BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
OF THE STATE OF MONTANA

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| In the matter of the amendment of ARM 37.40.307, 37.40.315, 37.85.104, 37.85.105, 37.85.106, 37.85.212, 37.86.1006, 37.86.2002, 37.86.2102, 37.86.2105, and 37.86.3607 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates | ) ) ) ) ) ) ) ) ) | NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT |

TO: All Concerned Persons

1. On June 17, 2024, at 11:00 a.m., the Department of Public Health and Human Services will hold a public hearing via remote conferencing to consider the proposed amendment of the above-stated rules. Interested parties may access the remote conferencing platform in the following ways:

(a) Join Zoom Meeting at: https://mt-gov.zoom.us/j/84197741181?pwd=dlhoM1dpTHFONjBLdjd6OTNmUVorZz09, meeting ID: 841 9774 1181, and password: 077061; or

(b) Dial by telephone: +1 646 558 8656, meeting ID: 841 9774 1181, and password: 077061. Find your local number: https://mt-gov.zoom.us/u/kdMq5Kp1OK.

2. The Department of Public Health and Human Services 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. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on June 3, 2024, to advise us of the nature of the accommodation that you need. Please contact Bailey Yuhas, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail hhsadminrules@mt.gov.

3. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services~~, other than ICF/IID 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) ~~2024~~ 2025 is ~~$257.54~~ $278.75.

(b) The quality component of each nursing facility's rate is based on the ~~5~~ five-star rating system for nursing facility services, calculated by the Centers for Medicare ~~and~~& Medicaid Services (CMS). It is set for each facility based on its ~~their~~ average ~~5~~ five-star ratings for staffing and for quality. Facilities with an average rating of ~~3~~ three to ~~5~~ 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 ~~5~~ five-star average of staffing and quality-component scores. A facility with a ~~5~~ five-star average of staffing and quality component scores will receive 100% of the quality-component payment, a ~~4~~ four-star average will receive 75%, a ~~3~~ three-star average will receive 50%, and ~~1~~ one- and ~~2~~ two-star average facilities will receive 0%~~, of the quality component payment~~. 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, 2023~~ July 1, 2024, through ~~June 30, 2024~~ June 30, 2025, 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#~~1875810541~~, 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, ~~2023~~ 2024. 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 ICF/IID services provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider as provided in ARM 37.40.336.~~

~~(5) In addition to the per diem rate provided under (2) or the reimbursement allowed to an ICF/IID provider under (4), the Montana Medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.~~

~~(6)~~(4) For nursing facility services~~, including ICF/IID 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.

(7) and (8) remain the same but are renumbered (5) and (6).

(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.

~~(9)~~(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 ~~which~~ that is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(10) through (12) remain the same but are renumbered (8) through (10).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-111, 53-6-113, MCA

37.40.315 STAFFING AND REPORTING REQUIREMENTS (1) Providers must provide ~~staffing at levels which are adequate to meet federal law, regulations, and requirements.~~:

(a) staffing at levels that are adequate to meet federal law, regulations, and requirements; and

(b) staffing, quality, and performance information on the online Monthly Nursing Facility Report, which includes information on occupancy, staffing, demand for services, employee training, and employee longevity.

~~(a)~~(2) Each provider must submit to the department within ~~ten~~ 15 days following the end of each calendar month a complete and accurate ~~DPHHS-SLTC-015, "Monthly Nursing Home Staffing Report"~~ Monthly Nursing Facility Report, prepared in accordance with all applicable department rules and instructions.

~~(b)~~(a) If ~~a complete and accurate DPHHS-SLTC-015 is not received by~~ the department does not receive complete and accurate reports within ~~ten~~ 15 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in ~~(1)(a)~~(2).

(b) If the provider excludes the quality and performance data from their Monthly Nursing Facility Report submission, they forfeit the provider-rate increase for the fiscal year ending June 30, 2025, until such time the quality and performance data is received.

(3) Each provider must submit a summary of the annual resident/family satisfaction survey by January 15, for the previous year. If the summary of annual resident/family satisfaction survey is not received by January 15, the department may reduce the per-diem to the prior year's base rate until it is submitted.

AUTH: 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-108, 53-6-111, 53-6-113, MCA

37.85.104 EFFECTIVE DATES OF PROVIDER FEE SCHEDULES FOR MONTANA NON-MEDICAID SERVICES (1) remains the same.

(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.

(b) Goal 189, as provided in ARM 37.89.201, is effective ~~October 1, 2022~~ July 1,2023.

(c) Youth respite care services, as provided in ARM 37.87.2203, is effective ~~July 1, 2023~~ July 1, 2024.

(d) Substance use disorder services provider reimbursement, as provided in ARM 37.27.905, is effective ~~October 1, 2022~~ July 1, 2023, and July 1, 2024.

(2) remains the same.

AUTH: 53-2-201, 53-6-101, 53-6-113, MCA
IMP: 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) and (2) remain the same.

