MONTANA
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DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-84.1

Summary

Amendment of ARM 37.82.205, 37.82.401, 37.82.701, 37.82.704, 37.82.904, and 37.82.1111 pertaining to Medicaid General Eligibility

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Hearing Date and Time

Thursday, August 27, 2026, at 3:30 p.m.

Virtual Hearing Information

Join Zoom Meeting

https://mt-gov.zoom.us/j/87516799751?pwd=S52WhkCLXvpYGO7sakFRLBzLakXwnW.1

Meeting ID: 875 1679 9751 Password: 275810

Dial by Telephone +1 646 558 8656

Meeting ID: 875 1679 9751 Password: 275810

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

Join by SIP 87516799751@zoomcrc.com

Join by H.323 (Polycom) 162.255.37.11##87516799751

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, September 4, 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, August 13, 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:

37.82.205 REDETERMINATION OF ELIGIBILITY

(1) Periodic redetermination of eligibility:

(a) where an individual has been determined eligible, eligibility will be reconsidered or redetermined:

(i) at the time required when the department has information obtained previously about anticipated changes in the individual's situation which might affect eligibility;

(ii) within 30 days after a report is obtained which indicates that changes in the individual's circumstances may affect the individual's eligibility; and

(iii) ~~at least~~ every six months if the client is ~~categorically~~ determined eligible ~~related to FAIM financial assistance~~ under Medicaid expansion for adults; or

(iv) ~~at least~~ every 12 months if the client is categorically eligible related to SSI~~.~~, to the state's MAGI equivalent standard, or medically needy related to cash assistance programs. American Indian/Alaska Native clients are redetermined every 12 months.

(2) The department will provide recipients with timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under ~~medicaid~~ Medicaid.

(a) Timely notice is as defined in ARM 37.5.505.

(3) In redetermining eligibility, the department will also review case records for the recipient's SSN or, in the case of families, each family member's SSN. If the case record does not contain the SSN's, the department will require them in accordance with ARM 37.82.201(6).

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

Implementing statute(s): 53-6-142, MCA

37.82.401 CITIZENSHIP AND ALIENAGE

(1) As a condition of eligibility for Medicaid, an otherwise eligible individual must be ~~either~~:

(a) a citizen or national of the United States; ~~or~~

(b) ~~a qualified alien as defined in ARM 37.78.220~~ granted status as lawfully admitted for permanent residence as an immigrant as defined by sections 1101(a)(15) and 1101(a)(20) of the Immigration and Nationality Act, excluding alien visitors, tourists, diplomats, and students who enter the United States temporarily ~~or who entered the U.S. after August 22, 1996, otherwise permanently residing in the United States, including any alien who is lawfully present in the United States under authority of sections 203(a)(7) or 212(d)(5) of the Immigration and Nationality Act.~~;

(c) ~~a noncitizen legal alien living in the U.S. prior to August 23, 1996.~~ an alien granted status as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980; or

(d) an individual who is lawfully residing in the United States in accordance with the Compacts of Free Association between the United States and Micronesia, the Marshall Islands, and Palau, and as defined at 45 C.F.R. § 152.2.

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

Implementing statute(s): 53-6-131, MCA

37.82.701 GROUPS COVERED, NONINSTITUTIONALIZED FAMILIES AND CHILDREN

(1) Medicaid will be provided to:

(a) Individuals under age 19 who currently reside in Montana and are receiving foster care, guardianship, or adoption assistance under Title IV-E of the Social Security Act, whether or not such assistance originated in Montana. Eligibility requirements for Title IV-E foster care and adoption assistance are found in ARM 37.50.101, 37.50.105, 37.50.106, and 45 CFR part 233.

(b) Individuals who have been receiving assistance in the nonmedically needy family Medicaid program and whose assistance is terminated because of earned income. These individuals may continue to receive Medicaid for any or all of the ~~6~~ six calendar months immediately following the month in which nonmedically needy family Medicaid is last received, providing:

(i) in cases where assistance was terminated due to earned income, a member of the assistance unit continues to be employed during the ~~6~~ six months; however, eligibility may continue even though no member of the assistance unit is employed if there was a good cause as defined in the family-related Medicaid Manual, section 1508-1, as incorporated by reference in ARM 37.82.101, for the termination or loss of employment;

(ii) they received nonmedically needy family Medicaid for three of the six months immediately prior to the month they became ineligible for nonmedically needy family Medicaid coverage; and

(iii) there continues to be an eligible child in the assistance unit. This coverage group is known as the "family-transitional."

(c) Individuals under age 19 who live with a specified caretaker relative as defined in the family-related Medicaid manual, section 201-1, as incorporated by reference in ARM 37.82.101, and who meet all other eligibility requirements.

