RESERVE

MONTANA ADMINISTRATIVE REGISTER

1981 ISSUE NO. 4
PAGES 156-183

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules or amendment or repeal of existing rules filed with the Secretary of State. Proposals of the Department of Revenue are reviewed only in regard to the procedural requirements of the Montana Administrative Procedure Act. The Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a Joint Resolution directing an agency to adopt, amend or repeal a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with existing or proposed rules. The address is Room 138, State Capitol, Helena, Montana, 59620.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a loose-leaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statute and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1.	Consult General Index, Montana Code Annotated to determine department or board associated with subject matter or statute number.
Department	2.	Refer to Chapter Table of Contents, Title 1 through 46, page i, Volume i, ARM, to determine title number of department's or board's rules.
	3.	Locate volume and title.
Subject Matter and Title	4.	Refer to topical index, end of title, to locate rule number and catchphrase.
Title Number and Department	5.	Refer to table of contents, page 1 of title. Locate page number of chapter.
Title Number and Chapter	6.	Go to table of contents of chapter, locate rule number by reading catchphrase (short phrase describing rule.)
Statute Number and Department	7.	Go to cross reference table at end of each title which lists each MCA section number and corresponding rules.
Rule in ARM	8.	Go to rule. Update by checking registers for past 3-4 months for notice of proposed or adopted amendments of rules listed in table of contents of MAR.

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 4

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BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 4.12.1016(1); increasing the fees for inspection of dry edible beans	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULE 4.12.1016(1) INCREASING FEES FOR INSPECTION OF DRY EDIBLE BEANS

TO: All Interested Persons.

1. On March 24, 1981 at 10:30 a.m., a public hearing will be held in room 225 of the Agriculture/Livestock Building, 6th and Roberts Streets, Helena, Montana, to consider the amendment of Rule 4.12.1016(1).

2. The proposed amendment replaces present rule 4.12.1016(1) found in the Administrative Rules of Montana. The proposed amendment would increase the inspection fee from that presently charged.

3. The rule as proposed to be amended provides as follows:

4.12.1016 STORAGE CHARGES FOR DRY BEANS-WAREHOUSEMAN (1) The fees for inspection of DRY EDIBLE BEANS shall be in accordance with the following:

	Minimum Fee	Maximum Fee
~~carlots in bulk~~	~~$10.00 per lot~~	~~$20.00 per lot~~
~~carlots in bags~~	~~6.00 per lot~~	~~20.00 per lot~~
~~warehouse lots~~	~~4.00 per lot~~	~~.03 per 100#~~
~~submitted samples~~		
~~cleaned beans~~	~~3.00 per sample~~	~~5.00 per sample~~
~~uncleaned beans~~	~~4.00 per sample~~	~~6.00 per sample~~

Fee For Certificate Issuance

Official Certificate	$7.50 per certificate
Submitted Certificates	
Cleaned beans	6.50
Uncleaned beans	7.50

Fee For Sampling

$7.00 per hour for every hour at the facility, rail/car, or truck (minimum of 2 hours).

Current mileage/per diem rate as allowed by state.

The above rates do not include travel time to and from the point of inspection.

4. The department is proposing this amendment to its rule to offset the inflationary costs of bean inspection.

5. Interested persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Oran Roy Bjornson, at room 110, Agriculture/Livestock Building, 6th and Roberts Streets, Helena, Montana, no later than March 26, 1981.

6. Raymond W. Brault, Room 229, Agriculture/Livestock Building, 6th and Roberts Streets, Helena, Montana 59620, has been designated to preside over and conduct the hearing.

7. The authority of the agency to make the proposed amendment is based on section 80-3-509 MCA, and the rule implements section 80-3-507 MCA.

BY: W. Gordon McOmber
W. Gordon McOmber, Director
Montana Department of Agriculture

Certified to the Secretary of State February 13, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.9.501, 46.9.504 and 46.9.505 pertaining to the county medical program.	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES 46.9.501, 46.9.504 AND 46.9.505 PERTAINING TO THE COUNTY MEDICAL PROGRAM

TO: All Interested Persons

1. On March 19, 1981, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, at 111 Sanders, Helena, Montana, to consider the amendment of Rules 46.9.501, 46.9.504 and 46.9.505 pertaining to the County Medical Program.

2. The rules as proposed to be amended provide as follows:

46.9.501 GENERAL (1) Medically needy persons may apply to county welfare departments in the county in which they are residing for medical aid and hospitalization care.

(a) Application by a recipient for payment of medical services rendered to him shall be effective retroactively in the minimum amount of five days prior to date of notification to the county of the intent of the recipient to apply for payment of said medical services.

(i) Retroactivity beyond the above five-day limit shall be allowed at the discretion of the county welfare board upon good cause shown for failure to meet said five-day limit.

(2) "Medically needy persons" are those persons who are eligible for general relief as provided in Title 53, Chapter 3, MCA, and meet the requirements set forth in this subchapter.

(3) "Medical aid and hospitalization" means those services under the federal medicaid program which are specified at ARM 46.12.501 and not excluded at ARM 46.12.502.

46.9.504 SCOPE AND DURATION OF SERVICES (1) Counties ~~are~~ shall not ~~required to~~ pay for services which are medically inappropriate. Each county should have a method of reviewing medical claims for appropriateness. Methods of review may include:

(a) review by county doctor or other medical professional contracted by the county;

(b) consultation with providers to assure good communications and relationships;

(c) requiring that utilization review procedures used for medicaid and medicare patients be applied to county medical cases; or

(d) submission of questionable or suspect cases to the ~~medical assistance bureau~~ economic assistance division for referral under the department's contract with the Montana foundation for medical care.

(2) As a minimum, county medical plans must provide needed hospitalization, and physicians' services, ~~and prescribed medications~~. At the option of individual counties, services in addition to ~~basic~~ these services may be offered, provided those services are limited to medical services as defined at ARM 46.9.501(3).