(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 ~~87 Federal Register 69404 (Nov. 18, 2022), effective January 1, 2023~~ 88 Federal Register 78818 (Nov. 16, 2023), effective January 1, 2024, which is adopted and incorporated by reference. Procedure codes created after ~~January 1, 2023~~ January 1, 2024 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, 2023~~ January 1, 2024, and July 1, 2024. When two dates are specified, the earlier fee schedule ceases to be effective with respect to services provided on and after the effective date of the later fee schedule. ~~The conversion factor for physician services is $44.32. The conversion factor for allied services is $26.13. The conversion factor for mental health services is $22.67. The conversion factor for anesthesia services is $32.04.~~

(i) Effective July 1, 2023, the conversion factor for physician services is $44.32. The conversion factor for allied services is $26.13. The conversion factor for mental health services is $22.67. The conversion factor for anesthesia services is $32.04.

(ii) Effective July 1, 2024, the conversion factor for physician services is $43.96. The conversion factor for allied services is $27.24. The conversion factor for mental health services is $22.47. The conversion factor for anesthesia services is $31.78.

(c) and (d) remain the same.

(e) The payment-to-charge ratio is effective ~~July 1, 2023~~ July 1, 2024, and is ~~46.8%~~ 48.02% of the provider's usual and customary charges.

(f) through (h) remain the same.

(i) Optometric services receive a ~~115.50%~~ provider rate of reimbursement adjustment to the reimbursement for allied services, as provided in ARM 37.85.105(2)~~, effective July 1, 2023~~.

(i) Effective July 1, 2023, the optometric services provider rate of reimbursement is 115.50%.

(ii) Effective July 1, 2024, the optometric services provider rate of reimbursement is 114.45%.

(j) through (3)(a) remain the same.

(i) the APR-DRG fee schedule for inpatient hospitals, as provided in ARM 37.86.2907, effective ~~October 1, 2023~~ July 1, 2024; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version ~~40.0~~ 41.0, contained in the APR-DRG Table of Weights and Thresholds, effective ~~October 1, 2023~~ July 1, 2024. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective ~~October 1, 2023~~ July 1, 2024.

(b) remains the same.

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the CMS in ~~87 Federal Register 71748 (Nov. 23, 2022), effective January 1, 2023~~ 89 Federal Register 9002 (Feb. 9, 2024), effective January 1, 2024, 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 1,2023~~ July 1, 2024 is ~~$58.39~~ $60.72;

(iii) the Medicaid statewide average outpatient cost-to-charge ratio is ~~48.95~~ 48.59%; and

(iv) the bundled composite rate of ~~$271.02~~ $281.86 for services provided in an outpatient maintenance dialysis clinic effective on or after ~~July 1, 2023~~ July 1, 2024.

(c) The hearing aid services fee schedule, as provided in ARM 37.86.805, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in ~~2023~~ 2024 resulting in a dental conversion factor of ~~$36.90~~ $38.37 and fee schedule is effective ~~July 1, 2023~~ July 1, 2024.

(e) The Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective ~~July 1, 2023~~ July 1, 2024.

(f) The outpatient drugs reimbursement dispensing fees range as provided in ARM 37.86.1105(3)(b) is effective ~~July 1, 2023~~ July 1, 2024:

(i) for pharmacies with prescription volume between 0 and 39,999, the minimum is ~~$5.11~~ $5.28 and the maximum is ~~$16.36~~ $17.01;

(ii) for pharmacies with prescription volume between 40,000 and 69,999, the minimum is ~~$5.11~~ $5.28 and the maximum is ~~$14.16~~ $14.73; or

(iii) for pharmacies with prescription volume greater than or equal to 70,000, the minimum is ~~$5.11~~ $5.28 and the maximum is ~~$11.98~~ $12.46.

(g) remains the same.

(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 ~~$18.65~~ $15.53 for each additional vaccine administered on the same date of service, effective ~~July 1, 2023~~ July 1, 2024.

(i) remains the same.

(j) The home infusion therapy services fee schedule, as provided in ARM 37.86.1506, is effective ~~July 1, 2023~~ July 1, 2024.

(k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, ~~effective October 1, 2023,~~ 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 ~~October 1, 2023~~ January 1, 2024, and July 1, 2024. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective ~~October 1, 2023~~ January 1, 2024, and July 1, 2024.

(l) The nutrition services fee schedule, as provided in ARM 37.86.2207(2), is effective ~~July 1, 2023~~ July 1, 2024.

(m) remains the same.

(n) The orientation and mobility specialist services fee schedule, as provide in ARM 37.86.2207(2), is effective ~~July 1, 2023~~ July 1, 2024.

(o) The transportation and per diem fee schedule, as provided in ARM 37.86.2405, is effective ~~July 1, 2023~~ July 1, 2024.

(p) The specialized nonemergency medical transportation fee schedule, as provided in ARM 37.86.2505, is effective ~~July 1, 2023~~ July 1, 2024.

(q) The ambulance services fee schedule, as provided in ARM 37.86.2605, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(r) The audiology fee schedule, as provided in ARM 37.86.705, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(s) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM 37.86.610, are effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(t) The optometric services fee schedule, as provided in ARM 37.86.2005, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(u) The chiropractic fee schedule, as provided in ARM 37.85.212(2), is effective ~~July 1, 2023~~ July 1, 2024.

