MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-127.1

Summary

Amendment of ARM 37.79.304, 37.79.326, and 37.85.105 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates

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Hearing Date and Time

Thursday, August 13, 2026, at 11:00 a.m.

Virtual Hearing Information

Join Zoom Meeting

https://mt-gov.zoom.us/j/81764228643pwd=Zzd1uRK3fb9UNPjW1pBQ4argMbLRPu.1

Meeting ID: 817 6422 8643 Password: 850210

Dial by Telephone +1 646 558 8656

Meeting ID: 817 6422 8643 Password: 850210

Find your local number: https://mt-gov.zoom.us/u/khFiLjLX6

Join by SIP 81764228643@zoomcrc.com

Join by H.323 (Polycom) 162.255.37.11##81764228643

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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Rulemaking Actions

AMEND

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

37.79.304 SERVICES COVERED

(1) The department adopts and incorporates by reference the HMK Evidence of Coverage dated ~~October 1, 2025~~ July 1, 2026, which is available on the department's web site at www.hmk.mt.gov.

(2) The HMK Evidence of Coverage describes the health care benefits available to an HMK coverage group enrollee if the service is medically necessary. Prior authorization may be required and copayments may apply.

Authorizing statute(s): 53-4-1009, 53-4-1105, MCA

Implementing statute(s): 53-4-1005, 53-4-1109, MCA

37.79.326 DENTAL BENEFITS

(1) ~~The maximum dental benefits paid under the basic dental plan will be 85% of the billed services received. Up to $1,615 in basic dental care will be paid per benefit year for each enrollee. For example, $1,900 in services received results in $1,615 paid.~~ Covered dental services are reimbursed at 85% of the billed charges. Providers may not balance bill the enrollee, parent, or guardian for the remaining 15% of the billed charges.

(a) ~~Providers may not balance bill the enrollee, parent, or guardian for the remaining 15% of the billed charges.~~

(b) ~~Providers may bill the enrollee, parent, or guardian for services received in excess of $1,900 per benefit year.~~

(2) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the American Dental Association Manual of Current Dental Terminology (CDT ~~2023~~ 2026).

(3) Effective July 1, ~~2023~~ 2026, only the dental procedures listed at http://dphhs.mt.gov/hmk are benefits of the HMK coverage group Dental Program.

(4) Providers must comply with all applicable state and federal statutes, rules and regulations, including the United States Code governing the HMK Plan and all applicable Montana statutes and rules governing licensure and certification.

(5) Providers must also comply with the requirements of ARM Title 37, chapter 85, subchapters 4 and 5 to the extent those provisions are not inconsistent with this subchapter.

(6) For purposes of applying the provisions of any Medicaid rule as required by this subchapter, references in the Medicaid rule to "Medicaid" or the "Montana Medicaid program" or similar references shall be deemed to apply to the HMK coverage group or the HMK Plus coverage group as the context permits.

Authorizing statute(s): 53-4-1004, 53-4-1005, 53-4-1009, 53-4-1105, MCA

Implementing statute(s): 53-4-1003, 53-4-1004, 53-4-1005, 53-4-1009, 53-4-1104, 53-4-1105, 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 ~~89 Federal Register 97710 (December 9, 2024)~~ 90 Federal Register 49266 (Nov. 5, 2025), effective January 1, ~~2025~~ 2026, which is adopted and incorporated by reference. Procedure codes created after January 1, ~~2025~~ 2026, 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 July 1, ~~2025~~ 2026. 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 ~~$45.41~~ $46.95. The conversion factor for allied services is ~~$28.23~~ $28.75. The conversion factor for mental health services is ~~$22.24~~ $21.48. The conversion factor for anesthesia services is ~~$32.82~~ $33.93.

(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, ~~2025~~ 2026, and is ~~47.42%~~ 47.70% 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 ~~114.53%~~ 110.59% provider rate of reimbursement adjustment to the reimbursement for allied services, as provided in ARM 37.85.105(2), effective July 1, ~~2025~~ 2026.

