RESERVE

MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 14

The Montana Administrative Register (MAR), a twice-monthly publication, has three sections. The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and place of public hearing and where written comments may be submitted. The rule section indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Special notices and tables are inserted at the back of each register.

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NOTICE SECTION

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF DENTISTRY

In the matter of the proposed amendment of rules pertaining to board organization, examinations, allowable functions, minimum qualifying standards, minimum monitoring standards, facility standards, reporting adverse occurrences and fees; repeal of rules pertaining to oral interview and applications; and adoption of new rules pertaining to mandatory CPR	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO DENTISTRY

TO: All Interested Persons:

1. On September 13, 1989, at 1:00, p.m., a public hearing will be held in the downstairs conference room of the Department of Commerce building, 1424 - 9th Avenue, Helena, Montana, to consider the amendment, repeal and adoption of the above-stated rules.

2. The proposed amendment of 8.16.101, 8.16.201 and 8.16.202 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rules is located at page 8-499, Administrative Rules of Montana)

"8.16.101 BOARD ORGANIZATION (1) The board of dentistry hereby adopts and incorporates for the practices of dentistry, dental hygiene and denturitry the organizational rules of the department of commerce as listed in Chapter 1 of this title."

Auth: Sec. 2-4-201, MCA; IMP, Sec. 37-1-131, 37-4-205, 37-29-201, MCA

"8.16.201 PROCEDURAL RULES (1) The board of dentistry hereby adopts and incorporates for the practices of dentistry, dental hygiene and denturitry the procedural rules of the department of commerce as listed in Chapter 2 of this title."

Auth: Sec. 2-4-201; IMP, Sec. 37-1-131, 37-4-205, 37-29-201, MCA

"8.16.202 PUBLIC PARTICIPATION (1) The board of dentistry hereby adopts and incorporates for the practices of dentistry, dental hygiene and denturitry by this reference the public participation rules of the department of commerce as listed in Chapter 2 of this title."

Auth: Sec. 2-4-201, MCA; IMP, Sec. 37-1-131, 37-4-205, 37-29-201, MCA

REASON: Section 3, Chapter 524, Laws of 1987, merged the Board of Denturitry and the Board of Dentistry. Amendments

to the above rules simply clarify that the Organization, Procedural and Public Participation rules of the Department of Commerce apply to all licensed dentists, dental hygienists and denturists.

3. The proposed amendment of 8.16.402 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at pages 8-503 and 8-504, Administrative Rules of Montana)

"8.16.402 DENTIST EXAMINATIONS (1) Applications for the ~~oral interview and~~ jurisprudence examinations must be submitted to the office of the board at least 20 days prior to the examination date.

(2) and (3) will remain the same.

(4) The grading will be done by ~~the~~ a board members ~~or~~ department staff. A final grade of at least 75% is required for passing the examination.

~~(5) Results of the state board oral interview and jurisprudence examinations shall be sent to examinees by letter from the department office.~~

(6) through (8) will remain the same but will be renumbered (5) through (7)."

Auth: Sec. 37-1-131, 37-4-205, 37-4-301, MCA; IMP, Sec. 37-4-301, MCA

REASON: The Board elects to delegate to department staff authority to administer and grade the jurisprudence examination. Candidates will be verbally notified by staff of their examination grade upon completing the examination. This change will expedite licensing procedures and allow candidates the opportunity to take the examination in the board office by appointment instead of at a regularly scheduled meeting of the board which limits the number of times to take per year to four. Mandatory oral interviews also are being repealed to expedite licensing procedures. However, the board will retain the authority to require an oral interview if an applicant files a questionable application or discloses in his application that he has been subject to legal or disciplinary action in another jurisdiction. Section 1, Chapter 62 of the Laws of 1987 made oral interviews of applicants discretionary with the Board.

4. The proposed amendment of 8.16.602 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at pages 8-509 through 8-511, Administrative Rules of Montana)

"8.16.602 ALLOWABLE FUNCTIONS FOR DENTAL HYGIENISTS AND DENTAL AUXILIARIES (1) through (4)(k) will remain the same.

(l) monitoring a patient who has been prescribed and administered nitrous oxide by a licensed dentist, and

(m) coronal polishing of the teeth only in preparation for application of fluoride treatment or other operative procedures by the dentist.

(5) through (12) will remain the same."
Auth: Sec. 37-1-131, 37-4-205, 37-4-408, MCA; IMP, Sec. 37-4-401, 37-4-405, 37-4-408, MCA

REASON: Coronal polishing of teeth by dental assistants falls within the acceptable traditional duties delegated to auxiliaries. However, a number of licensees have expressed confusion whether the function is allowable. Therefore, to clarify the issue, it is proposed to explicitly identify the function of coronal polishing by dental assistants as a function permissible under the direct supervision of a licensed dentist.

5. The proposed amendment of 8.16.605 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at pages 8-511 and 8-512, Administrative Rules of Montana)

"8.16.605 DENTAL HYGIENIST EXAMINATION ~~(1) Applicants may be required to write a short essay and answer questions posed to them by one or more members of the board and demonstrate satisfactorily the clinical capabilities required by the board.~~

(2) through (4) will remain the same but will be renumbered (1) through (3).

~~(5)~~ (4) The grading will be done by the a board members or department staff. A final grade of at least 75% is required for passing the examination.

(6) will remain the same but will be renumbered (5).

~~(7)~~ (6) through (e) will remain the same.

(f) certificate of successful completion of examination by the national board of dental hygiene examiners; and

~~(f)~~ (g) will remain the same."

Auth: Sec. 37-1-131, 37-4-205, 37-4-406, MCA; IMP, Sec. 37-4-402, MCA

REASON: The Board has contracted with a regional testing agency for the administration of the required clinical examination for dental hygienists. The examination contract provides that the examination will be in conformance with the standards established by the regional testing agency. Based on the regional testing standards this section in its present form is obsolete. Furthermore, section 2, Chapter 449 of the Laws of 1985 made oral interviews of applicants for licenses to practice dental hygiene discretionary with the board.

Section 8.16.604, ARM, is being repealed, as shown below, and the national board examination requirements are being inserted here with the other examination requirements as a style and drafting amendment.

6. The proposed amendment of 8.16.903, 8.16.904, 8.16.905 and 8.16.908 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rules

is located at pages 8-529 through 8-535, Administrative Rules of Montana)

"8.16.903 MINIMUM QUALIFYING STANDARDS (1) will remain the same.

(2) Dentists providing general anesthesia or conscious sedation must present competent evidence of successful completion of an advanced course in cardiac life support within the three most recent years.

(2) and (3) will remain the same but will be renumbered (3) and (4).

~~(4)--With-respect-to-nitrous-oxide/oxygen-sedation,-no dentist-shall-use-nitrous-oxide/oxygen-on-a-patient-unless he-has-completed-a-course-of-instruction-of-at-least-fourteen (14)-clock-hours-of-didactic-and-clinical-training.--This instruction-must-include-didactic-and-clinical-instruction in-an-accredited-dental-school,-hospital,-or-dental-society sponsored-course,-and-must-include-instruction-in-the-safety and-management-of-emergencies.~~

~~(a)--A-dentist-who-practices-dentistry-in-Montana-who can-provide-satisfactory-evidence-of-competence-and-skill in-administering-nitrous-oxide/oxygen-sedation-by-virtue-of experience-and/or-comparable-alternative-training-shall-be presumed-by-the-Montana-board-of-dentistry-to-have-appropriate credentials-for-the-use-of-nitrous-oxide/oxygen-sedation.~~"

Auth: Sec. 37-1-131, 37-4-205, 37-4-511, MCA; IMP, Sec. 37-4-511, MCA

"8.16.904 MINIMUM MONITORING STANDARDS (1) through (a)(i) will remain the same.

(ii) Electrocardiac monitoring; and

(iii) Pulse oximetery.

(b) through (b)(v) will remain the same.

(vi) Additional monitoring devices as indicated; and

(vii) Pulse oximetery.

(c) through (2)(b)(iii) will remain the same.

(iv) continuous monitoring skin and mucosal color; and

(v) pulse oximetery.

(c) through (c)(iii) will remain the same.

~~(3)--Minimum-standards-for-monitoring-nitrous oxide/oxygen-sedation-shall-include-the-following:~~

~~(a)--When-the-dentist-who-administers-the-nitrous oxide/oxygen-is-not-in-the-operatory-there-must-be-a-dental auxiliary-who-remains-with-the-patient-and-provides-direct observation.--The-dental-auxiliary-must-have-specific instruction-in-the-observation-of-nitrous-oxide/oxygen-sedated patients-and-shall-monitor-the-patient-until-discharged.~~"

Auth: Sec. 37-1-131, 37-4-205, 37-4-511, MCA; IMP, Sec. 37-4-511, MCA

"8.16.905 FACILITY STANDARDS (1) through (g) will remain the same.

(h) suction devices; and

(i) pulse oximeter.

(2) through (3)(b) will remain the same.

(c) When conscious sedation is used, the dentist ~~should~~ shall be qualified and permitted to administer the drugs and appropriately monitor the patient, and be qualified in ~~basic life-support-certified~~ advanced life support. In addition to the dentist, at least one other person in the office must be qualified in basic life support.

~~(4) A facility in which nitrous oxide/oxygen is administered must contain a minimum of equipment and supplies appropriate to meet emergencies.~~"

Auth: Sec. 37-1-131, 37-4-205, 37-4-511, MCA; IMP, Sec. 37-4-511, MCA

"8.16.908 REPORTING ADVERSE OCCURRENCES (1) All dentists engaged in the practice of dentistry in the state of Montana must submit written reports to the board within seven (7) days of any incident, injury, or death resulting in temporary or permanent physical or mental disability, or death involving the application of general anesthesia, or conscious sedation, ~~or nitrous oxide/oxygen sedation~~ administered to any dental patient for whom said dentist, or any other dentist, has rendered any dental or medical service. Routine hospitalization to guard against postoperative complications or for patient comfort need not be reported where complications do not thereafter result in injury or death as herein before set forth. The report required by this rule shall include, but not be limited to, the following information:

(a) through (4) will remain the same."

Auth: Sec. 37-1-131, 37-4-205, 37-4-511, MCA; IMP, Sec. 37-4-511, MCA

REASON: ACLS certification exposes the licensee to a broader spectrum of procedures which may be used in cases of emergencies. It is believed that this requirement will better prepare the dentist to handle adverse reactions in his office should they occur with the administration of general anesthesia and/or conscious sedation. To that extent it enhances the health and safety of the patient.

It is now felt that the board's rules regarding nitrous-oxide sedation could be found to exceed statutory authority. Nitrous oxide is currently defined by medical dictionaries and references an analgesia, not general anesthesia or conscious sedation. It is therefore proposed to delete all reference to administration of nitrous oxide by dentists in this subchapter.

The proposed amendments will require monitoring general anesthesia and conscious sedation with a pulse oximeter. Monitoring with this machine meets the standard of care as determined by the American Society of Anesthesiology and it is felt that the same standard of care should be established for the state of Montana. Requiring the pulse oximetery monitoring also will improve safety and patient care.

6. The proposed amendment of 8.16.909 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at page 8-535, Administrative Rules of Montana)

"8.16.909 FEE SCHEDULE

(1) will remain the same.

~~(2) Full General Anesthesia Original Permit Fee $15.00~~

(3) and (4) will remain the same but will be renumbered (2) and (3).

~~(5) Light General Anesthesia Original Permit Fee $15.00~~

(6) and (7) will remain the same but will be renumbered (4) and (5).

~~(8) Conscious Sedation Original Permit Fee $15.00~~

(9) through (11) will remain the same but will be renumbered (6) through (8)."

Auth: Sec. 37-1-131, 37-1-134, 37-4-105, 37-4-511, MCA; IMP, Sec. 37-4-511, MCA

REASON: The original application fee of $50.00 now adequately covers costs associated with the issuance of permits. Thus the deletion of all original permit fees is being proposed.

7. ARM 8.16.406 is being proposed for repeal. Full text of the rule is located at page 8-504, Administrative Rules of Montana. The authority sections are 37-1-131, 37-4-205, 37-4-301, MCA and the implementing section is 37-4-301, MCA. The reason for the proposed repeal is the same as the one given for the amendment of 8.16.402 shown above.

8. ARM 8.16.604 is being proposed for repeal. Full text of the rule is located at page 8-511, Administrative Rules of Montana. The authority sections are 37-1-131, 37-4-205, 37-4-402, MCA and the implementing section is 37-4-402, MCA. It is proposed to repeal this rule and insert the requirement under ARM 8.16.605, which provides examination requirements for licensure. This is a style and drafting revision.

9. The proposed new rules will read as follows:

"I. DENTIST MANDATORY CPR (1) All licensed active status dentists shall possess a current CPR certificate, a copy of which shall be submitted each year with the annual renewal application."

Auth: Sec. 37-1-131, 37-4-205, 37-4-307, MCA; IMP, Sec. 37-4-307, 37-4-511, MCA

"II. DENTAL HYGIENIST MANDATORY CPR (1) All licensed active status dental hygienists shall possess a current CPR certificate, a copy of which shall be submitted each year with the annual renewal application."

Auth: Sec. 37-1-131, 37-4-205, 37-4-406, MCA; IMP, Sec. 37-4-406, MCA

REASON: Mandatory CPR renewal licensure requirement will lend itself to demonstrating continued competency in a critical aspect of patient care and safety.

10. 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 Board of Dentistry, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than September 13, 1989.

11. Patricia I. England, attorney, of Helena, Montana, has been designated to preside over and conduct the hearing.

BOARD OF DENTISTRY
ROBERT COTNER, DDS

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF RADIOLOGIC TECHNOLOGISTS

In the matter of the proposed amendment of rules pertaining to permit applications, course requirements, permit examinations, temporary permits and the proposed repeal of a rule pertaining to permit restrictions	NOTICE OF PROPOSED AMENDMENT OF 8.56.602 PERMIT APPLICATION, 8.56.602B COURSE REQUIREMENTS FOR LIMITED PERMIT APPLICANTS, 8.56.602C PERMIT EXAMINATIONS, 8.56.604 TEMPORARY PERMITS AND THE PROPOSED REPEAL OF 8.56.606 PERMIT RESTRICTIONS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 26, 1989, the Board of Radiologic Technologists proposes to amend and repeal the above-stated rules.

2. The proposed amendments and the reasons for the amendments will read as follows: (new matter underlined, deleted matter interlined) (full text of the rules is located at pages 8-1571 through 8-1574, Administrative Rules of Montana)

"8.56.602 PERMIT APPLICATION (1) and (1)(a) will remain the same.

(b) application fee and exam fees, and

(c) through (3) will remain the same."

Auth: Sec. 37-1-134, 37-14-202, 37-14-306, MCA; IMP, Sec. 37-14-303, 37-14-306, MCA

REASON: It will be more convenient for applicants to pay all required fees at the same time and the processing of license applications will be expedited.

"8.56.602B COURSE REQUIREMENTS FOR LIMITED PERMIT

(1) All qualified courses applications for limited permits ~~shall~~ must be approved by the board in advance.

(a) Course approval shall be ~~completed by~~ based upon board review of the course outline, agenda and instructors qualifications.

(b) through (3)(b) will remain the same.

(c) Spine - ~~16 hours~~ 8 hours

(d) through (f) will remain the same.

(g) Positioning - 8 hours

(4) and (5) will remain the same."

Auth: Sec. 37-1-131, 37-14-202, 37-14-306, MCA; IMP, Sec. 37-14-306, MCA

REASON: Coursework requirements are being revised to reflect changes in the field of radiologic training and education. Currently it is generally felt that 8 hour's training with

respect to the spine is sufficient, but that more training with respect to positioning of patients should be offered.

"8.56.602C PERMIT EXAMINATIONS (1) will remain the same.

(2) The permit examination will be administered by at the board office at least twice a year. Applicants for examination will be notified at least 30 days in advance of the scheduled examination.

(a) will remain the same.

~~(b) Board members may administer the examination to applicants. Applicants shall make the request directly to the board member. If the board member agrees to proctor the examination, the applicant shall notify the board office in writing of the board member who shall be proctoring the examination, the examination date, time and place. All requests shall be received in the board office at least 10 days prior to the scheduled examination.~~

(3) through (8) will remain the same."

Auth: Sec. 37-1-131, 37-14-202, 37-14-306, MCA; IMP, Sec. 37-14-306, MCA

REASON: It will expedite the licensing process if applicants can take the examinations at the first convenient opportunity without deadlines or convenience of board members. The examinations, in their current format, can be administered by staff. Administering examinations by persons other than board members reduces suspicions of anti-competitive attitudes and other personal bias.

"8.56.604 HARDSHIP TEMPORARY PERMITS (1) and (1)(a) will remain the same.

~~(b) a letter from the applicant stating the total number of x-rays which the department has taken in the past month and the total number of x-rays which the applicant assisted on.~~

(c) through (3) will remain the same but will be renumbered.

Auth: Sec. 37-14-202, 37-14-306, MCA; IMP, Sec. 37-14-305, 37-14-306, MCA

REASON: This language is being proposed for deletion because the board feels it is superfluous and archaic.

3. ARM 8.56.606 is being proposed for repeal. Full text of the rule is located at page 8-1575, Administrative Rules of Montana. The authority section is 37-14-202, MCA and the rule implements section 37-14-301, MCA. This rule is being proposed for repeal to delete provisions that are archaic and unnecessarily repeat statutory language.

4. Interested persons may submit their data, views or arguments concerning the proposed amendments and repeal in writing to the Board of Radiologic Technologists, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than August 24, 1989.

5. If a person who is directly affected by the proposed amendments and repeal wishes to express his data, views or

arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Radiologic Technologists, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than August 24, 1989.

6. If the board receives requests for a public hearing on the proposed amendments and repeal from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed repeal, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 18 based on the 186 licensees in Montana.

BOARD OF RADIOLOGIC TECHNOLOGISTS
CAROLE ANGLAND, CHAIRPERSON

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF VETERINARY MEDICINE

In the matter of the proposed adoption of a new rule pertaining to an Advisory Committee	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF NEW RULE I. ADVISORY COMMITTEE

TO: All Interested Persons:

1. On Thursday, August 24, 1989, at 9:00, a.m., a public hearing will be held in the downstairs conference room of the Department of Commerce building, 1424 - 9th Avenue, Helena, Montana, to consider the proposed adoption of the above-stated rule.

