MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-152.1

Summary

Amendment of ARM 37.27.902, 37.85.104, 37.85.105, 37.85.106, 37.82.206, 37.86.1006, 37.86.3607, and 37.88.101 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates

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Hearing Date and Time

Friday, October 31, 2025, at 2:00 p.m.

Virtual Hearing Information

Join Zoom Meeting: https://mt-gov.zoom.us/j/89014858061?pwd=xG1MpJb30CXFjx0opwxHTtkO0yEkpf.1

Meeting ID: 890 1485 8061 and Password: 457068

Dial by Telephone +1 646 558 8656

Meeting ID: 890 1485 8061 and Password: 457068

Find your local number: https://mt-gov.zoom.us/u/kbXsI0qQfH

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, November 7, 2025, at 5:00 p.m.

Accommodations

The agency will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. Requests must be made by Friday, October 17, 2025, at 5:00 p.m.

Contact

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Rulemaking Actions

AMEND

The rules proposed to be amended are as follows, stricken matter interlined, new matter underlined:

37.27.902 SUBSTANCE USE DISORDER SERVICES: AUTHORIZATION REQUIREMENTS

(1) The purpose of rules contained in this subchapter is to establish standards for the coverage and reimbursement of substance use disorder services under the Montana Medicaid Program.

(2) In addition to the requirements contained in rule, the department has developed and published the Behavioral Health and Developmental Disabilities (BHDD) Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, dated January 1, 2025, which it adopts and incorporates by reference. The purpose of the manual is to implement requirements for utilization management and services. A copy of the manual may be obtained from the department by a request in writing to the Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities (BHDD) Division, 100 N. Park, Ste. 300, P.O. Box 202905, Helena, MT 59620-2905 or at: https://dphhs.mt.gov/bhdd/BHDDMedicaidServicesProviderManual.

(3) In addition to the requirements contained in rule, the department has developed and published the BHDD Division Non-Medicaid Services Provider Manual for Substance Use Disorder, dated ~~January 1, 2024~~ July 1, 2025, which it adopts and incorporates by reference. The purpose of the manual is to implement requirements for utilization management and services. A copy of the manual may be obtained from the department by a request in writing to the Department of

Public Health and Human Services, Behavioral Health and Developmental Disabilities (BHDD) Division, 100 N. Park, Ste. 300, P.O. Box 202905, Helena MT 59620-2905 or at: https://dphhs.mt.gov/bhdd/BHDDNonMedicaidServicesProviderManual.

Authorizing statute(s): 53-6-113, 53-24-204, 53-24-208, 53-24-209, MCA

Implementing statute(s): 53-6-101, 53-24-204, 53-24-208, 53-24-209, MCA

37.85.104 EFFECTIVE DATES OF PROVIDER FEE SCHEDULES FOR MONTANA NON-MEDICAID SERVICES

(1) The department adopts and incorporates by reference the fee schedule for the following programs within the Behavioral Health and Developmental Disabilities Division on the dates stated:

(a) Mental health crisis services, as provided in ARM 37.88.101, is effective ~~July 1, 2023 (fee schedule version 2), and July 1, 2024~~ July 1, 2025.

(b) Goal 189, as provided in ARM 37.89.201, is effective July 1, 2023.

(c) Youth respite care services, as provided in ARM 37.87.2203, is effective July 1, ~~2024~~ 2025.

(d) Substance use disorder services provider reimbursement, as provided in ARM 37.27.905, is effective ~~July 1, 2023, and July 1, 2024~~ July 1, 2025.

(2) Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered services are published in the chapter or subchapter of this title regarding that service.

Authorizing statute(s): 53-2-201, 53-6-101, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, MCA

37.85.105 EFFECTIVE DATES, CONVERSION FACTORS, POLICY ADJUSTERS, AND COST-TO-CHARGE RATIOS OF MONTANA MEDICAID PROVIDER FEE SCHEDULES

(1) The Montana Medicaid Program establishes provider reimbursement rates for medically necessary, covered services based on the estimated demand for services and the legislative appropriation and federal matching funds. Provider reimbursement rates are stated in fee schedules for covered services applicable to the identified Medicaid program. New rates are established by revising the identified program's fee schedule and adopting the new fees as of the stated effective date of the schedule. Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered service are published in the chapter or subchapter of this title regarding that service. The department will make periodic updates, as necessary, to the fee schedules noted in this rule to include new procedure codes and applicable rates and to remove terminated procedure codes.

(2) The department adopts and incorporates by reference, the resource-based relative value scale (RBRVS) reimbursement methodology for specific providers as described in ARM 37.85.212 on the date stated.

(a) Resource-based relative value scale (RBRVS) means the version of the Medicare resource-based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at ~~88~~ 89 Federal Register ~~78818~~ 97710 (~~Nov. 16, 2023~~ December 9, 2024), effective ~~January 1, 2024~~ January 1, 2025, which is adopted and incorporated by reference. Procedure codes created after January 1, 2025, will be reimbursed using the relative value units from the Medicare Physician Fee Schedule in place at the time the procedure code is created.

(b) Fee schedules are effective ~~January 1, 2025~~ July 1, 2025. The fee schedules are applicable to claims for services that are provided on or after the effective date; prior fee schedules remain applicable to claims for services provided prior to that date.