(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, ~~2025~~ 2026; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version ~~42.0~~ 43.0, contained in the APR-DRG Table of Weights and Thresholds, effective July 1, ~~2025~~ 2026. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective July 1, ~~2025~~ 2026.

(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)~~ 90 Federal Register 53448 (Nov. 25, 2025), effective January 1, ~~2025~~ 2026, 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, 2025 is $62.54;

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

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

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

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in ~~2025~~ 2026 resulting in a dental conversion factor of $39.52 and fee schedule is effective July 1, ~~2025~~ 2026.

(e) The Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective July 1, ~~2025~~ 2026.

(f) The outpatient drugs reimbursement dispensing fees range as provided in ARM 37.86.1105(3)(b), is effective July 1, ~~2025~~ 2026:

(i) for pharmacies with prescription volume between 0 and 39,999, the minimum is ~~$4.11~~ $4.25 and the maximum is $17.52;

(ii) for pharmacies with prescription volume between 40,000 and 69,999, the minimum is ~~$4.11~~ $4.25 and the maximum is $15.17; or

(iii) for pharmacies with prescription volume greater than or equal to 70,000, the minimum is ~~$4.11~~ $4.25 and the maximum is $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 ~~$16.04~~ $17.37 for each additional vaccine administered on the same date of service, effective July 1, ~~2025~~ 2026.

(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, 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 July 1, 2025.~~ The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective July 1, 2025. Pursuant to 2-4-307(9), MCA, future updates to this fee schedule to conform with updates made by the Centers for Medicare & Medicaid Services to its Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule are incorporated by reference without additional rulemaking.

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

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

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

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

(r) The audiology fee schedule, as provided in ARM 37.86.705, is effective July 1, ~~2025~~ 2026.

(s) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM 37.86.610, are effective July 1, ~~2025~~ 2026.

(t) The optometric services fee schedule, as provided in ARM 37.86.2005, is effective July 1, ~~2025~~ 2026.

(u) The chiropractic fee schedule, as provided in ARM 37.85.212(2), is effective July 1, ~~2025~~ 2026.

(v) The lab and imaging services fee schedule, as provided in ARM 37.85.212(2) and 37.86.3007, is effective July 1, ~~2025~~ 2026.

(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, 2025.

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

(y) The mobile imaging services fee schedule, as provided in ARM 37.85.212, is effective July 1, ~~2025~~ 2026.

(z) The licensed direct-entry midwife fee schedule, as provided in ARM 37.85.212, is effective July 1, ~~2025~~ 2026.

(aa) The private duty nursing services fee schedule, as provided in ARM 37.86.2207(2), is effective 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, ~~2025~~ 2026.

(b) The home health services fee schedule, as provided in ARM 37.40.705, is effective July 1, ~~2025~~ 2026.

(c) The personal care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, ~~2025~~ 2026.

(d) The self-directed personal care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, ~~2025~~ 2026.

(e) The community first choice services fee schedule, as provided in ARM 37.40.1026, is effective July 1, ~~2025~~ 2026.

(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 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, 2025.

(c) The substance use disorder services fee schedule, as provided in ARM 37.27.905, is effective 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, 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

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.79.304, 37.79.326, and 37.85.105 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates. The department administers the Montana Medicaid and non-Medicaid programs 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 a primary factor projected budget shortfalls. 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).

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.

ARM 37.79.304 Healthy Montana Kids (HMK) Services Covered

The department is proposing to amend ARM 37.79.304 to adopt the Healthy Montana Kids (HMK) Evidence of Coverage (EOC) document, which outlines the HMK benefit plan. When the benefit plan changes, the EOC and the rule's effective date must be updated. This update is necessary to reflect the removal of the HMK dental limit.

ARM 37.79.326 Healthy Montana Kids (HMK) Dental Benefits

The department proposes to eliminate the HMK dental limit to comply with 42 CFR 457.480, which prohibits states from applying annual benefit limits. The department also proposes to update the HMK dental covered codes list to align with changes in the state employee benchmark plan and to reflect new procedure code additions, deletions, revisions, and description updates. In addition, the amendments update the Current Dental Terminology (CDT) codebook from 2023 to 2026.