2. The proposed new rule will read as follows:

"I. ADVISORY COMMITTEE For the purpose of implementing 37-18-104(3)(B)(IX) as mandated by Sec. 2, Ch. 605 of the Laws of 1989, the following rules set forth the operation of the advisory committee which terminates by law July 1, 1991:

(1) Each entity designated by 37-18-104(3)(B)(IX)(A) will supply to the board on or before September 15, 1989, the name and address of its designated representative to the advisory committee. The Montana veterinary medical association shall designate the committee member who is the veterinarian specialist in theriogenology. As there is no known association or group representing reproductive specialists, the president of the board of veterinary medicine will appoint that committee member from among persons known to be active or knowledgeable in that field.

(2) The advisory committee business will be conducted using Roberts Rules of Order with each committee member, including the chairperson, having one vote.

(3) The advisory committee will be chaired by the representative from the board of veterinary medicine.

(4) A secretary responsible for keeping minutes of the committee meetings will be selected from the remaining members. Limited administrative support may be supplied by the board as requested by the advisory committee chairperson to the president of the board of veterinary medicine.

(5) To facilitate drafting of legislation for the 1991 legislative session, the report and recommendations of the advisory committee on embryo transfer certification will be submitted to the board of veterinary medicine on or before August 15, 1990.

(6) The expenses, if any, of the advisory committee members will be borne by the group they represent."

Auth: Sec. 37-1-131, 37-18-104, MCA; IMP, Sec. 37-1-131, 37-18-104, MCA

REASON: This rule is being proposed to implement the operation of the advisory committee to the Board of Veterinary Medicine mandated by Sec. 2, Chapter 650, of the Laws of

1989, and signed into law by the Governor. The Board hopes to facilitate the committee's tasks by clarifying operational procedures in the rules.

3. Interested 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 the Board of Veterinary Medicine, 1424 - 9th Avenue, Helena, Montana 59620-0407, no later than August 24, 1989.

4. Geoffrey L. Brazier, Helena, Montana, has been designated to preside over and conduct the hearing.

BOARD OF VETERINARY MEDICINE
JAMES N. BROGGER, DVM, PRESIDENT

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE MONTANA STATE LOTTERY

In the matter of the proposed amendment of rules pertaining to the organizational rule and retailer commissions	)))	NOTICE OF PROPOSED AMENDMENT OF 8.127.101 ORGANIZATIONAL RULE AND 8.127.407 RETAILER COMMISSION

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 26, 1989, the Montana State Lottery proposes to amend the above-stated rules.

2. The proposed amendment of 8.127.101 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at page 8-4875, Administrative Rules of Montana)

"8.127.101 ORGANIZATIONAL RULE (1) and (2) will remain the same.

(3) The commission consists of five members appointed by the governor. The commission is allocated to the department of commerce for administrative purposes as prescribed by 2-15-121, MCA. The names and addresses of the members of the commission are as follows:

Spencer Hegstad, 924 S. Pacific, Dillon, Montana 59725
Pat DeVries, P.O. Box 562, Polson, Montana 59806
~~Glenn Osborne, 600 Central Plaza, Suite 426, Great Falls, Montana 59401~~
Jim Moore, Box 1288, Bozeman, Montana 59715
~~Keith Colbo, 1424 9th Avenue, Helena, Montana 59620~~
Becky Erickson, 114 Lomond, Glasgow, Montana 59230
William Ware, 221 Breckenridge, Helena, Montana 59601

(4) The director of the Montana Lottery is appointed by the governor. The director is ~~Diana Stewart Bowling~~ Charles A. Brooke, 2525 North Montana, Helena, Montana 59601. The assistant director for security is appointed by the lottery director. A chart of the organization of the lottery is attached as the following page and by this reference is herein incorporated."

Auth: Sec. 23-5-1007, MCA; IMP, Sec. 23-5-1001 through 23-5-1036, MCA

REASON: The Governor appointed two new Montana Lottery Commission members and a new Lottery Director. This amendment shows those appointments.

3. The proposed amendment of 8.127.407 will read as follows: (new matter underlined, deleted matter interlined) (full text of the rule is located at page 8-4882, Administrative Rules of Montana)

"8.127.407 RETAILER COMMISSION (1) Each retailer is entitled to a 5% commission on of no more than 5% of the face value of tickets sold and chances that they purchase from the lottery and do not return. However, to further the sale of lottery products, the lottery commission may adopt rules providing additional commissions to sales agents based on incremental sales."

Auth: Sec. 23-5-1007, MCA; IMP, Sec. 23-5-1016, MCA

REASON: This amendment reflects the changes made in Sec. 4, Ch. 408, Laws of 1989.

4. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Montana State Lottery, 2525 North Montana, Helena, Montana 59601, no later than August 24, 1989.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any comments he has to the Montana State Lottery, 2525 North Montana, Helena, Montana 59601, no later than August 24, 1989.

6. If the Lottery receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a public hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

MONTANA STATE LOTTERY
SPENCER HEGSTAD, CHAIRMAN

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

BEFORE THE STATE LIBRARY COMMISSION
STATE OF MONTANA

In the matter of the adoption of Rule I pertaining to reimbursement to libraries for interlibrary loans	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I PERTAINING TO REIMBURSEMENT TO LIBRARIES FOR INTERLIBRARY LOAN

TO: All Interested Persons

1. On August 16, 1989, at 8:00 a.m., a public hearing will be held in the meeting room of the Polson Public Library, 112 1st Street East, Polson, Montana to consider the proposed adoption of Rule I pertaining to reimbursement to libraries for interlibrary loan under provisions of H.B. 193.

2. The rule as proposed to be adopted provides as follows:

Rule I REIMBURSEMENT TO LIBRARIES FOR INTERLIBRARY LOANS

(1) Definitions used in this section include:

(a) "Interlibrary loan" means the loaning or provision of copies of library materials from one Montana library to another Montana library. Such materials are to include, but are not limited to, the following: book, copy in lieu of book, magazine/periodical, copy in lieu of magazine/periodical, audiovisual title, government document/technical report and pamphlets, some of which are to be returned.

(b) "Libraries eligible for interlibrary loan reimbursement" means public libraries, libraries operated by public schools or school districts, libraries operated by public colleges or universities, libraries operated by public agencies for institutionalized persons, and libraries operated by nonprofit private educational or research institutions.

(2) Reimbursements will be made on a quarterly basis based on the following:

(a) Reimbursement will be made at the rate of $5.50 per item loaned.

(i) This rate is based upon the estimated number of annual interlibrary loans in Montana.

(ii) This rate may be adjusted if deemed necessary by the state library by dividing the remaining funds by the number of interlibrary loans claimed for reimbursement.

(b) A form for requesting reimbursement will be issued by the state library. No reimbursement shall be made to any library which does not use the reimbursement form to submit its reimbursement request, and which fails to meet specified submittal deadlines for such requests.

(c) Each quarterly payment shall be made only for interlibrary loans within the specified quarter for which reimbursement funding is available. No count of interlibrary loan transactions shall be carried over from one quarter to

another.

(d) Reimbursements will be made within 30 working days of the end of each calendar quarter.

(e) No library may levy service charges, handling charges, or user fees for interlibrary loans for which it is reimbursed under the provisions of H.B. 193 and these rules.

(i) Actual charges for postage are discouraged but not expressly prohibited under these rules.

(ii) Costs for special postal handling of interlibrary loan requests, when requested by the borrowing library, are chargeable costs.

(iii) Interlibrary loans, when completed via telefacsimile means also count as reimbursable interlibrary loans. Costs associated with such telefacsimile transmission are chargeable if such transmission was specified by the requesting library. Such transmissions qualify as special handling.

(iv) Per page photocopying charges may not be separately charged to the borrowing library but are assumed to be covered by the reimbursement under these rules.

(f) Providers of interlibrary loan are expected to follow the law in relation to copyright. Each is responsible for compliance with the law.

(g) Libraries applying for interlibrary loan reimbursement under H.B. 193 and these rules must retain certain records as follows:

(i) The library requesting reimbursement shall retain records of interlibrary loans which support and agree with the number submitted for reimbursement.

(ii) Libraries requesting reimbursement shall retain their records of interlibrary loan transactions for a period of three years and must produce these records for auditing purposes.

(h) For any questions arising because of this rule, the final arbiter is the state library commission.

AUTH: Sec. 22-1-330 MCA
IMP: Sec. 22-1-328 MCA

3. H.B. 193, passed by the 51st Legislature, recognized the need to provide state support for Montana's libraries. The portion of this bill with which this rule deals, provides for the following: (1) the sharing of already existing resources among all of Montana's libraries; (2) the subsidizing of this resource sharing to offset partially the costs of such sharing beyond each library's normal constituency and tax base; and (3) the maximizing of access to information for all Montana citizens no matter their status. This rule will provide an equitable means to reimburse libraries at least in part for such activity in Montana and will encourage the most cost-effective use of existing library materials.

4. Interested parties 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 Richard Miller, State Librarian, Montana State Library, 1515 East 6th

Avenue, Helena, Montana 59620, no later than August 24, 1989.

5. Mary Hudspeth, Chair of the State Library Commission, will preside over and conduct the hearing.

6. This rule will be applied retroactively to July 1, 1989.

Richard T. Miller, Jr.
Montana State
Librarian

Certified to the Secretary of State July 17, 1989

BEFORE THE DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION OF THE STATE OF MONTANA

In the Matter of Proposed New Rules to Reject Permit Applications for Consumptive Uses and to Modify Permits for Nonconsumptive Uses in Grant Creek Basin	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULES TO REJECT PERMIT APPLICATIONS IN GRANT CREEK BASIN

To All Interested Persons:

1. On September 22, 1989 at 7:00 p.m., a public hearing will be held in the Missoula City Council Chambers at City Hall, First Floor, 201 W. Spruce in Missoula, Montana to consider the adoption of new rules to reject permit applications in Grant Creek Basin.

2. The proposed new rules read as follows:

"RULE I DEFINITIONS For the purposes of these rules, the following definitions shall apply:

(1) 'Application' means an application for beneficial water use permit, form no. 600, or application for provisional permit for completed stockwater pit or reservoir, form no. 605.

(2) 'Consumptive use' means a use of water which removes water from the source of supply, such that the quality or quantity is reduced or the timing of return delayed, making it unusable or unavailable for use by others.

(3) 'Department' means the Department of Natural Resources and Conservation.

(4) 'Grant Creek Basin' means the Grant Creek drainage area, a tributary of the Clark Fork River, located in hydrologic basin 76M in Missoula County, Montana. The Grant Creek Basin designated as the closure area is all that drainage and headwaters originating in the Rattlesnake Mountains of Township 15 North, Range 19 West, MPM, flowing southwesterly through Township 14 North, Range 19 West, MPM and into the main valley of the Clark Fork River in Township 13 North, Ranges 19 and 20 West, MPM. The entire Grant Creek drainage, from its headwaters to its confluence with the Clark Fork River, including Grant Creek, East Fork of Grant Creek, and all unnamed tributaries is contained in the closure area, as outlined on Exhibit "A" (a copy of which is available for review from the department).

(5) 'Infiltration gallery' means a collection system consisting of one or more perforated pipes, culverts, or screens, placed horizontally beneath the streambed or vertically adjacent to the streambed, by which surface water is appropriated.

(6) 'Nonconsumptive use' means a beneficial use of water which does not cause a reduction in the source of supply, and where substantially all of the diverted water returns to the source of supply with little or no delay and without adverse effect to the quality of water.

(7) 'Surface water' means all water at the surface of the ground including any river, stream, creek, ravine, coulee, un-

developed spring, or lake, regardless of its character or manner of occurrence, including but not limited to, diffused surface water, sewage effluent, waste water, and return flows and any subsurface water which is a part of the surface flows."
AUTH: 85-2-112 and 85-2-319, MCA; IMP: 85-2-319, MCA

"RULE II BASIN CLOSURE (1) The department shall reject applications for surface water permits within the Grant Creek Basin for any diversions, including infiltration galleries, for consumptive uses during the period from July 1 through September 30.

(2) Permits for nonconsumptive uses during the closure period shall be modified or conditioned to provide that there will be no decrease in the source of supply, no disruption in the stream conditions below the point of return, and no adverse effect to prior appropriators within the reach of stream between the point of diversion and the point of return. The applicant for a nonconsumptive use shall prove by substantial credible evidence its ability to meet the conditions imposed by this rule.

(3) These rules apply to all surface water within the Grant Creek Basin.

(4) Any application for a storage facility to impound water only outside the period from July 1 through September 30, and from which water could subsequently be used during any portion of the year, is exempt from these rules. Permit applications for storage, except applications for provisional permits for completed stockwater pits or reservoirs, form 605, will be received and processed. All form 605 permit applications will be rejected.

(5) Emergency appropriations of water as defined in ARM 36.12.101(6) and 36.12.105 shall be exempt from these rules.

(6) These rules apply only to applications received by the department after the date of adoption of these rules.

(7) The department may, if it determines changed circumstances justify it, reopen the basin to additional appropriations and amend these rules accordingly after public notice and hearing."
AUTH: 85-2-112 and 85-2-319, MCA; IMP: 85-2-319, MCA

3. The rationale for Rule I is that it defines the boundaries of the basin to be closed i.e., where water permit applications will be rejected, and other terms used in these rules. The rationale for Rule II is that appropriable water may exist only during extremely high stream flow events. On June 7, 1983, a petition was filed according to § 85-2-319, MCA, with the Department of Natural Resources and Conservation. The petition was signed by eleven water users on Grant Creek requesting the Department to close the basin to all new appropriations of water. The petitioners state that a dependable flow of water is essential to the agricultural uses in the basin and that historically there has not been enough water in Grant Creek for the existing water right holders let alone water for any new users. They allege the increase in residential parcels in the upper basin has resulted in an additional

burden on senior appropriators to protect their historic uses from new diversions properly or improperly acquired. The department in response to the petition for basin closure made a water availability study of the Grant Creek basin. The department's study showed a critical water shortage during the period of July 1 through September 30. As a result of this study the department is proposing to reject water use permit applications for certain uses of water from July 1 through September 30. This rule is intended to assist in preserving existing stream flows for senior appropriators. Since unappropriated waters exist so infrequently in the source of supply from July 1 through September 30, any further uses during that time will adversely affect prior appropriators. This rule sets out the period for closure, the class of applications affected and the type of appropriations that are exempt from the rules. This rule also allows the department in its discretion to reopen the basin to additional appropriations if changed circumstances justify it. Reopening of the basin would necessitate amending these rules after public notice and hearing.

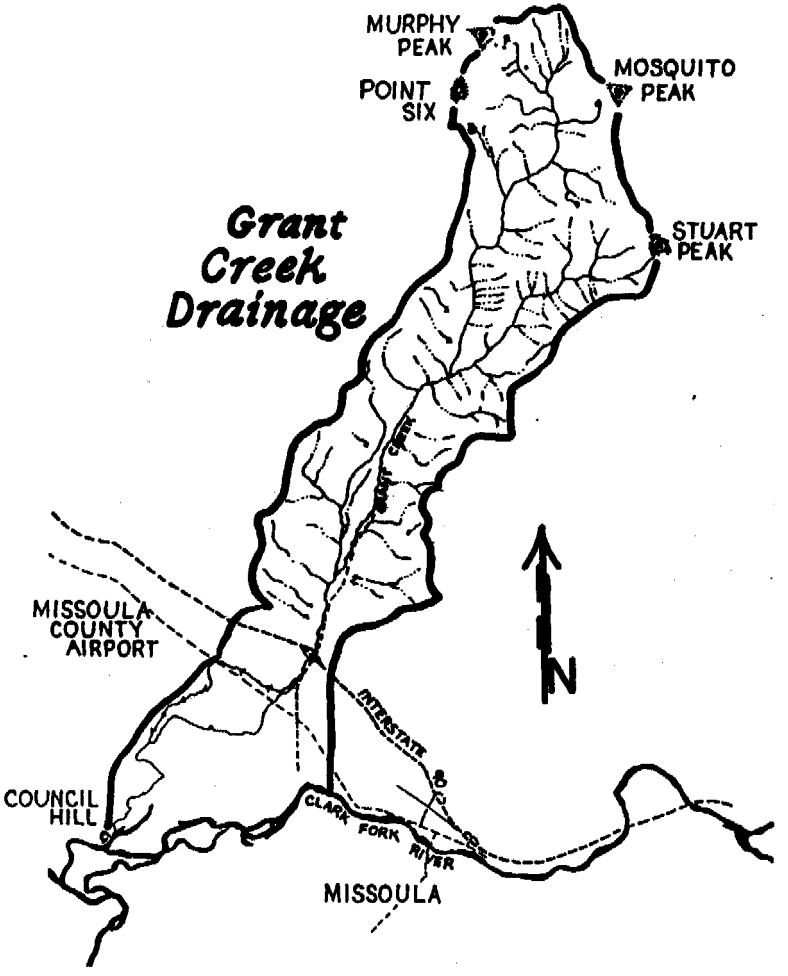
4. Interested parties may present their data, views or arguments in writing or orally at the hearing. Written data, comments or arguments in support of or in opposition to the adoption must be submitted to the Department of Natural Resources and Conservation, Water Rights Bureau, P.O. Box 5004, Missoula, Mt. 59806 no later than September 29, 1989.

5. Questions concerning the proposed adoption or requests for a copy of the Grant Creek Basin map of the affected area should be directed to the Department of Natural Resources and Conservation at the above Missoula address, or call 721-4284. In Helena, Montana, call, 444-6610.

6. Michael P. McLane has been designated to preside over and conduct the hearing.

JOHN ARMSTRONG
ACTING DEPUTY DIRECTOR
DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

Certified to the Secretary of State, July 14, 1989.


MURPHY PEAK
POINT SIX
MOSQUITO PEAK
STUART PEAK
Grant Creek Drainage
MISSOULA COUNTY AIRPORT
INTERSTATE
COUNCIL HILL
CLARK FORK RIVER
MISSOULA
N

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of revising rules regarding fee schedules for filing documents in the Secretary of State's office and establishing new rules for facsimile filings and priority fees.	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION (RULES I-III), AMENDMENT OF 44.6.105, 44.6.107 AND REPEAL OF 44.6.106 - FEES FOR FILING DOCUMENTS AND FACSIMILE FILING AND PRIORITY FEES.

TO: All Interested Persons:

1. On August 17, 1989, at 10:00 a.m. a public hearing will be held in the conference room of the office of the Secretary of State to consider the adoption of rules establishing new rules for facsimile filing and priority fees and amendment of 44.6.105 Fees for Filing Documents - Uniform Commercial Code; 44.6.107 Fees for Filing Notice of Agricultural Liens and repeal of 44.6.106.