(i) The conversion factor for physician services is ~~$43.96~~ $45.41. The conversion factor for allied services is ~~$27.24~~ $28.23. The conversion factor for mental health services is $~~22.47~~ 22.24. The conversion factor for anesthesia services is ~~$31.78~~ $32.82.

(c) Policy adjustors are effective July 1, 2023. The maternity policy adjustor is 100%. The family planning policy adjustor is 105%. The psychological testing policy adjustor is 200%. The psychological testing policy adjustor applies only to psychologists.

(d) The BCBA/BCBA-D services policy adjuster is 115.8%, effective July 1, 2021.

(e) The payment-to-charge ratio is effective ~~July 1, 2024~~ July 1, 2025, and is ~~48.02%~~ 47.42% of the provider's usual and customary charges.

(f) The specific percentages for modifiers adopted by the department are effective July 1, 2016.

(g) Psychiatrists receive a 112% provider rate of reimbursement adjustment to the reimbursement of physicians effective July 1, 2016.

(h) Midlevel practitioners receive a 90% provider rate of reimbursement adjustment to the reimbursement of physicians for those services described in ARM 37.86.205(5)(b), effective July 1, 2016.

(i) Optometric services receive a ~~114.45%~~ 114.53% provider rate of reimbursement adjustment to the reimbursement for allied services, as provided in ARM 37.85.105(2), effective ~~July 1, 2024~~ July 1, 2025.

(j) Reimbursement for physician-administered drugs described in ARM 37.86.105 is determined pursuant to 42 U.S.C. 1395w-3a.

(k) Reimbursement for vaccines described at ARM 37.86.105 is effective July 1, 2020.

(3) The department adopts, and incorporates by reference, the fee schedule for the following programs within the Health Resources Division, on the date stated.

(a) The inpatient hospital services fee schedule and inpatient hospital base fee schedule rates including:

(i) the APR-DRG fee schedule for inpatient hospitals, as provided in ARM 37.86.2907, effective ~~July 1, 2024~~ July 1, 2025; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version ~~41.0~~ 42.0, contained in the APR-DRG Table of Weights and Thresholds, effective ~~July 1, 2024~~ July 1, 2025. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective ~~July 1, 2024~~ July 1, 2025.

(b) The outpatient hospital services fee schedules including:

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the CMS in 89 Federal Register 93912 (Nov. 27, 2024), effective January 1, 2025, and reviewed annually by CMS, as required in 42 CFR 419.50 and as updated by the department;

(ii) the conversion factor for outpatient services on or after ~~July 1, 2024~~ July 1, 2025 is ~~$60.72~~ $62.54;

(iii) the Medicaid statewide average outpatient cost-to-charge ratio is 48.59%; and

(iv) the bundled composite rate of ~~$281.86~~ $290.32 for services provided in an outpatient maintenance dialysis clinic effective on or after ~~July 1, 2024~~ July 1, 2025.

(c) The hearing aid services fee schedule, as provided in ARM 37.86.805, is effective ~~January 1, 2025~~ July 1, 2025.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in ~~2024~~ 2025 resulting in a dental conversion factor of ~~$38.37~~ $39.52 and fee schedule is effective ~~July 1, 2024~~ July 1,2025.

(e) The Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective ~~July 1, 2024~~ July 1, 2025.

(f) The outpatient drugs reimbursement dispensing fees range as provided in ARM 37.86.1105(3)(b), is effective ~~July 1, 2024~~ July 1, 2025:

(i) for pharmacies with prescription volume between 0 and 39,999, the minimum is ~~$5.28~~ $4.11 and the maximum is ~~$17.01~~ $17.52;

(ii) for pharmacies with prescription volume between 40,000 and 69,999, the minimum is ~~$5.28~~ $4.11 and the maximum is ~~$14.73~~ $15.17; or

(iii) for pharmacies with prescription volume greater than or equal to 70,000, the minimum is ~~$5.28~~ $4.11 and the maximum is ~~$12.46~~ $12.83.

(g) The outpatient drugs reimbursement compound drug dispensing fee range, as provided in ARM 37.86.1105(5), will be $12.50, $17.50, or $22.50, based on the level of effort required by the pharmacist, effective July 1, 2013.

(h) The outpatient drugs reimbursement vaccine administration fee, as provided in ARM 37.86.1105(6), will be $21.32 for the first vaccine and ~~$15.53~~ $16.04 for each additional vaccine administered on the same date of service, effective ~~July 1, 2024~~ July 1, 2025.

(i) The outpatient drugs reimbursement, unit dose prescriptions fee as provided in ARM 37.86.1105(10), will be $0.75 per pharmacy-packaged unit dose medication, effective November 1, 2013.

(j) The home infusion therapy services fee schedule, as provided in ARM 37.86.1506, is effective ~~July 1, 2024~~ July 1, 2025.

(k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, which outlines the Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs), as provided in ARM 37.86.1802, effective ~~January 1, 2025~~ July 1, 2025. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective ~~January 1, 2025~~ July 1, 2025.

(l) The nutrition services fee schedule, as provided in ARM 37.86.2207(2), is effective ~~July 1, 2024~~ July 1, 2025.