ARM 37.85.105 Effective Dates, Conversion Factors, Policy Adjusters, and Cost-to-Charge Ratios of Montana Medicaid Provider Fee Schedules

(2)(a) and (b) Resource-Based Relative Value Scale (RBRVS) Federal Register
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 November 5, 2025, federal register 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 proposed allied services conversion factor is $28.75 and the proposed mental health services conversion factor is $21.48. When the proposed conversion factor changes are applied against utilization, RVUs, applicable policy adjustors, and provider rates of reimbursement, the result is budget neutral.

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 3.4%.

(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 47.70%. 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 110.59% of the reimbursement for allied services. When this pricing factor is applied against utilization, relative value units, and the proposed allied services conversion factor, the result is budget neutral.

(3)(a) Inpatient Hospital Services Rates
The department proposes to adopt Version 43.0 of the 3M APR-DRG grouper. This grouper update includes changes to DRG relative weights, average lengths of stays, and adds or deletes some DRGs.

(3)(b)(i) Outpatient Prospective Payment System (OPPS) Federal Register
The department is proposing to adopt the Outpatient Prospective Payment System fee schedule published by CMS in the November 25, 2025, federal register for the OPPS reimbursement methodology. This adoption is necessary to ensure outpatient hospital updates are aligned with CMS.

(3)(d) Dental Reimbursement

The department proposes to adopt the Relative Values for Dentists (RVD) reference published in 2026. This update ensures the department utilizes the most current reference file available to align with the 2026 American Dental Association's Current Dental Terminology.

(3)(e) Dental and Denturist Provider Manual Update

The Dental Provider manual is proposed to be amended 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 $4.25.

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

The department proposes to increase the fee paid for each additional vaccine administered to $17.37. 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 amend this rule to allow for the prosthetic devices, durable medical equipment, and medical supplies fee schedule to automatically incorporate updates to Medicare rates made by CMS in accordance with 2-4-307(9), MCA.

(3)(r), (s), (t), (u), (v), (y), and (z) Fee Schedules

The department is proposing the adoption of updated fee schedules. The fee schedules incorporate changes due to the proposed amendments within this rule notice, including federal register changes, conversion factor updates, and applicable pricing factors. The above-listed subsections are for the following fee schedules: audiology services, occupational, physical, and speech therapy services, optometeric services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) chiropractic services, lab and imaging services, mobile imaging services, and licensed direct-entry midwife services.

(4) Senior and Long-Term Care Division

The department proposes the adoption of updated fee schedules.

The updated fee schedules for CFCS/PCS will include:

- The addition of two modifiers, one for agency-based services and one for self-direct services, to allow temporary authorization for applicable services.

- Removal of the TS modifier from the fee schedule and cover sheets. With the implementation of Electronic Visit Verification, this modifier is no longer needed.

- Adding prior authorization (PA) requirement for S5125, S5125 U9, S5126, S5126 U9, T1019, T1019 U9, T2001, and T2001 U9. A prior authorization requirement has been added to specific CFCS/PCS services to ensure appropriate utilization, support consistency in service delivery, and promote alignment with current CMS standards for program integrity and cost-effective care.

The proposed Big Sky Waiver (BSW) fee schedule has been updated to remove Community Supports Services and Supported Living to implement changes required by CMS to Montana's 1915(c) Home and Community Based Montana Medicaid Big Sky Waiver.

The proposed home health services fee schedule has been updated to remove all home health prior authorization requirements except for the Home Health Aide Visit Charge, code 571. The proposed changes are necessary to align with the federally approved Home Health State Plan.

Small Business Impact

The class of small businesses affected by the proposed rulemaking are those operating as Medicaid providers. The probable and significant direct effects on these small businesses are as follows:

ARM 37.79.304 and 37.79.326
Eliminating the HMK dental limit will have an impact on small business Medicaid providers who offer dental services because dentists will be able to bill for services that were previously not covered. The department is unable to determine if this change will result in increased revenue for these small businesses, as it is unknown how many providers may have billed members, parents, or guardians the full charge for services that exceed the $1,615 HMK dental limit.