(d) A pregnant woman whose pregnancy has been verified and whose family income and resources meet the requirements listed in ARM 37.82.1106, 37.82.1107, and 37.82.1110. This coverage group is known as the "qualified

pregnant woman group." The unborn child shall be considered an additional member of the filing unit for purposes of determining eligibility.

(e) A pregnant woman whose pregnancy has been verified, whose family income does not exceed 157% of the federal poverty guidelines. This coverage group is known as the "pregnancy group."

(i) The unborn child shall be considered an additional member of the filing unit for purposes of determining eligibility.

(ii) Newborn children are continuously eligible through the month of their first birthday, provided they continue to reside in Montana. This coverage group is known as the "child-newborn group."

(f) A pregnant woman during a period of presumptive eligibility.

(i) Presumptive eligibility is established by submission of an application by the applicant on the form specified by the department, to a qualified presumptive eligibility provider, verification of pregnancy and a determination by the qualified presumptive eligibility provider that applicant's household income and resources do not exceed the income and resource standards specified in (1)(e).

(A) A qualified presumptive eligibility provider is an entity which meets the requirements specified in section 3570 of the state Medicaid Manual, published by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services and who is enrolled with the department as a qualified presumptive eligibility provider under the presumptive eligibility program. Section 3570 of the state Medicaid Manual is adopted and incorporated by this reference. A copy of the manual section may be obtained from the Department of Public Health and Human Services, Human and Community Services Division, ~~111 N. Jackson St.~~ 2021 N. Montana Avenue, P.O. Box 202925, Helena, MT 59620~~-2925~~.

(B) Presumptive eligibility determinations shall be effective through the earlier of the date the department makes a determination of eligibility or ineligibility based upon a Medicaid application, or the last day of the month following the month of the presumptive eligibility determination, if no Medicaid application is filed within such period. An individual is limited to one presumptive eligibility period per pregnancy.

(C) The applicant or recipient shall be entitled to a fair hearing with respect to a determination by the department based upon a Medicaid application.

(ii) During a period of presumptive eligibility, a pregnant woman is limited to ambulatory prenatal care services covered under the Montana Medicaid program. Such services may be provided by any Medicaid provider eligible to receive Medicaid reimbursement for such services under applicable law and regulations.

(g) A pregnant woman who becomes ineligible for Medicaid due solely to increased income and whose countable resources do not exceed $3,000 and whose pregnancy is disclosed to the department prior to the effective date of Medicaid closure. This coverage group is known as the "continuous pregnant woman group." Eligibility shall be continuous without lapse in Medicaid eligibility from the prior Medicaid eligibility and shall terminate on the last day of the month in which the 12-month postpartum period ends.

(h) A child who has not yet reached age 19, whose family income does not exceed 143% of the federal poverty guidelines. This coverage group is known as the "Healthy Montana Kids (HMK) Plus" group. Children determined eligible under the Healthy Montana Kids Plus program will receive up to 12 months of continuous coverage.

(i) Individuals under the age of 21 who are receiving foster care or subsidized adoption payments through child welfare services. These individuals must have full or partial financial responsibility assumed by public agencies and must have been placed in foster homes, private institutions, or private homes by a nonprofit agency.

(j) A child of a minor custodial parent when the custodial parent is living in the child's grandparent's home and the grandparent's income is the sole reason rendering the child ineligible for nonmedically needy family Medicaid.

(k) Needy caretaker relatives as defined in the family-related Medicaid Manual, section 201-1, as incorporated by reference in ARM 37.82.101, who have in their care an individual under age 19 who is eligible for Medicaid, and whose countable income does not exceed the state's family Medicaid standards as defined in the family-related Medicaid Manual, section 002.

(l) A child through the month of the child's 19th birthday, who lives in a household whose income exceeds the categorically needy standards and resources do not exceed the resource standards specified in ARM 37.82.1106, 37.82.1107, and 37.82.1110. This coverage group is known as the "family medically needy group."

(m) Individuals, under the age of 65 who have been screened through the Montana Breast and Cervical Health Program who:

(i) have been diagnosed with cancer or precancer of the breast or cervix;

(ii) do not have creditable coverage to pay for their cancer/precancer treatment;

(iii) have countable income that does not exceed 250% of the federal poverty level at the time of screening and enrollment into the Montana Breast and Cervical Health Program; and

(iv) are not eligible for any other nonmedically needy Medicaid coverage group. This coverage group is known as "breast and cervical cancer treatment."

(n) Families who, due to receipt of new or increased spousal support, lose eligibility for nonmedically needy family Medicaid. To be eligible the family must:

(i) receive new or increased spousal support in an amount great enough to cause their nonmedically needy family Medicaid eligibility to end; and

(ii) have received nonmedically needy family Medicaid in Montana for three of six months prior to the closure of nonmedically needy family Medicaid. The coverage will continue for four consecutive months. This program is known as the "family-extended group."