(v) The lab and imaging services fee schedule, as provided in ARM 37.85.212(2) and 37.86.3007, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(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, 2023~~ July 1, 2024.

(x) The Targeted Case Management for High-Risk Pregnant Women fee schedule, as provided in ARM 37.86.3415, is effective ~~July 1, 2023~~ July 1, 2024.

(y) The mobile imaging services fee schedule, as provided in ARM 37.85.212, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(z) The licensed direct-entry midwife fee schedule, as provided in ARM 37.85.212, is effective ~~July 1, 2023~~ January 1, 2024, and July 1, 2024.

(aa) The private duty nursing services fee schedule, as provided in ARM 37.86.2207(2), is effective ~~July 1, 2023~~ July 1, 2024.

(4) remains the same.

(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, 2023~~ July 1, 2024.

(b) The home health services fee schedule, as provided in ARM 37.40.705, is effective ~~July 1, 2023~~ July 1, 2024.

(c) The personal assistance services fee schedule, as provided in ARM 37.40.1135, is effective ~~July 1, 2023~~ July 1, 2024.

(d) The self-directed personal assistance services fee schedule, as provided in ARM 37.40.1135, is effective ~~July 1, 2023~~ July 1, 2024.

(e) The community first choice services fee schedule, as provided in ARM 37.40.1026, is effective ~~July 1, 2023~~ July 1, 2024.

(5) remains the same.

(a) The mental health center services for adults fee schedule, as provided in ARM 37.88.907, is effective July 1, 2023 (fee schedule version 2) and July 1, 2024.

(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, 2023~~ July 1, 2024.

(c) The substance use disorder services fee schedule, as provided in ARM 37.27.905, is effective ~~July 1, 2023~~ July 1, 2024.

(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.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 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) remains the same.

(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, 2023~~ July 1, 2024, for the following programs within the Behavioral Health and Developmental Disabilities Division:

(a) through (c) remain the same.

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

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-113, MCA

37.85.212 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) through (1)(h) remain the same.

(i) "Resource-based relative value scale (RBRVS)" means the Medicare resource-based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare ~~and~~ & Medicaid Services (CMS) of

the U.S. Department of Health and Human Services. The effective date and citation for the RBRVS is adopted at ARM 37.85.105(2).

(2) through (2)(u) remain the same.

(v) EPSDT orientation and mobility specialists; ~~and~~

(w) mobile imaging/portable x-ray providers~~.~~; and

(x) BCBA/BCBA-D.

(3) through (10) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-125, 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) through (5)(d) remain the same.

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

(6) through (18) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.86.2002 OPTOMETRIC SERVICES, REQUIREMENTS (1) and (2) remain the same.

(3) Members are ~~A Medicaid member under 21 years of age is~~ limited to one eye examination for determination of refractive state per 365-day period~~. A Medicaid member 21 years of age or older is limited to one eye examination for determination of refractive state per 730-day period~~ unless one of the following circumstances exist:

(a) and (b) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.2102 EYEGLASSES, SERVICES~~,~~ AND REQUIREMENTS ~~AND RESTRICTIONS~~ (1) through (3) remain the same.

(4) ~~A member under 21 years of age is~~ Members are limited to one pair of eyeglasses per 365-day period ~~and a member 21 years of age or older is limited to one pair of eyeglasses every 730-day period~~.

(5) through (7) remain the same.

~~(8) If a member is unable to wear bifocals because of a diagnosed medical condition and a provider requests an exception:~~

~~(a) a member under 21 years of age may be allowed two pairs of single vision eyeglasses every 365-day period; and~~

~~(b) a member 21 years of age and older may be allowed two pairs of single vision eyeglasses every 730-day period.~~

(8) A member is allowed two pairs of single vision eyeglasses in the place of bifocals when medically necessary, per 365-day period.

(9) and (9)(a) remain the same.

~~(b) The dispensing provider must receive prior authorization from the department for contact lenses and dispensing fee.~~

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.2105 EYEGLASSES, REIMBURSEMENT (1) and (2) remain the same.

(3) The department adopts and incorporates by reference the department's Eyeglasses Fee Schedule effective ~~December 2016~~ May 1, 2024. A copy of the department's fee schedule is posted at the Montana Medicaid provider web site at https://medicaidprovider.mt.gov. A copy of the department's fee schedule may also be obtained from Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, 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, 2023~~ July 1, 2024.

(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, 2023~~ July 1, 2024. The manual is posted at https://dphhs.mt.gov/bhdd/disabilityservices/developmentaldisabilities/ddpratesinf.

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.40.307, 37.40.315, 37.85.104, 37.85.105, 37.85.106, 37.85.212, 37.86.1006, 37.86.2002, 37.86.2102, 37.86.2105, and 37.86.3607 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates. 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.

The reasonable necessity for proposing these rule changes is to establish rates of reimbursement in conformity with appropriations passed by the 2023 Montana Legislature. 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 2023 regular legislative session, the actual cost of services, and the availability of services.