46.9.505 INCOME (1) Applicants and recipients whose income is at or below the current AFDC standard ~~in effect~~ for the ~~medically needy program, as provided in ARM 46.12.201, may be~~ size of household are eligible for medical ~~assistance~~ aid and hospitalization.

(2) Applicants and recipients whose income is between the ~~"medicaid" medically needy~~ current AFDC standard for the size of household and ~~300~~ 200 percent of ~~the current SSI or AFDC~~ that standard ~~for the size of household meet the income requirement subject to a prorated deduction of~~ are eligible for medical aid and hospitalization if they apply all income in excess of the ~~"medicaid" medically needy maximum for a period of six months,~~ current AFDC standard for the size of household to incurred medical expenses. The county will evaluate available income over a period of six months to determine the amount of excess income which must be applied to incurred medical expenses.

(3) The ~~deduction to~~ applicant's or recipient's excess income may be applied to ~~current and future medical needs, but not to retroactive needs. Current needs are those~~ medical expenses which have been incurred within 30 days prior to the date of application, and to medical expenses which are incurred during the six month period over which available income is evaluated.

(4) Applicants or recipients, ~~except for nursing home patients,~~ whose income exceeds current ~~SSI or~~ AFDC standards for the size of household by ~~300~~ 200 percent or more are not ~~considered~~ eligible for ~~the income requirement,~~ medical aid and hospitalization. However, ~~persons in~~ skilled nursing homes patients may be eligible for medical aid and hospitalization without regard to any of the income limits above ~~subject to persons spending~~ if they apply all their income over $25.00 per month ~~for their medical needs,~~ to the cost of their care.

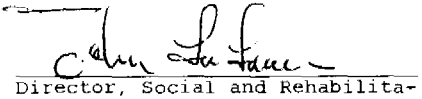
(5) Income is defined as actual or potential gross income from any and all sources. Income may be adjusted by costs necessary to create the income. The ~~department~~ county will evaluate applicants whose income was substantial prior to an illness or injury to determine whether the applicant has the future potential for the same earnings following the illness or injury.

3. The Department finds that Medicaid program expenditures are exceeding the fiscal year 1981 budget authorized by the legislature. To bring expenditures into balance with the budget, the Department is eliminating certain medical services from the program and the medically needy eligibility category. The Department does not intend for the cost of these services to be passed on to county governments. In order to prevent the cost of noncovered medical services from passing on to county medical programs, the Department is limiting allowable county medical expenditures to the same set of services allowed under the Medicaid program. The Department cannot prevent allowable medical expenditures for those who used to qualify under the medically needy eligibility category from passing on to county governments. In order to offset this added cost, the Department is lowering the upper eligibility limit for the county medical program.

4. Interested persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P. O. Box 4210, Helena, Montana, 59604, no later than March 27, 1981.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services, 111 Sanders, Helena, Montana, 59604, has been designated to preside over and conduct the hearing.

6. The authority of the agency to make the proposed amendments is based on Sections 53-2-201, 53-3-102, and 53-3-103, MCA, and the rule implements 53-3-103, MCA.



Director, Social and Rehabilitation Services

Certified to the Secretary of State February 13, , 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.201, 46.12.203, 46.12.501, 46.12.514, 46.12.550 46.12.552, and 46.12.912 pertaining to medical services.	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES 46.12.201, 46.12.203, 46.12.501, 46.12.514, 46.12.550, 46.12.552 and 46.12.912 PERTAINING TO MEDICAL SERVICES

TO: All Interested Persons

1. On March 19, 1981, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, at 111 Sanders, Helena, Montana to consider the amendment of Rules 46.12.201, 46.12.203, 46.12.501, 46.12.514, 46.12.550, 46.12.552, and 46.12.912, pertaining to medical services.

2. The rules as proposed to be amended provide as follows:

46.12.201 MEDICAL ASSISTANCE, ELIGIBILITY REQUIREMENTS

(1) Medical assistance shall be granted on behalf of all persons in the state of Montana, including persons temporarily absent from the state who meet the following requirements:

(a) For the categorically needy:

(i) ~~Those who receive all or part of their income from the federally aided assistance programs which include people who, in December 1973, were eligible for medical assistance as an essential spouse or who has, as spouse, continued to live with and be essential to the well-being of a recipient of cash assistance, so long as the recipient with whom the essential spouse is living continues to meet the December 1973 criteria of the state of Montana's aid to the aged, blind, aid to the permanently and totally disabled assistance, those people who were eligible for aid to dependent children including the unborn child and needy caretaker relative of such children, and recipients of supplemental security income under the categories of aged, blind or disabled, or who would be eligible for such a program if application were made, those persons who, for any month from September 1972, who for the current month would have been eligible for AFDC or SSI, if the increase in monthly insurance benefits under Title II of the Social Security Act resulting from the enactment of P.L. 92-336 had not been applicable to him, provided such individual was, for the month of August 1972, eligible for or receiving OAA, AB, APTD or AFDC and also entitled to monthly payments under Title II of the Act, all blind and disabled persons who meet the current financial eligibility standard of this plan, and in December 1973 met the conditions of eligi-~~

~~bility including financial eligibility for aid under the State's approved ANB or APTD plan and who were eligible under this plan, and who continue to meet the criteria for blindness and disability and meet the financial criteria under the State's approved ANB or APTD plan as in effect in December 1973.~~ Those who receive all or part of their income from the Aid to Families with Dependent Children program (AFDC) or from the Supplemental Security Income program (SSI) or who would have been eligible for such a program if application were made. The AFDC standards are found in ARM 46.10.101 et. seq. The SSI standards are found in 20 CFR, Part 416, which are federal regulations which set eligibility standards for recipients of SSI, and which regulations the department hereby adopts and incorporates herein by reference. A copy of these regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT, 59604.