(m) The children's special health services fee schedule, as provided in ARM 37.86.2207(2), is effective July 1, 2019.

(n) The orientation and mobility specialist services fee schedule, as provided in ARM 37.86.2207(2), is effective ~~July 1, 2024~~ July 1, 2025.

(o) The transportation and per diem fee schedule, as provided in ARM 37.86.2405, is effective ~~July 1, 2024~~ July 1, 2025.

(p) The specialized nonemergency medical transportation fee schedule, as provided in ARM 37.86.2505, is effective ~~July 1, 2024~~ July 1, 2025.

(q) The ambulance services fee schedule, as provided in ARM 37.86.2605, is effective ~~January 1, 2025~~ July 1, 2025.

(r) The audiology fee schedule, as provided in ARM 37.86.705, is effective ~~January 1, 2025~~ July 1, 2025.

(s) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM 37.86.610, are effective ~~January 1, 2025~~ July 1, 2025.

(t) The optometric services fee schedule, as provided in ARM 37.86.2005, is effective ~~January 1, 2025~~ July 1, 2025.

(u) The chiropractic fee schedule, as provided in ARM 37.85.212(2), is effective ~~July 1, 2024~~ July 1, 2025.

(v) The lab and imaging services fee schedule, as provided in ARM 37.85.212(2) and 37.86.3007, is effective ~~January 1, 2025~~ July 1, 2025.

(w) The Targeted Case Management for Children and Youth with Special Health Care Needs fee schedule, as provided in ARM 37.86.3910, is effective ~~July 1, 2024~~ July 1, 2025.

(x) The Targeted Case Management for High-Risk Pregnant Women fee schedule, as provided in ARM 37.86.3415, is effective ~~July 1, 2024~~ July 1, 2025.

(y) The mobile imaging services fee schedule, as provided in ARM 37.85.212, is effective ~~January 1, 2025~~ July 1, 2025.

(z) The licensed direct-entry midwife fee schedule, as provided in ARM 37.85.212, is effective ~~January 1, 2025~~ July 1, 2025.

(aa) The private duty nursing services fee schedule, as provided in ARM 37.86.2207(2), is effective ~~July 1, 2024~~ July 1, 2025.

(4) The department adopts and incorporates by reference, the fee schedule for the following programs within the Senior and Long Term Care Division on the date stated:

(a) The Big Sky Waiver home and community-based services for elderly and physically disabled persons fee schedule, as provided in ARM 37.40.1421, is effective July 1, ~~2024~~ 2025.

(b) The home health services fee schedule, as provided in ARM 37.40.705, is effective July 1, ~~2024~~ 2025.

(c) The personal ~~assistance~~ care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, ~~2024~~ 2025.

(d) The self-directed personal ~~assistance~~ care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, ~~2024~~ 2025.

(e) The community first choice services fee schedule, as provided in ARM 37.40.1026, is effective July 1, ~~2024~~ 2025.

(5) The department adopts and incorporates by reference, the fee schedule for the following programs within the Behavioral Health and Developmental Disabilities Division on the date stated:

(a) The mental health center services for adults fee schedule, as provided in ARM 37.88.907, is effective ~~January 1, 2025~~ July 1, 2025.

(b) The home and community-based services for adults with severe disabling mental illness fee schedule, as provided in ARM 37.90.408, is effective ~~July 1, 2024~~ July 1, 2025.

(c) The substance use disorder services fee schedule, as provided in ARM 37.27.905, is effective ~~January 1, 2025~~ July 1, 2025.

(6) For the Behavioral Health and Developmental Disabilities Division, the department adopts and incorporates by reference the Medicaid youth mental health services fee schedule, as provided in ARM 37.87.901, effective ~~July 1, 2023 (fee schedule version 2) and July 1, 2024~~ July 1, 2025.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-125, 53-6-402, MCA

37.85.106 MEDICAID BEHAVIORAL HEALTH TARGETED CASE MANAGEMENT FEE SCHEDULE

(1) The Montana Medicaid Program establishes provider reimbursement rates for medically necessary, covered services based on the estimated demand for services and the legislative appropriation and federal matching funds.

(2) The Department of Public Health and Human Services (department) adopts and incorporates by reference the Medicaid Behavioral Health Targeted Case Management Fee Schedule effective ~~July 1, 2024~~ July 1, 2025, for the following programs within the Behavioral Health and Developmental Disabilities Division:

(a) Targeted Case Management Services (TCM) for Youth with Serious Emotional Disturbance (SED), as provided in ARM 37.87.901;

(b) Targeted Case Management Services for Substance Use Disorders (SUD), as provided in ARM 37.27.905; and

(c) Targeted Case Management Services for Adults with Severe Disabling Mental Illness (SDMI), as provided in ARM 37.86.3515.

(3) Copies of the department's current fee schedules are posted at https://medicaidprovider.mt.gov.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-113, MCA

37.85.206 SERVICES PROVIDED

(1) Except as otherwise provided in this rule, the following medical or remedial care and services are available to all persons who are eligible for Medicaid benefits under this chapter, including deceased persons, categorically related, who would have been eligible had death not prevented them from applying.