Proposed changes to provider rates that are the subject of this rulemaking notice, including rates in fee schedules and rates in provider manuals, can be found at https://medicaidprovider.mt.gov/proposedfs.

Proposed Increases for Four Categories of Rates Studied by Guidehouse
In 2021, the Montana Legislature directed the department to contract with an independent health care consulting firm to conduct a comprehensive rate review of services provided through the Adult Behavioral Health, Children's Mental Health, Developmental Disabilities, and Senior and Long Term Care programs. The department contracted with Guidehouse consulting firm to conduct the multifaceted study of Medicaid rates within the four programs and make recommendations for rate increases. Through this rule notice, the department proposes to apply funding appropriated by the 2023 legislature across all studied rates using the methodology recommended by Guidehouse. The following fee schedules have proposed rates that were recommended by the Guidehouse study: Medicaid Youth Mental Health Fee Schedule, Medicaid Behavioral Health Targeted Case Management Fee Schedule, Targeted Case Management Services for Individuals with Developmental Disabilities Enrolled in the 1915 (c) 0208 Home and Community Based (HCBS) Comprehensive Waiver, Medicaid Mental Health Center Services for Adults, Medicaid Substance Use Disorder Services, Home and Community-Based Services for Adults with Severe Disabling Mental Illness, Non-Medicaid Mental Health Crisis Services, Non-Medicaid Substance Use Disorder Services, Nursing Facility Reimbursement, and Nursing Facility Staffing and Reporting Requirements.

Proposed Increase For Provider Rates Not Studied by Guidehouse
The 2023 legislature appropriated funds for a provider rate increase of 4.0% for the state fiscal year 2025 for provider rates that were not part of the Guidehouse study. The department considered all factors in proposing these rates, and the proposed rates represent a weighted average rate increase of 4.0%.

Combined Rule Filings
On average it takes two to three months from publication of a proposed rule amendment to its adoption. As the department is unable to file stacked proposed amendments, a rule filing must be fully adopted before new changes can be proposed. Therefore, any delay with the rule filing timeline has a cascading effect on subsequent rule amendments.

The department was unable to file the proposed July 1, 2023, changes until HB 2 was signed on June 14, 2023. The department filed the proposed July 1, 2023, rate changes on the earliest available filing date of June 27, 2023. MAR Notice No. 37-1037 was published on July 7, 2023, and adopted on September 8, 2023, two months after the effective date.

On December 12, 2023, the department filed MAR Notice No. 37-1061, pertaining to the October 1, 2023, inpatient hospital provider rate increases. MAR Notice No. 37-1061 was adopted on March 22, 2024, almost six months after the effective date.

With the delays in July and October 2023 rule adoptions, the department was unable to file proposed January 2024 changes until April 2, 2024. Subsequently, the proposed July 2024 changes could not be filed until the end of June, with an adoption date at the end of August.

Understanding the impact rate implementation delays have on providers and department resources, the department made the administrative decision to incorporate proposed January 2024 and July 2024 updates under one rule filing. This decision was necessary to limit the financial impact to providers and to decrease the quantity of provider claim adjustments. For some services, the proposed rule text has two dates, the first of which is intended to establish rates of reimbursement for services provided through the first date listed; and the second date is intended to establish rates of reimbursement for services provided from the second date listed.

The following sections explain proposed amendments to the following specific subsections: ARM 37.40.307, 37.40.315, 37.85.104, 37.85.105, 37.85.106, 37.85.212, 37.86.1006, 37.86.2002, 37.86.2102, 37.86.2105, 37.86.3607, 37.88.101, and 37.89.201.

ARM 37.40.307 Nursing Facility Reimbursement
The proposed amendment to (2)(a) updates the flat-rate component for SFY 2024 to reflect a proposed 8.24% increase for SFY 2025. The department is proposing to set the flat-rate component for state fiscal year (SFY) 2025 at $278.75, which is an

8.24% increase from SFY 2024. The rate change will align with the FY 2024 rate proposed in the Guidehouse rate study completed in 2022.

The proposed amendment to (2)(c) updates the SFY reference from July 1, 2023, through June 30, 2024, to July 1, 2024, through June 30, 2025. This change is necessary for the department to provide notice of the current period for funding of Medicaid nursing facility provider rates.

The proposed amendment to (3) updates the 2023 reference to 2024. This change is necessary for the department to provide notice to newly constructed facilities that have not participated in the Medicaid program for at least six months.

The department proposes to remove all references to ICF/IID services, as the department no longer provides any of these types of services.
The department is also proposing to clean up grammar and style formatting issues.

ARM 37.40.315 Staffing and Reporting Requirements
The proposed amendment will expand the current reporting requirements and further define the information that needs to be provided. The proposed amendment will also extend the timeframe required for submitting the information. Language in HB 2 relating to the nursing home rate increase stated that the FY 2025 rate increases are conditional on facility participation in Department of Public Health and Human Services' efforts to collect quality and performance data.

The proposed amendment will list the staffing and quality and performance information that will be collected on the online Monthly Nursing Facility Report. This includes information on occupancy, staffing, demand for service, employee training, employee longevity, and annual resident/family satisfaction survey.