(ii) ~~Persons in medical institutions who, if they were no longer in such institution, would be eligible for financial assistance under any one of the above programs, including all individuals in medical institutions in December 1973 who, if not institutionalized, would have been eligible for OAA, ANB and APTD and continue to meet December 1973 eligibility criteria.~~ Those who are eligible for medical assistance under the provisions of 42 CFR 435.130 through 435.135 which are federal regulations which allow for the continued eligibility of certain persons eligible for medical assistance in 1972, 1973 and 1977, and which regulations the department hereby adopts and incorporates herein by reference. A copy of these regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT. 59604.

(iii) All children under 21 years who meet the conditions of eligibility for AFDC, other than with respect to school attendance or age.

(iv) All children under 21 years who are in foster care under the supervision of the state, private non-profit child care agency, or private child care institution.

(v) All children under 21 years who were in foster care under the supervision of the state, and who have been adopted as "hard-to-place" children as defined in 53-4-303, ~~section~~ MCA.

(vi) Persons under 21 years who are eligible for any of the above-enumerated federally aided categories shall receive such early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of the conditions discovered to the extent of the services offered under the medical assistance program including the amount, duration and scope of such services.

(b) For ~~the medically needy~~ individuals in skilled nursing facilities who would not be eligible for cash

assistance if they were not institutionalized:

~~(i) Whose income is less than 133 1/3% of the income level for AFDC or the income level for supplemental security income under the categories of aged, blind, or disabled, and,~~ Aged, blind, and disabled individuals in skilled nursing facilities who, because of their income, would not be eligible for SSI or SSI state supplemental payments if they were not institutionalized are eligible for medical assistance if:

(A) Their countable income does not exceed 300 percent of the current SSI standard for an individual or couple in their own home, which standards have been incorporated by reference into this rule. (See ARM 46.12.201(a)(i)); and

(B) All their available income over $40.00 for an individual and $80.00 for a couple is applied to the cost of their care.

~~(ii) In arriving at a determination of whether an individual is eligible for the medically needy program, the division shall evaluate resources and income in the following manner:~~ determining the eligibility of individuals under the income standard established above, countable income means SSI countable income less SSI income disregards. The SSI standards have been incorporated by reference into this rule. (See ARM 46.12.201(a)(i)).

(iii) The department will apply the income standards above effective with the first full month of institutionalization.

~~(A) Clients most closely related to eligibility criteria of supplemental security income and AFDC for the medically needy program shall have their resources and income evaluated in the following manner:~~

~~(I) All real property including a home and lot not to exceed a market value of $26,000 shall be imposed. Income producing property necessary for self-support, producing a reasonable rate of return, is to be excluded as a resource for medically needy eligibility.~~

~~(II) A personal property limitation of $1,500 shall be imposed for a single person or $2,250 for two people with an additional $100 for each additional eligible person in the household and an automobile not to exceed $1,500 retail value. Where the auto is encumbered, the amount of owner equity only will be considered. Exempted for the personal property limitations stated above are household goods, life insurance policies not exceeding a cash value of $1,500 and an auto used for employment or needed for medical purposes. Any individual in a nursing home will be allowed a $25.00 exemption from his income.~~

~~(III) The first $20 of unearned or earned income is to be disregarded and the next $65 plus half the remainder or earned income will be disregarded.~~

~~(IV) Educational grants, scholarships, fellowships, foster care payments and 1/3 of the child support payments~~

~~shall be disregarded.~~

~~(V) A transfer of real property made to bring the persons within the real property limitation of $26,000 is subject to the personal property limitation outlined in (ii) above.~~

~~(VI) All other supplemental security income criteria concerning treatment of income and resources shall be observed where it is appropriate.~~

~~(B) AFDC cases shall have their resources and income evaluated in the manner for medically needy as outlined above.~~

~~(i) The income and resource requirements found in the above paragraph (b) (ii) of this rule shall govern in medically needy cases related to AFDC.~~

~~(ii) The $30 plus 1/3 disregard of earned income is not available as a disregard under the medically needy program.~~

~~(iii) Who meet eligibility requirements under any federally aided assistance program above enumerated with the exception that where the other requirements of AFDC are met, assistance will be granted where it is an unemployed parent in the family who qualifies for assistance as an unemployed parent under ARM 46.10.304.~~

~~(iv) Medically needy individuals who have incomes in excess of 133 1/3% of AFDC eligibility standards become eligible for medical assistance when their incurred medical expenses, both paid and unpaid, are greater than or equal to their excess incomes for four consecutive months, including the month in which eligibility is sought. These medical expenses may be for medical insurance premiums and/or medical services licenses under state law not subject to third party liability.~~

~~(v) Individuals under the age of 21 who are placed in foster homes or private institutions by a public or private non-profit agency or who reside in intermediate care facilities or psychiatric hospitals are eligible for Title XIX, medically needy, if they meet the following requirements:~~

~~(A) Are not within the definition of dependent children, and~~

~~(B) After all of the disregards and set-asides allowed under the AFDC plan and after applying any payment the individual is making toward his care and after any spend down is deducted, has no more than $56.00 per month personal need money, and~~

~~(C) Payments on behalf of persons in state-operated institutions shall be made only from funds appropriated specifically for this purpose, as such funds are available. However, if available funds are not sufficient to provide an adequate medical care program for all eligible persons, first as the categorically needy.~~

46.12.203 ~~MEDICALLY NEEDY, PERSONAL NEEDS All~~ persons Medicaid recipients in a medical institution which partici-

pates in the medicaid program shall be allowed to retain up to $40.00 per month of their income for personal needs.

3. The authority of the agency to make the proposed amendments is based on Section 53-6-113, MCA, and the rules implement Sections 53-6-102, 53-6-113 and 53-6-141, MCA.

