MONTANA
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REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-113.1

Summary

Amendment of ARM 37.40.307 pertaining to Nursing Facility Reimbursement

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Hearing Date and Time

Thursday, August 13, 2026, at 1:00 p.m.

Virtual Hearing Information

Join Zoom Meeting

https://mt-gov.zoom.us/j/87406581116?pwd=OKYpg8qnABrkpKSZggZ9xJpHikSPEQ.1

Meeting ID: 874 0658 1116 Password: 887696

Dial by Telephone +1 646 558 8656

Meeting ID: 874 0658 1116 Password: 887696

Find your local number: https://mt-gov.zoom.us/u/kcYBKkNol9

Join by SIP 87406581116@zoomcrc.com

Join by H.323 (Polycom) 162.255.37.11##87406581116

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, August 21, 2026, 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 Thursday, July 30, 2026, at 5:00 p.m.

Contact

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HHSAdminRules@mt.gov
Fax: 406-444-9744

Rulemaking Actions

AMEND

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

37.40.307 NURSING FACILITY REIMBURSEMENT

(1) For nursing facility services provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a per-diem rate determined in accordance with this rule, minus the amount of the Medicaid recipient's patient contribution.

(2) Effective July 1, 2020, and in subsequent rate years, the reimbursement rate for each nursing facility will be determined using the flat-rate component specified in (2)(a) and the quality component specified in (2)(b).

(a) The flat-rate component is the same per-diem rate for each nursing facility and will be determined each year through a public process. Factors that could be considered in the establishment of this flat-rate component include the cost of providing nursing facility services and Medicaid recipient access to nursing facility services. The flat-rate component for state fiscal year (SFY) ~~2026~~ 2027 is $287.11.

(b) The quality component of each nursing facility's rate is based on the five-star rating system for nursing facility services, calculated by the Centers for Medicare & Medicaid Services (CMS). It is set for each facility based on its average five-star ratings for staffing and for quality. Facilities with an average

rating of three to five stars will receive a quality-component payment. The funding for the quality-component payment will be divided by the total estimated Medicaid bed days to determine the quality component per Medicaid bed day. The quality component per bed day is then adjusted based on each facility's five-star average of staffing and quality-component scores. A facility with a five-star average of staffing and quality-component scores will receive 100% of the quality-component payment, a four-star average will receive 75%, a three-star average will receive 50%, and one- and two-star average facilities will receive 0%. Funds unused by the first allocation round will be reallocated based on the facility's percentage of unused allocation against the available funds.

(c) The total payment rate available for the period July 1, ~~2025~~ 2026, through June 30, ~~2026~~ 2027, will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361. Copies of the department's current nursing facility Medicaid reimbursement rates per facility are posted at https://medicaidprovider.mt.gov/26, or may be obtained from the Department of Public Health and Human Services, Senior and Long-Term Care Division, P.O. Box 4210, Helena, MT 59604-4210.

(3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months' participation in the Medicaid program in a newly constructed facility will have a rate set at the flat rate component as computed on July 1, ~~2025~~ 2026. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider will be set at the previous provider's rate, as if no change in provider had occurred.

(4) For nursing facility services provided by nursing facilities located outside the state of Montana, the Montana Medicaid program will pay a provider only as provided in ARM 37.40.337.

(5) The Montana Medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(6) Reimbursement for Medicare coinsurance days will be as follows:

(a) for dually eligible Medicaid and Medicare individuals, reimbursement is limited to the per-diem rate, as determined under (1) or ARM 37.40.336, or the Medicare co-insurance rate, whichever is lower, minus the Medicaid recipient's patient contribution; and

(b) for individuals whose Medicare buy-in premium is being paid under the qualified Medicare beneficiary (QMB) program under ARM 37.83.201, but are not otherwise Medicaid eligible, payment will be made only under the QMB program at the Medicare coinsurance rate.

(7) The department will not make any nursing facility per-diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed that is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(8) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(9) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider the amount determined under these rules upon receipt of an appropriate billing, which reports the number of patient days of nursing facility services provided to authorized Medicaid recipients during the billing period.

(a) Authorized Medicaid recipients are those residents determined eligible for Medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq.

(10) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules, and policies. All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules.

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

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

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) proposes to amend ARM 37.40.307 to update Medicaid nursing facility reimbursement rates for state fiscal year (SFY) 2027.

The proposed amendments set the SFY 2027 flat rate component for Medicaid nursing facility reimbursement at $287.11, which is the same rate from SFY 2026. In balancing the factors that may be considered under 53-6-113, MCA, and ARM 37.40.307(2) to establish the rate, the department primarily considered availability of appropriated funds and availability of services.

Due to projected budget shortfalls and following a comprehensive review of options to ensure the continued stability of Montana's Medicaid program, the department has determined that it would not be fiscally sound to implement additional Medicaid provider rate adjustments in SFY 2027 — except those required by state statute, federal regulation (i.e., Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services, and Hospice), or for rates implemented through a CMS-established fee schedule (i.e., Durable Medical Equipment and Ambulatory Surgery Centers).

Copies of the department's proposed nursing facility Medicaid reimbursement rates per facility are located at: https://medicaidprovider.mt.gov/proposedfs. Pursuant to the existing quality component methodology under ARM 37.40.307(2)(b), these facility rates have been calculated based on the total estimated Medicaid bed days for SFY 2027 and each facility's current assigned rating under the Centers for Medicare & Medicaid Services' Five Star Rating System.

The proposed amendments are necessary for the department to provide notice of the change to Medicaid nursing facility provider rates.

Small Business Impact

The class of small businesses affected by the proposed rulemaking are those operating skilled nursing facilities that are enrolled as Medicaid providers. The probable and significant direct effects on these small businesses is that the rulemaking maintains the same flat rate component for SFY 2027 as compared to SFY 2026.

Fiscal Impact

The estimated total funding available for SFY 2027 for nursing facility reimbursement is approximately $185,662,590 of combined state funds, federal funds, and patient contributions. These amounts include expansion but do not include at risk provider funds or direct care-wage funding.

The proposed rulemaking will impact approximately 2,724 Medicaid members and 59 nursing facility providers.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

Effective Date

The department intends to apply the proposed rule amendments retroactively to July 1, 2026.

Interested Persons

The department maintains a list of interested persons who wish to receive notices of the rulemaking actions proposed by the department. 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. Such written request may be emailed, mailed or otherwise delivered to the contact person 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

Robert Lishman

Approval

Charles T. Brereton, Director
Department of Public Health and Human Services