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) non-hospital laboratory and x-ray services;

(d) nursing facility services;

(e) early and periodic screening, diagnosis, and treatment services;

(f) physician's services;

(g) podiatry services;

(h) outpatient physical therapy services;

(i) speech therapy, audiology and hearing aid services;

(j) outpatient occupational therapy services;

(k) home health care services;

(l) personal care services in a member's home;

(m) home dialysis services;

(n) private duty nursing services;

(o) clinic services;

(p) dental services;

(q) outpatient drugs;

(r) durable medical equipment, prosthetic devices, and medical supplies;

(s) eyeglasses and optometric services;

(t) transportation and per diem;

(u) ambulance services;

(v) specialized nonemergency transportation;

(w) family planning services;

(x) home and community services;

(y) mid-level practitioner services;

(z) hospice services;

(aa) licensed psychologist services;

(bb) licensed clinical social worker services;

(cc) licensed professional counselor services;

(dd) inpatient psychiatric services;

(ee) mental health center services;

(ff) case management services;

(gg) institutions for mental diseases for persons aged 65 and over;

(hh) payment of premiums, co-insurance, deductibles, and other cost sharing obligations under an individual or group health plan in accordance with the provisions of ARM 37.82.424;

(ii) diabetes and cardiovascular disease prevention services;

(jj) habilitative services;

(kk) rehabilitative services; and

(ll) pediatric complex care assistant services.

(2) Only those medical or remedial care and services also covered by Medicare are available to a person who is eligible for Medicaid benefits as a qualified Medicare beneficiary under ARM 37.83.201 and 37.83.202.

(3) State plan Medicaid benefits are available for members who are Medicaid-covered through the Waiver for Additional Services and Populations (WASP) Medicaid 1115 Waiver as approved by the Centers for Medicare and Medicaid Services (CMS).

(a) A person may receive coverage through the WASP Medicaid 1115 Waiver if the person is 18 or older, has severe disabling mental illnesses (SDMI), would qualify for or be enrolled in the state-financed mental health services plan (MHSP) or the WASP Medicaid 1115 Waiver but is otherwise ineligible for Medicaid benefits, and either:

(i) the person's income is 0 to 138% of the federal poverty level and the person is eligible for or is enrolled in Medicare; or

(ii) the person's income is 139 to 150% of the federal poverty level whether Medicare-eligible or not.

(b) A person determined categorically eligible for Medicaid as aged, blind, or disabled (ABD) in accordance with ARM 37.82.901 through 37.82.903 is not subject to the annual ~~$1,125~~ dental treatment limit incorporated under ARM 37.86.1006. The monies expended for treatment costs exceeding the limit are covered through the WASP Medicaid 1115 Waiver.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-103, 53-6-111, 53-6-113, 53-6-131, 53-6-141, MCA

37.86.1006 DENTAL SERVICES, COVERED PROCEDURES

(1) For purposes of specifying coverage of dental services through the Medicaid program, the department adopts and incorporates by reference the Dental and Denturist Program Provider Manual as provided in ARM 37.85.105(3). The Dental and Denturist Program Provider Manual informs the providers of the requirements applicable to the delivery of services. Copies of the manual are available on the

Montana Medicaid provider web site at https://medicaidprovider.mt.gov and from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Dentists who are Medicaid provider participants under ARM 37.85.401 may bill medical CPT procedure codes as provided in ARM 37.85.212 and 37.86.101 for any Medicaid covered medical procedure that they are allowed to provide under the Dental Practice Act that is not otherwise listed in the Dental and Denturist Program Provider Manual.

(3) All services which require prior authorization from the designated review organization are identified in the department's fee schedule. Reimbursement is not provided for such services unless prior authorization has been given by the designated review organization.

(4) A licensed dental hygienist practicing under public health supervision may provide dental hygiene preventative services as defined by the Board of Dentistry.

(5) Covered services for adults age 21 and over include:

(a) diagnostic;

(b) preventative;

(c) basic restorative services including prefabricated crown;

(d) extractions; and

(e) porcelain fused to base metal crowns, and porcelain/ceramic crowns are limited to two per person per year, total.

(6) Medically necessary dental services outlined in (5)(c) through (e), excluding anesthesia services, have an annual limit. ~~are subject to an annual limit of $1,125 per benefit year. A benefit year begins on July 1st and ends the following June 30th.~~ The limit is applied per benefit year, which runs from July 1 through June 30. Members determined categorically eligible for Aged, Blind, and Disabled (ABD) Medicaid, in accordance with ARM 37.82.204, are not subject to the annual limit. The annual limit is:

(a) $1,125 for dates of service June 30, 2024, and earlier;

(b) $1,170 for the benefit year starting July 1, 2024, and ending on June 30, 2025; and

(c) $1,205 for the benefit year starting July 1, 2025, and ending on June 30, 2026.

(7) Full maxillary and full mandibular dentures are a Medicaid-covered service. Coverage is limited to one set of dentures every ten years. Only one lifetime exception to the ten-year time period is allowed per person if one of the following exceptions is authorized by the department:

(a) The dentures are no longer serviceable and cannot be relined or rebased; or

(b) The dentures are lost, stolen, or damaged beyond repair.

