53-6-101 Montana Medicaid Program – Authorization of Services

Medicaid Change Reporting

September 1, 2025

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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SUMMARY

This report is to complete the requirements set forth in 53-6-101 (12)(a) by reporting changes to provider rates, Montana Medicaid waivers, and/or the Montana Medicaid State Plan to the Children, Families, Health, and Human Services Interim Committee, the Legislative Finance Committee, and the Health and Human Services Interim Budget Committee. The effective date of each proposed change is indicated.

PROVIDER RATE CHANGES

MEDICAID PROVIDER RATE INCREASES

Effective July 1, 2025, DPHHS proposed an increase to many of Montana Medicaid's provider rates and fee schedules appropriated in the 2025 Montana Legislative Session. In establishing the proposed rates, the Department considered as primary factors the availability of funds appropriated by the Montana legislature during the 2025 regular legislative session, the actual cost of services, and the availability of services. Proposed changes to provider rates that are the subject of this public notice, including rates in fee schedules and rates in provider manuals, can be found on the Proposed Fee Schedules page.

PROVIDER PARTICIPATION CHANGES

COMMUNITY FIRST CHOICE SERVICES (CFCS) AND PERSONAL CARE SERVICES (PCS)

Effective July 1, 2025, DPHHS proposed to update Community First Choice Services (CFCS) and Personal Care Services (PCS) State Plans with the following changes:

- Funding for Health Care for Health Care Workers (HCHCW): $3,411,285 in SFY 2026 and SFY 2027, to provide CFCS and PCS provider agencies the ability to purchase insurance for direct care workers (DCW).
- Funding for DCW wages will provide for wage or lump-sum payments to workers who provide direct care services under the CFCS and PCS state plans. CFCS and PCS state plan funding will be $6,121,811 in both SFY 2026 and SFY 2027.
- The CFCS and PCS state plan amendments are budget neutral, as the appropriations, per SFY, are the same as the previous biennium.

RECOVERY AUDIT CONTRACTOR

Effective April 1, 2025, Montana received a renewal of a two-year period through April 2027 for an exemption from the Recovery Audit Contractor. During the 2017 legislative session, Montana enacted Montana Code Annotated 53-6-1402, which adjusts the Medicaid review time frame from a four-year lookback, excluding the current year, to a six-month data review within a three-year lookback for an initial audit. Due to this restriction, DPHHS received no bids on the released Recovery Audit Contractor Request for Proposals. The two-year waiver from CMS is in accordance with 42 CFR 455.502.

EVIDENCE-BASED PRACTICE ADMINISTRATION

Effective January 1, 2025, DPHHS proposed to create an Evidence-Based Practice (EBP) Administration code H0050 with a rate of $16.51 per unit for the Other Rehabilitation State Plan. Corresponding intent of reimbursement is included in the Contingency Management Policy 610 within the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health.

CLINIC BENEFIT SERVICES

Effective January 1, 2025, DPHHS submitted the Clinic Benefit Services State Plan template. CMS published a final rule for 42 CFR 440.90 in the Federal Register on November 27, 2024. This final rule created an exception to the clinic services benefit four walls requirement and authorized Medicaid payments for clinic services provided outside the four walls of the clinic for IHS and Tribal clinics. This submission is in response to the new final rule that impacts the location where clinic services may be delivered, but it does not alter the types of services that a clinic is allowed to provide. All previous clinic State Plan Amendment authorities have been incorporated into this new template as required by CMS.

ELIGIBILITY CHANGES

HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP WAIVER

DPHHS is seeking a Section 1115 Demonstration waiver to comply with Montana legislative requirements (MCA 53-6-1307, 53-6-1308, and 53-6-1309) and advance the Gianforte administration’s commitment to helping Montanans become self-sufficient and independent while reducing government dependency. DPHHS will also seek to align and comply with recently enacted federal requirements included in HR 1 related to community engagement and cost-sharing for Medicaid enrollees.

Specifically, the HELP Demonstration program seeks to require non-exempt enrollees to meet community engagement requirements and pay premiums as a condition of enrollment. By requiring working-age, able-bodied adult Medicaid enrollees to take an active role in their health care and become engaged in their communities, Montana can achieve lasting improvements in both the health and economic well-being of its citizens, as well as the financial health of the Medicaid program.

SUMMARY OF PROPOSED WAIVER FEATURES

Montana is seeking:

- Community Engagement: To require non-exempt individuals aged 19 – 64 to participate in 80 hours per month of community engagement activities to gain Medicaid coverage and continue to participate in community engagement activities to maintain an active Medicaid enrollment status in the Demonstration; and
- Cost Sharing: To require non-exempt individuals to pay gradually increasing monthly premiums not to exceed 4% of their income, the amount of which is dependent upon the number of years of enrollment in the Demonstration. Additionally, DPHHS recognizes that HR 1 requires the collection of copayments for expansion enrollees by October 1, 2028. It is the state's intention to eventually implement copayments as required by HR 1 and as permitted by MCA.

The HELP Demonstration program will apply to all non-exempt Medicaid expansion adults aged 19-64 with an income up to 138% of the federal poverty level (FPL). Separate from the requirements set forth in HR 1, Montana is requesting authority for additional exemptions based on state statute, including but not limited to those who are mentally or physically unable to work, foster parents, or primary caregivers for a person who is unable to provide self-care.