2. The proposed rules provides as follows:

I. FEES FOR RECEIPT OF FACSIMILE FILING OF DOCUMENTS

(1) Effective October 1, 1989 the secretary of state shall charge and collect ten ($10) dollars for each document transmitted by facsimile machine for filing in its office.

(2) These fees are in addition to the established filing fees as provided in these rules.

(3) All fees including filing fees must be paid within five (5) working days of the receipt of the facsimile document submitted for filing. Failure to make payments within the five day period will result in the filing date not relating back to the date of the receipt of the facsimile copy and the facsimile filing being treated as void.

AUTH: 30-9-403, 35-1-1201, 35-2-1001, 35-12-521, 30-13-217, 30-13-311, MCA; Chapter 235, L. 1989
IMP: 30-9-403, 30-13-311, 71-3-125, 35-1-1201, 35-2-1001, 35-12-521, 30-13-217, MCA

II. FEES FOR FACSIMILE TRANSMISSIONS OF DOCUMENTS

(1) The secretary of state's office shall charge three dollars ($3) for the facsimile transmission of documents, ten pages or less. Documents exceeding 10 pages shall cost twenty-five cents ($.25) for each additional page transmitted by facsimile machine to the requester.

(2) All fees must be paid prior to the transmission of

the documents. Persons having accounts with the secretary of state's office shall have their fees charged to their account unless other acceptable arrangements have been made.

AUTH: 30-9-403, 35-1-1202, MCA IMP: 30-9-403, 35-1-1202, MCA

III. PRIORITY HANDLING OF DOCUMENTS (1) The office shall charge a priority handling fee of ten dollars ($10) for foreign or domestic profit or not for profit corporation filings.

(2) The priority handling fee for all other documents shall be five dollars ($5).

(3) This fee shall cover the costs of same day filing of the documents. If the documents are not in proper order for filing then the office shall attempt to notify the submitter the same day and inform him of the defects by telephonic or facsimile transmission.

AUTH: 30-9-403, 35-1-1201, 35-2-1001, 35-12-521, 30-13-217, 30-13-311, MCA
IMP: 30-9-403, 30-13-311, 71-3-125, 35-1-1201, 35-2-1001, 35-12-521, 30-13-217, MCA

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

44.6.105 FEES FOR FILING DOCUMENTS -- UNIFORM COMMERCIAL CODE (1)(a) through (i) remain the same.

(j) ~~certificate of information obtained by public access, $2.00;~~ monthly hookup fee for public access to uniform commercial code computer system $25.00.

(k) and (l) remain the same.

(m) no additional fee shall be charged for an updated search of facsimile filing when the original search listed a provisional facsimile filing.

AUTH: 30-9-403, MCA; Ch. 273 L. 1989
IMP: 71-3-125, 30-9-403, MCA

44.6.107 FEES FOR FILING NOTICE OF AGRICULTURAL LIENS

(1) ~~Effective December 1, 1987, t~~The secretary of state shall charge and collect for:

(a) filing a notice of agricultural lien, $7.00:

(i) the office of the secretary of state will enter on the farm bill list only the first eight (8) agricultural products (crops, livestock and unmanufactured products) listed;

(ii) if additional agricultural products are listed the following fees are required:

(A) 9-16 products a fee of $14.00.

(B) 17-24 products a fee of $21.00.

(c) 25 products or more a fee of $28.00.
(b) filing a termination statement, no fee.

AUTH: 30-9-403, MCA IMP: 71-3-125, MCA

4. ARM 44.6.106 is being proposed for repeal. The text of the rule is located at page 44-240 of the Administrative Rules of Montana. The authority section is 30-9-403 and the rule implements 30-9-403 (10).

5. Statement of necessity. These rules are necessary to implement the fee structure for House Bill 345 which establishes facsimile filing of documents with the office of the secretary of state. These fees are based upon the estimated increase in handling that will occur for provisional filing a Fax document. The original will be compared to the Fax copy for final determination of the filing's acceptability.

A new priority handling fee is being established to accommodate persons who insist upon preferential treatment of their documents. This fee is based upon anticipated labor and overhead costs associated with the immediate attention the document will receive. This priority handling fee may be necessary for persons who facsimile file their documents with the office and need an immediate determination as to the acceptability of their filing. This is particularly important because the original must be identical to the facsimile copy. If the original is not acceptable then the filing date would be lost. Therefore the submitter of the documents must be advised immediately if there is a problem with his filing in order to correct it and be able to protect that date for filing.

The fee change for public access is being made to properly correlate the cost of the service with the use. Most users of the public access service are not obtaining certificates of information via computer and thereby are avoiding the expense of using the public access system. In addition the Information Services Division of the Department of Administration charges the SOS office on a per user basis with only limited charges on a certificate of information basis. The records indicate that there are at least 150 dormant users of the system. ISD charges the SOS office $9 per user per month even if they do not use the system. The $25 fee is established by adding the monthly hookup fee with an average monthly use cost of approximately $16.

The no cost search update for UCC searches that initially listed temporary fax filings is being provided so as to prevent double charging. The verification of the completion of a temporary filing is necessary for those individuals needing the

information. Without this rule they would have to request and pay for a second search within five days after their first search.

The repeal of ARM 44.6.106 is necessary to reflect the changes made by the 1987 legislature. The requirements are set forth in 30-9-403(10) and no further explanation of the process is necessary.

The amendments to ARM 44.6.107 are necessary to properly reflect the costs of providing the filing services.

6. Interested parties 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 Garth Jacobson, Chief Legal Counsel, Secretary of State, Room 225, Capitol Building, Helena, MT 59620, no later than August 25, 1989.

7. Garth Jacobson, from the Office of the Secretary of State has been designated to preside over and conduct the hearing.

MIKE COONEY
Secretary of State

Dated this 17th day of July, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF ATHLETICS

In the matter of the amendment of rules pertaining to prohibitions, boxing contestants, physician requirements, weights and classes, scoring, down, equipment, judges, inspectors, and appeals and adoption of a new rule pertaining to appeal of decisions of officials	NOTICE OF AMENDMENT OF 8.8.2803, 8.8.2901, 8.8.2904, 8.8.3001, 8.8.3103, 8.8.3105, 8.8.3201, 8.8.3403, AND ADOPTION OF NEW RULE I - 8.8.3108 PERTAINING TO ATHLETICS

TO: All Interested Persons:

1. On May 25, 1989, the Board of Athletics published a notice of proposed amendment and adoption of the above-stated rules at page 630, 1989 Montana Administrative Register, issue number 10.

2. The Board amended ARM 8.8.2904, 8.8.3001, 8.8.3103, 8.8.3105, 8.8.3201, 8.8.3403 and adopted new rule ARM 8.8.3108 exactly as proposed.

3. The Board amended ARM 8.8.2803 as proposed but received one comment from the staff of the Administrative Code Committee regarding the statement of reasonable necessity. The new statement of reasonable necessity is, "Prohibitions contained in the rule are being deleted to conform to sanction authority of the statute, which provides that the licensee must obtain a separate permit or sanction from the board before holding any specific boxing or wrestling contests."

4. The Board amended ARM 8.8.2901 as proposed but received one comment from the staff of the Administrative Code Committee suggesting that section 23-3-603 be removed as an implementing section. The Board concurred and the deletion has been completed.

5. No other comments or testimony were received.

BOARD OF ATHLETICS
JOHN R. HALSETH, M.D., CHAIRMAN

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF HORSE RACING

In the matter of the amendment of rules pertaining to definitions; parimutuel exercise persons; jockeys; pony persons; trainers; veterinarians; general requirements; and general rules; and adoption of new rules pertaining to medication	)))))))	NOTICE OF AMENDMENT OF 8.22.501, 8.22.502, 8.22.703, 8.22.705, 8.22.709 - 8.22.711, 8.22.801, 8.22.1401 AND ADOPTION OF NEW RULE I - 8.22.1402 PERTAINING TO HORSE RACING

TO: All Interested Persons:

1. On May 25, 1989, the Board of Horse Racing published a notice of public hearing on the above-stated rules at page 635, 1989 Montana Administrative Register, issue number 10.

2. The board amended ARM 8.22.502, 8.22.705, 8.22.711, 8.22.801 and 8.22.1401 exactly as proposed.

3. The board amended 8.22.501, 8.22.703, 8.22.709, 8.22.710 and new rule 8.22.1402 as proposed but with the following changes:

"8.22.501 DEFINITIONS (1) through (22) will remain as proposed.

(23) Maiden - for purposes of eligibility at race meetings ~~whose race records are recorded in an official chart book or the Daily Racing Form~~, is a horse which, at the time of starting, has never won a race on the flat in any country, ~~at a track whose racing records are recorded in an official chart book or the Daily Racing Form~~ EXCEPT A HORSE WINNING A MAIDEN RACE IN WHICH THE WINNER'S SHARE OF THE PURSE IS $300.00 OR LESS, SHALL BE CONSIDERED A MAIDEN AT RECOGNIZED TRACKS IN THE STATE OF MONTANA.

~~(a) A maiden for purposes of eligibility at race meetings whose racing records are not recorded in an official chart book or the Daily Racing Form is a horse which at the time of starting has never won a race on the flat in any country;~~

(b) will remain as proposed, but will be renumbered (a)

(24) through (49) will remain as proposed."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP, Sec. 23-4-104, MCA

"8.22.703 EXERCISE PERSONS (1) and (2) will remain as proposed.

(3) Before approving an application for an exercise person's license, A MAJORITY OF A MEMBER OF the board of stewards, the jockey ~~guild~~ representative and the starter shall concur that the applicant has the ability to safely and correctly perform duties of an exercise person, pony person and outrider."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP Sec. 23-4-104, MCA

"8.22.709 PONY PERSONS (1) through (4) will remain as proposed.

(5) Before approving an application for a pony person's license, A MAJORITY OF A MEMBER OF the board of stewards, the jockey ~~guild~~ representative and the starter shall concur the applicant has the ability to safely and correctly perform the duties of an exercise person, pony person and outrider."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP, Sec. 23-4-104, MCA

"8.22.710 TRAINERS AND ASSISTANT TRAINERS (1) Each trainer shall obtain a license from the board. Minors shall not be licensed as trainers. Any application for trainer's license must establish financial responsibility to the satisfaction of the board. Each applicant for trainer's, OWNER'S, AND OWNER-TRAINER'S license must provide evidence of workers compensation insurance OR ITS EQUIVALENT AS DETERMINED BY THE STATE WORKERS' COMPENSATION FUND for the protection of his employees and workers prior to being issued a license. Failure to maintain financial responsibility and workers' compensation insurance OR ITS EQUIVALENT shall be grounds for revocation of license.

(2) through (29) will remain as proposed."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP, Sec. 23-4-104, MCA

"I. (8.22.1402) PERMISSIBLE MEDICATION (1) through (8) will remain as proposed.

(9) A horse on a bleeder list may cannot be treated at ~~least~~ within four hours prior to post time with furosemide (lasix). No other medication may be administered for bleeder treatment. Bleeder medication must be administered in the manner approved by the track veterinarian. Oral administration of furosemide (lasix) is not permitted for such purpose. Permitted bleeder medication shall be administered by the horse's regular veterinarian, and shall be witnessed by the track veterinarian, or his designee, at a place designated by the track veterinarian.

(10) through (21) will remain as proposed."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP, Sec. 23-4-104, MCA

4. All comments received have been thoroughly considered. Comments received and the Board's responses thereto are as follows:

COMMENT: One comment was received in favor of mending the "maiden" rule to recognize the problem that small tracks have in recruiting good horses.

COMMENT: One comment in opposition argued that the proposed amendment would be confusing to the betting public and undermine the development of winning spirit in younger horses and that having the younger horses run against four-time winners would be unfair to the horses and their owners.

RESPONSE: The Board concurred and has amended the rule as shown above. The Board wanted to provide more opportunity for horses to start at nonrecognized tracks. This is consistent with the practice being experimented with by both the recognized and nonrecognized tracks in the state. The amendment of the rule will make the experiment more permanent, enhance stability of the industry, and be consistent with the manner in which neighboring jurisdictions are handling the problem.

COMMENT: One comment was received regarding ARM 8.22.703 and 8.22.709 to the effect that the proposed rule amendment was too detailed, vague, and would be difficult to apply and enforce and too detailed. It was suggested that one person would be sufficient to decide whether the applicant had the ability to perform.

RESPONSE: Safety is an overriding concern because incompetency increases the burden on workers' compensation funds. However the amendment adopted will expedite the evaluation process.

COMMENT: HBPA voted 43 to 3 in favor of the workers' compensation compromise which broadens the base for insurance premiums and tightens control over fraudulent claims and covered occupations. The compromise provides the most favorable workers' compensation rates to the industry.

RESPONSE: The Board's response is that amendments which reflect the compromise between the HBPA and the Workers' Compensation Division is the most favorable amendment for the Board's rules at this time.

COMMENT: Five comments in support of the proposed permissible medication rule were to general effect that the proposed rule would allow for a higher quality of treatment of horses, allow them to run to their potential, and encourage better horses to run in this state.

COMMENT: One comment was received stating that the first sentence of subsection (9) was vague.

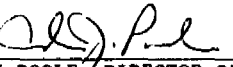
RESPONSE: The Board concurred and adopted clarifying amendments as shown above.

COMMENT: A spokesperson from the HBPA requested that the board wait until the national HBPA investigative report on medication is released.

RESPONSE: Permissible medication has been the subject of an ongoing study for years. During that time Montana has become the only remaining state that does not permit some medication.

The rule as adopted is always subject to amendment in the light of experience.

BOARD OF HORSE RACING
CHUCK O'REILLY, CHAIRMAN

BY: 
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
POLYGRAPH EXAMINERS

In the matter of the amendment of a rule pertaining to license renewals) NOTICE OF AMENDMENT OF 8.47.404 LICENSE RENEWAL - DATE - CONTINUING EDUCATION

TO: All Interested Persons:

1. On April 27, 1989, the Department of Commerce published a notice of proposed amendment of the above-stated rule at page 465, 1989 Montana Administrative Register, issue number 8.

2. The Department amended the rule exactly as proposed.

3. No comments or testimony were received.

POLYGRAPH EXAMINERS

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

BEFORE THE BOARD OF MILK CONTROL
STATE OF MONTANA

In the matter of amendment of rule 8.86.504(1)(g) and 8.86.506(13) as it relates to quota plans	))))	**NOTICE OF AMENDMENT OF RULE 8.86.504(1)(6), AND 8.86.506 (13) -- QUOTA RULES** **DOCKET #92-89**

TO: ALL LICENSEES UNDER THE MONTANA MILK CONTROL ACT (SECTION 81-23-101, MCA, AND FOLLOWING), AND ALL INTERESTED PERSONS:

1. On May 1, 1989, the Montana board of milk control published notice of a proposed amendment of rule 8.86.504(1)(g) and 8.86.506(13) regarding quota plans and reporting those results. Notice was published at page 501 of the 1989 Montana Administrative Register, Issue No. 9, as MAR Notice No. 8-86-31.
2. The board of milk control has amended the rules exactly as proposed.
3. No comments or testimony were received concerning the proposed amendments.
4. The authority for the board to amend the rule is contained in section 81-23-302, MCA, and implements section 81-23-302, MCA.

MONTANA BOARD OF MILK CONTROL
MILTON J. OLSEN, CHAIRMAN

BY: _____
Andy Poole, Director of Operations
Department of Commerce

Certified to the Secretary of State July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION

In the matter of the adoption by reference of new rules for the administration of the 1989 federal community development block grant program	))))))	NOTICE OF ADOPTION OF 8.94.3705 INCORPORATION BY REFERENCE OF RULES FOR THE ADMINISTRATION OF THE 1989 FEDERAL COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) PROGRAM

TO: All Interested Persons:

1. On June 15, 1989, the Department of Commerce published a notice of public hearing on the proposed adoption by reference of the above-stated rule at page 718, 1989 Montana Administrative Register, issue number 11.

2. The hearing was held on July 6, 1989, at 1:30, p.m., in Room C-409 of the Cogswell Building in Helena, Montana.

3. The Department has adopted ARM 8.97.3705 essentially as proposed. However, in response to comments received at the hearing and during the public comment period, the Department has modified the 1989 Application Guidelines with respect to the disposition of program income derived from economic development grants and with respect to the minimum score required before an economic development project will be funded. These modifications are discussed more fully in item 4, below. Copies of the final wording of the Guidelines may be obtained from the Local Government Assistance Division, Department of Commerce, Capitol Station, Helena, Montana 59620.

4. Six persons presented oral testimony at the hearing. In addition the Department received 14 written comments during the comment period provided under the Administrative Procedure Act. Summaries of the principal negative comments regarding the 1989 Application Guidelines and the Department's responses thereto follow:

COMMENT: In past years the Department's CDBG guidelines have permitted all local government recipients of economic development grants to retain and reuse the funds repaid to them by the private businesses to whom they have loaned the proceeds of the grants. In a departure from this practice, the 1989 Application Guidelines originally proposed that all such program income be returned to the Department for the establishment of a statewide revolving economic development loan fund. This change will weaken communities' efforts to stimulate local economic development efforts by depriving them of an important source of funds to establish revolving loan funds. It will also eliminate a major incentive for local governments to cooperate with business in seeking CDBG funds. As an alternative to this proposal the Department should establish criteria for determining which communities are qualified to retain and manage program income and allow these communities to do so.

RESPONSE: The proposed return of program income to the state was intended to allow the creation of a statewide fund to use as a hedge against the decline in, or elimination of, federal funding for the CDBG program. However, in response to the general concerns registered in connection with the proposal the Department has modified the 1989 Guidelines to provide that CDBG grantees which can demonstrate an existing or proposed capacity to administer a local revolving loan fund may retain program income for this purpose consistent with HUD requirements.

COMMENT: The proposed scoring system for economic development applications may preclude many worthwhile projects from competing successfully. Either the minimum score to be eligible for funding should be lowered, or the point spread for the cost per job, debt to equity ration, and matching funds threshold requirements should be narrowed.

RESPONSE: This comment is well taken. The final draft of the guidelines will reduce the minimum score required to be eligible for funding from the 210 points proposed in the draft to 190 points.

COMMENT: Under the proposed guidelines the economic development category of the CDBG program would be administered by the Department's Business Assistance Division rather than by the Local Government Assistance Division as it now is.

RESPONSE: The Department is proposing this change to better serve the needs of both businesses and the local governments that are interested in utilizing the CDBG program for economic development. This arrangement will provide a "one stop" source of information and technical assistance for businesses and local governments and will clarify and simplify the program's requirements for local officials and business people. Regardless of this internal reorganization of CDBG administrative functions, the Department will maintain its commitment to manage the program fairly and efficiently.