(8) Maxillary partial dentures and mandibular partial dentures are a Medicaid-covered service. Coverage is limited to one set of partial dentures every five years. Only one lifetime exception to the five-year limit is allowed per person if one of the following exceptions is authorized by the department:

(a) The partial dentures are no longer serviceable and can no longer be relined or rebased; or

(b) The partial dentures are lost, stolen, or damaged beyond repair.

(9) The limits on coverage of denture replacement may be exceeded when the department determines that the existing dentures are causing the person serious physical health problems. The dentist or denturist should indicate "replacement dentures" on the request for prior authorization of replacement dentures and document the medical necessity for the replacement.

(10) Coverage of all denture services is subject to the following requirements and limitations:

(a) A denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed in writing by a dentist. The prescription must be signed and dated within 90 days of the order and must be maintained in the patient file.

(b) Requests for full prosthesis must show the approximate date of the most recent extractions, and/or the age and type of the present prosthesis.

(11) Orthodontia for persons age 21 and older who have maxillofacial anomalies that must be corrected surgically and for which the orthodontia is a necessary adjunct to the surgery is a covered service.

(12) Full band comprehensive orthodontic or interceptive orthodontic treatment for persons 20 and younger who have one of the following handicapping conditions, indicated with an 'X' on the HLD score sheet:

(a) cleft palate;

(b) deep impinging overbite;

(c) anterior impaction; or

(d) who score a 30 or higher without a handicapping condition (as listed above) on the Handicapping Labio-Lingual Form (HLD Index).

(13) Unless otherwise provided by these rules, interceptive orthodontia is limited to children 12 years of age or younger with one or more of the following conditions:

(a) posterior unilateral crossbite;

(b) bilateral crossbite; or

(c) anterior crossbite.

(14) All orthodontia treatment plans must receive prior authorization from the department's designated peer reviewer to determine individual eligibility for such orthodontia services.

(15) Orthodontic treatment not progressing to the extent of the treatment plan because of noncompliance by the person and which jeopardizes the health of the person may result in termination of orthodontic treatment. If termination of orthodontic treatment occurs because of noncompliance by the person, Medicaid will not authorize any future orthodontic requests for that person.

(16) Cosmetic dentistry is not a covered service of the Medicaid program.

(17) Dental implants are not a covered benefit of the Medicaid program.

(18) Nobel metal crowns, and bridges are not covered benefits of the Medicaid program for individuals age 21 and over.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-6-101, 53-6-113, MCA

37.86.3607 CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, REIMBURSEMENT

(1) Reimbursement for the delivery by provider entities of Medicaid funded targeted case management services to persons with developmental disabilities is provided as specified in the Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Targeted Case Management Services for Individuals with Developmental Disabilities Enrolled in the 1915(c) 0208 Home and Community Based (HCBS) Comprehensive Waiver or Eligible Individuals Age 16 and Over, dated July 1, ~~2024~~ 2025.

(2) The department adopts and incorporates by this reference the Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Targeted Case Management Services for Individuals with Developmental Disabilities Enrolled in the 1915(c) 0208 Home and Community Based (HCBS) Comprehensive Waiver or Eligible Individuals Age 16 and Over, dated July 1, ~~2024~~ 2025. The manual is posted at ~~https://dphhs.mt.gov/bhdd/disabilityservices/developmentaldisabilities/ddpratesin~~

~~f~~
https://dphhs.mt.gov/BHDD/DisabilityServices/developmentaldisabilities/ddpratesinf.

Authorizing statute(s): 53-6-113, MCA

Implementing statute(s): 53-6-101, MCA

37.88.101 MEDICAID MENTAL HEALTH SERVICES FOR ADULTS, AUTHORIZATION REQUIREMENTS

(1) Mental health services for a Medicaid adult under the Montana Medicaid program will be reimbursed only if the client is 18 or more years of age and has been determined to have a severe disabling mental illness.

(2) In addition to the requirements contained in rule, the department has developed and published the Behavioral Health and Developmental Disabilities (BHDD) Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, dated ~~October 1, 2024~~ July 1, 2025, which it adopts and incorporates by reference. The purpose of the manual is to implement requirements for utilization management and services. A copy of the manual may be obtained from the department by a request in writing to the Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities (BHDD) Division, 100 N. Park, Ste. 300, P.O. Box 202905, Helena, MT 59620-2905 or at: https://dphhs.mt.gov/bhdd/BHDDMedicaidServicesProviderManual.

(3) Medicaid reimbursement for mental health services will be the lowest of:

(a) the provider's actual (submitted) charge for the service; or

(b) the rate established in the department's fee schedule. Reimbursement fees are as provided in ARM 37.85.105 and 37.85.106.

(4) The department may review the medical necessity of services or items at any time either before or after payment in accordance with the provisions of ARM 37.85.410. If the department determines that services or items were not medically necessary or otherwise not in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements.

(5) The department or its designee may require providers to report outcome data or measures regarding mental health services, as determined in consultation with providers and consumers.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.27.902, 37.85.104, 37.85.105, 37.85.106, 37.85.206, 37.86.1006, 37.86.3607, and 37.88.101 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates, and updating the BHDD Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. The department administers the Montana Medicaid and non-Medicaid program to provide health care to Montana's qualified low income, elderly, and disabled residents. Medicaid is a public assistance program paid for with state and federal funds appropriated to pay health care providers for the covered medical services they deliver to Medicaid members.

