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DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-285.1

Summary

Amendment of ARM 37.86.5102 and 37.86.5303 pertaining to the Passport to Health Program

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Hearing Date and Time

Friday, February 27, 2026, at 9:00 a.m.

Virtual Hearing Information

Join Zoom Meeting: https://mt-gov.zoom.us/j/87223149708?pwd=jQM73Ib0hEimbboj2GIa0bBfibhk93.1

Meeting ID: 872 2314 9708 and Password: 830174

Dial by Telephone: +1 646 558 8656

Meeting ID: 872 2314 9708 and Password: 830174

Find your local number: https://mt-gov.zoom.us/u/kefd6numpS

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, March 6, 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 Friday, February 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:

37.86.5102 PASSPORT TO HEALTH PROGRAM: DEFINITIONS

(1) "Case management" means directing and overseeing the delivery of certain services to an enrollee.

(2) "Clinic" means a federally qualified health center, a rural health clinic, an Indian health service clinic on a reservation, or any other clinic as defined in ARM 37.86.1401 which can meet the requirements of ARM 37.86.5111.

(3) "Emergency service" means, as defined at ARM 37.82.102(11), inpatient and outpatient services that are necessary to treat an emergency medical condition.

(4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(5) "Enroll" means to choose a primary care provider.

(6) "Enrollee" means a Medicaid member participating in the program and who is enrolled with a primary care provider under the program.

(7) "Exempt" means a Medicaid member who is:

(a) eligible for managed care but able to establish that participating would be a hardship;

(b) enrolled in a health maintenance organization that provides case management services;

(c) unable to find a primary care provider willing to provide case management; ~~or~~

(d) residing in a county in which there are not enough primary care providers to serve the Medicaid population required to participate in the program; or~~. The department has the discretion to determine hardship and to place time limits on all exemptions described in (a) through (d) on a case-by-case basis.~~

(e) a Medicaid member who has entered into a Direct Patient Care agreement as defined by 50-4-107, MCA, for primary care services as defined in ARM 37.86.5102(12), who is receiving primary care services under such agreement in accordance with 53-6-116(7), MCA. The department has the discretion to determine hardship and to place time limits on all exemptions described in (a) through (e) on a case-by-case basis.

(8) "Ineligible" means a Medicaid member who is not eligible to participate in a managed care program, such as the Passport to Health Program, but is eligible for regular Medicaid. The following categories of members are ineligible for the Passport to Health Program:

(a) eligible for Medicaid with a spend down (medically needy);

(b) living in a nursing home or institutional setting;

(c) receiving Medicaid for less than three months;

(d) eligible for Medicare;

(e) eligible for Medicaid adoption assistance or guardianship;

(f) eligible for pregnancy Medicaid;

(g) retroactive Medicaid eligibility;

(h) receiving Medicaid home and community-based services for persons who are aged or disabled;

(i) eligible for Plan First;

(j) receiving Medicaid under a presumptive eligibility program; and

(k) eligible for the Breast and Cervical Cancer program.

(9) "Medical care" means care provided to meet the medical and medically related needs of a person.

(10) "Participate" means compliance with the requirements of the program.

(11) "Passport to Health Program" or "the program" means the Primary Care Case Management (PCCM) Program for Medicaid members.

(12) "Primary care" means medical care provided at a person's first point of contact with the health care system, except for emergencies. It includes treatment of illness and injury, health promotion and education, identification of persons at special risk, early detection of serious disease, promotion of preventive health care, and referral to specialists when appropriate.

(13) "Primary care case management" or "managed care" means promoting the access to, coordination of, quality of, and appropriate use of medical care, and containing the costs of medical care by having an enrollee obtain certain medical care from and through a primary care provider.

(14) "Primary care provider" means a physician, clinic, or midlevel practitioner other than a certified registered nurse anesthetist that is responsible by agreement with the department for providing primary care case management to enrollees in the Passport to Health Program.

(15) "Referral" means the approval by the Passport enrollee's primary care provider for the delivery by another provider of a service(s) that requires Passport referral. Referral is the provision of the primary care provider's ~~Passport~~ program referral number to the other provider. The primary care provider shall establish the parameters of the referral.

(16) "Team Care" means a program for members identified as excessive or inappropriate utilizers of the Medicaid program as set forth in ARM 37.86.5303.

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

Implementing statute(s): 53-6-113, 53-6-116, MCA

37.86.5303 PASSPORT TO HEALTH'S TEAM CARE PROGRAM

(1) A recipient may be subject to restrictions on, or prior approval for, physician related services, pharmacy services or any other services covered by the Mmedicaid Pprogram if the department determines that the recipient's utilization of service is excessive, inappropriate, or fraudulent with respect to medical need.

(2) The restrictions described in (1) may be imposed if any of the following events occur:

(a) the recipient seeks medical services that are not medically necessary;

(b) there is multiple provider usage that results in the receipt of unnecessary services;

(c) there is repeated use of emergency rooms for routine medical services;

(d) there is unwarranted multiple pharmacy usage, indicated by the use of more than three pharmacies, that results in the receipt of unnecessary prescriptions;

(e) there is admission of or conviction for forgery of Mmedicaid drug prescriptions by the recipient; or

(f) the recipient utilizes a Mmedicaid card in any unlawful or fraudulent manner.