ARM 37.85.105
Overall, the proposed rate changes are budget neutral for services not reimbursed under the RBRVS physician services conversion factor. Although the overall impact is budget neutral, certain service categories will experience a rate decrease, while others will see an increase.

Small business Medicaid providers that are reimbursed for services using the physician services or anesthesia conversion factors may see an increase in overall reimbursement because those conversion factors were increased as required by 53-6-125, MCA.

The overall impact on each small business Medicaid provider is dependent on the particular types of Medicaid services provided and the percentage of their clients that are covered by Medicaid.

Fiscal Impact

ARM 37.79.304 and 37.79.326

The following table displays the number of providers affected by the proposed elimination of the HMK dental limit.

Provider Type	SFY 2027 Budget Impact (Federal Funds)	SFY 2027 Budget Impact (State Funds)	SFY 2027 Budget Impact (Total Funds)	Active Provider Count
Dental - HMK	$1,238,492	$820,171	$2,058,663	617

ARM 37.85.105

The following table displays the number of providers affected by the amended fee schedules, effective dates, conversion factors, and rates for services for SFY 2027 based on the proposed amendments to ARM 37.85.105.

Provider Type	SFY 2027 Budget Impact (Federal Funds)	SFY 2027 Budget Impact (State Funds)	SFY 2027 Budget Impact (Total Funds)	Active Provider Count
Audiologist	$0	$0	$0	83
BCBA/BCBA-D	$0	$0	$0	79
Chemical Dependency Clinic	$0	$0	$0	56
Community First Choice Services	$0	$0	$0	49
Crisis Diversion	$0	$0	$0	8
Dental	$0	$0	$0	662
Denturist	$0	$0	$0	22
Durable Medical Equipment	$0	$0	$0	425
EPSDT - Chiropractic	$6,453	$4,274	$10,727	172
Free Standing Birthing Center	$0	$0	$0	3

HEART Waiver	$0	$0	$0	0
Home & Community Based Services - Big Sky Waiver	$0	$0	$0	272
Home & Community Based Services - SDMI Waiver	$0	$0	$0	133
Home Health Agency	$0	$0	$0	23
Hospital - Inpatient	$0	$0	$0	459
Hospital - Outpatient	$0	$0	$0	459
Independent Diagnostic Testing Facility	$215	$142	$357	20
Laboratory	$6,215	$4,116	$10,331	194
Licensed Addiction Counselor	$0	$0	$0	272
Licensed Clinical Social Worker	$0	$0	$0	1,343
Licensed Marriage and Family Therapist	$0	$0	$0	33
Licensed Professional Counselor	$0	$0	$0	1,531
Mid-Level Practitioner	$3,013,187	$1,995,435	$5,008,622	6,513
Mobile Imaging Service	$1,699	$1,125	$2,824	2
Occupational Therapist	$0	$0	$0	337
Optician	$0	$0	$0	18
Optometrist	$0	$0	$0	247
Personal Care Services	$0	$0	$0	49
Personal Care Services - Adult MH	$0	$0	$0	52
Personal Care Services - Child MH	$0	$0	$0	21
Pharmacy Dispensing Fee	$0	$0	$0	437
Physical Therapist	$0	$0	$0	939
Physician	$1,061,439	$702,921	$1,764,360	13,731

Podiatrist	$31,539	$20,886	$52,425	67
Psychiatrist	$252,599	$167,280	$419,879	427
Psychologist	$0	$0	$0	363
Public Health Clinic	$113	$75	$188	41
School Based Services - Non-CSCT	$0	$0	$0	81
Speech Pathologist	$0	$0	$0	312
Total	**$4,373,459**	**$2,896,254**	**$7,269,713**	**29,935**

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.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

Effective Date

The department intends to apply these 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.

Rule Reviewer

Justin Kraske

Approval

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