Pursuant to 53-6-113, MCA, the Montana Legislature has directed the department to use the administrative rulemaking process to establish rates of reimbursement for covered medical services provided to Medicaid members by Medicaid providers. The department proposes these rule amendments to establish Medicaid rates of reimbursement. 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 rule notice, including rates in fee schedules and rates in provider manuals, can be found at https://medicaidprovider.mt.gov/proposedfs.

The following sections explain proposed amendments to the following rules: ARM 37.27.902, 37.85.104, 37.85.105, 37.85.106, 37.85.206, 37.86.1006, 37.86.3607, and 37.88.101.

<u>ARM 37.85.104</u>

(1)(a), (c), and (d) Behavioral Health and Developmental Disabilities Division Fee Schedules – July 1, 2025

The department is proposing to adopt the July 1, 2025, updates, for the following non-Medicaid fee schedules: mental health crisis services for adults, youth respite care services, and substance use disorder services. This is necessary to update provider rates and mirror those rates found on the Medicaid fee schedules.

<u>ARM 37.85.105</u>

(2)(a) and (b) Resource-Based Relative Value Scale (RBRVS) Federal Register
Effective July 1, 2025, the department is proposing to adopt the version of the RBRVS contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare & Medicaid Services (CMS) in the December 9, 2024, federal register (effective January 1, 2025) for the RBRVS reimbursement methodology. This adoption is necessary to incorporate the most up-to-date changes made by CMS.

(2)(b) RBRVS Conversion Factors (CF)
RBRVS rates are calculated by multiplying code-specific relative value units (RVU) by the applicable conversion factor. During the annual RBRVS reimbursement modeling process, the department considers all these factors in the aggregate using a weighted average based on utilization. The 2025 legislature appropriated funds for a provider rate increase of 3.0% for the state fiscal year 2026. Considering the pricing factors and the appropriated provider rate increase, the department proposes increases to the allied services and mental health services conversion factors. The proposed allied services conversion factor is $28.23, and the proposed mental health services conversion factor is $22.24. When the proposed conversion factor increases are applied against utilization and RVUs, the result is a weighted average rate increase of 3%.

For the physician services and anesthesia conversion factor, the department is directed by 53-6-125, MCA, to increase the conversion factor by the consumer price index for medical care for the previous year, which for this adjustment period is 3.3%. Physician services are not included in the 2025 legislature appropriated provider rate increase.

(2)(e) Payment to Charge Ratio
The payment to charge ratio, which is used to price some allowable procedures which do not have set reimbursement, is proposed to be 47.42%, effective July 1, 2025. This ratio is updated annually as part of the department's annual RBRVS updates and will change when there are changes in the average provider charges and/or changes to reimbursement.

(2)(i) Optometric Services Provider Rate of Reimbursement (PRR)
The department is proposing to change the optometric services PRR, which is a pricing factor, to 114.53% of the reimbursement for allied services with an effective date of July 1, 2025. When this pricing factor is applied against utilization, relative value units, and proposed allied services conversion factor, optometrists and opticians will have no change in their weighted average provider rate.

(3)(a) Inpatient Hospital Services Rates
The department proposes a 3% increase to inpatient hospital reimbursement, effective July 1, 2025. The department proposes to adopt Version 42.0 of the 3M APR-DRG grouper, effective July 1, 2025. This grouper update includes changes to DRG relative weights, average lengths of stays, and adds or deletes some DRGs.

(3)(b)(ii) Outpatient Prospective Payment System (OPPS) Conversion Factor

The department is proposing to increase the OPPS conversion factor to $62.54, effective July 1, 2025, to effectuate the legislatively approved provider rate increase.

(3)(b)(iv) Outpatient Maintenance Dialysis Clinic

The bundled composite rate for outpatient maintenance dialysis clinics is proposed to increase by 3% to $290.32, effective July 1, 2025, to incorporate the provider rate increase approved by the Montana Legislature.

(3)(c), (j), (l), (n), (o), (p),(q), (r), (s), (t), (u), (v), (w), (x), (y), (z), and (aa) Fee Schedules

The department is proposing the adoption of fee schedules effective July 1, 2025. The fee schedules incorporate changes due to the proposed amendments within this rule notice, including federal register changes, conversion factor updates, legislatively required provider rate increases. The above-listed subsections are for the following fee schedules -- hearing aid services; home infusion therapy services; nutrition services; orientation and mobility specialist services; transportation and per diem fee schedule; specialized non-emergency medical transportation; ambulance services; audiology services; occupational, physical, and speech therapy services; optometric services; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) chiropractic services; lab and imaging services; Targeted Case Management (TCM) for Children and Youth with Special Health Care Needs; TCM for High-Risk Pregnant Women; mobile imaging services; licensed direct-entry midwife; and private duty nursing.

(3)(d) Dental Reimbursement

The department proposes three changes to this subsection: 1) adoption of the Relative Values for Dentist reference published in 2025; 2) modification of the dental conversion factor to $39.52; and 3) adoption of the July 1, 2025, Dental Services fee schedules. These proposed changes are necessary to incorporate the legislatively approved provider rate increase and to keep current with updated dental procedure codes.