(o) Women ages 19 through 44, who have not been otherwise determined eligible for Medicaid under this title, who are able to become pregnant but are not now pregnant, whose household income does not exceed 211% of the federal poverty level. Services are limited to those family planning services defined at ARM 37.86.1707 and not covered by third party health coverage. This program is limited to 4,000 women at any given time and is known as Plan First. Plan First will not pay any copay or deductible required by a member's third party health coverage.

(2) Medicaid will continue until the last day of the month in which the 12-month postpartum period ends for pregnant women as long as the pregnant woman was eligible for and receiving Medicaid on the date pregnancy ends.

(3) Medicaid may be provided for up to ~~three~~ two months prior to the date of application for individuals listed in (1)(a), (1)(c), (1)(d), (1)(g), (1)(h), (1)(i), (1)(j), (1)(k), (1)(l), and (1)(m) if all financial and nonfinancial eligibility criteria are met as of the date medical services were received in each of those months.

Authorizing statute(s): 53-4-212, 53-4-1105, 53-6-113, MCA

Implementing statute(s): 53-4-231, 53-4-1104, 53-4-1105, 53-6-101, 53-6-131, 53-6-134, MCA

37.82.704 ~~THREE MONTH~~ RETROACTIVE MEDICAID COVERAGE~~, NONINSTITUTIONALIZED FAIM FINANCIAL ASSISTANCE RELATED FAMILIES AND CHILDREN~~

(1) ~~Three month~~ Two-month retroactive coverage will be provided to individuals who request retroactive coverage and are determined eligible for Medicaid ~~under this subchapter~~ if:

(a) they received medical services during any of the ~~three~~ two months prior to application; and

(b) they are determined eligible for Medicaid on the 1st day of the month in the month or months medical services were received.

~~(c)~~(2) Eligibility in the retroactive period will be determined in accordance with this subchapter, except that eligibility with respect to income will be determined using actual income received in the month or months of service.

~~(2)~~(3) ~~Under (1),~~ Medicaid will pay only unpaid bills for services:

(a) incurred in the retroactive period;

(b) provided for in ARM Title 37, chapters 82, 83, 85, 86, and 88; and

(c) for which no third-party payment is available.

(4) One-month retroactive coverage will be provided to individuals who request retroactive coverage and are determined eligible for expansion Medicaid if:

(a) they received medical services during the month prior to application; and

(b) they are determined eligible for Medicaid on the 1st day of the month in the month medical services were received.

(5) Eligibility in the retroactive period will be determined in accordance with this subchapter, except that eligibility with respect to income will be determined using actual income received in the month of service.

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

Implementing statute(s): 53-6-131, MCA

37.82.904 ~~THREE~~ TWO-MONTH RETROACTIVE COVERAGE, NON-INSTITUTIONALIZED SSI-RELATED INDIVIDUALS AND COUPLES

(1) ~~Three month~~ Two-month retroactive coverage will be provided to individuals who request retroactive coverage and are determined eligible for ~~medicaid~~ Medicaid under this subchapter if:

(a) they received medical services during any of the ~~three~~ two months prior to application; and

(b) they are determined eligible for ~~medicaid~~ Medicaid in the month or months medical services were received.

~~(c)~~(2) Eligibility in the retroactive period will be determined in accordance with this subchapter, except that eligibility with respect to income will be determined using actual income received in the month or months of service.

~~(2)~~(3) Under (1), ~~medicaid~~ Medicaid will pay only unpaid bills for service:

(a) incurred in the retroactive period;

(b) provided for in this chapter; and

(c) for which no third-party payment is available.

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

Implementing statute(s): 53-6-131, MCA

37.82.1111 ~~THREE~~ TWO-MONTH RETROACTIVE COVERAGE, NON-INSTITUTIONALIZED MEDICALLY NEEDY

(1) The retroactive period may include any or all of the ~~three~~ two months immediately preceding the month of application.

(2) To be eligible for retroactive medically needy coverage, during each month of the retroactive period, SSI and AFDC-related persons and families must ~~meet~~:

(a) meet the non-financial criteria of ARM 37.82.1102;

(b) meet the resource criteria of ARM 37.82.1110 as of the first day of the month; ~~and~~

(c) meet the income criteria of ARM 37.82.1107 except that income will be determined using actual income received in the retroactive period~~.~~; and

(d) request retroactive coverage.

(3) Medical expenses incurred during the retroactive period will be paid according to ARM 37.82.1107(4).

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

Implementing statute(s): 53-6-131, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.82.205, 37.82.401, 37.82.701, 37.82.704, 37.82.904, and 37.82.1111.

The proposed rule amendments concern general Medicaid eligibility. These changes are intended to align state regulations with "An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (Public Law 119-21)," or "The One Big Beautiful Bill Act" (H.R. 1), which was signed into law on July 4, 2025.

