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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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

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

In the matter of the amendment of rule 16.24.104 concerning eligibility requirements for the handicapped children's services program	)))))	NOTICE OF PROPOSED AMENDMENT OF RULE NO PUBLIC HEARING CONTEMPLATED

(Handicapped Children)

To: All Interested Persons

1. On August 27, 1991, the department proposes to amend rule 16.24.104 concerning eligibility requirements for the services offered by the handicapped children's services program.

2. The proposed amendment would incorporate by reference the most current federal low income guidelines.

3. The rule, as proposed to be amended, appears as follows (new material is underlined; material to be deleted is interlined):

16.24.104 APPLICANT ELIGIBILITY (1)-(7) Remains the same.

(8) Effective ~~July 1, 1990,~~ September 13, 1991, the department hereby adopts and incorporates by reference the ~~1990~~ 1991 federal poverty income guidelines published by the U.S. department of health and human services in the February ~~16, 1990,~~ 20, 1991, federal register [~~55 FR 5664~~ 56 FR 6859]. Copies of the federal poverty income guidelines may be obtained from the Family/Maternal and Child Health Services Bureau, HCS Program, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620 [phone: (406)444-~~4740~~ 3617].

AUTH: 50-1-202, MCA; IMP: 50-1-202, MCA

4. The proposed amendment is necessary to allow the department to provide handicapped children's services to all those children who should be eligible under the federal poverty guidelines.

5. Interested persons may submit their written data, views, or arguments concerning this amendment to Ellie Parker, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620, no later than August 23, 1991.

6. If a party who is directly affected by the proposed amendment wishes to express his data, views, and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Ellie Parker, Department of Health

and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620, no later than August 23, 1991.

7. If the department receives requests for a public hearing under Section 2-4-315, MCA, on the proposed amendment, from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not fewer 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 in excess of 25, based on the current numbers of children receiving handicapped children's services.

DENNIS IVERSON, Director

Certified to the Secretary of State July 15, 1991.

BEFORE THE FIRE PREVENTION AND INVESTIGATION BUREAU
OF THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the adoption and amendment of Rules of the fire prevention and investigation bureau, describing enforcement of the rules and other provisions generally dealing with fire safety.	))))))	NOTICE OF PROPOSED ADOPTION, AMENDMENT AND REPEAL OF RULES PERTAINING TO FIRE SAFETY. NO PUBLIC HEARING CONTEMPLATED.

TO: All Interested Persons:

1. On September 26, 1991, the Department of Justice proposes to adopt Rules I through XII, to amend ARM 23.7.121, 23.7.122, 23.7.124, 23.7.125, 23.7.131, 23.7.133, and 23.7.134, to amend and transfer ARM 23.2.111, 23.7.101, and to repeal ARM 23.2.131 and 23.7.111.

2. The department proposes to adopt the following rules:

RULE I ENFORCEMENT OF FIRE PREVENTION AND INVESTIGATION BUREAU RULES (1) The fire prevention and investigation bureau shall administer and enforce in every area of the state of Montana all the provisions of the Fire Codes of Montana and rules adopted pursuant thereto. The chief fire official of each municipality or organized fire district shall have responsibility for enforcement of applicable fire codes within the limits of his jurisdiction, and shall assist the bureau in the enforcement of laws and rules pertaining to fire safety in public buildings.

(2) Each local authority responsible for fire prevention inspections shall maintain reports of inspections performed. The local authority shall submit to the fire prevention and investigation bureau, annually, a report listing inspections performed. Fire prevention inspection reports shall be accessible to and provided to the fire prevention and investigation bureau when deemed necessary by the bureau chief.

(3) Each official responsible for investigating fires shall file with the fire marshal a fire incident report on each and every fire occurring within the official's jurisdiction. Forms may be obtained from the state fire prevention and investigation bureau, and reports must be submitted on the forms supplied by the bureau. Incomplete forms may be returned for resubmission with complete information.

AUTH: 50-3-102(2) MCA.
IMP: 50-3-102, 50-61-102, 50-63-203(1) MCA.

RULE II NOTICE OF VIOLATION Upon determination by an officer of the fire prevention and investigation bureau that any person or entity is in violation of any provision of the Fire

Codes of Montana or any rule adopted pursuant thereto, the bureau shall serve upon the person or a designated representative of the entity a notice of violation, as provided in section 50-61-115, MCA, or, if a fire hazard is present, the bureau shall proceed in accordance with sections 50-62-102 and 50-62-103, MCA.

