



**MONTANA
ADMINISTRATIVE
REGISTER**



DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-93.1

Summary

Amendment of ARM 37.40.307 and 37.40.315 pertaining to Medicaid Nursing Facility Rates

Hearing Date and Time

Monday, December 1, 2025, at 11:00 a.m.

Virtual Hearing Information

Join Zoom Meeting: <https://mt-gov.zoom.us/j/81304733358?pwd=RUrbnbD4ci2oSVAmAQ9yQ1QmNbbcDw.1>

Meeting ID: 813 0473 3358 Password: 236862

Dial by Telephone: +1 646 558 8656

Meeting ID: 813 0473 3358 Password: 236862

Find your local number: <https://mt-gov.zoom.us/j/81304733358?pwd=RUrbnbD4ci2oSVAmAQ9yQ1QmNbbcDw.1>

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, December 5, 2025, 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 Monday, November 17, 2025, 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:

37.40.307 NURSING FACILITY REIMBURSEMENT

- (1) For nursing facility services provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a per-diem rate determined in accordance with this rule, minus the amount of the Medicaid recipient's patient contribution.
- (2) Effective July 1, 2020, and in subsequent rate years, the reimbursement rate for each nursing facility will be determined using the flat-rate component specified in (2)(a) and the quality component specified in (2)(b).
 - (a) The flat-rate component is the same per-diem rate for each nursing facility and will be determined each year through a public process. Factors that could be considered in the establishment of this flat-rate component include the cost of providing nursing facility services and Medicaid recipient access to nursing facility services. The flat-rate component for state fiscal year (SFY) ~~2025~~ 2026 is ~~\$278.75~~ \$287.11.
 - (b) The quality component of each nursing facility's rate is based on the five-star rating system for nursing facility services, calculated by the Centers for Medicare & Medicaid Services (CMS). It is set for each facility based on its average five-star ratings for staffing and for quality. Facilities with an average rating of three to five stars will receive a quality-component payment. The funding for the quality-component payment will be divided by the total

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

- (c) The total payment rate available for the period July 1, ~~2024~~ 2025, through June 30, ~~2025~~ 2026, will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361. Copies of the department's current nursing facility Medicaid reimbursement rates per facility are posted at <https://medicaidprovider.mt.gov/26>, or may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, Helena, MT 59604-4210.
- (3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months' participation in the Medicaid program in a newly constructed facility will have a rate set at the flat rate component as computed on July 1, ~~2024~~ 2025. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider will be set at the previous provider's rate, as if no change in provider had occurred.
- (4) For nursing facility services provided by nursing facilities located outside the state of Montana, the Montana Medicaid program will pay a provider only as provided in ARM 37.40.337.
- (5) The Montana Medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.
- (6) Reimbursement for Medicare coinsurance days will be as follows:
 - (a) for dually eligible Medicaid and Medicare individuals, reimbursement is limited to the per-diem rate, as determined under (1) or ARM 37.40.336, or the Medicare co-insurance rate, whichever is lower, minus the Medicaid recipient's patient contribution; and
 - (b) for individuals whose Medicare buy-in premium is being paid under the qualified Medicare beneficiary (QMB) program under ARM 37.83.201, but are not otherwise Medicaid eligible, payment will be made only under the QMB program at the Medicare coinsurance rate.
- (7) The department will not make any nursing facility per-diem or other reimbursement payments for any patient day for which a resident is not admitted

to a facility bed that is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

- (8) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.
- (9) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider the amount determined under these rules upon receipt of an appropriate billing, which reports the number of patient days of nursing facility services provided to authorized Medicaid recipients during the billing period.
 - (a) Authorized Medicaid recipients are those residents determined eligible for Medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq.
- (10) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules, and policies. All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules.

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

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

37.40.315 STAFFING AND REPORTING REQUIREMENTS

- (1) Providers must provide:
 - (a) staffing at levels ~~which~~ 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.
- (2) Each provider must submit to the department within 15 days following the end of each calendar month a complete and accurate Monthly Nursing Facility Report, prepared in accordance with all applicable department rules and instructions.

- (a) If the department does not receive complete and accurate reports within 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 (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~~ withhold all payments for nursing facility services until the survey is submitted.

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

Implementing statute(s): 53-2-201, 53-6-101, 53-6-108, 53-6-111, 53-6-113, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) proposes to amend ARM 37.40.307 and 37.40.315 pertaining to nursing facility reimbursement and reporting requirements.

These proposed amendments update Medicaid nursing facility rates for state fiscal year (SFY) 2026 and requirements related to reporting.

ARM 37.40.307

The proposed amendments set the flat rate component for Medicaid nursing facility reimbursement at \$287.11 for SFY 2026, which equates to a 3.00% rate increase from SFY 2025. The rate calculation includes House Bill 2 funding appropriated by the Montana Legislature during the 2025 Legislative Session and annualized SFY 2025 Medicaid paid days to determine nursing facility providers' reimbursement methodology outlined under (2) of the rule. In balancing the factors that may be considered under 53-6-113, MCA, and ARM 37.40.307(2) to establish the rate, the department's primary consideration was availability of appropriated funds and availability of services.

Copies of the department's proposed nursing facility Medicaid reimbursement rates are located at: <https://medicaidprovider.mt.gov/proposedfs>.

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

ARM 37.40.315

The department is proposing to revise and simplify this rule by removing language under (2)(b) that is redundant to language in (2)(a) requiring quality and performance data to be provided as part of submitting a complete and accurate Monthly Nursing Facility Report. The department is also proposing to revise (3) to provide for consistency in the action that may be taken by the department when a provider fails to report data required under the rule.

Fiscal Impact

The estimated total cost of the proposed rate increase is approximately \$5,194,100 for SFY 2026. These amounts do not include at risk provider funds or direct care-wage funding.

The estimated total funding available for SFY 2026 for nursing facility reimbursement is estimated at approximately \$173,136,662 of combined state funds, federal funds, and patient contributions.

The proposed rulemaking will impact approximately 2,269 Medicaid members and 57 nursing facility providers.

Small Business Impact

Pursuant to 2-4-111, MCA, the class of small businesses affected by the proposed rulemaking are those operating skilled nursing facilities that are enrolled as Medicaid providers. The probable and significant direct effects on these small businesses are that they will receive an increased rate of reimbursement for Medicaid nursing facility services that are provided.

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 department intends to apply the proposed rate increase under ARM 37.40.307 retroactively to July 1, 2025. All other proposed amendments are intended to be effective the day after the date of publication of the adoption notice.

Medicaid Performance-Based Statement

Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

Rule Reviewer

Robert Lishman

Approval

Charles T. Brereton, Director

Department of Public Health and Human Services