The department is also proposing to clean up grammar and style formatting issues.

ARM 37.85.104
(1)(a), (b), and (d) Behavioral Health and Developmental Disabilities Division Fee Schedules – July 1, 2023
The department is proposing to revise the July 1, 2023, non-Medicaid mental health crisis services fee schedule to align nomenclature for Mobile Crisis Response Services with the proposed Mobile Crisis Response Services manual policy. This proposal will ensure uniform and consistent use of terminology, ensuring clarity for providers and the department. These updates will be reflected in non-Medicaid mental health crisis services fee schedule version 2.

Additionally, the department is proposing to revise the effective date for the non-Medicaid substance use disorder services fee schedule to July 1, 2023, to reflect rate increases from the provider rate study. This fee schedule was not updated in a previous rule notice due to an internal department oversight.

(1)(a), (c), and (d) Behavioral Health and Developmental Disabilities Division Fee Schedules – July 1,2024
The department is proposing to adopt the July 1, 2024, 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.

ARM 37.85.105
(2)(a) 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 16, 2023, Federal Register (effective January 1, 2024) for the RBRVS reimbursement methodology. This adoption is necessary to incorporate the most up-to-date changes made by CMS.

(2)(b) RBRVS Fee Schedules
The department is proposing to adopt the January 1, 2024, and July 1, 2024, fee schedule updates. The January 1, 2024, fee schedules utilize the conversion factors listed in ARM 37.85.105(2)(b)(i) and the July 1, 2024, fee schedules utilize the conversion factors described in ARM 37.85.105(2)(b)(ii). This change is necessary to ensure the fee schedules incorporate new, deleted, and replacement codes, as well as revised rates.

(2)(b)(ii) RBRVS Conversion Factors (CF) – July 1, 2024
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 2023 legislature appropriated funds for a provider rate increase of 4.0% for the state fiscal year 2025 for provider rates other than the rates studied by Guidehouse. Considering the pricing factors and the appropriated provider rate increase, effective July 1, 2024, the department proposes changes to the allied services and mental health services conversion factors. The proposed allied services conversion factor is $27.24, and the proposed mental health services conversion factor is $22.47. When the proposed conversion factor increases are applied against utilization and RVUs, the result is a weighted average rate increase of 4.0%.

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 -0.8%. Physician services are not included in the 2023 legislature-appropriated provider rate increase.

(2)(e) Payment to Charge Ratio – July 1, 2024
The payment-to-charge ratio, which is used to price some allowable procedures that do not have set reimbursement is proposed to be 48.02%, effective July 1, 2024. 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)(i) and (ii) Optometric Services Provider Rate of Reimbursement (PRR)
Due to the necessity to propose the January 2024 and July 2024 fee schedule changes under the same rule filing, the department proposes to clearly define the optometric services PRR that is effective from July 1, 2023 through June 30, 2024 and the proposed July 1, 2024 optometric services PRR.

Effective July 1, 2024, the department is proposing to change the optometric services PRR, which is a pricing factor, to 114.45% of the reimbursement for allied services. When this pricing factor is applied against utilization, relative value units, and proposed allied services conversion factor, optometrists and opticians will receive a weighted average provider rate increase of 4.0%, which is consistent with the weighted average rate increase for providers not included in the Guidehouse study.

(3)(a) Inpatient Hospital Services Rates – July 1, 2024
The House Bill (HB) 2 Narrative for the 2025 biennium provides for an increase appropriation from the 2023 biennium for Medicaid services provided by non-critical access hospitals in an amount equivalent to a 4.0% provider rate increase. The provider rate increase for inpatient non-critical access hospital services is contingent on the department's evaluation of the Upper Payment Limit methodology. The department has completed the Upper Payment Limit demonstration, which has been approved by the Centers for Medicare & Medicaid Services, and the demonstration confirms Montana Medicaid provider payments do not exceed the Upper Payment Limit.

The 2025 biennium inpatient hospital provider rate increase equates to an approximate 8.16% increase from the 2023 biennium. The State Fiscal Year 2024 increase for inpatient hospitals was implemented effective October 1, 2023. Since the rate increase was to be applied over 9 months, instead of 12, the department increased reimbursement by 5.3%. To ensure that hospital rates are not increased beyond the 2025 biennium appropriated increase, the department proposes to implement a 2.72% increase to inpatient hospital reimbursement. This increase results in an estimated 8.16% over the 2025 biennium.

| Year | Provider Rate Increase |
|---|---|
| 1 (12 Months) | 4.0% |
| 2 (12 Months) | 4.0% |
| **Total Increase** | =(1.04) X (1.04) – 1 = 8.16% |

| Year | Provider Rate Increase |
|---|---|
| 1 (9 Months) | 5.3% |
| 2 (12 Months) | 2.72% |
| **Total Increase** | =(1.053) X (1.0272) – 1 = 8.16% |

The department proposes to adopt Version 41.0 of the 3M APR-DRG grouper, effective July 1, 2024. 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
Effective July 1, 2024, the department is proposing to adopt the Outpatient Prospective Payment System fee schedule published by CMS in the February 9, 2024, federal register (effective January 1, 2024) for the OPPS reimbursement methodology. This adoption is necessary to ensure outpatient hospital updates are aligned with CMS.