AUTH: 50-3-102(2) MCA. IMP: 50-3-103, 50-3-102(4) MCA.

RULE III INTERPRETATION Interpretations of rules adopted by the fire prevention and investigation bureau shall be made by the state fire marshal.

AUTH: 50-3-102 MCA. IMP: 50-3-102, 50-61-102 MCA.

RULE IV ADOPTION OF UNIFORM FIRE CODE AND DEFINITIONS (1) The fire prevention and investigation bureau hereby adopts and incorporates by reference the Uniform Fire Code, International Conference of Building Officials, 1988 edition, and the 1988 edition of the UFC Standards. Copies of the Uniform Fire Code and related materials may be obtained from the International Conference of Building Officials, 5360 South Workman Mill Road, Whittier, California 90601, or from the Building Codes Bureau of the State of Montana Department of Commerce, 1218 East Sixth Avenue, Helena, Montana 59620. Information is available upon request from the Fire Prevention and Investigation Bureau, Department of Justice, 303 North Roberts, Helena MT 59620.

(2) As used in these rules, all definitions contained within the Uniform Fire Code apply with the following exceptions and additions:

(a) "Apprentice" is a person in a training position, for a period of no more than 12 months, for the installation or service of fire protection equipment.

(b) "Building Code" means the latest edition of the Uniform Building Code adopted by the department of commerce. Whenever a provision of the Building Code is incorporated within the Uniform Fire Code by reference, such provision is hereby adopted for application to all buildings within the jurisdiction of the state fire prevention and investigation bureau, unless the bureau chief determines otherwise in accordance with UFC Section 2.301. Copies of the Uniform Building Code may be obtained from the Building Codes Bureau of the Department of Commerce, 1218 East Sixth Avenue, Helena, Montana 59620.

(c) "Building official" refers to the bureau chief of the building codes bureau of the department of commerce or, when made applicable by statute or rule, the building official of the local jurisdiction.

(d) "Chief," "fire chief," "fire marshal," and "fire prevention engineer" all are treated as referring to the chief of the fire prevention and investigation bureau of the department of justice or, when made applicable by statute or rule or the context thereof, to the chief official of the appropriate local fire protection agency.

(e) "City" is treated as referring to the state of Montana or, when made applicable by statute or rule or the context thereof, to the appropriate local jurisdiction.

(f) "District", as used in section 50-61-114, means a rural fire district established under Title 7, chapter 33, part 21, MCA.

(g) "Fire department" and "bureau of fire prevention" are treated as referring to the fire prevention and investigation bureau of the department of justice or, when made applicable by statute or rule or the context thereof, to the appropriate local jurisdiction.

(h) "Fire protection equipment" means any listed and/or labeled fire alarm system, automatic fire alarm system, automatic fire-extinguishing system or portable fire extinguisher.

(i) "Installation and service," when applicable to fire protection equipment, means such installation and servicing as required by the Uniform Fire Code and by nationally recognized standards referenced in the Uniform Fire Code. Required service for fire protection equipment is to be based on the purchase date.

(j) "Mechanical Code" means the latest edition of the Uniform Mechanical Code adopted by the department of commerce. Whenever a provision of the Mechanical Code is incorporated within the Uniform Fire Code by reference, such provision is hereby adopted for application to all buildings within the jurisdiction of the state fire prevention and investigation bureau, unless the bureau chief determines otherwise in accordance with UFC Section 2.301.

(k) "Ordinance" means state law, city or county ordinance, or rule adopted by the fire prevention and investigation bureau.

(l) "Portable fire extinguisher" means a hand-portable or wheeled container filled with any approved fire extinguishing agent that can be used to extinguish small fires.

(m) "Registrant" means a person certified by the state fire marshal who performs the installation or service of fire protection equipment.

(n) "Single family private house" means a dwelling unit as defined in the Uniform Fire Code, no part of which is rented to another person.

(o) "Uniform Fire Code" means the latest edition of the Uniform Fire Code adopted by the state fire prevention and investigation bureau.

(3) The fire prevention and investigation bureau does not adopt Articles 4 and 78 of the Uniform Fire Code, and does not adopt the following appendices: II-C (Marinas), II-D (Rifle Ranges).