COMMENT: The draft guidelines propose to reduce the grant ceiling for economic development projects from $375,000 to $300,000 while, at the same time, award extra points to projects demonstrating a greater leveraging of funds.

RESPONSE: The intention of the lowered ceiling is to make CDBG assistance available to more communities than it has been in the past. According to the National Association of State Development Agencies, the states that have gone from a periodic grant competition to a continuous application cycle, as the 1989 Guidelines propose to do, have found that grant requests are for lower amounts than were requests under the periodic schedule.

COMMENT: The Guidelines propose to set interest rates for economic development loans at the 10-year U.S. Treasury Securities rate. This is undesirable because the CDBG program will see fewer applications and the higher interest rate could threaten the viability of the businesses that are selected for funding.

RESPONSE: The proposed guidelines contain a job creation interest discount of 1/8 of a percent for each job created for a low or moderate income person. In addition the guidelines include the following statement: "Lower interest rates may be considered by the Department of Commerce if it can be conclusively demonstrated that a lower rate is essential to the economic viability of the project." The Department is aware that only a healthy business will provide long-term jobs for Montanans. It has no intention of imposing financial terms that would threaten the viability of any firm assisted with CDBG funds.

5. No other comments or testimony were received.

6. The reasons for and against adopting the rules are embodied in the comments and responses contained in item 4, above.

DEPARTMENT OF COMMERCE
LOCAL GOVERNMENT ASSISTANCE
DIVISION

BY: _____
MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE BOARD OF INVESTMENTS

In the matter of the amendment of a rule pertaining to interest rate reduction for loans	))))	NOTICE OF AMENDMENT OF 8.97.1502 INTEREST RATE REDUCTION FOR LOANS FUNDED FROM THE COAL TAX TRUST

TO: All Interested Persons:

1. On April 27, 1989, the Board of Investments published a notice of proposed amendment of the above-stated rule at page 472, 1989 Montana Administrative Register, issue number 8.

2. The Board amended the rule exactly as proposed.

3. No comments or testimony were received.

BOARD OF INVESTMENTS
W. E. SCHREIBER, CHAIRMAN

BY: _____
ANDY POOLE, DIRECTOR OF OPERATIONS
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
DEPARTMENT OF COMMERCE
BEFORE THE MONTANA BOARD OF HOUSING

In the matter of the amendment of 8.111.305 pertaining to lending institutions	)))	NOTICE OF AMENDMENT OF 8.111.305 QUALIFIED LENDING INSTITUTIONS

TO: All Interested Persons:

1. On May 11, 1989, the Board of Housing published a notice of proposed amendment of the above-stated rule at page 504, 1989 Montana Administrative Register, issue number 9.

2. The Board amended the rule exactly as proposed.

3. No comments or testimony were received.

MONTANA BOARD OF HOUSING

BY: _____
MICHAEL L. LETSON, DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 17, 1989.

STATE OF MONTANA
BEFORE THE MONTANA ARTS COUNCIL

In the matter of the amendment of Rule 10.111.705 pertaining to Challenge Grants for Permanent Endowment Development)	NOTICE OF AMENDMENT OF RULE 10.111.705 CHALLENGE GRANTS FOR PERMANENT ENDOWMENT DEVELOPMENT

TO: All Interested Persons:

1. On May 25,1989, the Montana Arts Council published notice of the proposed amendment of Rule 10.111.705 pertaining to Challenge grants for endowment development at page 649 of the 1989 Montana Administrative Register, issue number 10.

2. The Council has amended the Rule 10.111.705 as proposed.

3. The Council has thoroughly considered all commentary received:

COMMENT: Charles A. Banderob, coordinator of the Huntley Project Museum commented that the proposed rules shouldn't apply to grants applied for and received under the previous rules.

RESPONSE: The proposed rule changes were to make technical modifications to more clearly define the intent of the prior rules. Not amending the rules would limit a grantee's choice of the holder of their permanent endowment fund. Therefore, the Council has approved adoption of rules as proposed.

BY: _____
DAVID E. NELSON
EXECUTIVE DIRECTOR
MONTANA ARTS COUNCIL

BY: _____
ROBERT CLARK
ACTING DIRECTOR
MONTANA HISTORICAL SOCIETY

Certified to the Secretary of State, July 7, 1989.

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the adoption of a new rule concerning the temporary licensing of tourist homes during the Montana Centennial Cattle Drive	))))	NOTICE OF ADOPTION OF NEW RULE - ARM 16.10.606 (Food and Consumer Safety)

To: All Interested Persons

1. On June 15, 1989, at page 720 of the 1989 Montana Administrative Register, Issue Number 11, the Department published notice of the proposed adoption of a new temporary rule concerning the licensing of tourist homes during the Montana Centennial Cattle Drive.
2. The Department adopted the rule as proposed.
3. No comments or testimony were received.

for William J. Opitz
DONALD E. PIZZINI, Director

Certified to the Secretary of State July 17, 1989.

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of Amendment of Rule 38.5.301(1) to change the conditions under which municipal water and sewer utilities must meet minimum filing requirements.	NOTICE OF AMENDMENT OF RULE 38.5.301(1), FILING REQUIREMENTS FOR MUNICIPAL WATER AND SEWER UTILITIES

TO: All Interested Persons

1. On June 15, 1989 the Department of Public Service Regulation published notice of the proposed amendment of rule 38.5.301(1), which pertains to rate increase applications by municipal water and sewer utilities at pages 743-744 of the 1989 Montana Administrative Register Issue Number 11.

2. The Commission has amended the rule as proposed.

3. Comments: No comments were received.

CLYDE JARVIS, Chairman

CERTIFIED TO THE SECRETARY OF STATE JULY 17, 1989

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

In the matter of the amendment of Rules 46.12.555, 46.12.556 and 46.12.557 pertaining to personal care services	))))	NOTICE OF THE AMENDMENT OF RULES 46.12.555, 46.12.556 AND 46.12.557 PERTAINING TO PERSONAL CARE SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.555, 46.12.556 and 46.12.557 pertaining to personal care services at page 517 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended Rules 46.12.555, 46.12.556 and 46.12.557 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: A commentor supported the proposed rule amendments but encouraged the Department to implement a pilot project to allow self-directed recipients more flexibility in obtaining personal care.

RESPONSE: The 1989 Legislature authorized such a pilot project in an amendment to HB 100. Once the specific language is reviewed, the Department will proceed with implementation according to the timelines indicated.

4. This rule change will be applied retroactively to July 1, 1989.

Julia E. Roberts
Director, Social and Rehabilitation Services

Certified to the Secretary of State July 17, 1989.

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

In the matter of the amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, and 46.12.1209 pertaining to reimbursement for skilled nursing and intermediate care services	)	NOTICE OF THE AMENDMENT OF Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, AND 46.12.1209 PERTAINING TO REIMBURSEMENT FOR SKILLED NURSING AND INTERMEDIATE CARE SERVICES

TO: All Interested Persons

1. On May 11, 1989, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206, 46.12.1207, 46.12.1208, and 46.12.1209 pertaining to reimbursement for skilled nursing and intermediate care services at page 525 of the 1989 Montana Administrative Register, issue number 9.

2. The Department has amended ARM 46.12.1208 as proposed.

3. The Department has amended the following rules as proposed with the following changes:

46.12.1201 PAYMENT RATES FOR SKILLED NURSING AND INTERMEDIATE CARE SERVICES ~~TRANSITION--FROM--RULES--IN-EFFECT SINCE-JULY-1-1987~~ (1) These rules shall be effective FOR RATE YEARS BEGINNING ON OR AFTER July 1, 1988.

Subsection (2) remains as proposed.

(3) The payment rate for nursing facilities other than ICF/MR providers OR OUT OF STATE PROVIDERS, is a result of computing the formula:

R=RO+RP, where:

(a) For providers delivering services in ~~long-term-care~~ nursing facilities ~~who-were-owners~~ on June 30, 1982, ~~or-for providers-delivering-services-in-long-term-care-facilities-who were-not-owners-on-June-30,-1982,~~ until the June 30, 1982 provider changes AS PROVIDED IN SUBSECTION (K):

RO=T PLUS THE OBRA INCREMENT DEFINED IN ARM 46.12.1204 (2), if A-T is less than 0

RO=A, if A-T is equal to or greater than 0

RP=S, if M_1-S is less than 0

RP=S(1) for providers DESCRIBED IN SUBSECTION (3)(a) delivering services in ~~long--term care~~ nursing facilities constructing new beds after July 1, 1984 where M_1-S is less than or equal to 0

RP=S(2) for providers DESCRIBED IN SUBSECTION (3)(a) delivering services in ~~long--term--care~~ nursing facilities extensively remodeled after July 1, 1984 where M_1-S is less than or equal to 0

RP=M, if M-S is equal to or greater than 0

~~A change in provider will be considered to have occurred under any of the following circumstances:~~

~~(i) the addition or substitution of a partner having a substantial interest in the partnership as permitted by applicable state law;~~

~~(ii) the sale of an unincorporated sole proprietorship or the transfer of title to, or possession of, a facility used in the provision of long term care facility services from the provider to another party or entity;~~

~~(iii) the merger of the provider corporation into another corporation or the consolidation of two or more corporations. However, the transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of provider, unless the provider corporation is closely held and a substantial interest in stock held is transferred from one party or entity to another party or entity;~~

~~(iv) the lease of all or part of a provider owned facility used in the provision of long term care services or the transfer of a lease from the provider to another party or entity.~~

Subsections (3)(b) through (3)(d) remain as proposed.

(e) S(1) = [(V x S) + (Y x ~~0.14~~ 8.309)] divided by (V + Y)

where:

V is the total square footage of the original structure before construction of new beds.

Y is the square footage added to the facility as a result of the construction of new beds.

(f) S(2) = the lower of ~~0.14~~ 8.309 or S + (((F x 12) divided by 365) x ~~1.0716~~ 1.1037)

where:

F is ((B divided by D) x .80) amortized over 360 months at 12% per annum.

D is the number of licensed beds in the facility.

B is the total allowable remodeling costs AS DEFINED IN ARM 46.12.1202(2)(t).

(g) T is the interim operating rate plus estimated incentive factor in effect on June 30, 1982.

(h) A is the CALCULATED operating rate effective July 1 of the current year COMPUTED in accordance with ARM 46.12.1204(2) and 46.12.1204(5), and revised as of the effective date of a change which results in a change in operating rate. ~~or, at least annually, in accordance with ARM 46.12.1204(5).~~

Operating Rrate revisions, including increases or decreases, effective as of a date other than July 1 may occur only under the following circumstances: ~~a--change--in--the--number--of licensed-beds-or-a-change-in-provider.~~

(i) a change in the number of licensed beds, a change in provider, or ~~due-to~~ a retroactive adjustment of the patient assessment score resulting from the first monitor of a new provider occurring after the new provider has PARTICIPATED ~~been~~ in the medicaid program for three months UNDER AN ~~and-has had-its~~ interim rate BASED UPON ~~set-by-using~~ the statewide average patient assessment score;

(ii) a provider whose operating rate effective July 1, is computed with a deficient patient assessment monitor score, as determined in accordance with ARM 46.12.1206(4), MAY REQUEST THAT A NEW MONITOR BE PERFORMED OF A MONTH IN THE SURVEY PERIOD MAY THROUGH OCTOBER, AS SELECTED BY THE DEPARTMENT OR ITS DESIGNEE. THE PROVIDER'S RATE SHALL BE REVISED, EFFECTIVE JANUARY 1, BASED UPON THE AVERAGE FROM THE NEW SURVEY PERIOD, REGARDLESS OF WHETHER SUCH REVISION RESULTS IN AN INCREASED OR DECREASED RATE, IF THERE IS NO SIGNIFICANT DIFFERENCE (10%) BETWEEN THE NEW MONITOR FINDINGS AND THE ABSTRACTS SUBMITTED BY THE PROVIDER FOR THE MONTH OF THE MONITOR. ~~will-be-allowed to-have-a-new-monitor-performed-and-a-revised-rate-computed effective-January-1.--The-provider-must-not-have-a-significant difference-(10%)-in-the-new-monitor,-of-a-month-in-the-survey period-May-through-October,-in-order-to-have-a-revised-rate computed-effective-January-1-using-the-provider's-average-patient--assessment--computation.~~ If THE NEW MONITOR FINDINGS INDICATE THAT a significant difference ~~still~~ exists there will be no change in rate effective January 1. ~~If-there-is-no-significant-difference-the-provider-must-use-the-new-six-month average-patient-assessment-score-for-the-period-May-through October-to-compute-the-rate-effective-January-1.~~ Providers who acquire a new patient assessment score must staff in relation to the new patient assessment score and in accordance with ARM 46.12.1206(2)~~,--or~~.

~~(iii)--with-respect-to-light-care-or-heavy-care-patients according-to-the-provisions-of-ARM-46.12.1204(2)(b).~~

(i) M is the CALCULATED property rate effective July 1 of the current year COMPUTED in accordance with ARM 46.12.1204 (3) and 46.12.1204(5), and revised as of the effective date of a change which results in a change in property rate ~~or,--at least-annually,-in-accordance-with-ARM-46.12.1204(5)~~. Property Rrate revisions effective as of a date other than July 1 may occur only under the following circumstances: certification of newly constructed beds, ~~or~~ completion of an extensive remodeling project, as defined in ARM 46.12.1202(2)(s), or a change in provider AS DEFINED IN SUBSECTION (3)(k) or refinancing of a mortgage or renegotiation of a lease.

Subsections (3)(j) through (3)(k)(iv) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1202 PURPOSE AND DEFINITIONS (1) The purpose of ARM 46.12.1201 THROUGH 1210 ~~the following rules~~ is to define the basis and procedures the department will use to pay for ~~long-term-care~~ nursing facility services provided to medicaid recipients from July 1, 19889 forward AND TO SPECIFY OTHER MEDICAID REQUIREMENTS APPLICABLE TO NURSING FACILITIES.

~~(a) These rules meet the requirements of Title XIX of the Social Security Act including 42 U.S.C. § 1396a(a)(13) and allow the department to pay for long-term care nursing facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable Montana and federal laws, regulations, and quality and safety standards.~~

~~(b) Efficiently and economically operated providers are those providers who provide adequate long-term care nursing facility services at a cost that is less than or equal to the payment rate determined in ARM 46.12.1201 AND 46.12.1204.~~

~~(c) Adequate long-term care nursing facility services are those provided in conformity with applicable Montana and federal laws, regulations, quality and safety standards, by providers having no deficiencies as determined in according to ARM 46.12.1206(9).~~

(da) The rules for determining rates and the rate-setting methodology may be amended or revised from time to time as determined by the department and according to procedures established under Montana ~~state~~ law.

(2) As used in these rules governing ~~long-term care~~ nursing facility services, the following definitions apply:

(a) "~~Long-term care~~ Nursing facility services" means skilled nursing facility services provided in accordance with 42 CFR 405 Subpart K AND, EFFECTIVE AUGUST 1, 1989, 42 CFR 483, intermediate care facility services provided in accordance with 42 CFR 442 Subpart F, AND EFFECTIVE AUGUST 1, 1989, 42 CFR 483, and intermediate care facility services for the mentally retarded provided in accordance with 42 CFR 483 ~~442 Subpart G~~. The department hereby adopts and incorporates herein by reference 42 CFR 405 Subpart K, ~~and~~ 42 CFR 442 Subparts F and G, AND 42 CFR 483, which define the participation ~~standards~~ conditions REQUIREMENTS for providers, copies of which may be obtained through the Department of Social and Rehabilitation Services, P. O. Box 4210, 111 Sanders, Helena, Montana 59604-4210. The term "nursing facility services" includes the term "long TERM care facility services". These NURSING FACILITY services include, but are not limited to, a medically necessary room, dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet, nursing services, minor medical and surgical

supplies, and the use of equipment and facilities. The services and examples of services listed in this subsection are included in the rate determined by the department under ARM 46.12.1201 and ARM 46.12.1204 and no additional reimbursement is provided for such services. Examples of ~~long term care~~ nursing facility services are:

(i) all general nursing services including but not limited to administration of oxygen and related medications, hand-feeding, incontinent care, tray service, nursing rehabilitation services, ~~and~~ enemas~~;~~, and ~~decubitus treatment~~ ROUTINE PRESSURE SORE/DECUBITIS TREATMENT;

Subsection (2)(a)(ii) remains as proposed.

(~~ii~~iii) items furnished routinely ~~and relatively uniformly~~ to all patients without charge, such as patient gowns, water pitchers, basins and bed pans;

Subsections (2)(a)(iv) through (2)(a)(iv)(D) remain as proposed.

(E) ~~disposable diapers; cloth diapers if requested;~~ ROUTINE INCONTINENCE CARE ITEMS APPROPRIATE FOR THE RESIDENT'S INDIVIDUAL MEDICAL NEEDS;

Original subsections (2)(a)(iii)(F) through (2)(a)(v) remain the same in text but will be recategorized as (2)(a)(iv)(F) through (2)(a)(vi).

(~~v~~vii) transportation of patients for routine services as defined in ARM 46.12.1202(2)(~~t~~r).

Subsection (2)(a)(vii) remains the same in text but will be recategorized as (2)(a)(viii).

(b) "Provider" means any person, agency, corporation, partnership or other entity that furnishes ~~long-term care~~ nursing facility services and has entered into an WRITTEN agreement with the department for providing those services.

Subsections (2)(c) and (2)(d) remain as proposed.

(e) "Patient day" means a whole 24-hour period that a person is present and receiving ~~long-term care~~ NURSING facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a patient who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

Subsections (2)(f) through (2)(h) remain as proposed.