4. The rule as proposed to be amended provides as follows:

46.12.501 SERVICES PROVIDED (1) The following items of medical or remedial care and services shall be available to all persons who are certified eligible for Medicaid benefits (including deceased persons, categorically related, who would have been eligible but whose fatal condition prevented them from applying), subject to the conditions and limitations contained in the rules on definitions, requirements and reimbursement for each type of service:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services;

(d) skilled ~~and intermediate~~ nursing services in long term care facilities;

(e) early and periodic screening, diagnosis and treatment;

(f) physician's services~~;~~, except for routine eye examinations;

~~(g) podiatry services;~~

~~(h) outpatient physical therapy services;~~

~~(i) speech therapy; audiology and hearing aids;~~

~~(j) outpatient occupational therapy services;~~

~~(k)~~ (g) home health care services;

~~(l) personal care services in a recipient's home;~~

~~(m)~~ (h) home dialysis;

~~(n) private duty nursing services;~~

~~(o) clinic services;~~

~~(p) dental services;~~

~~(q) outpatient drugs;~~

~~(r) prosthetic devices and medical supplies;~~

~~(s) eyeglasses and optometric services;~~

~~(t)~~ (i) transportation and per diem;

~~(u-~~ (j) family planning services;

~~(v) psychological services.~~

(2) These services will be furnished in or after the third month before the month in which the application was made if the individual was, or upon application would have been, eligible for assistance at the time the care and services were furnished. Coverage is provided for any full month if the individual met all the eligibility requirements at any time during the month.

5. The authority of the agency to make the proposed amendment is based on Section 53-6-113, MCA, and the rule implements Sections 53-6-141 and 53-6-102, MCA.

6. The rules as proposed to be amended provide as follows:

46.12.514 EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT, DEFINITION (1) Early periodic screening diagnosis and treatment services (EPSDT) includes the screening and diagnosis of eligible individuals under the age of 21 to ascertain their physical or mental defects and the ~~full range of~~ services provided ~~by the medicaid program~~ upon EPSDT referral to treat, correct, or alleviate defects in chronic conditions discovered.

(2) Screening services are standardized tests performed under medical direction in a mass examination of a designated population.

(3) Treatment services provided are limited to:

(a) The services listed in ARM 46.12.501; and

(b) The following additional services:

(i) intermediate nursing services in long term care facilities;

(ii) routine eye examinations conducted by a physician;

(iii) podiatry services;

(iv) outpatient physical therapy services;

(v) speech therapy, audiology and hearing aids;

(vi) outpatient occupational therapy services;

(vii) personal care services in a recipient's home;

(viii) private duty nursing services;

(ix) clinic services;

(x) dental services;

(xi) outpatient drugs;

(xii) prosthetic devices and medical supplies;

(xiii) eyeglasses and optometric services;

(xiv) psychological services.

46.12.550 HOME HEALTH SERVICES, DEFINITION (1) Home health services are the following services provided by a licensed home health care agency on a part-time or intermittent basis to a recipient in his place of residence:

(a) nursing services;

(b) home health aide services;

~~(c) physical therapy;~~

~~(d) occupational therapy;~~

~~(e) speech therapy;~~

~~(f)~~ (c) medical supplies and equipment suitable for use in the home.

(2) Nursing service may be provided by a licensed registered nurse in geographic areas not covered by a licensed home health agency.

46.12.552 HOME HEALTH SERVICES, REIMBURSEMENT (1) Reimbursement for home health services will be at cost, subject to upper limits defined in (3), as determined by an audit conducted according to Title XVIII of the Social Security Act definition of allowable costs~~, except that payment by the home health agency for contracted therapy services may not exceed the Montana state medicaid therapy fee schedule as an allowable cost for the contracted service~~.

(2) Reimbursement will be paid through interim rates during a cost report period as determined by the home health agencies' Title XVIII of the Social Security Act fiscal intermediary, with retroactive settlement for actual allowable costs at the conclusion of the report period.

(3) Reimbursement for home health services will be the lesser of usual and customary charges which are reasonable or the maximum amount payable by medicare.

(4) Total payment for home health services will not exceed $400.00 per recipient per month without prior authorization of the department.

(5) Reimbursement for nursing service provided by a licensed registered nurse in geographic areas not covered by a home health agency will be $7.50 per hour.

(6) These rules take precedence over any other home health service reimbursement rules found in this title.

46.12.912 EYEGLASSES, REQUIREMENTS (1) Each recipient ~~21 years old or younger~~ is limited to one pair of eyeglasses per fiscal year ~~and each recipient over 21 years old is limited to one pair of eyeglasses every two fiscal years~~ unless one of the following circumstances exists:

(a) a recipient has had cataract surgery;

(b) when there is:

(i) a .50 diopter change in correction in can sphere, cylinder, vertical prism or near heading power; or

(ii) a minimum of a 5 degree change in any cylinder axis of .50 diopters or more; or

(iii) any 1 degree or more prism change in lateral prism; or

(c) a recipient is unable to wear bifocals because of a diagnosed medical condition.

(2) Contact lenses may be provided only when they are medically necessary. They shall not be allowed for cosmetic reasons. Claims for contact lenses must be accompanied by a statement explaining the medical reason for them.

(3) A recipient shall be allowed repairs on a pair of glasses during the fiscal year not to exceed the amount of an additional pair of glasses.

7. The authority of the agency to make these remaining proposed amendments is based on Section 53-6-113 and 53-2-201, MCA, and the rules implement Sections 53-6-101, 53-6-102 and 53-6-141, MCA.