(3)(b)(ii) Outpatient Prospective Payment System (OPPS) Conversion Factor – July 1, 2024
The department is proposing to increase the OPPS conversion factor to $60.72, effective July 1, 2024, to incorporate the provider rate increase approved by the Montana Legislature.

(3)(b)(iii) Medicaid Statewide Average Cost-to-Charge Ratio
The Medicaid statewide average cost-to-charge ratio is calculated utilizing submitted cost reports and is updated annually. The proposed updated cost-to-charge ratio is 48.59%. Individual hospital cost-to-charge ratios can fluctuate annually which can result in shifts to the Montana statewide average cost-to-charge ratio. This ratio is required to be updated annually to keep the ratio current.

(3)(b)(iv) Outpatient Maintenance Dialysis Clinic – July 1, 2024
The bundled composite rate for outpatient maintenance dialysis clinics is proposed to increase by 4.0% to $281.86, effective July 1, 2024, to incorporate the provider rate increase approved by the Montana Legislature.

(3)(c), (q), (r), (s), (t), (v), (y), and (z) Fee Schedules - January 1, 2024
The department proposes to revise the effective date for the following fee schedules to January 1, 2024, to reflect updated Medicare procedures codes adopted by CMS for the following services: hearing aid services; ambulance services; audiology; occupational therapists; physical therapists, and speech therapists; optometric services; lab and imaging services; mobile imaging services; and licensed direct-entry midwives fee schedules.

(3)(c), (j), (l), (n), (o), (p), (q), (r), (s), (t), (u), (v), (y), (z), and (aa) Fee Schedules – July 1, 2024
The department is proposing the adoption of fee schedules effective July 1, 2024. 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; mobile imaging services; licensed direct-entry midwife; and private duty nursing.

(3)(d) Dental Reimbursement – July 1, 2024
The department proposes three changes to this subsection: 1) adoption of the Relative Values for Dentist reference published in 2024; 2) modification of the dental conversion factor to $38.37; and 3) adoption of the July 1, 2024, 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 – July 1, 2024
The Dental Provider manual is proposed to be amended, effective July 1, 2024, to incorporate the information from provider notices published throughout the year and the changes proposed to ARM 37.86.1006. Provider notices are archived after a few years; therefore, pertinent information should be incorporated into the manual.

(3)(f) Outpatient Drugs Minimum Dispensing Fee – July 1, 2024
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 $5.28.

(3)(f) Outpatient Drugs Maximum Dispensing Fees – July 1, 2024
Effective July 1, 2024, 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 – July 1, 2024
The department proposes to update the fee paid for each additional vaccine administered to $15.53. This change is necessary to maintain a vaccine administration fee aligned with the physician services fee.

(3)(k) Prosthetic Devices, Durable Medical Equipment, and Medical Supplies – January 1, 2024
The department proposes to adopt and incorporate by reference the Medicare Region D Supplier Manual effective January 1, 2024. 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 January 1, 2024, the department proposes to adopt the Calendar Year 2024 Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. This update is necessary to incorporate the calendar year 2024 Medicare fees, additions, deletions, and changes to procedure codes.

(3)(k) Prosthetic Devices, Durable Medical Equipment, and Medical Supplies – July 1, 2024
The department proposes to adopt and incorporate by reference the Medicare Region D Supplier Manual effective July 1, 2024. 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, 2024, the fee schedule will incorporate the July 2024 Medicare DMEPOS fee schedule changes and updates to department-set fees. The department proposes a 4.0% increase to the department set fees on the DMEPOS fee schedule.

(3)(w) and (x) Targeted Case Management (TCM) for Children and Youth with Special Health Care Needs (CYSHCN) and TCM for High-Risk Pregnant Women Fee Schedules – July 1, 2024
Effective July 1, 2024, the department is proposing to align the TCM for CYSHCN and TCM High-Risk Pregnant Women fee schedule rates with the TCM youth behavioral health fee schedule rates. This change is necessary for rate parity.

(4) Senior and Long Term Care Division– July 1, 2024
The department proposes the adoption of updated fee schedules effective July 1, 2024. The updated fee schedules implement legislatively appropriated Medicaid provider-rate increases for Community First Choice, Personal Assistance Services (CFC/PAS), Big Sky Waiver, and Home Health programs.

(5)(a) Behavioral Health and Developmental Disabilities Division Mental Health Center Services Adult Fee Schedule– July 1, 2023
The department proposes to revise the July 1, 2023, Medicaid mental health center services for adults fee schedule to align Mobile Crisis Response Services with the proposed Mobile Crisis Response Services program updates. These updates will be reflected in Medicaid mental health crisis services fee schedule version 2.

(5)(a), (b), and (c) Behavioral Health and Developmental Disabilities Division Fee Schedules – July 1, 2024
The department is proposing to amend the effective date to July 1, 2024, 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 2023 regular session.