(i) ~~"Average wage" means 50% of the sum of starting salaries for job openings in the 300 series in the dictionary of occupational titles identified by the department in its most recent survey of jobs opened in Montana's job service offices during a twelve month or more period, divided by the number of job openings surveyed, plus 50% of the sum of the average starting nursing care salaries identified by the department in its fiscal year 1987 wage survey, divided by the number of facilities surveyed.~~ "AVERAGE WAGE" MEANS THE AVERAGE NURSING

CARE HOUPLY WAGE, INCLUDING BENEFITS, FOR EACH PROVIDER IN THE WAGE AREA MULTIPLIED BY THE ESTIMATED ANNUALIZED MEDICAID DAYS FOR EACH PROVIDER AS IDENTIFIED IN THE DEPARTMENT'S MEDICAID BED DAY REPORT, DIVIDED BY THE SUM OF THE ESTIMATED ANNUALIZED MEDICAID DAYS FOR PROVIDERS IN THE WAGE AREA. THE AVERAGE NURSING CARE HOURLY WAGE FOR EACH PROVIDER IS CALCULATED ACCORDING TO THE DEFINITION IN ARM 46.12.1202(2)(f). THE ESTIMATED ANNUALIZED MEDICAID DAYS ARE DETERMINED BASED UPON THE ACTUAL PAID MEDICAID DAYS OBTAINED FROM THE DEPARTMENT'S MEDICAID BED DAY REPORT FOR A REPORT PERIOD PRIOR TO JUNE 1 OF EACH YEAR. ~~"licensed-to-non-licensed-ratio" means that ratio computed when the weighted sum of the hourly wages, including benefits for RN's and LPN's employed by providers, identified by the department in its January 1989 wage survey of providers, divided by the hours included in the survey is divided by the average nursing care hourly wage. This ratio is used to convert licensed hours into equivalent non-licensed hours for staffing and patient assessment computations provided for in ARM 46.12.1206(3). This factor is updated each time a wage survey is compiled.~~

(j) ~~"Wage area" means the geographic area serviced by the Montana job service office in which a provider is located. State institution providers licensed for skilled or intermediate nursing service shall constitute a wage area regardless of locations.~~ "WAGE AREA" MEANS THE GEOGRAPHIC AREA SERVICED BY THE MONTANA JOB SERVICE OFFICE IN WHICH A PROVIDER IS LOCATED. STATE INSTITUTION PROVIDERS LICENSED FOR SKILLED OR INTERMEDIATE NURSING SERVICES SHALL CONSTITUTE A WAGE AREA REGARDLESS OF LOCATIONS. ~~"Medically necessary room" means a double occupancy room. Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.~~

~~(i) A provider must provide a private room at no additional charge when it is medically necessary and the provider may not bill recipients extra for a medically necessary private room. A medicaid resident may pay an additional amount on a voluntary basis for a private room when such a room is not medically necessary. The resident must be clearly informed that additional payment is strictly voluntary.~~

Subsection (2)(k) remains as proposed.

(l) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with day-to-day responsibility for the operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be some person (other than the titled administrator of the facility), with day-to-day responsibility for the long-term care portion of the facility. In such cases, this other person must also be a STATE-licensed nursing home administrator.

(m) "Related parties" WITHIN THE MEANING OF THESE RULES ~~for purposes of interpretation hereunder~~, shall include the following:

(i) A person or entity shall be deemed a related party to his spouse, ancestors, descendants, brothers and sisters, ~~or~~ AND the spouses of any of the above, and also to any corporation, partnership, estate, trust, or other entity in which he or a related party has a substantial interest or in which there is common ownership.

(ii) For purposes of determining whether parties are related within the meaning of this rule, A a substantial interest shall be deemed an DIRECT OR INDIRECT interest ~~directly or indirectly~~, in excess of five percent (5%) of the control, voting power, equity, or other beneficial interest of the entity concerned.

Subsections (2)(m)(iii) through (2)(q) remain the same.

(r) "Nonemergency routine transportation" means ~~routine~~ transportation for routine activities such as facility scheduled outings, nonemergency visits to physicians, dentists, optometrists, etc. Such transportation will be considered routine when provided within the community served by the facility or within 20 miles of the facility, whichever is greater.

(s) "Extensive remodeling" means a renovation or refurbishing of all or part of a provider's physical facility, in accordance with certificate of need requirements, when the project's total cost depreciable under generally acceptable accounting principles exceeds, in a twelve month period, $2,400 times the number of total licensed NURSING FACILITY beds in the facility. "Extensive remodeling" does not include the construction of additional new beds, but may include construction of additional square feet, or conversion of existing hospital beds to nursing facility beds IF THE COST REQUIREMENTS OF THIS DEFINITION ARE MET.

(t) "Total allowable remodeling costs" means those costs which are supported by adequate documentation. These costs include, but are not limited to, all costs of construction. Costs of moveable equipment, supplies, furniture, appliances, etc. are specifically excluded. ~~Also excluded are those remodeling costs related to certification of additional nursing home beds as required by the department of health and environmental sciences.~~

Subsections (2)(u) through (2)(z) remain as proposed.

~~(aa) "Heavy care" patient means a medicaid recipient with a patient assessment score of 7.10 or above for any month.~~

~~(bb) "Light care" patient means a medicaid recipient with a patient assessment score of 1.15 or below for any month.~~

(aa) "ABSTRACTS" MEANS PATIENT ASSESSMENT ABSTRACTS SUBMITTED BY PROVIDERS TO THE DEPARTMENT EACH MONTH WHICH REPORT TO THE DEPARTMENT THE CARE REQUIREMENTS FOR EACH MEDICAID

PATIENT IN THE FACILITY ON FORMS PROVIDED AND ACCORDING TO INSTRUCTIONS SUPPLIED BY THE DEPARTMENT.

(ab) "LICENSED TO NON-LICENSED RATIO" MEANS THAT RATIO COMPUTED WHEN THE WEIGHTED SUM OF THE HOURLY WAGES, INCLUDING BENEFITS FOR RN'S AND LPN'S EMPLOYED BY PROVIDERS, IDENTIFIED BY THE DEPARTMENT IN ITS JANUARY 1989 WAGE SURVEY OF PROVIDERS, DIVIDED BY THE HOURS INCLUDED IN THE SURVEY IS DIVIDED BY THE AVERAGE NURSING CARE HOURLY WAGE. THIS RATIO IS USED TO CONVERT LICENSED HOURS INTO EQUIVALENT NON-LICENSED HOURS FOR STAFFING AND PATIENT ASSESSMENT COMPUTATIONS PROVIDED FOR IN ARM 46.12.1206(3). THIS FACTOR IS UPDATED EACH TIME A WAGE SURVEY IS COMPILED BY THE DEPARTMENT.

(ac) SERVICES PROVIDED IN PRIVATE ROOMS WILL BE REIMBURSED BY THE DEPARTMENT AT THE SAME RATE AS SERVICES PROVIDED IN A DOUBLE OCCUPANCY ROOM. A PROVIDER MUST PROVIDE A PRIVATE ROOM AT NO ADDITIONAL CHARGE WHEN IT IS MEDICALLY NECESSARY AND THE PROVIDER MAY NOT BILL RECIPIENTS EXTRA FOR A MEDICALLY NECESSARY PRIVATE ROOM. A MEDICAID RESIDENT MAY PAY AN ADDITIONAL AMOUNT ON A VOLUNTARY BASIS FOR A PRIVATE ROOM WHEN SUCH A ROOM IS NOT MEDICALLY NECESSARY. THE RESIDENT MUST BE CLEARLY INFORMED THAT ADDITIONAL PAYMENT IS STRICTLY VOLUNTARY. A PROVIDER MAY BILL A RESIDENT EXTRA WHO REQUESTS A NON-MEDICALLY NECESSARY PRIVATE ROOM.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1203 PARTICIPATION REQUIREMENTS (1) ~~The~~ Nursing facility providers participating in the Montana medicaid program MUST ~~shall~~, in addition to the regulations AND LAWS GENERALLY APPLICABLE TO MEDICAID PROVIDERS ~~set forth in ARM 46.12.301~~, meet the following basic requirements to receive payments for NURSING FACILITY services:

Subsections (1)(a) through (1)(e) remains as proposed.

(6f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used only for those purposes for which the patient, legal guardian, or personal representative of the patient has given written ~~delegation~~ AUTHORIZATION. A provider may not borrow funds from these accounts for any purpose. ~~The provider must maintain resident funds in excess of $50 in an interest bearing account separate from the facility funds with credit for all interest earned. The facility must maintain other personal funds in a noninterest bearing account or petty cash fund. The provider must notify each medicaid resident when their account reaches $200 less than the applicable resource eligibility guideline set forth in the department's rules and that an increased balance could result in loss of eligibility for medicaid benefits;~~

~~(g) Nursing facilities must meet the participation requirements regarding training of nurses aides at the times and~~

~~in the manner required under 42 U.S.C. section 1395i-3(b)(5) and (f)(2) and 42 U.S.C. section 1396r(b)(5) and (f)(2) (as amended by public law 100-203, known as the Omnibus Budget Reconciliation Act of 1987 (OBRA 87)), which the department hereby adopts and incorporates by reference. A copy of these statutes may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604;~~

~~(h) protect and promote resident rights including freedom of choice, freedom from restraint, physical or chemical, unless necessary for resident safety, right to privacy, right to receive notice before change of a room or roommate, confidentiality of personal and clinical records, right to examine survey results, and right to voice grievances. The provider must provide notice orally and in writing of these rights upon admission and apprise the resident of items and services covered by the medicaid rate for which the resident may not be charged;~~

~~(i) provide for transfer and discharge notice 30 days in advance except if health or safety is endangered due to medical needs. The provider must notify the resident and a family member in advance of a transfer or discharge, chart in the resident's record the reason for discharge, identify the resident's right to appeal and provide the resident with the name, address and telephone number of the state long term care ombudsman; and~~

(~~j~~g) maintain admission policies which do not discriminate on the basis of diagnosis or handicap or violate federal or state laws prohibiting discrimination against the handicapped, including persons infected with Acquired Immunity Deficiency Syndrome/Human Immunodeficiency Virus (AIDS/HIV).

(h) COMPLY WITH THE RULES REGARDING SCREENING FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES SET FORTH AT ARM 46.12.1301 THROUGH 1310.

(i) COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS REGARDING NURSING FACILITIES AT THE TIMES AND IN THE MANNER REQUIRED THEREIN, INCLUDING BUT NOT LIMITED TO 42 U.S.C. §1396r(b)(5) AND 1396r(c). THE DEPARTMENT HEREBY ADOPTS AND INCORPORATES HEREIN BY REFERENCE 42 U.S.C. §1396r (b)(5) and 1396r(c). A COPY OF THESE STATUTES MAY BE OBTAINED FROM THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, P.O. BOX 4210, HELENA, MONTANA 59604-4210.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 50-5-105 and 53-6-141 MCA

46.12.1204 PAYMENT RATE (1) A provider's payment rate FOR NURSING FACILITY SERVICES is the sum of an operating rate and a property rate, AS provided in ARM 46.12.1201(3).

(2) The calculated operating rate A, in dollars per patient day, is given by the following effective July 1, 1988~~9~~:

A=A(1), if T_1 is equal to or greater than A(1), or
A=A(2), if T_1 is equal to or less than A(2), or
A=T_1, if T_1 is less than A(1) and greater than A(2), or
A=A(3) if the facility was constructed after 6/30/82
where:

A(1) = ~~B times~~ B TIMES ((C times (($27.77 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.

A(2) = ~~B times~~ B TIMES ((C times (($27.09 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.

A(3) = ~~B times~~ B TIMES ((C times (($27.43 + ($54,627 divided by D)) divided by .9)) + E) + ~~$1.23~~ the OBRA increment.

~~B is the area wage adjustment for a provider,~~ B IS THE AREA WAGE ADJUSTMENT FOR A PROVIDER,

C is the inflation factor used to compute the per diem rates. The inflation factor is the factor necessary to calculate increases in R(1) such that, effective July 1, 1987~~9~~, R(2) = R(1) x 1.02~~3~~.

D is the number of licensed beds for a provider times 366 days, or FOR FACILITIES NEWLY CONSTRUCTED AFTER JUNE 30, 1985 OR NOT IN THE PROGRAM ON JUNE 30, 1985 OR PARTICIPATING IN THE PROGRAM WITH MORE THAN 25 LICENSED BEDS ON JUNE 30, 1985, D is ~~either~~ the number of licensed beds, BUT NO LESS THAN 25 AND NO MORE THAN 120, for a provider ~~or 25, whichever is greater or is the number of licensed beds for a provider or 120 whichever is smaller,~~ times 366 ~~for facilities newly constructed after June 30, 1985 or not in the program on June 30, 1985 or participating in the program with greater than 25 licensed beds on June 30, 1985~~.

E is the patient care adjustment for a provider,

T_1 is C times the interim operating rate in effect on June 30, 1982, indexed to December 31, 1982.

R(1) = The statewide weighted average per diem rate for R as of June 1, 1987~~9~~.

R(2) = The statewide weighted average per diem rate for R indexed from R(1) by 1.02~~3~~ effective July 1, 1987~~9~~.

The OBRA 87 cost increment effective July 1, 1989 is $2.00. THE DEPARTMENT INTENDS THAT PROVIDERS USE THE OBRA 87 COST INCREMENT TO MEET THE FISCAL YEAR 1990 COSTS OF COMPLYING WITH THE REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987, PUBLIC LAW 100-203, AND ALL STATE AND FEDERAL LAWS AND REGULATIONS ADOPTED THEREUNDER, INCLUDING BUT NOT LIMITED TO THE COSTS OF TRAINING FOR NURSE AIDES OTHER THAN THE COST OF ACTUAL TESTING REQUIRED FOR NURSE AIDES.

~~(a) The area wage adjustment for a provider is the result of computing the following formula:~~

~~B=1 + (((F-G) divided by G) times the ratio of total labor costs to total operating costs, based on the fiscal year 1987 information) if F is equal to or greater than one standard deviation from the average wage, or~~

~~B=1.0 if F is less than one standard deviation from the average wage,~~

~~where:~~

~~F is the average wage for a provider's wage area,~~

~~G is the average wage for all wage areas plus one standard deviation, if F is more than one standard deviation above the average wage, or~~

~~G is the average wage for all wage areas minus one standard deviation, if F is more than one standard deviation below the average wage.~~

(a) THE AREA WAGE ADJUSTMENT FOR A PROVIDER IS THE RESULT OF COMPUTING THE FOLLOWING FORMULA:

B=1 + (((F-G) DIVIDED BY G) TIMES THE RATIO OF TOTAL LABOR COSTS TO TOTAL OPERATING COSTS, BASED ON FISCAL YEAR 1987 INFORMATION) IF F IS EQUAL TO OR GREATER THAN ONE STANDARD DEVIATION FROM THE AVERAGE WAGE, OR

B=1.0 IF F IS LESS THAN ONE STANDARD DEVIATION FROM THE AVERAGE WAGE,

WHERE:

F IS THE AVERAGE WAGE FOR A PROVIDER"S WAGE AREA,

G IS THE AVERAGE WAGE FOR ALL WAGE AREAS PLUS ONE STANDARD DEVIATION, IF F IS MORE THAN ONE STANDARD DEVIATION ABOVE THE AVERAGE WAGE, OR

G IS THE AVERAGE WAGE FOR ALL WAGE AREAS MINUS ONE STANDARD DEVIATION, IF F IS MORE THAN ONE STANDARD DEVIATION BELOW THE AVERAGE WAGE.

Subsection (2)(a) remains as proposed in text but will be recategorized as (2)(b).

~~(b) The operating rate (P) for individual medicaid recipients who meet the definition of "heavy care" in ARM 46.12.1201(2)(aa) or "light care" in 46.12.1202 (2)(bb) is the result of computing the following:~~

~~P= A + ((Q - d) ÷ d) x b)~~

~~where:~~

~~P is the operating rate adjustment INCREMENT attributable to heavy care or light care medicaid recipients;~~

~~A is the operating rate calculated for the provider;~~

~~Q is the individual patient assessment score for the heavy care or light care recipient;~~

~~d is the provider's average patient assessment score;~~

~~b is the average nursing care hourly wage including benefits.~~

~~The operating rate P is to be billed for services provided to heavy care and light care recipients for every month in which the recipient meets the definition of heavy care or light care. This operating rate is subject to retroactive adjustment.~~

(3) The calculated property rate is the result of computing the formula:

(a) M = N x Z except for facilities extensively remodeled or with new beds constructed after July 1, 1984.

M = N(1) x Z for facilities with new beds constructed after July 1, 1984,

M = N(2) x Z for facilities extensively remodeled after July 1, 1984.

where:

M is the property rate per day of service,

N is the provider's property rate as of 6/30/85. For entire facilities built after 6/30/85

N is $7.60.

For facilities new to the program constructed prior to 6/30/82 a 6/30/85 rate will be computed according to property rules effective 6/30/85. That rate will be carried forward using M = N x Z

N(1) = the lower of ~~8.14~~ 8.389 or (((A x D) + (B x 7.60)) divided by (A + B)) x ~~1.0716~~ 1.1037

N(2) = the lower of ~~8.14~~ 8.389 or D x ~~1.0716~~ 1.1037 + ((F x 12) divided by 365).

where:

A is the total square footage of the original NURSING FACILITY structure.

B is the square footage added TO THE NURSING FACILITY with the construction of new beds.

D is the property rate as of 6/30/85 for the original structure.

F is ((G divided by H x .80) amortized over 360 months at 12% per annum.

H is the total number of licensed beds in the NURSING facility after extensive remodeling.

G is total allowable remodeling costs.

Z is ~~1.0716~~ 1.1037.

Subsections (4) through (4)(c) remain as proposed.

(5) The averages, standard deviations, or prorating for additions AND AREA WAGE ADJUSTMENTS ~~or area wage adjustments~~ are recalculated once a year, using the ~~fiscal year 1987~~ most currently available data FROM A PERIOD prior to June 1. Revised rates based on ~~the~~ new calculations are EFFECTIVE ONLY ON ~~issued by~~ July 1 of each year EXCEPT AS OTHERWISE PROVIDED IN ARM 46.12.1201(3)(h) OR (i).

Subsections (6) through (6)(b)(ii) remain as proposed.

(iii) a Level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the applicant's need for active treatment. A LEVEL I ~~This~~ screening form may be obtained from the department;

(iv) a copy of the preadmission-screening determination for the client. The preadmission-screening determines

the level of care and may be obtained from the Montana-Wyoming Foundation for medical care. ~~A--telephone,--post admission screening-determination-may-be-acceptable~~ PAYMENT WILL BE MADE FOR SERVICES BEGINNING ON THE DATE OF REFERRAL FOR SCREENING, OR THE DATE OF SCREENING, WHICHEVER IS EARLIER;;

Subsections (6)(b)(v) through (6)(c) remain as proposed.