(3)(e) Dental Provider Manual Update

The Dental Provider manual is proposed to be amended, effective July 1, 2025, to incorporate the information from provider notices. Provider notices are archived after a few years; therefore, pertinent information should be incorporated into the manual.

(3)(f) Outpatient Drugs Minimum Dispensing Fee

Annually the department surveys enrolled pharmacies to establish the state fiscal year minimum dispensing fee. The results from the annual survey provide the data necessary to calculate the minimum dispensing fee, which is proposed to be $4.11.

(3)(f) Outpatient Drugs Maximum Dispensing Fees

The department proposes to increase the maximum dispensing fee, for each volume range, to incorporate the legislatively approved provider rate increase.

(3)(h) Outpatient Drugs Reimbursement Vaccine Administration Fee

The department proposes to increase the fee paid for each additional vaccine administered to $16.04. This change is necessary to maintain a vaccine administration fee aligned with the physician services rate.

(3)(k) Prosthetic Devices, Durable Medical Equipment, and Medical Supplies
The department proposes to adopt and incorporate by reference the Medicare Region D Supplier Manual effective July 1, 2025. This proposal is necessary to ensure the department adopts newly added, revised, or deleted Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs).

Effective July 1, 2025, the fee schedule will incorporate the July 2025 Medicare DMEPOS fee schedule changes and updates to fees set by the department. The department proposes a 3.0% increase to the fees set by the department on the DMEPOS fee schedule.

(4) Senior and Long-Term Care Division
The department proposes the adoption of updated fee schedules, effective July 1, 2025. The updated fee schedules implement legislatively appropriated Medicaid provider-rate increases for Community First Choice Services, Personal Care Services (CFCS/PCS), Big Sky Waiver (BSW), and Home Health programs.

(5)(a) Behavioral Health and Developmental Disabilities Division Mental Health Center Services Adult Fee Schedule
The department proposes the adoption of updated fee schedules effective July 1, 2025. The fee schedules implement legislatively appropriated Medicaid provider rate increases.

(5)(a), (b), and (c) Behavioral Health and Developmental Disabilities Division Fee Schedules
The department is proposing to amend the effective date to July 1, 2025, for the following fee schedules: mental health center services for adults, home and community-based services for adults with severe disabling mental illness, and substance use disorder services. This is necessary to update provider rates in accordance with funding appropriated by the Montana Legislature during the 2025 regular session.

(6) Behavioral Health and Developmental Disabilities Division Medicaid Youth Mental Health Services Fee Schedule
The department proposes to revise the effective dates and reimbursements on the Medicaid youth mental health services fee schedule to July 1, 2025. This update incorporates the legislatively approved provider rate increase.

ARM 37.85.106
(2) Fee schedule
The department is proposing to amend ARM 37.85.106 to update the fee schedule date for the Medicaid Behavioral Health Targeted Case Management Fee Schedule to July 1, 2025. This is

necessary to update provider rates in accordance with funding appropriated by the Montana Legislature during the 2025 regular session.

ARM 37.85.206
(3)(b) Reference to the Adult Dental Treatment Services Limit
The department proposes to amend this rule to replace the existing dollar value reference for the adult dental treatment services limit with a reference to ARM 37.86.1006. The objective of this subsection is to establish that members categorically eligible for Medicaid as aged, blind, or disabled are exempt from the dental treatment services limit, and a dollar value does not affect this exemption.

ARM 37.86.1006
(6) Adult Dental Treatment Services Limit
The department proposes to increase the adult dental treatment services limit by 4% for SFY 2025 and 3% for SFY 2026. These updates match the legislatively appropriated provider rate increases for SFY 2025 and 2026. Increasing the adult dental treatment services limit is necessary to prevent a reduction in the level of dental treatment services adult members can obtain when provider rates are increased.

ARM 37.86.3607
(1) and (2) Reimbursement
The department is proposing to amend ARM 37.86.3607 pertaining to reimbursement rates in the Targeted Case Management Services for Individuals with Developmental Disabilities Enrolled in the 1915 (c) 0208 Home and Community Based (HCBS) Comprehensive Waiver or Eligible Individuals Age 16 and over.

The rule amendment would adopt and incorporate an updated version of the manual dated July 1, 2025, to incorporate the legislatively approved provider rate increase. The rule amendment would also update the weblink to the Targeted Case Management manual.

ARM 37.27.902 Substance Use Disorder Services: Authorization Requirements and ARM 37.88.101 Medicaid Mental Health Services for Adults, Authorization.

The department is proposing to amend the effective date to July 1, 2025, for the BHDD Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. This is necessary to ensure that the manual includes new and updated policies and service requirements for the implementation of Contingency Management, which is included in the Healing and Ending Addiction through Recovery and Treatment waiver. This consists of the following amendments to the BHDD Medicaid Manual:

Amend Policy 505 – Specimen Collection to align with new program roles and responsibilities.

- Add medical necessity criteria and service requirements for specimen collection specific to Contingency Management services.