Updates to the mental health fee schedule include the addition of services including but not limited to repealing PACT, MACT, and establish a new MT-ACT Policy, and amending CMP policies which include service delivery, staffing requirements, and potential overhead costs. This will affect the cost of reimbursing a MT-ACT team.

(6) Behavioral Health and Developmental Disabilities Division Medicaid Youth Mental Health Services Fee Schedule- July 1, 2023
The department proposes to revise the July 1, 2023, Medicaid youth mental health services fee schedule to align Mobile Crisis Response Services with proposed Mobile Crisis Response Services program updates. These updates will be reflected in Medicaid youth mental health services fee schedule, version 2.

(6) Behavioral Health and Developmental Disabilities Division Medicaid Youth Mental Health Services Fee Schedule - July 1, 2024
The department proposes to revise the effective dates and reimbursements on the Medicaid youth mental health services fee schedule to July 1, 2024. This update incorporates the legislatively approved provider rate increase.

ARM 37.85.106

(2) Fee schedule- July 1, 2024
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, 2024. This is necessary to update provider rates in accordance with funding appropriated by the Montana Legislature during the 2023 regular session.

ARM 37.85.212
(2) Providers Reimbursed under the RBRVS Methodology
The department proposes to include BCBA and BCBA-D in the list of providers reimbursed under the RBRVS methodology.

ARM 37.86.1006
(5)(e) Adult Crown Limits – July 1, 2024
The department proposes to cover porcelain/ceramic crowns on second molars for members aged 21 and over. This change is necessary to ensure members have access to quality dental treatment. The provider community has expressed preference for porcelain/ceramic crowns over base metal crowns for second molars due to strength and resistance to fracture.

ARM 37.86.2002
(3) Adult Eye Examination Limits – July 1, 2024
The department proposes to allow one eye examination per year, to determine refractive state for members aged 21 and over. This change is necessary to ensure members have access to timely medically necessary eye examinations. This change does not impact members aged 20 and under.

ARM 37.86.2102
(4) and (8) Adult Eyeglass Limits – July 1, 2024
The department proposes to allow one pair of eyeglasses per 365 days for members aged 21 and over. When medically necessary, members may receive two pairs of single vision eyeglasses per 365 days, in lieu of bifocals. This change is necessary to ensure members have sufficient access to medically necessary vision hardware

and does not impact members aged 20 and under. In accordance with ARM 37.86.2102(9), this change also applies to contact lenses.

(9)(b) Contact Lens and Dispensing Fee Prior Authorizations – May 1, 2024
The department proposes to remove the prior authorization requirement for contact lenses and dispensing from rule. The department has determined a vast majority of the prior authorization requests processed have been medically necessary. The department will monitor program utilization to ensure the removal of prior authorization does not result in inappropriate utilization.

ARM 37.86.2105
(3) Fee Schedule – May 1, 2024
The department has completed the competitive bidding process for the single volume purchase eyeglasses contract that has a contract start date of May 1, 2024. The department propose to adopt a May 1, 2024, Eyeglasses Fee Schedule to incorporate the new contracted rates.

ARM 37.86.3607
(1) and (2) Reimbursement – July 1, 2024
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, 2024, to incorporate the legislatively approved provider rate increase.

Fiscal Impact

Fiscal Impact - July 1, 2023 and January 1, 2024
The proposed July 1, 2023, and January 1, 2024, changes are anticipated to be budget neutral.

Fiscal Impact – May 1, 2024
The SFY 2024 and SFY 2025 fiscal impact for the proposed May 1, 2024, fee schedule changes for eyeglasses are provided below.

| | Budget Impact (Federal Funds) | Budget Impact (State Funds) | Budget Impact (Total Funds) | Active Provider Count |
|---|---|---|---|---|
| SFY 2024 | $24,873 | $9,645 | $34,517 | 1 |
| SFY 2025 | $211,473 | $77,556 | $289,029 | 1 |

Fiscal Impact – July 1, 2024

The following table displays the number of providers affected by the amended fee schedules, effective dates, conversion factors, and rates for services for SFY 2025 based on the July 1, 2024, proposed amendments.

| Provider Type | SFY 2025 Budget Impact (Federal Funds) | SFY 2025 Budget Impact (State Funds) | SFY 2025 Budget Impact (Total Funds) | Active Provider Count |
|---|---|---|---|---|
| Ambulance | $343,515 | $99,486 | $443,001 | 474 |
| Audiologist | $6,425 | $2,872 | $9,297 | 81 |
| BCBA/BCBA-D | $79,810 | $47,565 | $127,375 | 58 |
| Case Management Services for Persons with Developmental Disabilities | $4,927 | $3,286 | $8,213 | 1 |
| Chemical Dependency Clinic | $54,127 | $10,495 | $64,622 | 66 |
| Commercial Transportation | $114,017 | $47,594 | $161,611 | 15 |
| Community First Choice | $5,256,034 | $2,221,247 | $7,477,281 | 46 |
| Crisis Services | $97,411 | $10,823 | $108,234 | 11 |
| CSCT Children's Mental Health | $14,531 | $8,481 | $23,012 | 405 |
| Dental | $2,135,966 | $913,283 | $3,049,249 | 710 |
| Denturist | $95,241 | $28,502 | $123,743 | 21 |
| Dialysis Clinic | $99,549 | $42,465 | $142,014 | 25 |
| Durable Medical Equipment | $146,432 | $53,378 | $199,810 | 457 |
| EPSDT - Chiropractic | $20,778 | $11,646 | $32,424 | 156 |
| Free Standing Birthing Center | $3,476 | $1,250 | $4,726 | 2 |
| Hearing Aid Dispenser | $6,612 | $2,309 | $8,921 | 36 |
| Home & Community Based Services - Big Sky Waiver | $2,481,124 | $1,477,306 | $3,958,430 | 275 |