(d) The out-of-state provider must enroll in the Montana medicaid program. ENROLLMENT INFORMATION AND INSTRUCTIONS MAY BE OBTAINED FROM ~~by-contacting~~ the state's fiscal intermediary, Consultec, at P.O. Box 4286, Helena, MT 59604-4286.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1205 PAYMENT PROCEDURES (1) The department pays providers amounts determined under these rules on a monthly basis upon receipt of an appropriate billing which represents the number of patient days of ~~long-term-care~~ nursing facility services provided to authorized medicaid recipients times the payment rate ~~applicable-to-each-recipient~~ minus the amount each medicaid recipient pays toward the cost of care. Authorized medicaid recipients are those residents who have been determined eligible for medicaid and have been authorized for either skilled or intermediate level of care as a result of the screening process described in ARM 46.12.~~1101~~ 1301, ET SEQ.

Subsection (1)(a) remains as proposed.

(b) In accordance with section 9435(b) of P.L. 99-509, the Omnibus Budget Reconciliation Act of 1986, payment may not be made for services provided to aN ~~fully~~ eligible MEDICAID/MEDICARE individual when the individual elects the medicare hospice benefit. This denial of payment is required when the hospice and the provider have made a written agreement under which the hospice is responsible for the professional management of the individual's hospice care and the provider agrees to provide room and board to the individual. Payment under such circumstances will be made to the hospice for room and board services in accordance with the rates established under section 1902(a)(13) of the Social Security Act. In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, ~~in~~ socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

Subsection (2) remains as proposed.

(a) A provider may bill additionally at direct cost, with no indirect charges or mark-up added, on a per-patient

basis, for the following items, if such items are medically necessary~~,~~ in accordance with ARM 46.12.306, ~~which~~ AND are prescribed by a physician:

Subsections (2)(a)(i) through (2)(a)(cvii) remain as proposed.

(cviii) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. ~~These~~ PAYMENT FOR THESE solutions will be allowable only if they are determined medically appropriate and prior authorized by the DEPARTMENT ~~director of the medicaid bureau~~; and

(cviv) routine nursing supplies used in extraordinary amounts and prior authorized by the department.

(b) If the above items are also covered by the medicare program and provided to medicaid recipients who are also medicare recipients, reimbursement will be limited to the lower of the medicare prevailing charge or the provider's direct cost. ~~Medicare Part A is all inclusive.~~ No Aancillary services MAY NOT can be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

Subsections (2)(c) through (2)(f) remain as proposed.

(g) Non-emergency TRANSPORTATION (FOR ACTIVITIES OTHER THAN ~~exclusive of~~ those outlined in ARM 46.12.1202(2)(~~e~~r)) ~~transportation~~ may be billed additionally in accordance with ARM 46.12.1012 and ARM 46.12.1015. Emergency transportation may be billed additionally by an ambulance service in accordance with ARM 46.12.1021-1022 and ARM 46.12.1025.

Subsections (2)(h) through (4) remain as proposed.

(5) No payment or subsidy will be made to a provider for holding a bed while the recipient is temporarily receiving medical services elsewhere, such as in a hospital, except in a situation where a provider is full and has a current waiting list of potential residents. The requirements of being full and maintaining a current waiting list applies~~s~~Y to each hold bed day claimed for reimbursement. A provider will be considered full if all medicaid certified beds are occupied or being held for a recipient temporarily receiving medical services elsewhere or away on a therapeutic home visit. A provider will also be considered full as to gender if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients. In this exceptional instance, a payment will be made for holding a bed while the resident is temporarily receiving medical services elsewhere, except in another ~~long term care~~ nursing facility, is expected to return to the provider, and the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available. The provider must

provide documentation, upon request, that the absence is expected to be temporary and the anticipated duration of the absence. Temporary absences which are of indefinite duration should be followed up at least weekly by the provider in order to reasonably assure the department that the absence is indeed temporary. Furthermore, payment in this exceptional instance will be made only upon written approval from the department's medicaid bureau. A request for nursing home bed reservation during a resident's temporary medical leave in this instance must be submitted to the department on the appropriate forms provided by the department within 90 days AFTER ~~of~~ the first day of the requested absence. The request form submitted to the department must be accompanied by a copy of the current waiting list applicable to each hold bed day claimed for reimbursement. In situations where conditions of billing for holding a bed are met, providers are required to hold the bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill medicaid for the hold bed day until all conditions of billing are met.

Subsection (6) remains the same.

~~(7) Before a nursing facility resident is transferred for hospitalization or therapeutic leave, the facility must provide written notice to the resident and a family member or legal representative on the expected duration of the transfer and written information concerning state plan provisions regarding the period during which the resident will be permitted to return and resume residency in the facility. Facilities must have a written return policy under which medicaid eligible residents will be readmitted as soon as a semi-private bed is available, should a transfer from the facility for a hospitalization or therapeutic leave exceed the bed hold period as specified under the state plan.~~

Proposed subsection (8) remains as proposed but is recategorized as subsection (7).

Original subsection (7) remains as proposed but will be recategorized as subsection (8).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-141 MCA

46.12.1206 PATIENT ASSESSMENTS, STAFFING REPORTS AND DEFICIENCIES (1) Each provider will report to the department each month the care requirements for each medicaid patient in the facility on the forms provided and ~~according to~~ ACCORDING TO ~~in accordance with the patient assessment manual and~~ instructions supplied by the department. ~~The patient assessment manual dated February 1985 is hereby adopted and incorporated by reference. A copy of this manual is available~~

~~from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604.~~

Subsections (2) through (4)(a) remain as proposed.

(b) For providers who object to the sampling technique used by the monitor team to select the abstracts to be monitored for rate years beginning July 1, 1986 OR LATER, the following procedure will be the only appeal available:

Subsections (4)(b)(i) through (4)(e) remain as proposed.

~~(f) The department will conduct periodic monitoring of the abstracts for recipients reported as meeting the definitions of heavy care and light care as defined in ARM 46.12.1202(2)(i) and (j). Individual patient assessment scores will be recalculated based upon the monitor findings without regard to the definition of "significantly different" in ARM 46.12.1206(4)(e). Operating rates will be recalculated retroactively based upon the monitor findings. Objections to the monitor findings, recalculation of the patient assessment score or retroactive adjustment of the operating rate may be pursued in accordance with ARM 46.12.1210.~~

Subsections (5) through (9)(d) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP Sec. 53-6-141 MCA

46.12.1207 INCLUDABLE COSTS Subsections (1) through (1)(d)(ii)(A) remain as proposed.

(B) employee benefits excluding employer contributions required by state or federal law--FICA, Workers' Compensation Insurance (WCI), Federal Unemployment Insurance (FUI), State Unemployment Insurance (SUI). ~~For a self-employed administrator, an amount equal to what would have been the employer's contribution for FICA and WCI may be excluded from such employee benefits;~~

Subsections (1)(d)(ii)(C) through (1)(m) remain as proposed.

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-111, 53-6-141 and 53-2-201 MCA

46.12.1209 OVERPAYMENT AND UNDERPAYMENT Subsection (1) remains as proposed.

(2) ~~In the event of an overpayment the department will,~~ wWithin 30 days of the day the department notifies the provider that an overpayment exists, THE DEPARTMENT WILL arrange to recover the overpayment by set-off against amounts paid for ~~long-term care~~ nursing facility services or by repayments by the provider.

(3) If an AGREEMENT HAS NOT BEEN REACHED, WITHIN 30 DAYS OF NOTIFYING THE PROVIDER OF THE OVERPAYMENT, WHICH PROVIDES ~~arrangement~~ for FULL repayment WITHIN 60 DAYS OF THE OVERPAYMENT NOTICE ~~cannot be worked out within 30 days after~~

~~notification of the provider~~, the department will IMMEDIATELY COMMENCE OFFSETTING ~~make deductions~~ from rate payments SO AS TO COMPLETE ~~with full~~ recovery ~~to be completed~~ within sixty (60) days from the date of the initial request for payment OR AS SOON THEREAFTER AS POSSIBLE. The sixty (60) day recovery period coincides with requirements of section 1903(d)(2) of the Social Security Act, as amended. This section requires states to repay the federal share of medicaid payments within sixty (60) days of determination of a medicaid overpayment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment. ~~In the discretion of the department such recovery may be delayed in whole or in part if a request for fair hearing under ARM 46.12.1210 has been made.~~ A request for administrative review or fair hearing shall not entitle a provider to delay repayment of any overpayment determined by the department.

Subsections (4) through (6) remain as proposed.

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-111, 53-6-141 and 53-2-201 MCA

4. The Department has thoroughly considered all commentary received:

COMMENTS REGARDING ADEQUACY OF RATES

COMMENT: A number of comments were received favoring immediate rebasing of costs used in the reimbursement formula. Commentors stated that the department must use a cost base more current than 1980 to accurately reflect current costs. Specific costs such as nursing wages, workers' compensation, and liability insurance rates have increased dramatically. Current costs should be used and inflators should be used only to update for short time periods and to estimate current operational costs. Conservative estimates show inflation at 6% for FY90, yet the department proposes a 3% increase. The only way for facilities to make up the shortfall is by increasing private pay rates. The department should make it a priority to rebase costs to the most current available year.

RESPONSE: The department will not rebase costs for fiscal year 1990 rate-setting purposes. The department has received 1987 cost reports, but desk reviews and audits have not been completed so as to allow use of the data as a cost base.

The 1989 Legislative session would have been the appropriate occasion and forum to address this issue. Providers and their representative associations did not present this issue to the Legislature, which could have responded specifically to this request.

The department advised the Office of Budget and Program Planning (OBPP) of the request for rebasing. The department's objective in doing so was to allow for appropriate surveys and studies, followed by proposal to the 1991 Legislature of rebasing for the 1992-93 biennium. The department has obtained approval from OBPP to hire an outside consultant to study alternative reimbursement methodologies and to develop nursing facility cost data. Based upon the results of this study and the cost data developed, the department will propose rebasing under an appropriate methodology and will propose a budget modification for required funding to implement rebasing for the 1992-93 biennium.

COMMENT: The department should undertake an effort to statistically validate the currently proposed rate formula. Since 1982 the department has failed to seriously evaluate the reimbursement system in any fashion.

RESPONSE: The department will evaluate the reimbursement system as part of the study it will conduct regarding rebasing of costs for the 1992-93 biennium.

COMMENT: Are reported costs attributable to Medicaid patients for 1987 over $2 million above Medicaid payments for 1987? Is it true that the department's own calculations showing profit and loss on Medicaid days indicate that over half of participating facilities did not receive Medicaid reimbursement in 1987 in an amount meeting their 1987 costs of providing care to Medicaid patients?

RESPONSE: The department prepared a spread sheet which made a preliminary comparison of reported costs to medicaid payments. The spread sheet indicated a difference of approximately $2.3 million between total reported costs and Medicaid payments. Further, the spread sheet indicates that 39 facilities received Medicaid reimbursement totalling more than their reported costs and 56 facilities received Medicaid reimbursement totalling less than reported costs. However, most of the cost information used in the analysis was not audited or reviewed. Further, because a prospective payment system is designed to reimburse the costs that would be incurred by economically and efficiently operated providers, it is expected that not all actual costs will be reimbursed. This preliminary comparison is not an adequate basis upon which to determine whether 1987 rates were sufficient to meet the costs of economically and efficiently operated providers.

COMMENT: Are audited costs higher than reported costs for 1987 as shown on the spread sheet prepared by the department?

RESPONSE: The department has prepared a preliminary analysis of 1987 SNF costs as reported. At first glance, this comparison suggests that costs as reported are lower than the 1987 adjusted costs after audit for some providers, but higher for others. However, not all adjusted costs are settled. The audit adjustments were prepared by outside audit contractors and the cost report step down process has not been completed to determine final allowable SNF costs. The adjustments submitted for combined facility audits or desk reviews are being analyzed further by Blue Cross/Blue Shield and the department to determine whether adjustments are appropriate.

COMMENT: A number of comments inquired regarding the basis for the proposed fiscal year 1990 rate. These comments include the following:

What has the department done to determine whether 1980 costs indexed forward in fact reflect current costs experienced by facilities?

Has the department compared actual inflation with the inflation factors applied to 1980 costs since this reimbursement system was developed? What does this comparison yield? What reliable index or measure of inflation representative of inflation in nursing facilities was used in these comparisons? Would the department consider applying an industry index to 1980 costs indexed forward as alternative to rebasing?

What inflationary index or other predictor of inflation did the department use as a basis for the 3% inflation factor included in this rule? Did the department consider the inflationary trends experienced by nursing facilities during fiscal years 1988 and 1989 in developing this rule and determining whether it can expect to meet facilities' costs of providing care?

What did the department determine inflation has been for FY88 and FY89? Did the 2% inflators for FY88 and FY89 cover inflation, in the judgment of the department?

New staffing requirements have been imposed by the department since the 1980 cost base was established. Such requirements have been implemented in response to new federal requirements of participation and new federal requirements for patient care and services surveys. How has the department taken into account the increased costs resulting from these new requirements?

How has the department taken into account the costs associated with higher wage levels for registered nurses due to the nurse shortage being experienced in some parts of Montana?

How has the department taken into account the increase in the acuity level of patients cared for in nursing homes, as reflected in the statewide average patient assessment score, that has taken place between the 1980 base year and FY90?

To soften the impact of the department's decision not to rebase costs until seeking more funding from the next Legislature, the department should modify the proposed rule to provide that reimbursement to nursing facilities will not be less than 90% of reported costs.

The department should adopt a rule which assures that a proportionate share of the losses inherent in the system are shared by all participating facilities. It is unreasonable for some providers to receive excess reimbursement while providing no reasonable opportunity for an entire class of providers to obtain their actual allowable costs. A ceiling on Medicaid profits could be imposed as a source of funds to implement a stop loss provision.

RESPONSE: The department has considered these comments. The department has applied a 3% inflation factor to fiscal year 1989 aggregate nursing facility rates to determine fiscal year 1990 aggregate reimbursement. The department will not rebase costs for fiscal year 1990, but will study and propose a specific rebasing plan to the 1991 Legislature. As part of this study, the department will consider various methods of determining costs and measuring inflation. The study will include review and development of cost data relating to staffing costs and patient acuity, and will include consideration of alternative methods for distributing reimbursement funds as equitably as possible, including any appropriate caps on medicaid "profits." The study will include a comprehensive examination of present and alternative cost determination and reimbursement methodologies.

COMMENT: The department should provide an extension for public comments to allow five days for comments after the actual per diem rates are calculated and publicized. It is unreasonable to expect providers to fully provide input without benefit of knowledge of what specific impact various department proposals will have on reimbursement.

RESPONSE: The department will not extend the deadline for receipt of public comments. However, the department has

considered all comments received after the deadline to the date of this notice.

COMMENTS REGARDING PROPERTY REIMBURSEMENT RATE

COMMENT: The department should develop data to measure the current performance and appropriateness of its existing property rate rule, but any changes should be made in a separate rule.

RESPONSE: The department will evaluate the current property rate rule as part of its analysis of the fair rental system and other methods of property reimbursement.

COMMENT: The proposed remodeling reimbursement formula at Section 46.12.1201(3)(f) unfairly discounts by 20% money spent on remodeling the nursing facility. This money is most likely borrowed to remodel an old or outdated facility to meet current standards. The present policy encourages gradual deterioration and eventual replacement of an existing facility, rather than ongoing maintenance by remodeling or upgrading.

RESPONSE: The remodeling add-on computation historically has been based upon an imputed 20% downpayment on all remodeling projects. The $2,400 per bed threshold will screen out minor renovation and repair but will allow adjustment for major work. The formula imputes a 20% downpayment because only part of the actual cost of renovation will be paid by Medicaid. This insures that remodeling work is genuinely necessary before a provider commences such a project. The department will analyze the remodeling computation in conjunction with the new bed construction formula and property appraisal systems.

COMMENT: The current system discourages providers from maintaining buildings. Because of the high threshold, providers are forced to hold needed expenditures until they can be combined into a larger project that will qualify for a rate adjustment. This results in more deterioration and higher costs than if work were done when needed. We urge the department to revise this system in conjunction with the fair rental system.

RESPONSE: The department intends that a portion of the per diem rate be used to maintain and provide repairs to the facility sufficient to provide for adequate and appropriate patient care and to maintain the facility's licensing and certification. Remodeling is not routine maintenance and repair. When the department analyzes the remodeling costs prior to

determining the allowable cost to be included in the remodeling adjustment, costs are evaluated to verify if they are adequately supported by documentation and if they meet the criteria for remodeling. Routine maintenance and repair do not meet the criteria for remodeling and may be disallowed from the remodeling costs computation. Moreover, maintenance of the facility will be a necessity if appraisals are to be used as the basis for a property reimbursement formula. If a building is not adequately maintained and repaired, its appraisal value will be lower than one that is adequately maintained. The department will undertake further analysis and study to determine whether the threshold of $2,400 times the number of licensed facility beds remains an appropriate limit to be used in this analysis.

COMMENT: ARM 46.12.1202(2)(s), dealing with extensive remodeling, should be clarified to ensure that the addition of the word "total" includes only licensed nursing facility beds and not beds such as personal care beds, swing beds, and acute care beds.

RESPONSE: The department will change the reference to "total licensed beds in the facility" to read "total licensed nursing facility beds" to further clarify that this refers to only licensed skilled and intermediate care beds.

COMMENT: The property reimbursement system is based upon costs incurred in 1980 and before. This system must be revised and updated to account for current construction costs. A proper system should cover the costs of newly constructed buildings.

RESPONSE: The department has not completed research on the various fair rental and other systems that are available for property reimbursement. The department will solicit information from other states, providers and consultants regarding property reimbursement issues. The department will also continue to meet with association groups regarding nursing home issues, including property reimbursement.

COMMENT: What is the basis for the $8.38 maximum reimbursement rate for newly constructed facilities? What studies has the department done to determine that $8.38 compensates a newly constructed facility for its reasonable costs?

RESPONSE: The new construction limit will be $8.39 rather than $8.38, and is derived by the base period new construction rate computation of $7.60 indexed forward to the current level of

$8.39 for fiscal year 1990. The department will study and evaluate the rate paid for newly constructed facilities when it analyzes the total property reimbursement methodology and fair rental system.

COMMENT: What are the per diem property costs for the most recently constructed facilities in Montana?

RESPONSE: In response to this question, the department has reviewed the available FY 1988 cost information on the two newest facilities, Parkview of Billings and Riverside of Missoula. Riverside has not yet filed a cost report. Fiscal year 1988 per diem reported property costs for Parkview have been computed by dividing the property costs reported on worksheet B, part II, of the cost report by total days reported on form MA14, yielding a per diem reported property cost of $14.39. The reported information has not been desk reviewed or audited.

COMMENTS REGARDING OBRA COSTS

COMMENT: The addition of $2.00 per day for OBRA-related costs will not meet the need of providers to provide competitive salaries for certified nurse aides. As the profession is upgraded through the OBRA certification requirement, salaries for these people should be upgraded, so that staff shortages are avoided.