Add new BHDD Policy 610 Contingency Management

- Define the service
- Identify eligibility requirements and medical necessity criteria
- Define standards for eligible Contingency management providers

Define service requirements

Fiscal Impact

The following table displays the number of providers affected by the amended fee schedules, effective dates, conversion factors, and rates for services for SFY 2026 based on the proposed amendments.

Provider Type	SFY 2026 Budget Impact (Federal Funds)	SFY 2026 Budget Impact (State Funds)	SFY 2026 Budget Impact (Total Funds)	Active Provider Count
Ambulance	$233,710	$145,637	$379,347	251
Audiologist	$3,981	$2,480	$6,461	107
BCBA/BCBA-D	$73,908	$46,055	$119,963	77
Case Management Services for people with developmental disabilities	$63,685	$39,685	$103,371	2
Chemical Dependency Clinic	$253,929	$158,236	$412,165	75
Commercial and Personal Transportation	$74,967	$46,716	$121,683	11
Community First Choice	$1,246,080	$776,495	$2,022,574	61
CSCT Children's Mental Health	$151,147	$94,187	$245,334	359
Crisis Diversion	$88,573	$55,194	$143,768	7
Dental	$1,275,678	$794,939	$2,070,616	774
Denturist	$52,331	$32,610	$84,942	25
Dialysis Clinic	$60,526	$37,717	$98,243	26
Durable Medical Equipment	$56,540	$35,233	$91,772	479
EPSDT - Chiropractic	$12,253	$7,635	$19,889	169
Free Standing Birthing Center	$339	$211	$550	2
Hearing Aid Dispenser	$3,536	$2,203	$5,739	39
HEART Waiver	$560,630	$349,356	$909,986	7
HCBS - Big Sky Waiver	$1,317,301	$820,876	$2,138,177	278
HCBS - SDMI Waiver	$547,918	$341,435	$889,353	144

Home Health Agency	$8,044	$5,013	$13,057	34
Home Infusion Therapy	$39,493	$24,610	$64,104	13
Hospital – Inpatient	$3,177,183	$1,979,861	$5,157,044	596
Hospital - Outpatient	$2,278,610	$1,419,916	$3,698,526	596
Independent Diagnostic Testing Facility	$17,497	$10,904	$28,401	29
Laboratory	$6,148	$3,831	$9,979	273
Licensed Addiction Counselor	$13,169	$8,207	$21,376	224
Licensed Clinical Social Worker	$333,031	$207,528	$540,560	1,239
Licensed Marriage and Family Therapist	$2,638	$1,644	$4,282	22
Licensed Professional Counselor	$504,859	$314,603	$819,462	1,464
Mental Health Center	$599,628	$373,658	$973,287	61
Mid-Level Practitioner	$1,759,597	$1,096,493	$2,856,090	7,493
Mobile Imaging Service	$3,624	$2,259	$5,883	2
Nutritionist/ Dietitian	$3,574	$2,227	$5,801	180
Occupational Therapist	$120,128	$74,858	$194,985	468
Optician	$2,103	$1,311	$3,414	24
Optometrist	$138,450	$86,275	$224,725	283
Personal Care Agency	$11,381	$7,092	$18,473	79
Personal Care Agency - Adult MH	$592	$369	$962	49
Personal Care Agency - Child MH	$2,893	$1,803	$4,696	19
Pharmacy Dispensing Fee	$373,233	$232,580	$605,814	465
Physical Therapist	$179,396	$111,791	$291,186	1,303
Physician	$3,461,385	$2,156,962	$5,618,347	16,573
Podiatrist	$61,338	$38,223	$99,561	91
Private Duty Nursing Agency	$75,075	$46,783	$121,858	10
Psychiatric Res Treatment Facility	$446,469	$278,217	$724,686	29
Psychiatrist	$139,053	$86,651	$225,704	404
Psychologist	$21,486	$13,389	$34,875	327
Public Health Clinic	$10,872	$6,775	$17,647	43

School Based Services - Non-CSCT	$110,747	$69,012	$179,759	90
Specialized Transportation	$313	$195	$509	14
Speech Pathologist	$80,798	$50,349	$131,147	417
Targeted Case Management - Children and Youth with Special Health Care Needs	$666	$415	$1,082	5
Targeted Case Management - High Risk Pregnant Women	$26	$16	$42	2
Targeted Case Management - Mental Health	$193,302	$120,456	$313,758	35
Therapeutic Family Care	$394,355	$245,743	$640,098	22
Therapeutic Group Home	$244,655	$152,457	$397,112	41

Effective Date

The department intends to apply these rule amendments retroactively to July 1, 2025.

Small Business Impact

Provider rate increases will benefit Medicaid providers that are small businesses by adjusting reimbursement rates to account for inflation and supporting financial stability. Higher reimbursement rates will make it more viable for providers to accept Medicaid members, expanding access to care. This increased revenue will also allow small businesses to invest in staff and technology, ultimately leading to better quality of care and fostering growth. The exact benefit for each small business is dependent on the Medicaid services they provide and the percentage of their clients that are covered by Medicaid.

Otherwise, with regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

Interested Persons

The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Written requests may be mailed or delivered to the contact information listed above.

Medicaid Performance Based Statement

Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

Rule Reviewer

Bree Gee

Approval

Charles T. Brereton, Director

Department of Public Health and Human Services