The State does not propose any other changes to the Medicaid health care delivery system or benefits offered to enrollees.

BENEFIT PLAN CHANGES

STATE PLAN DENTAL SERVICES

Effective July 1, 2025, DPHHS proposed to update the Dental Services State Plan to reflect an increase to the adult dental treatment services limit by 3%, resulting in a new

limit of $1,205. This increase ensures the quantity of services a member can receive remains unaffected by the provider rate increases, and is therefore anticipated to be budget neutral.

YOUTH REENTRY SERVICES

Effective January 1, 2025, the Medicaid, Alternative Benefit Plan (ABP), and the Children's Health Insurance Program/Healthy Montana Kids (CHIP/HMK) State Plans were amended to include Section 5121 of the Consolidated Appropriations Act (CAA) mandatory youth reentry services. This provides for the availability of services for incarcerated youth enrolled in Medicaid, Medicaid Expansion, and CHIP/HMK. Coverage timeframe begins 30 days prior to release and at least 30 days after release from incarceration.

TRIBAL HEALTH IMPROVEMENT PROGRAM

DPHHS is seeking a Tribal Health Improvement Program (THIP) State Plan Amendment to include the Little Shell Tribe to participate as an eligible provider, as the tribe does not have a reservation. DPHHS examined the authority (42 Code of Federal Regulations 438.14) and researched all the possible impacts to the THIP, including the effects on other Tribes.

DPHHS held an in-person consultation in November 2024, mailed a consultation letter in February 2025, and held another in-person consultation in June 2025. DPHHS continues to work with CMS regarding this amendment, and potential changes to the program eligibility criteria will require further consultation with the Tribes

BENEFIT PLAN RENEWALS

SEVERE AND DISABLING MENTAL ILLNESS (SDMI) WAIVER

Effective October 1, 2025, DPHHS submitted a request to CMS to renew the 1915(c) SDMI Waiver and propose changing the name to the Hope Waiver. The Department is requesting a five-year renewal.

The SDMI Waiver provides long-term services and supports to members with a severe and disabling mental illness in a community setting as an alternative to receiving long-term care services in a nursing facility setting. It is a combination 1915(c) and 1915(b)(4) waiver, combining a specialized array of services with conflict-free case management statewide.

Montana Medicaid Members can access the waiver if they meet a nursing home level of care, have an approved SDMI diagnosis and level of impairment, and are 18 years of age or older. The proposed waiver renewal includes changes to members served, the services offered, and language improvements to clearly describe the program design. The waiver currently serves approximately 450 members statewide.

MEMBERS SERVED

There is a proposed Reserved Waiver Capacity to respond to the following situations:

- Transitioning individuals with Money Follows the Person grant funding.
- Transitioning individuals from youth-based Medicaid programs to adult coverage through the SDMI Waiver.
- Transitioning individuals from Montana State Hospital or the Montana Mental Health Nursing Care Center.

SERVICES OFFERED

The following changes are proposed to improve service definitions to better serve the needs of members and to alleviate duplicative services:

- Update service definitions to define individual service delivery model;
- Update Residential Habilitation, Case Management, Consultative Clinical and Therapeutic Services, Health and Wellness, and Pain and Symptom Management service definitions and scope;
- Update provider definitions for Health and Wellness and Specialized Medical Equipment and Supplies;
- Update the provisions of care by Legally Responsible Individuals/Relatives/Legal Guardians; and
- Respond to HCBS settings process and assurances required by the new waiver application document.

PROGRAM DESIGN

The following changes are proposed to improve the overall program design and operations:

- Update program name from the Severe and Disabling Mental Illness Home and Community Based Services (SDMI) waiver to the Hope Waiver;
- Update language to remove outdated information, correct entity name changes, program staff position titles, update contracted case management entity from two to one, correct grammar, and provide clarifying details regarding the overall waiver administration, oversight, and operations;
- Update performance measures/quality assurance standards;
- Address updates outlined in CMS's new waiver application document and 1915(c) technical guide;
- Update prior authorization situations managed by the Quality Improvement Organization (QIO);
- Remove requirement for BHDD program staff to review and approve all PCRPs;
- Update quality assurance review processes;
- Update reserve capacity purposes and determination and add a new reserve capacity group;
- Remove the requirement for Person-Centered Recovery Plans to be submitted to the program for approval and oversight;
- Update case management team's responsibilities for record maintenance;
- Remove the requirement for the department to approve initial, annual, and/or updated PCRPs;
- Remove the requirement for the department to review specific components in the PCRPs prior to authorization;
- Update program staff quality assurance review responsibilities;
- More clearly define risk assessment and mitigation processes;
- Update the list of services provided by the contracted case management entity and the providers' availability for each service;

- Remove the requirement for direct approval from the State for the approval of the Intensive Mental Health Group Home service;
- Respond to Conflict of Interest assurances list required by the new waiver application document;
- Clarify the telephone contact (monthly call) requirements with members must be completed verbally;
- Add requirement to use SMART goal process within the PCRP goal definitions;
- Remove reference to MP completing capacity assessment;
- Update program survey process;
- Update claim review process from program staff to QIO;
- Update financial oversight details;
- Remove requirement for case management teams to conduct quarterly internal audits;
- Update rate methodology, rates, billing, and claims information; and
- Update utilization estimates and rate methodologies.