RESPONSE: The OBRA increment of $2.00 is intended to cover the estimated costs of nurse aide training and other requirements of OBRA to be incurred during FY 1990. The Legislature did not specifically address the costs of nurse aide testing. It is expected this testing will be provided by the state to nurse aides free of charge. The Legislature appropriated an additional $390,209 for FY 1990 to provide payments to providers for nurse aide wage increases. The funds appropriated may be used only for salary increases for nurse aides who have completed all training and competency evaluation requirements mandated under OBRA. The department will propose, prior to January 1, 1990, a rule specifying the requirements and methods for obtaining such additional reimbursement.

COMMENT: The proposed OBRA increment should be increased from $2.00 to $2.05 per patient day. The Legislature appropriated $2,725,930 for OBRA costs for FY 90, and approved 1,331,425 days of care. These days are based on a general appropriation of 1,360,000 days reduced by 41,500 days for new Medicare coverage and increased by 12,925 days related to spousal impoverishment.

RESPONSE: The department has used the appropriations and bed days specified in House Bill 100 and the Legislative Fiscal Analyst's report to develop the $2.00 OBRA increment. The provisions of HB 100 allowed for $2,723,765 to be used in fiscal year 1990 for OBRA costs. The Legislature adopted a figure of 1,360,000 Medicaid bed days for fiscal year 1990. No separate bed day figures were adopted for the OBRA increment. The department will use the days and dollars specifically adopted by the Legislature to calculate the $2.00 OBRA increment for 1990. The department will reevaluate OBRA costs after the end of fiscal 1990. OBRA costs are not necessarily an ongoing cost item and will not necessarily be included in the cost base for future rate years.

COMMENTS REGARDING GEOGRAPHIC WAGE COMPONENT

COMMENT: We object to removal of language related to "average wage," "wage area" and the geographic wage adjustment to the operating rate formula. The geographic wage adjustment should be retained but computed based only upon wages actually being paid by nursing homes in the state.

RESPONSE: The wage adjustment will be retained but will be defined and calculated in a different manner. Average aide compensation will be used in the calculation rather than starting wages. Only nursing facility data will be used.

COMMENT: A provider-specific wage index should be developed using actual nursing wage costs, which would result in higher rates to facilities which incur higher wage costs. The facilities actually incurring higher labor costs have not always benefitted from the old wage index because wages were averaged geographically.

RESPONSE: The department will not adopt this approach at this time because the effectiveness and impacts of such an approach are uncertain. This idea will be evaluated in relation to the geographic wage area concept for possible use in future rate years.

COMMENTS REGARDING THE OPERATING FORMULA "BAND"

COMMENT: The department has not eliminated the operating formula "band" from the formula. The band was a temporary measure to allow facilities time to bring their cost of providing care in line with industry standards. Eight years is more than adequate time for a facility to bring costs in line with industry norms. The department's formula allows dollars

to be spent on facilities which spend outside of the norm. Facilities that operate within the norms are penalized. The time has come to allow all facilities to compete for the short supply of Medicaid dollars on an equal basis by elimination of the band.

RESPONSE: The department will not eliminate or narrow the band further this year. The department does not believe it should eliminate a key component of the reimbursement formula that affects a number of providers until rebasing or other adjustment to the rule is proposed. The department will propose elimination of the band when rebasing is proposed.

COMMENTS REGARDING WORKERS' COMPENSATION COST INCREASES

COMMENT: How has the department taken into account the costs associated with an increase in workers' compensation premiums for FY 89 from $7.49 per $100 of payroll to $9.71 per $100 of payroll, an increase of nearly thirty percent?

RESPONSE: The department has not specifically identified workers compensation premiums in setting rates because operating rate increases apply in general to total operating costs.

COMMENT: The proposed rule fails to take into account increases in workers' compensation insurance premiums for FY 90. Language should be added to allow increases in premiums in excess of 3% to be passed through to the Medicaid program. How has the department taken into account in setting rates the 44.7% increase to be experienced by facilities for workers' compensation premiums during FY 90?

RESPONSE: The need for additional reimbursement for all employers providing services under contract with the state is an issue which must be addressed by the Legislature. A similar increase is expected for all employers subject to workers' compensation premiums. As of this writing, it is our understanding that the Legislature has passed legislation preventing the expected increases from taking effect. The department will explore alternatives for recognizing these potential increased costs in the reimbursement system but at this time has not revised the proposed methodology to increase reimbursement for this cost category.

COMMENTS REGARDING REIMBURSEMENT TO OUT-OF-STATE FACILITIES

COMMENT: ARM 46.12.1204(6)(a)(ii) provides that payment will be made to out-of-state facilities "if the services required are not provided in Montana." Trauma and rehabilitation

facilities in other states have much higher payment rates than in Montana. This proposal should be changed to clarify that the department will pay in-state providers of specialized care the same types of reimbursement rates that it is willing to pay out-of-state providers for these services.

RESPONSE: The proposed rule applies to payment for skilled nursing and intermediate care services which are provided in Montana and covered under the Medicaid program. This exception will apply only if the necessary skilled or intermediate services are not provided by any provider within the state. Trauma and rehabilitation facility services are not separately covered under this reimbursement rule.

COMMENT: The proposed rule provides that the Montana Medicaid program will make payment to out-of-state providers if the recipient is a Montanan who chooses to use an out-of-state provider, so long as it is "general practice for recipients in a particular locality to use medical resources in another state." This should be changed so that out-of-state reimbursement is not provided for services available in the recipient's local community. In the alternative, if such reimbursement is provided it should not exceed the payment rate of the local Montana provider.

RESPONSE: This rule provision is intended to provide for reasonable access to necessary skilled nursing and intermediate care services for rural Medicaid recipients residing nearer to out-of-state providers than to Montana providers. It is assumed that where services are available in the local community it is not general practice to obtain services out of state. Therefore, it can reasonably be interpreted to cover out-of-state services only when services are not provided in the local community. The payment rate of the out-of-state provider is limited to its home state Medicaid rate. The department believes it is appropriate to set payment rates based upon the Medicaid rate established by the provider's Medicaid program.

COMMENTS REGARDING THE PATIENT ASSESSMENT SCORE SYSTEM

COMMENT: Under the proposed system, the statewide average (SWA) patient assessment score will be determined annually. Since the base period costs were developed using a specific patient assessment, the average score should remain unchanged unless costs are updated. Costs in 1980 were reflective of the acuity level of patients residing in facilities in 1980. Although costs have been increased by inflators, even if adequate, they would only account for increased costs of caring for the same patients. It is unfair to expect providers to

care for high acuity patients while being paid for those of low acuity. To remedy this patient assessment scores should only be changed in years that costs are rebased.

RESPONSE: The present patient assessment system computes a new facility specific patient assessment score and a new SWA each year. The increased acuity of patients in nursing facilities is measured by using the most current month's patient assessment history for computing the SWA and facility patient assessment score. The commentor argues that if base period costs were developed using a specific patient assessment index, there should be no change in facility specific or SWA patient assessment factors unless the cost base is adjusted. Such a system would not apply current acuity levels as an adjustment factor in issuing rates. Patient acuity and facility costs would still be increasing, but the rate would fail to account for increases in acuity by using updated patient assessment data. Under the proposed system, providers receive a greater share of the aggregate nursing facility reimbursement based upon a higher score when compared to the statewide average. To adjust the facility specific patient assessment information and not the statewide average information does not seem reasonable either. If the facility data is updated to the most current data that is reasonably available, the corresponding statewide average should also be kept as current as possible.

COMMENT: ARM 46.12.1202(2)(h) defining the "provider's average patient assessment score" should be changed to clarify that the survey period used must be representative of the full year. Under the Medicare Catastrophic Coverage Act of 1988 (MCCA), many patients are entitled to 150 days of Medicare coverage, commencing on January 1 of each year. Thus, for approximately five months, patients who are normally part of the Medicaid population are removed from that population for Medicaid patient assessment purposes, which affects the patient assessment score for those months. The provider's average patient assessment score should be computed using a period that includes at least an equal number of months from both the January to May period and the June to December period. The last sentence in paragraph (h) should be revised to read:

> "The most recent survey shall include a survey period of not less than three months nor more than six months, which period should be determined in a manner which can reasonably be considered representative of all months of the provider's rate year."

This section should also be clarified to ensure that the period of time used is a time period within the last year, since nothing in this section indicates that the department must perform annual surveys. Under the current language it is conceivable that the "most recent" survey could be several years old.

RESPONSE: The department has taken into account the new coverage under MCCA in determining which months will be used in the FY90 patient assessment computation. The department has used two months when lower Medicare utilization is expected, November 1988 and December 1988, and two months when Medicare utilization is expected to be higher, February and March of 1989. The department will continue to use the most current data available, which provides the most representative available sample for providers in computing the facility specific and statewide patient assessment averages. The department will continue to perform annual surveys.

COMMENT: What was the statewide average patient assessment score in 1980, FY 83, FY 87, and FY 89? What is the statewide average patient assessment score that will be used under the proposed rule in the calculation of the patient care adjustment effective July 1, 1989?

RESPONSE: The statewide average patient assessment scores are as follows:

FY 1990	(proposed)	3.265
FY 1989		3.157
FY 1988		3.157
FY 1987		3.032
FY 1986		2.935
FY 1985		2.985
FY 1984		2.997
FY 1983		3.016

There was no computation of the statewide average patient assessment score in 1980 because the patient assessment system was not adopted until 1982.

COMMENT: The department should remove the patient care adjustment from the operating rate formula and provide a 3% increase for each provider. Some legislators have said that the 3% increase is to be applied to all rates.

RESPONSE: The department considers the patient care adjustment factor to be a reasonable and essential component of the rate distribution process. The department has complied with

legislative intent as expressed in House Bill 100 and the Legislative Fiscal Analyst's report in applying the appropriate index factor to formula property rates and to aggregate operating rates as measured by the statewide weighted average.

COMMENT: The department should not adopt and incorporate by reference the patient assessment manual. The manual is an internal department document, and the Montana Administrative Procedure Act (MAPA) allows incorporation only of other state or federal agency regulations or publications. Providers and provider organizations have not had an opportunity to comment upon the specifics of this manual, which contains vague and ambiguous language and has been subject to significant changes and conflicting interpretation by department staff and agents of the department.

RESPONSE: The notice of proposed amendment published on March 11, 1989, indicated that the department proposed adoption and incorporation of the manual, and that interested persons could comment upon the proposal. The department assumed providers would comment upon the manual. Since providers did not feel they had an opportunity to comment, the department is more than willing to provide another opportunity to comment. The department will continue to use the manual as it has since 1985 but will not adopt and incorporate the manual in this rule amendment. The department will propose a separate rule amendment by October 1989 to adopt and incorporate the patient assessment manual.

COMMENT: Proposed changes at 46.12.1201(3)(h)(ii) require providers, whose rate is recomputed after initial calculation using a deficient patient assessment monitor score, to "staff to the new patient assessment level". Does this section conflict with the language at 46.12.1209 dealing with facility deficiencies? Will providers using a deficient patient assessment score be held to a standard different than other providers?

RESPONSE: Providers using a deficient patient assessment score will be held to the same standard as under the previous rules. The deficient provider will be required, at the minimum, to staff to the patient assessment score that is used in issuing their reimbursement rate. This requirement applies to all providers. The patient assessment score used in setting the individual provider's reimbursement rate sets the minimum staffing requirement for the rate year for that provider.

COMMENT: The proposed rule would allow a provider to obtain a new patient assessment monitor if the provider's rate has been calculated with a deficient monitor. This proposal should be modified to allow the new rate to be effective on the date the new monitor is requested. This allows a rate consistent with patient care to be reimbursed in a more timely fashion, dependent on the provider's correction of problems demonstrated by a patient assessment monitor.

RESPONSE: The requested change would require the department to monitor the month in which the request was made, rather than randomly selecting a month in the new survey period May through October. In the original monitor period, November through April, the department assumes the provider is not deficient until the monitor is performed and a deficiency is identified. In a follow up monitor, the department will assume the provider is deficient until the monitor verifies that deficiencies have been corrected. The proposed patient assessment system provides that the facility's rate will be adjusted only on January 1, if the July 1 rate was set with a deficient score. This is an improvement from the current rule, which does not allow an adjustment until the beginning of the next fiscal year on July 1. The adjustment of deficient rates on January 1 will allow the department time to perform a follow-up monitor of the period May through October and will allow the department to compute and issue new rates for deficient providers at one specific time during the rate year rather than numerous times.

COMMENT: The department should allow a provider who incurs a significant change in patient assessment to request on a quarterly basis that a new rate be calculated. This change would allow a provider to more expeditiously recover current costs of providing an increased level of patient care and would help enhance access to nursing homes for heavy care patients.

RESPONSE: The department has considered this request and has determined that such a system could be detrimental to some providers because rates could decrease as well as increase. A provider's rate could decrease if one or two patients with high patient assessment scores died within the quarter. This could result in a substantial decrease in reimbursement for that quarter. Some providers would have difficulty budgeting, as rates could fluctuate several times a year, while other providers might have no changes. This system would also require a substantial amount of administrative time to recompute and reissue rates, to perform additional monitors,and to collect overpayments if a rate decrease was warranted.

COMMENT: The definitions of "heavy care" and "light care", and the payment methodology for these designations should be totally removed. Providers requested that heavy care rates be set based upon diagnosis or service requirements, or negotiation of rates according to the cost of providing care. Examples of such heavy care patients include ventilator dependent patients and head injured patients. Heavy care payment rate adjustments are necessary to improve access to nursing homes and to reimburse providers in relation to the increased costs of serving heavy care patients. Because heavy care costs more to provide, reimbursement should not be budget neutral. Heavy care should be redefined as 1.5 standard deviations over the average patient assessment score. Light care adjustments should be excluded. The heavy care provision is not responsive to providers' request for heavy care reimbursement because the patient assessment score of 7.10 is too high. Based on experience, a PAS of 5.50 or 6.00 would be considered "heavy". What is the department's methodology and rationale for determining these specific upper and lower limits?

RESPONSE: The department will remove all proposed amendments pertaining to heavy and light care. The heavy and light care rate increment methodology was proposed to recognize the basic differences in the cost of care between nursing home residents at the extreme ends of the patient assessment spectrum. However, there was no special funding nor specific legislative intent to pay increased heavy care rates to nursing homes. Therefore it must reasonably be approached as a budget neutral methodology. The department has consistently indicated that any heavy care payment system would be budget neutral and would be based upon the existing patient assessment system. However, providers and provider organizations have all expressed dissatisfaction with the proposed heavy care/light care system. The department will review and consider alternative approaches to reimbursing for such patients and will consult with providers and provider organizations in an attempt to adopt an acceptable system in the future.

COMMENT: Rather than alleviate the access problems for heavy care patients, the system of heavy care and light care increments will create access problems for light care patients. The department should use a simpler system of an additional flat per diem amount to be billed for heavy care patients. An alternative is to contract rates on an individual basis.

RESPONSE: The department will delete the heavy and light care methodology and will consider other options for future implementation.

COMMENTS REGARDING INCORPORATION OF FEDERAL OBRA & OTHER REQUIREMENTS

COMMENT: The language in proposed ARM 46.12.1202(2)(a)(ii), requiring nursing facilities to "provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life," is so vague and broad that it could be interpreted to mean whatever the department desires. The requirement should be clarified.

RESPONSE: The proposed language has been adopted from 42 U.S.C §1396r(b)(1)(A), which is part of OBRA '87. This is a federal requirement and will be adopted as proposed by the department.

COMMENT: The department should not restate the provisions of OBRA '87 in its rule as proposed at ARM 46.12.1203(1)(f) through (i) and 1205(7). The proposal appears to require providers to comply earlier than required under federal law. Further, some of the proposed requirements are to be enforced by the state Department of Health and Environmental Sciences (DHES) rather than SRS. It would be sufficient to merely require providers to comply with all state and federal laws and regulations or to incorporate the OBRA provisions by reference. Further, OBRA has been amended and may be further amended prior to the federal effective dates.

RESPONSE: The department does not intend to change the federal OBRA requirements or to require compliance on a schedule different from that required under federal law. The proposed language was intended as an additional means of notifying providers of the requirements. Further, although DHES has primary responsibility for enforcement through the survey process, SRS also must enforce these requirements by entering into provider agreements and sanctioning providers or terminating agreements where appropriate. However, the department agrees that it is preferable to incorporate the federal law rather than repeating its language. The department will incorporate the OBRA Medicaid nursing facility requirements, which will include the statute as amended to the effective date of the proposed rule and the OBRA screening requirements as implemented in the department's rules. If the federal law is later amended, the department will propose a retroactive amendment to incorporate the change. The department will comply with any direction from HCFA that part of the statute is invalid and should not be enforced by this department. It is the department's intent to require compliance with OBRA as it may be amended by Congress or interpreted by HCFA in the Code of Federal Regulations.

COMMENT: The written notice requirement regarding bed hold during therapeutic leave or hospitalization is difficult to meet. Often the length of a resident's hospitalization is unpredictable, making the prior written notice requirement next to impossible to implement. The department should address this issue.

RESPONSE: OBRA '87 requires that facilities provide written information to the resident and a family member or legal representative. The information must specify the duration of the bed hold policy, if any, under the state plan, and the facility's policies on bed hold periods. This information must be provided before a resident is transferred to a hospital or for therapeutic leave and at the time of transfer. The department will delete from the rule proposed ARM 46.12.1205 (7), but will adopt and incorporate by reference the OBRA requirements. Nursing facilities will be required to meet all requirements of federal law including the provisions of OBRA '87 concerning written notice upon admission and prior to transfer for hospital or therapeutic leave.

MISCELLANEOUS COMMENTS

COMMENT: The proposed rule at ARM 46.12.1202(2)(a) should be updated to reflect renumbering of the incorporated federal regulations effective August 1, 1989.

RESPONSE: The proposal has been amended to incorporate the updated citations as of their effective dates. The term "participation standards" has been changed to "participation requirements" for consistency with language in the federal regulations.

COMMENT: The rules are not written in a clear and understandable manner. First, the definition of "adequate nursing facility services" in ARM 46.12.1202(1)(c) is difficult to determine, because the definition refers to another regulation in ARM 46.12.1206, which in turn refers to a regulation which incorporates another regulation. Tracing these references ultimately leads to the suggestion that provision of adequate services requires compliance with only the criteria relating to necessity of Medicaid admissions, rather than compliance with state and federal regulations and standards generally. Second, the definition in ARM 46.12.1202(1)(b) of "efficiently and economically operated providers" is ludicrous because it suggests that facilities which do not make a profit from the underfunded Medicaid program are inefficient and uneconomical. These definitions should be corrected.