8. The Medicaid Program has experienced a greater number of recipients using Medicaid services than had been anticipated when the budget for fiscal year 1981 was prepared two years ago. The increase in recipient users has caused expenditures to exceed budget projections for the fiscal year by an estimated $7.5 million dollars. The Director of the Department is required by law to hold expenditures within appropriations granted by the state legislature. In order to meet existing budget limits, the Department must eliminate services that are defined by federal Medicaid standards to be optional and the medically needy eligibility category. The medical services that will remain in the program are considered to be essential, medically necessary services to prevent life threatening situations or services needed by eligible children.

9. Interested persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana, 59604, no later than March 27, 1981.

10. The Office of Legal Affairs, Department of Social and Rehabilitation Services, 111 Sanders, Helena, Montana, 59604, has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State February 17, 1981.

BEFORE THE DEPARTMENT OF REVENUE

OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT OF RULE 42.21.122, relating to the valuation of livestock.	NOTICE OF DEPARTMENT DECISION ON PROPOSED AMENDMENT OF RULE 42.21.122, relating to the valuation of livestock.

TO: All Interested Parties:

1. On November 15, 1980, the Department of Revenue published notice of a public hearing on a proposed amendment to Rule 42.21.122, relating to the valuation of livestock, at pages 2897 and 2898 of the 1980 Montana Administrative Register, issue no. 21. This rule-making proceeding was and is pursuant to a petition submitted by the Montana Stockgrowers' Association.

2. The Department has decided not to amend the rule as proposed, but rather to leave the rule in its present form.

3. Pursuant to the Stockgrowers' petition, the Department conducted a public hearing on December 9, 1980. Numerous parties appeared on behalf of the Stockgrowers' proposal. However, while instances of discrepancies between market value under the existing rule and market value from sales data were presented, the Stockgrowers' did not present detailed market studies. On the other hand, Ms. Betty Whaley, Big Horn County Assessor, presented considerable data to show a market value considerably in excess of that computed pursuant to the rule. However, the Stockgrowers challenged the validity of the data presented by Ms. Whaley. In reviewing the presentation given by both proponents and opponents, the Department is left with a difficult decision. One party has data indicating the present rule overestimates market value, the other party data that the present rule underestimates market value. Given this conflicting data, the Department believes it best to retain the present rule and reject the amendments proposed by the Stockgrowers and the alternative presented by Ms. Whaley.

It should be noted that there was no opposition expressed at the hearing to reducing the two classes of bulls to a single class and to using the cow average price in lieu of the beef average price. The disagreement between proponents and opponents concentrated on the factors to be used to determine market value. Rather than compute a third set of factors, the Department has decided to simply retain the existing rule. It is the intention of the Property Assessment Division to conduct its own market studies and to assess the need for amending Rule 42.21.122 for next year.

The recommendation of the hearings officer was to accept the Stockgrower proposal. This decision was based on the fact that since all parties agreed that cow average price could be used, the factor was to be determined solely on the basis of average

weight of the various classes of cattle. On this basis, the hearings officer recommended adoption of the Stockgrower proposal. However, the Department must be guided by the concept of market value. Hence as discussed above, the Department will retain the present language of the rule.

The question was raised as to the treatment of livestock that were not fairly treated by the rule, regardless of which particular version. It is the Department's position that an appeal to the County Tax Appeal Board provides the mechanism to address individual grievances.

ELLEN FEAVER, Director
Department of Revenue

Certified to the Secretary of State 2-12-81.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.12.1204(3) pertaining to the reimbursement for skilled nursing and intermediate care services, reimbursement method and procedures.	)))))	NOTICE OF THE AMENDMENT OF RULE 46.12.1204(3) FOR SKILLED AND INTERMEDIATE CARE SERVICES, REIMBURSEMENT METHOD AND PROCEDURE

TO: All Interested Persons

1. On December 26, 1980, the Department of Social and Rehabilitation Services published notice of a proposed amendment to Rule 46.12.1204(3) pertaining to reimbursement for skilled and intermediate care services, reimbursement method and procedure at page 3099 of the Montana Administrative Register, issue number 24.

2. The agency has amended the rules with the following changes:

46.12.1204(3) Retrospective Rate. The retrospective rate shall be issued upon audit of a cost report for the rate year and shall be determined as follows:

~~(a) The retrospective rate for not-for-profit facilities shall be the lesser of the actual allowable cost per day experienced during a provider's rate year or the actual allowable cost from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204(3)(d)).~~

(a) ~~(b)~~ The retrospective rate for ~~for-profit~~ all facilities shall be the lesser of the actual allowable costs per day experienced during the provider's rate year plus a performance incentive factor (see ARM 46.12.1204(b)(i)) or the actual allowable cost per day from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204(3)(d) plus a performance incentive factor (see ARM 46.12.1204(3)(b)~~(i)~~).

(i) To the extent that an interim rate is based on a cost report which did not include return on net invested equity as an allowable cost, for periods beginning January 1, 1981, the interim rate shall be adjusted to allow for the inclusion of this cost when necessary in calculating the retrospective rate.

~~(ii) The performance incentive factor is the amount which is added to a for-profit facility's retrospectively determined rate if the facility meets the department's definition of cost containment. A facility shall have met the definition of cost containment if its operating cost per day is less than the maximum reimbursable operating cost per day as defined in ARM 46.12.1204(3)(e).~~

~~(iii) The performance incentive factor for a facility is determined by the relationship of its allowable operating cost per day in the rate year to the allowable operating costs per day of all participating Montana facilities from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204 (d)). A facility with operating costs per day which are equal to or less than the 66th percentile of all reported costs plus the applicable trend factor shall receive a performance incentive factor of $1.50 per patient day. A facility with operating costs per day which fall between the 66th percentile and the 76th percentile of all reported operating costs per day plus the applicable trend factor shall receive a performance incentive factor of $1.00 per patient day. A facility with operating costs per day which are equal to or greater than the 76th percentile of all reported costs per day plus the applicable trend factor, but which are less than the maximum reimbursable cost per day, shall receive a performance incentive factor of $0.50 per patient day.~~

(b) The performance incentive factor is the amount which is included in a provider's retrospectively determined rate if the provider meets the department's definition of cost containment. A facility shall have met the definition of cost containment if its operating cost per day is less than the maximum reimbursable operating cost per day as defined in ARM 46.12.1204(3)(c) and if the facility has been operated economically as defined in 46.12.1202(1).