| | | | | |
|---|---|---|---|---|
| Home & Community Based Services - SDMI Waiver | $1,092,005 | $649,846 | $1,741,851 | 234 |
| Home Health Agency | $23,380 | $7,881 | $31,261 | 26 |
| Home Infusion Therapy | $63,564 | $24,659 | $88,223 | 14 |
| Hospital - Inpatient | $3,336,844 | $1,082,648 | $4,419,492 | 523 |
| Hospital - Outpatient | $4,113,523 | $1,170,371 | $5,283,894 | 523 |
| Independent Diagnostic Testing Facility | $28,889 | $7,796 | $36,685 | 28 |
| Laboratory | $49,896 | $10,271 | $60,167 | 224 |
| Licensed Clinical Social Worker | $530,230 | $191,211 | $721,441 | 970 |
| Licensed Professional Counselor | $768,158 | $289,353 | $1,057,511 | 1,190 |
| Licensed Marriage and Family Therapist | $4,803 | $2,129 | $6,932 | 12 |
| Mental Health Center | $1,476,207 | $735,165 | $2,211,372 | 55 |
| Mid-Level Practitioner | $174,235 | $51,056 | $225,291 | 5,897 |
| Mobile Imaging Service | $3,935 | $1,469 | $5,404 | 2 |
| Nursing Home | $9,157,356 | $5,145,645 | $14,303,001 | 59 |
| Nutritionist/Dietician | $5,686 | $3,097 | $8,783 | 123 |
| Occupational Therapist | $148,325 | $82,089 | $230,414 | 384 |
| Optician | $3,543 | $1,319 | $4,862 | 21 |
| Optometrist | $230,547 | $81,925 | $312,472 | 258 |
| Orientation and Mobility | $0 | $0 | $0 | 2 |

| | | | | |
|---|---|---|---|---|
| Personal Care Agency | $49,390 | $25,417 | $74,807 | 72 |
| Personal Care Agency - Adult MH | $1,325 | $502 | $1,827 | 37 |
| Personal Care Agency - Child MH | $650 | $388 | $1,038 | 13 |
| Pharmacy Dispensing Fee | $666,637 | $179,517 | $846,154 | 493 |
| Physical Therapist | $294,654 | $83,434 | $378,088 | 1,139 |
| Physician | $75,926 | $24,960 | $100,886 | 13,251 |
| Podiatrist | $673 | $182 | $855 | 83 |
| Private Duty Nursing Agency | $390,687 | $233,214 | $623,901 | 5 |
| Psychiatric Res Treatment Facility | $1,101,233 | $643,880 | $1,745,113 | 27 |
| Psychiatrist | $30,665 | $8,102 | $38,767 | 303 |
| Psychologist | $39,495 | $16,080 | $55,575 | 260 |
| Public Health Clinic | $12,719 | $4,222 | $16,941 | 42 |
| School Based Services | $137,297 | $80,888 | $218,185 | 79 |
| Speech Pathologist | $104,752 | $61,348 | $166,100 | 332 |
| Targeted Case Management - Children and Youth with Special Health Care Needs | $25,581 | $12,784 | $38,365 | 17 |
| Targeted Case Management - High Risk Pregnant Women | $1,664 | $832 | $2,496 | 17 |
| Targeted Case Management - Mental Health | $207,021 | $79,648 | $286,669 | 24 |
| Therapeutic Family Care | $496,490 | $293,141 | $789,631 | 14 |

| | | | | |
|---|---|---|---|---|
| Therapeutic Group Home | $357,957 | $210,310 | $568,267 | 24 |
| Specialized Transportation | $673 | $324 | $997 | 10 |

5. The department intends to apply these proposed rule amendments retroactively to July 1, 2023, January 1, 2024, May 1, 2024, and July 1, 2024.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Bailey Yuhas, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail hhsadminrules@mt.gov, and must be received no later than 5:00 p.m., June 21, 2024.

7. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

8. 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. Such written request may be mailed or delivered to the contact person in 6 above.

9. An electronic copy of this notice is available on the department's web site at https://dphhs.mt.gov/LegalResources/administrativerules, or through the Secretary of State's web site at http://sosmt.gov/ARM/register.

10. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

11. 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.

12. 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.

/s/ Brenda K. Elias
Brenda K. Elias
Rule Reviewer

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

Certified to the Secretary of State May 14, 2024.