(3) The department will use payment records, reports from medical consultants, provider referrals or other pertinent recipient or service information, to determine if recipient overutilization, or other abuses, have occurred.

(4) A recipient's restriction does not apply to other members of the household.

(5) Restriction of Mmedicaid services may include limiting a recipient to a designated provider or providers or requiring the recipient to obtain department approval to receive non-emergent services. A recipient with restricted services is participating in the Tteam Ccare Pprogram. Medicaid payment for medical services provided to a Tteam Ccare Program participant will only be made to the recipient's designated provider(s) except:

(a) when emergency services, as defined at ARM 37.82.102(11), are required;

(b) when the designated provider refers the recipient to another provider; or

(c) when the department approved the service prior to performance.

(6) A recipient restricted to the Tteam Ccare Pprogram is required to participate in the Ppassport to Hhealth Pprogram set forth in this subchapter unless the recipient is ineligible, or exempt, as ~~that~~ those terms ~~is~~ are defined in ARM 37.86.5102.

(7) A recipient whose medical service usage meets the criteria for restriction listed in (2), but who is ineligible for the Ppassport to Hhealth Pprogram for the reasons listed in ARM 37.86.5102, may be required to participate in the Tteam Ccare Pprogram. A recipient living in a nursing home or institutional setting or a recipient whose eligibility period is only retroactive cannot be required to participate in either the Ppassport ~~for~~ to Hhealth or the Tteam Ccare Pprograms.

(8) The department will notify a recipient in writing at least 10 days prior to the date of the intended action restricting medical services paid by the Mmedicaid Pprogram.

(9) The department will determine the provider type to which the recipient is restricted (pharmacy, physical health provider or both). The recipient will have an opportunity to choose the recipient's primary care provider and pharmacy unless:

(a) the department determines that the selected provider has been sanctioned by the department in accordance with ARM 37.85.501;

(b) the designated review organization has determined that the selected provider has not properly managed the medical care of a recipient who has been restricted; or

(c) the selected provider will not accept the recipient as a patient.

(10) The recipient will have 10 days from the date of notification of restriction by the department to choose a primary care provider and a pharmacy provider. If the recipient does not choose a primary care provider and a pharmacy provider within 10 days, a primary care provider and a pharmacy will be selected for the recipient. If the department is unable to obtain a primary provider for the restricted recipient, all non-emergency services must be prior authorized by the department.

(11) A restricted recipient may request a change of provider. The request must be in writing and submitted to the department for approval. Provider changes will not be approved unless the department determines that there is good cause for the requested provider change. The department will have 30 days to take action on the request.

(12) The department will review all restricted recipients annually unless the recipient's medical service usage indicates an earlier review should occur. Restriction may be continued if:

(a) the department determines the recipient's use of services has remained excessive or unnecessary. Examples of excessive or unnecessary usage include, but are not limited to, those listed in (2);

(b) the designated provider recommends, with supporting rationale, that the recipient should remain restricted; or

(c) the recipient has received or attempted to receive ~~m~~Medicaid services not authorized under the restricted card program.

(13) A recipient aggrieved by an adverse departmental action under this rule may request a fair hearing in accordance with ARM Title 37, chapter 5, subchapter 3 ~~37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337~~.

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

Implementing statute(s): 53-6-104, 53-6-113, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing amendments to ARM 37.86.5102 and ARM 37.86.5303 governing the Passport to Health Program and Team Care Program.

These amendments are reasonably necessary to implement recent changes in Montana law, including amendments to the Montana Code Annotated and 2025 legislative direction specifying that Medicaid members who have entered into a Direct Patient Care (DPC) agreement are not required to participate in the Primary Care Case Management (PCCM) Program. The amendments clarify eligibility, exemption, and participation requirements for the Passport to Health Program, update definitions in accordance with current administrative practice, and align rule language with statutory changes.

The proposed amendments:

- Clarify that Medicaid members receiving services under a DPC agreement are exempt from Passport to Health Program participation, consistent with the requirements in 53-6-116(7), MCA, and the legislative directive from the 2025 session.
- Clarify the requirements for a member to be ineligible, or exempt, from the Team Care Program in accordance with ARM 37.86.5102.
- Update terminology and program names throughout the rules to provide consistent references to the "Passport to Health Program," "Team Care Program," and related managed care requirements.
- Make grammatical and structural improvements for clarity and consistency.

These changes are intended to increase clarity for providers, stakeholders, and members, and to support compliance with new state legislative requirements.

Small Business Impact

Pursuant to 2-4-111, MCA, the department has determined that the rule changes proposed in this notice will not create a significant and direct impact upon small businesses.

Bill Sponsor Notification

The bill sponsor contact requirements apply and have been fulfilled. The primary bill sponsor of HB 953 from the 2025 Legislative Session was notified by mail on September 15, 2025.

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.

Rule Reviewer

Chanan Brown

Approval

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