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: **11-028**

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 **August 1, 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:
42 CFR 447 (250-272)

7. FEDERAL BUDGET IMPACT;
a. FFY **2011** ($2,816,353)
b. FFY **2012** ($8,449,059)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19 D
13 of 56
24 of 56
30 of 56
54 of 56

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 D
13 of 56
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10. SUBJECT OF AMENDMENT:
NURSING FACILITY REIMBURSEMENT

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 STATE AGENCY

12. SIGNATURE OF STATE AGENCY OFFICIAL: Mary E. Dalton

13. TYPED NAME: **Mary E Dalton**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 9/21/2011

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:

18. DATE APPROVED: DEC - 2 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)