(i) The performance incentive factor to be included in the retrospectively determined rate of a provider which has operated economically (see ARM 46.12.1202(1)) is determined by the relationship of its allowable operating cost per day in the rate year to the allowable operating costs per day of all participating Montana facilities from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204(3)(d)). A facility with operating costs per day which are equal to or less than the 66th percentile of all reported operating costs plus the applicable trend factor shall receive a performance incentive factor of $1.50 per patient day. A facility with operating costs per day which fall between the 66th percentile and the 76th percentile of all reported operating costs per day plus the applicable trend factor shall receive a performance incentive factor of $1.00 per patient day. A facility with operating costs per day which are equal to or greater than the 76th percentile of all reported operating costs per day plus the applicable trend factor, but which are less than the maximum reimbursable cost per day, shall receive a performance incentive factor of $0.50 per patient day.

(ii) The performance incentive factor to be included in the retrospectively determined rate of a provider which has not operated economically (see ARM 46.12.1202 ~~(2)~~ (1)) is determined by the relationship of its allowable operating cost

per day in the rate year to the allowable operating cost per day of all participating Montana facilities from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204 (3)(d)) and by the relationship of its allowable operating cost per day of the rate year to its allowable operating cost per day of the applicable prior fiscal year plus a trend factor. The maximum performance incentive factor for this provider will be determined under the method indicated in ARM 46.12.1204(3)(b)(i), however, this maximum performance incentive factor shall be adjusted by subtracting from it twice the difference between the allowable operating cost per day for the rate year and the allowable cost per day from the applicable prior fiscal year plus a trend factor (see ARM 46.12.1204(3)(d)). The amount of the adjustment shall not exceed the maximum performance incentive factor. Any amounts overpaid by the department under this section shall be recovered by the department in accordance with ARM 46.12.1205 (8)(b) through (g).

(iii) An estimation of the performance incentive factor includable in the retrospective rate shall be included in the interim rate except where a provider requests that the rate not include the performance incentive factor. The amount of estimated performance incentive factor to be included in the interim rate will be determined by the relationship of a provider's allowable operating cost per day from the applicable prior fiscal year to the allowable operating cost per day of all participating Montana facilities for the same period. The amount of performance incentive to be included in the interim rate will be determined through the method set forth in 46.12.1204.3(b)(i).

3. Comment: Inclusion of a penalty factor with respect to facilities whose operating costs total more than the previous year's costs plus the trend factor fails to take into account many circumstances which would cause an efficiently operated facility to be unable to meet the Department's definition of an economically operated facility. Examples would include: 1) Uncontrollable increases in utility costs or taxes; or 2) Federal and/or State laws and regulations which could mandate changes resulting in increased costs.

Response: ARM 46.12.1204 (7) provides that any facility which can demonstrate that its current rate of reimbursement does not cover its actual operating costs will, upon request, be granted a rate review. Under that process, costs which are found to be extraordinary and uncontrollable will be reimbursed in full. Extraordinary costs include utility increases, property tax increases, and cost increases directly caused by Federal or State mandates.

Comment: How will facilities whose costs have increased above the trend factor, but whose increased costs have been approved through the rate review process, be treated under this rule?

Response: A facility whose rate for a given period has been determined under rate review, and who then operates at or below that rate, will meet the definition of an economically operated facility. For future periods, since actual allowable costs will be used as a base for determining economic operation, facilities having undergone rate review and which return to the formula system will be treated in exactly the same manner as non-rate reviewed facilities.

Comment: Registered Nurse's wages must be raised more than the CPI due to an industry shortage nationwide, and thus indexing will fall short of increased costs.

Response: The Department's inflation index is not based exclusively on the CPI but rather it includes a separate labor component as well as food and other components. Therefore, the cost of any nationwide shortage of RN's will be adequately reflected in the change in hourly wages for employees in nursing and personal care facilities. The change in wages for this group is the basis of the labor component of the index.

Comment: Collective bargaining wage increases cannot be controlled by a facility.

Response: It is the Department's position that wage increases are always controllable, regardless of whether or not the facility is unionized.

Comment: This incentive factor should be used to upgrade services within the homes. A facility will be penalized if it spends these funds on patients but not if those funds are taken out as profit.

Response: The specific purpose of the incentive factor is cost containment. The proposed system will allow facilities to utilize some incentive funds to upgrade services in allowable cost areas. But to encourage the full use of these funds to increase allowable costs would be counter-productive to the stated purpose of the incentive factor.

Comment: The penalty section of this proposed rule change is not necessary because private pay patients and their relatives, as well as locally controlled Boards of Directors, put enough pressure on facilities to contain costs.

Response: If this were the case, there would be no need for an incentive factor at all.

Comment: Replacement of a major item of equipment can become necessary at any time and, when it does, a facility might appear to be operating uneconomically.

Response: Indexed limits applicable to incentive factor determination apply only to operating costs, not to property costs.

Comment: No facility, particularly a for-profit facility, is going to spend its discretionary money on allowable costs unless it is absolutely necessary in order to adequately care for the patients. Therefore, there should be no penalty.

Response: The purpose of the performance incentive factor is to reward providers for cost containment. A provider who elects to use the funds provided under the incentive program to operate uneconomically should not be rewarded in the same manner as the provider who operates economically. The method of determining the incentive factor does not prevent a provider from using some of these funds for allowable costs. In fact a provider may use up to one-third of the incentive funds for allowable costs and return only the remaining two-thirds to the Department.