ARM 37.82.205
The proposed amendments will update and clarify the renewal timelines for individuals on expansion Medicaid. The department proposes requiring individuals on expansion Medicaid to be redetermined every six months for Medicaid eligibility. The department also proposes to clarify that Medicaid clients who are American Indian or Alaskan Native must have their eligibility redetermined every 12 months. Pursuant to H.R. 1, states must implement these changes to renewal timelines no later than January 1, 2027.

The department proposes to remove the language referencing FAIM (a pilot project that has ended). This change is necessary to modernize the rule and to remove an outdated and potentially confusing reference to a state program that is no longer in existence. Finally, the department proposes to capitalize "Medicaid" for style uniformity across all rules pertaining to this subject.

ARM 37.82.401
The proposed amendments would bring this regulation into compliance with H.R. 1 as it relates to immigrant eligibility. H.R.1 restricts Medicaid eligibility to U.S. citizens or nationals, lawful permanent residents, Cuban Haitian entrants, or Compacts of Free Association migrants lawfully residing in the United States. These proposed changes are necessary to bring this regulation into alignment with federal law.

ARM 37.82.701
The department also proposes updates to the retroactive coverage time period that is available to Medicaid recipients. The department is proposing these changes to align this rule with Medicaid retroactive coverage changes that are mandated by H.R. 1.

Finally, the department proposes updating the mailing address to which individuals may mail a request for a copy of the Medicaid Manual. This update will modernize the rule and help ensure that the public knows where to send such a request.

ARM 37.82.704

The department proposes updates to the retroactive coverage period that is available to Medicaid recipients. The department is proposing these changes to align this rule with Medicaid retroactive coverage changes that are mandated by H.R. 1.

To this, the department proposes amending (1) and (1)(a) to reduce the general retroactive coverage window from three-months to two-months. The department also proposes adding (3), which would limit retroactive coverage to one month for the expansion Medicaid population. These changes are required to align with federally required changes to retroactive coverage in H.R. 1. Incorporating these changes into regulation ensures clarity, transparency, and consistency for both applicants and eligibility staff, preventing confusion between standard Medicaid rules and federal law.

The department also proposes that retroactive Medicaid coverage must be explicitly requested by the applicant. This clarification will help ensure that the department allocates its investigative and administrative resources to individuals who actively require and seek retroactive coverage. This change promotes fiscal and administrative efficiency by eliminating unnecessary eligibility look-backs for applicants who did not incur medical bills during the retroactive window.

The department proposes to remove the language referencing FAIM (a pilot project that has ended). This change is necessary to modernize the rule and to remove an outdated and potentially confusing reference to a state program that is no longer in existence.

Minor phrasing updates, such as modifying "third party" to "third-party" in (2)(c), are necessary for modern grammatical consistency and clarity.

ARM 37.82.904

The department proposes updates to the retroactive coverage time period that is available to Medicaid recipients. The department is proposing these changes to align this rule with Medicaid retroactive coverage changes that are mandated by H.R. 1. The department also proposes that retroactive coverage will be available to applicants who request such coverage, the reasoning for which is explained above.

Finally, the department proposes capitalizing “Medicaid” and other minor style changes for uniformity across all rules pertaining to this subject.

ARM 37.82.1111

The department proposes updates to the retroactive coverage time period that is available to Medicaid recipients. The department is proposing these changes to align this rule with Medicaid retroactive coverage changes that are mandated by H.R. 1. The proposed amendment to this rule would be consistent with the same proposed change to ARM 37.82.704, which would ensure programmatic and structural uniformity.

Small Business Impact

Pursuant to 2-4-111, MCA, the department has determined that there is no class or group of small businesses affected by the proposed rules and the proposed rules will not have probable significant and direct effects on any class or group of small businesses. The proposed rulemaking impacts Medicaid applicants and members, who do not meet the definition of a small business.

Fiscal Impact

Increasing the frequency of eligibility verification to every six months is projected to optimize caseload accuracy and generate an annualized cost savings of $28,133,416 across state and federal matching pools.

Narrowing the scope of covered non-citizen categories is anticipated to result in an additional annualized savings of $3,947,229, subject to final actuarial verification.

Shortening the retroactive eligibility window will reduce look-back claims liability, yielding an estimated annualized savings of $451,084.

The combined implementation of these rules is projected to achieve a net annualized savings of $32,531,729 to the State of Montana. These figures reflect a proportional split between State General Funds and Federal Special Revenue matching accounts. Final automated system updates to execute these changes will be absorbed using existing department operating appropriations.

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 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.

Effective Date

The proposed amendments to ARM 37.82.401 are intended to be effective on October 1, 2026. The other proposed amendments are intended to be effective on January 1, 2027.

Rule Reviewer

Heidi Sanders

Approval

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