RESPONSE: The department has made a considerable effort to improve the rule to make it easier to understand. However, this is an ongoing project and work remains to be done. The subject matter of the rules is complex and the rules must be read as a whole to determine the intent of the department regarding all nursing facility requirements. The comment regarding "adequate services" inaccurately characterizes the purpose and effect of references to other rules, and as a result oversimplifies and misstates the essence of the rules. No alternative approaches to this difficult task are suggested. The referenced sections in fact directly address their respective subjects, but also refer to additional applicable material. The alternative is to unnecessarily repeat rule language, which is also potentially confusing and increases the administrative costs of the department and the length of the rules. The provisions of ARM 46.12.1202(1)(a), (1)(b), and (1)(c) originally were included in the rule to simplify presentation to HCFA of the state plan regarding nursing facility services. Because these items need not be included in the rule itself, they are being deleted from the final rule. Other language in 46.12.1202(1) is retained and clarified. The department believes the use of referenced sections in ARM 46.12.1206 appropriately addresses the subject of deficiencies and those references will be retained.

COMMENT: The nursing facility rule does not allow providers to recover any of the indirect expenses associated with providing residents necessary medical items. Providers should be allowed to charge a reasonable mark-up for these items, to cover the real costs of storing, processing, marking, accounting for and delivering these items to the resident.

RESPONSE: The department considers the per diem rate to cover the cost of storing, processing, marking, accounting for, and delivering these items to the resident. These are all routine services being provided by the facility for which no additional reimbursement is provided. The department allows billing for ancillary items at direct cost when medically necessary and physician prescribed. These items are not considered routine and the provider is allowed to recover its cost of providing these items.

COMMENT: ARM 46.12.1205(8) lists items which may be charged to a nursing facility resident. Since there may be other items similar to the specific ones listed, the department should add a section to include "other similar items". Subsection (6) excludes certain routine stock items such as aspirin. It is our understanding that if routine items are used

in extraordinary amounts they may be billed separately. This should be clarified.

RESPONSE: The listing included at ARM 46.12.1205(8) was inserted into the state plan as a requirement of OBRA '87. The OBRA language requires that the listing be as specific as possible as to the items not covered by the per diem rate. Routine items that are used in extraordinary amounts may be billed to Medicaid, not the resident, if they meet the criteria of ARM 46.12.1205(2)(a) and are prior authorized by the department. Under no circumstances can aspirin or acetaminophen be billed to Medicaid or to the resident.

COMMENT: In ARM 46.12.1202(2)(j) a "medically necessary room" is defined as a double-occupancy room. It appears the department will require that providers always use a double-occupancy room. In cases where isolation is ordered by the physician due to a diagnosis or for an infectious disease, is the department ordering the provider to use a double-occupancy room? Is the department willing to indemnify the provider for any possible consequences in such a case? We urge the department to pay for a private room when ordered by a physician for medical reasons.

RESPONSE: Under proposed ARM 46.12.1202(2)(j), a private room will be reimbursed by the department at the same rate as a double-occupancy room. It has not been demonstrated that provision of a private room significantly increases operating cost to providers. The rule does not require providers to place patients in a double-occupancy room where a physician orders a private or isolation room for medical reasons. However, a provider must provide a private or isolation room at no additional charge to Medicaid when it is determined medically necessary. The provider may not bill recipients extra for a medically necessary private room. A Medicaid resident may pay an additional amount on a voluntary basis for a private room when it is not medically necessary, but the resident must be clearly informed that it is strictly voluntary. Language has been added to clarify that a resident who requests a private room when it is not medically necessary may be required to pay for the amount of the private room rate that exceeds the Medicaid per diem rate.

COMMENT: Proposed ARM 46.12.1202(2)(a)(iv)(E) requires providers to provide disposable diapers, or cloth diapers at the patient's request. Providers should be required to provide either cloth or disposable diapers, but not both. To require providers to provide both is an unnecessary expense. The term

"diaper" should be replaced with a term that is consistent with residents' dignity.

RESPONSE: The department inserted the reference to cloth diapers at the request of individuals who felt that a resident should be allowed to use cloth diapers without extra charge if they have a skin sensitivity to disposable diapers. The department is not requiring the provider to provide a dual system for incontinent care depending on the whims of patients. However, providers should make available the type of incontinent care suitable to the patient's medical needs. The department considers the provision of diapers for incontinent care to be a routine service item, whether the facility routinely provides cloth or disposable diapers. The department will eliminate the reference to diapers in ARM 46.12.1202(2)(a)(iv)(E) and insert "routine incontinence care items appropriate for the resident's individual medical needs" in its place. This phrase will be interpreted by the department to mean any incontinence care item that is not specifically defined as billable as an ancillary service. Providers will be required to provide at their discretion either cloth or disposable diapers as part of routine incontinence care covered under the per diem rate. Providers must also provide the type of diaper appropriate to the medical needs of individual patients for whom the provider's routine type is medically inappropriate.

COMMENT: ARM 46.12.1202(2)(a)(i) should be clarified to state that "decubitis treatment" includes the routine services associated with actual treatment of pressure sores, such as necessary salves, coverings, wound dressings, turning and positioning, but does not include special beds, mattresses and wheelchair cushions, which can cost thousands of dollars. The term "pressure sore" should be used in place of "decubitis", since that is now the accepted term to describe the condition.

RESPONSE: The department will revise the rule language to read "routine pressure sore/decubitis treatment". The rules define which services or items are included in the payment rate as routine. The rules also indicate when services are no longer routine and therefore separately billable. Mattresses (foam-type and water), beds, and bedside furniture are specifically included in ARM 46.12.1202 as routine items. Antibacterial ointments, lotions, surgical dressings and surgical tape are also contained in the list of items covered by the basic per diem rate. Any item that would meet the criteria for extraordinary use of a routine item or the criteria for reimbursement under 46.12.1205 (2)(e), as durable medical equipment and medical supplies, and which are intended to treat a unique condition which cannot be met by routine nursing care, may be

billed separately by the medical supplier in accordance with ARM 46.12.801 through 802 and ARM 46.12.805 through 806.

COMMENT: ARM 46.12.1202(2)(k), defining "administrator" should be clarified to provide for those administrators who hold temporary licenses awaiting final licensure by the state.

RESPONSE: The department does not believe that this additional clarification is necessary. A temporary license allows an administrator to work in the capacity as an administrator until a final license is issued by the state and an individual holding a temporary license would meet the requirements as an administrator under ARM 46.12.1202(2)(k).

COMMENT: The rule language is inconsistent in the use of the terms "patient" and "resident". The language used should be consistently "resident".

RESPONSE: The department agrees that "resident" is the appropriate term. During preparation of rule replacement pages, the department will review the rules and insert resident in the place of patient where it is appropriate to do so.

COMMENT: The old language in ARM 46.12.1209(3) should be restored to allow the department the discretion to review the circumstances surrounding an appeal to determine if a delay in repayment is appropriate. Or, in the alternative, the new language should be clarified to state that although filing a request for administrative review or fair hearing does not automatically entitle a provider to a delay in repayment, the department may determine that a delay is appropriate.

RESPONSE: Federal repayment requirements are such that to allow repayments to exceed the proposed time period may in effect result in a loan of state general fund to the provider. The department has no authority to grant such loans.

COMMENT: Section 46.12.1208(6)(c) provides that "failure of the department to complete desk reviews within any particular time shall not entitle the provider to retain any overpayment discovered at any time." The department should be required to conduct its desk reviews and audits in a timely fashion, and cost reports should be closed out at the expiration of some particular length of time. It is inappropriate for a provider's cost report to be "open" forever and subject to audit and paybacks long after the rate year ends. Providers are

expected to meet many standards and time frames, and the department should be expected to do likewise.

RESPONSE: The department agrees that desk reviews and audits should be completed timely. However, the department does not agree that providers should be allowed to retain overpayments simply because audits or desk reviews have not been completed as soon as desirable. The department will attempt to complete audits and desk reviews as soon as possible, but will not allow providers to retain overpayments simply because they are not identified within a particular period of time.

5. This rule change will be applied retroactively to July 1, 1989.

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State July 17, 1989.

VOLUME NO. 43 OPINION NO. 23

CONFLICT OF INTEREST - Enforcement of nepotism laws on Indian reservations;
CONTRACTS - Effect of nepotism statute violation;
CRIMINAL LAW AND PROCEDURE - Enforcement of nepotism laws on Indian reservations;
EDUCATION - Enforcement of nepotism laws against school board members;
INDIANS - Enforcement of nepotism laws on Indian reservations;
NEPOTISM - Enforcement of nepotism laws on Indian reservations;
PUBLIC OFFICERS - Enforcement of nepotism laws on Indian reservations;
SCHOOL BOARDS - Enforcement of nepotism laws on Indian reservations;
SCHOOL DISTRICTS - Enforcement of nepotism laws on Indian reservations;
MONTANA CODE ANNOTATED - Sections 2-1-301, 2-2-301 to 2-2-304, 2-2-302, 2-2-304, 20-3-324, 20-4-201 to 20-4-207;
MONTANA LAWS OF 1987 - Chapter 117;
MONTANA LAWS OF 1933 - Chapter 12;
OPINIONS OF THE ATTORNEY GENERAL - 42 Op. Att'y Gen. No. 91 (1988), 41 Op. Att'y Gen. No. 57 (1986), 39 Op. Att'y Gen. No. 67 (1982), 34 Op. Att'y Gen. No. 3 (1971);
UNITED STATES STATUTES AT LARGE - 57 Stat. 588 (1953).

HELD: Montana's nepotism statutes apply to members of public school boards for districts lying wholly or partially within an Indian reservation. Criminal prosecution of nepotism law violations by members who are Indians with respect to decisions made and implemented wholly on-reservation may be initiated only in federal court by the United States except for those violations occurring on the Flathead Indian Reservation. Finally, contracts entered into in contravention of the nepotism statutes are voidable.

July 11, 1989

James C. Nelson
Glacier County Attorney
P.O. Box 428
Cut Bank MT 59427

Dear Mr. Nelson:

You have requested my opinion concerning the following question:

> Does the prohibition against nepotism in section 2-2-302(1), MCA, apply to members of a public school board whose district is located wholly or partially within an Indian reservation and, if so, what enforcement mechanisms are available against such members who are Indians?

I conclude that the Montana nepotism statutes, §§ 2-2-301 to 304, MCA, apply uniformly to all persons specified thereunder and that such statutes are not preempted by federal law. I further conclude that, while criminal prosecution in state court under section 2-2-304, MCA, is unavailable in some instances, other remedies exist for violation of the nepotism prohibition, including possible criminal prosecution by the United States pursuant to 18 U.S.C. § 13 and employment termination of the person to whom the board member is related.

Your question arises with respect to a state school district located within the exterior boundaries of the Blackfeet Indian Reservation. Information submitted with the opinion request indicates that school district employees have been employed despite the fact that, at the time their employment commenced, they were related by consanguinity within the fourth degree to a member of the school district's board of trustees. Section 2-2-302(1), MCA, states, however, that "[i]t shall be unlawful for any person or any member of any board, bureau, or commission or employee at the head of any department of this state or any political subdivision thereof to appoint to any position of trust or emolument any person related or connected by consanguinity within the fourth degree or by affinity within the second degree." There is no dispute that the nepotism prohibition in section 2-2-302(1), MCA, facially applies to employment decisionmaking by members of a school board. See State ex rel. Hoagland v. School District No. 13, 116 Mont. 294, 298-99, 151 P.2d 168, 169-70 (1944); 41 Op. Att'y Gen. No. 57 (1986); 39 Op. Att'y Gen. No. 67 at 250 (1982); 34 Op. Att'y Gen. No. 3 at 89 (1971). The school board has nonetheless suggested that a 1987 amendment to section 2-2-302, MCA, validates at least some initial hiring determinations which, when made, conflicted with such statute, and that, as discussed below, federal preemption issues exist.

First, the 1987 amendment to section 2-2-302 (1987 Mont. Laws, ch. 117) added subsection (2)(b) which excepts from the prohibition in subsection (1) "the renewal of an employment contract of a person who was initially hired before the member of the board, bureau, or commission or the department head to whom he is related assumed the duties of the office." (Emphasis added). The amendment's purpose was to overturn 41 Op. Att'y Gen. No. 57 at 233 (1986) to the extent it held that contract renewal decisions were subject to the general nepotism prohibition even though, at the time the affected employee was first employed, no nepotism violation had occurred. Neither the purpose nor the literal language of the amendment justifies a construction, such as has been urged by the school board, that subsection (2)(b) encompasses renewals of contracts which were proscribed by subsection (1) when initially made; i.e., the clause "before the member ... assumed the duties of his office" refers only to those periods of time when the involved public official was not serving and is not intended to insulate from the nepotism prohibition an otherwise invalid initial hiring decision made by the official during a previous term in office.

Second, federal preemption issues are present since the involved school board members are Indians, their employment decisions were made within the exterior boundaries of their reservation, and such decisions relate to individuals whose employment occurs on such reservation. Preemption may derive from interference with a specific federal statutory scheme or, under somewhat more limited circumstances, from infringement on tribal self-government authority. E.g., White Mountain Apache Tribe v. Bracker, 448 U.S. 136, 142-43 (1980); Williams v. Lee, 358 U.S. 217, 220 (1959). Under either preemption prong the applicability of the nepotism statutes to tribal members must be determined by balancing state, federal and tribal interests. E.g., California v. Cabazon Band of Mission Indians, 480 U.S. 202, 214-16 (1987); Washington v. Confederated Tribes of Colville Indian Reservation, 447 U.S. 134, 156-57 (1980). In this case, the material facts and underlying interests are quite well defined and lead inevitably to the conclusion that the nepotism provisions do apply.

Montana's nepotism laws date back to 1933 (1933 Mont. Laws, ch. 12) and reflect a basic public policy against even the appearance of impropriety attendant to the use of contracting authority by public officers to benefit their relatives. See 41 Op. Att'y Gen. No. 57 at 234 ("[t]he intent of the [nepotism] statutes is to prevent favoritism and conflicts of interest by public agencies

in hiring, and to concentrate on the applicant's merit and qualifications"). Like any statute which speaks broadly and admits few exceptions, these provisions may occasionally penalize a worthy applicant, but such a penalty has been legislatively deemed necessary to ensure against the possibility of conflicted decisionmaking. Nepotism prohibitions directly promote confidence in the integrity of elected or appointed officials' discharge of their statutory responsibilities and therefore touch upon matters of a uniquely state and local governmental concern.

In contrast, no federal statutory scheme is affected by the Montana nepotism statutes, and the state statutes govern activities over which tribes have no sovereign responsibility. This is accordingly not a situation where state law interferes with comprehensive federal, joint federal-tribal or purely tribal regulation. E.g., California v. Cabazon Band of Mission Indians, supra (on-reservation tribal gaming enterprise); New Mexico v. Mescalero Apache Tribe, 462 U.S. 324 (1983) (on-reservation federal-tribal resource management program); White Mountain Apache Tribe v. Bracker, supra (on-reservation tribal timber harvesting management by Bureau of Indian Affairs). The State is also not seeking through the guise of its nepotism provisions to exact an economic benefit from reservation activities which it has declined to provide pursuant to its own laws. See Ramah Navajo School Board v. Bureau of Revenue, 458 U.S. 832, 843 (1982). These provisions instead reflect an important state public policy uniformly and nondiscriminatorily applicable to individuals who, by their own choice, have assumed positions of trust under Montana law.

Enforcement of state nepotism statutes is nonetheless affected by whether the challenged conduct has occurred on-reservation by a public officer who is an Indian. Section 2-2-304, MCA, subjects public officers to criminal prosecution for violation of section 2-2-302(1), MCA, with a maximum penalty of a $1,000 fine and/or six months' imprisonment. Decisional law has further established that contracts entered into in contravention of nepotism laws are voidable. State ex rel. Hoagland v. School District No. 13, supra. The second of these remedies is administrative in nature, and its use is governed by statute. See §§ 20-3-324(2), 20-4-201 to 207, MCA. The somewhat more complex issue is whether the criminal sanctions under section 2-2-304, MCA, may be applied to the reservation-based conduct of a public officer who is an Indian.

It is settled that state criminal laws have no application to Indians for crimes committed within Indian country, as defined by 18 U.S.C. § 1151, unless expressly made so by Congress. E.g., United States v. John, 437 U.S. 634, 651 (1978); United States v. Antelope, 430 U.S. 641, 646 (1977); Seymour v. Superintendent, 368 U.S. 351 (1962); State v. Greenwalt, 204 Mont. 196, 205-07, 663 P.2d 1178, 1182-83 (1983); State ex rel. Irvine v. District Court, 125 Mont. 398, 404, 239 P.2d 272, 275 (1951). Thus, except for the Flathead Indian Reservation over which criminal jurisdiction has been assumed pursuant to section 6 of Public Law No. 280, 67 Stat. 588, 590 (1953) (§ 2-1-301, MCA), Montana has no authority to prosecute Indians with respect to violation of section 2-2-302(1), MCA, if the challenged decision is made on-reservation and relates to employment or other services to be rendered there. Nonetheless, because nepotism is against the State's public policy (42 Op. Att'y Gen. No. 91 (1988)) and is prohibited rather than merely regulated, such violations are subject to prosecution in federal court by the United States pursuant to the Assimilative Crimes Act, 18 U.S.C. § 13. See Cabazon, 480 U.S. at 211 n.10. Such prosecution is thus a matter subject to the discretion of the United States Attorney, not the involved county attorney, and the former is, of course, not bound by my view of the federal law issues addressed above.

THEREFORE, IT IS MY OPINION:

> Montana's nepotism statutes apply to members of public school boards for districts lying wholly or partially within an Indian reservation. Criminal prosecution of nepotism law violations by members who are Indians with respect to decisions made and implemented wholly on-reservation may be initiated only in federal court by the United States except for those violations occurring on the Flathead Indian Reservation. Finally, contracts entered into in contravention of the nepotism statutes are voidable.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

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 bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt or amend 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 the existing or proposed rules. The address is Room 138, Montana 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 looseleaf 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 statutes 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 ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.

Statute Number and Department

2. Go to cross reference table at end of each title which list MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1989. This table includes those rules adopted during the period April 1, 1989 through June 30, 1989 and any proposed rule action that is pending during the past 6 month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1989, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1989 Montana Administrative Register.

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