Comment: Does Medicaid have any rules disallowing penalties assessed against incentive factors?

Response: No.

Comment: If one segment of the industry can earn the incentive factor, any other segment should also be able to earn it without a penalty clause. SRS is implying that non-profits are inefficient and that we would add additional costs.

Response: The provisions of this rule will apply equally to all facilities, without regard to their profit status.

Comment: A change in patient mix could require added staff not accounted for by indexing.

Response: This issue will be addressed more fully when a patient assessment technique is adopted. For now, however, the Department's preliminary data indicates that patient mix tends to change very slowly within any given facility and that such change will not significantly impact over-all operating costs, at least not in the short run. A provider having

drastic changes in patient mix may request a rate review to determine if a rate increase is warranted.

Comment: A maximum incentive factor of $1.50 was acceptable for 1980. But as inflation erodes the value of our money, this $1.50 must be increased in order to produce the same degree of incentive.

Response: The cost of Medicaid reimbursement has been increasing dramatically during the past 3 years. The cost per service increased 22% from 1978 through 1980 in Montana and is expected to increase another 30% during the period 1981 through 1983. Many states are facing financial crises in their Medicaid programs and have been forced to take drastic measures to curb cost escalation. For example, one state has recently decreased the performance incentive factor from $1.50 per day to $1.00 per day. This Department has an obligation to taxpayers to curtail the ever increasing cost of the Medicaid program. Therefore, the maximum performance incentive factor will remain at $1.50 per patient day during the 1982-83 biennium. The Department maintains that the proposed performance incentive is sufficient to encourage cost containment. Should it become evident during the next biennium that this amount is not contributing to cost containment objectives, the Department will amend the rule accordingly.

Comment: Because the amount of incentive decreases as a facility's relative operating costs increase, non-economical facilities are already being penalized. Why make a punitive system worse?

Response: The Medicaid program is designed to reimburse providers for the cost of providing care to the poor and medically needy and to recognize the right of for-profit providers to receive a reasonable return on their investment. The only reason that a performance incentive factor is included in rates is that this Department has assumed that by rewarding providers for cost containment, the long term effect will be to control the cost of this program to taxpayers. The past rules on performance incentive factor were causing Medicaid costs to increase at a greater rate than inflation because the funds from the incentive were being used for allowable costs. Rather than completely removing the incentive factor from the rate, the method of paying these funds was redesigned to insure that the original goal of cost containment would be met.

Comment: You are making the rule too complex.

Response: The Department has tried to keep its rules as uncomplicated and direct as possible while at the same time maintaining an equitable and cost-conscious reimbursement system.

Comment: Under this proposed rule, a facility could be encouraged to reduce its level of care to the State and/or Federal minimums in order to reap a maximum incentive amount. Have monetary considerations become more important than the residents?

Response: Quality care for Medicaid recipients is the most basic concern of the entire Medicaid program. However, it is also necessary to recognize the reality of limited funding. The Department is, in effect, charged with insuring quality care within the framework of a cost-contained environment. Properly enforced State and Federal standards coupled with implementation of this proposed incentive rule will serve to effectively balance the need for quality care with the need for cost containment.

Comment: Why were the 66th, 76th, and 90th percentiles chosen as the break-points for incentive factor categories?

Response: Through an analysis of 1978 operating costs, the Department determined that half of the facilities above the mean cost should receive the maximum performance incentive. The 67th percentile was chosen because 50 percent of the facilities with costs above the mean fell below this percentile. In order to stay within the declining percentile concept as suggested by the Denver Regional Office of the Health Care Finance Agency, it was determined that half of the facilities above the 66th percentile should receive two-thirds of the maximum incentive and that the remaining facilities should receive one-third of the maximum incentive.

By: _____
Director, Social and Rehabilitation Services

Certified to the Secretary of State February 11, 1981.

VOLUME NO. 39 OPINION NO. 5

CONSERVATION DISTRICTS - Duty of board of county commissioners to levy assessment reported by conservation district supervisors;
COUNTY COMMISSIONERS - Duty of board of county commissioners to levy assessment reported by conservation district supervisors;
TAXATION AND REVENUE - Duty of board of county commissioners to levy assessment reported by conservation district supervisors;
MONTANA CODE ANNOTATED - Sections 76-15-501, 76-15-505, 76-15-506, 76-15-515, 76-15-516, 76-15-520.

HELD: Section 76-15-516, MCA, imposes a mandatory duty on the board of county commissioners of each county in which there is a conservation district to levy an assessment on the taxable real property within the district sufficient to raise the amount reported to them in the estimate of the supervisors.

6 February 1981

Harold F. Hanser, Esq.
Yellowstone County Attorney
Yellowstone County Courthouse, Room 508
Billings, Montana 59101

Dear Mr. Hanser:

You have requested my opinion concerning the duty of the board of county commissioners to levy assessments under section 76-15-516, MCA. Specifically, you have asked "whether the language in section 76-15-516, MCA, is mandatory or may the commissioners decline to make a levy within the statutory limit?" Read in the context of Title 76, chapter 15, I conclude that section 76-15-516, MCA, requires the board of county commissioners to levy an assessment sufficient to raise the amount reported to them by the supervisors of a conservation district.

Section 7-15-516, MCA, provides as follows:

> Levy of regular and special assessment. (1) The board of county commissioners of each county in which there lies any portion of the district, may, annually at the time of levying county taxes, levy

an assessment on the taxable real property within the district, except that cities that voted to be included in a district prior to July 1, 1971, shall be excluded from the district by a majority of the council. It shall be known as the "... (name of district) conservation district regular assessment" and shall be sufficient to raise the amount reported to them in the estimate of the supervisors.

(2) The board of county commissioners of each county in which there lies any portion of a project area may, annually at the time of levying county taxes, levy an assessment not to exceed 3 mills on the taxable real property within the project area. It shall be known as "... (name of project area) special assessment" and shall be sufficient to raise the amount reported to them in the estimate of the supervisors.

