of Public Health and Human Services** **Mary E. Dalton** **Acting Medicaid Director** **Attn: Jo Thompson** **PO Box 4210** **Helena, MT 59604**
13. TYPED NAME: **Mary E. Dalton**	
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: 9/28/10	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/28/10	18. DATE APPROVED: 12/1/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/10	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO

23. REMARKS:

Revision: HCFA-PM-87--4 (BKRC) OMB No.: 0938-0193
MARCH 1987

State/Territory: MONTANA

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), per TN 88-06, (g), (h), (j), and (k).

____ Yes.

_X_ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

(c) PERM reviews will be substituted for traditional MEQC reviews in the selected years beginning 10/1/10 and every three years thereafter.