(Emphasis added.)

Under this statute the board of county commissioners is given the power to levy an assessment on the taxable real property within the district. Section 76-15-515, MCA, limits the amount of this assessment.

Although the term "may" is generally considered to be permissive the Montana Supreme Court has ruled that the term can be construed as mandatory. State ex rel Griffin v. Greene, 104 Mont. 460, 469, 67 P.2d 995 (1937). Other provisions of Title 76, chapter 15, MCA, clearly contemplate that the duty of the board of county commissioners to levy a proper assessment is mandatory.

Section 76-15-501, MCA, provides in pertinent part:

A conservation district and the supervisors thereof shall have the power to:
* * *
(4) cause taxes to be levied in the same manner provided for in this part for the purpose of paying any obligation of the district and to accomplish the purposes of this chapter in the manner herein provided;
* * *

This section implies that the district, and not the board of county commissioners, is vested with any discretion that attends the taxing authority in this part.

Likewise, section 76-15-506, MCA, providing the board of supervisors with the power to issue bonds, would be of no effect if the county commissioners could refuse to make the necessary assessment. In addition, section 76-15-520, MCA, makes county officers liable on their official bonds to "faithfully discharge" their duties connected with the assessment of district taxes.

The final part of your question asks if it would be proper for the Yellowstone Conservation District to register warrants up to the amount of their submitted budget inasmuch as no levy was made for this fiscal year. Section 76-15-505, MCA, indicates that when funds raised through the collection of the assessments are not sufficient for the proper maintenance and operation of the district the board may:

> (a) borrow additional funds needed to an amount not to exceed 50 cents per acre for the lands within the district and may pledge the credit of the district for the payment of the same; or
>
> (b) request the county commissioners to issue and register warrants in anticipation of further collections.

THEREFORE, IT IS MY OPINION:

> Section 76-15-516, MCA, imposes a mandatory duty on the board of county commissioners of each county in which there is a conservation district to levy an assessment on the taxable real property within the district sufficient to raise the amount reported to them in the estimate of the supervisors.

Very truly yours,

MIKE GREELY
Attorney General

VOLUME NO. 39 OPINION NO. 6

COUNTIES - Federal Revenue sharing funds, allocation of water and sewer districts.
WATER AND SEWER DISTRICTS - Counties, federal revenue sharing funds.
MONTANA CODES ANNOTATED - Title 7, Chapter 13, parts 22 and 23.

HELD: A Board of County Commissioners does not have authority to allocate federal revenue sharing funds to a water and sewer district.

9 February 1981

Mr. Myron Wheeler
Board of County Commissioners
Teton County Courthouse
Choteau, Montana 59422

Dear Mr. Wheeler:

You have requested my opinion on the following question:

> Does the Board of County Commissioners have the authority to allocate federal revenue sharing funds to a water and sewer district?

A group of rural residents in Teton County has organized to develop a rural water distribution system to provide water to families who presently have to haul their domestic water supplies. These residents propose to create a water district pursuant to Title 7, Ch. 13, pts. 22 and 23, MCA, and have requested that the county grant the district $10,000 in federal revenue sharing funds to use for water quality testing and test drilling.

Federal revenue sharing funds may be spent for any purpose for which local governments may spend or pledge general tax revenues under state law. 37 OP. ATT'Y GEN. NOS. 61 and 105. A county such as Teton County which has not adopted a self-government form of local government has only the powers that are expressly conferred by statute or that are necessarily implied therefrom. Roosevelt County v. State Board of Equalization, 118 Mont. 31, 37, 162 P.2d 887 (1945); State ex rel. Bowler v. County Commissioners, 106 Mont. 251, 257, 76 P.2d 648 (1938).

Article V § 11(5) of the Montana Constitution prohibits appropriations "for religious, charitable, individual, educational or benevolent purposes" unless made to an organization "under the control of the state." This provision has been applied to subdivisions of the state such as counties. 37 OP. ATT'Y GEN. NOS. 25 and 105. Section 7-7-2103, MCA, provides:

> No county must ever give or loan its credit in aid of or make any donation or grant, by subsidy or otherwise, to any individual, association or corporation . . . .

Counties may pay money to individuals or organizations on an exchange basis to provide services or materials that they are authorized by statute to provide to their constituents. 37 OP. ATT'Y GEN NO. 105. Thus the first difficulty with the instant proposal is that no power can be found or necessarily implied to allow counties to directly provide for rural water distribution systems.

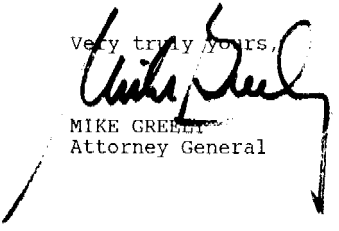
To the contrary, there are specific mechanisms provided in the statutes to provide for the establishment of these services. One of these mechanisms is the water district provided for by Title 7, Ch. 13, parts 22 and 23. See, e.g., 7-13-2218, MCA. While 7-13-2221, MCA, empowers the districts to accept funds from "federal, state, and other public or private sources" there is no apparent power anywhere for the county to be in effect a general fund donor to the district. The financing of district operations is specifically provided for (7-13-2301 et seq., MCA), and the county's only specific involvement is the duty to levy an assessment on the land in the district when the district's revenues are insufficient to pay the principal and interest on any district bonded indebtedness 7-13-2302, MCA.

Therefore, since the county has no specific or necessarily implied power to make the proposed grant, and since specific means of financing and county involvement are provided for, the conclusion is that the county may not make the proposed grant.

THEREFORE IT IS MY OPINION:

A Board of County Commissioners does not have authority to allocate federal revenue sharing funds to a water and sewer district.

Very truly yours,



MIKE GREELY
Attorney General