(4) If there is any conflict between the Uniform Fire Code and the Montana Code Annotated, the provisions of the Montana Code Annotated control.

(5) This rule establishes a minimum fire protection code to be used in conjunction with the Uniform Building Code, ARM

8.70.101, et seq. Nothing in this rule prohibits any local government unit from adopting those chapters of the Uniform Fire Code that are not adopted for application by the fire prevention and investigation bureau.

AUTH: 50-3-102(2), 50-61-102 MCA.
IMP: 50-3-102, 50-61-102 MCA.

RULE V APPOINTMENT OF SPECIAL FIRE INSPECTORS (1) Special fire inspectors may be appointed in accordance with this section.

(2) A special fire inspector may be appointed to conduct inspections and investigations when the services are deemed necessary by the department of justice.

(3) Qualifications for persons appointed special fire inspector are:

(a) Any person appointed special deputy state fire marshal, except for a qualified inspector employed by another state agency, must have a degree in fire protection engineering or related field from a recognized institution of higher education or 2 years' experience in fire protection, and must complete a training course administered or approved by the fire prevention and investigation bureau.

(b) An employee of another agency of the state of Montana may be appointed special fire inspector for the purpose of conducting inspections or investigations authorized by the fire prevention and investigation bureau if such employee is qualified by the employing agency as an inspector or investigator and is approved to conduct inspections or investigations by the department of justice.

(4) A special fire inspector may perform any duty with which the fire prevention and investigation bureau is charged by state law or rule, subject to the direction of the bureau chief.

AUTH: 50-3-106 MCA. IMP: 50-3-106 MCA.

RULE VI FIRE ESCAPES FOR PUBLIC BUILDINGS (1) All buildings described in section 50-61-103, MCA, of two or more stories in height, except private residences, shall be equipped with adequate fire escapes in accordance with this rule.

(2) Appendix I-A of the Uniform Fire Code is adopted for application to all existing buildings subject to this rule other than high-rise buildings, and subsection 2 thereof shall govern the provision of exits and fire escapes in all such buildings. Appendix I-B of the Uniform Fire Code is adopted for application to all existing high-rise buildings subject to this rule. Appendix I-C of the Uniform Fire Code shall govern stairway identification.

(3) Provision of fire escape exits in new buildings shall be in accordance with the Building Code.

AUTH: 50-3-103 MCA. IMP: 50-61-105 MCA.

RULE VII HOUSING OF PHYSICALLY HANDICAPPED (1) Any building defined as a residential occupancy by section 50-61-103(6), MCA, or as an institutional occupancy by section 50-61-103(5), MCA, shall not house any physically handicapped person in a unit or room where escape is not feasible if elevators are disabled.

(2) The state fire marshal may, during the course of an inspection, make inquiry and determine whether adequate egress or exiting provisions have been made for any handicapped residents. If a violation occurs, the fire marshal may issue a notice and proceed in accordance with sections 50-61-115 to 118, MCA.

AUTH: 50-3-102 MCA. IMP: 50-3-102 MCA.

RULE VIII SMOKE DETECTORS IN RENTAL UNITS (1) In accordance with the Residential Landlord and Tenant Act of 1977, an approved smoke detector shall be installed by the landlord in each dwelling unit rented to another person.

(2) An approved smoke detector is a device that is capable of detecting visible or invisible particles of combustion, that emits an alarm signal, and that bears a label or other identification issued by an approved testing agency having a service for inspection of materials and workmanship at the factory during fabrication and assembly.

(3) Appendix I-A(6) of the Uniform Fire Code shall govern the installation of smoke detectors in all dwelling units subject to this rule.

AUTH: 70-24-303(1)(g) MCA. IMP: 70-24-303(1)(g) MCA.

RULE IX CERTIFICATE OF APPROVAL FOR DAY CARE CENTERS FOR THIRTEEN OR MORE CHILDREN (1) Any applicant for a license from the department of family services to operate a day care center for 13 or more children under Title 52, chapter 2, MCA, must obtain a certificate of approval from the state fire marshal in accordance with this rule.

(2) To obtain a certificate of approval, the applicant shall submit a written application to the state fire marshal setting forth the following information:

(a) Name and address of applicant and location of proposed day care center; and

(b) Number of children for which proposed day care center will provide care.

(3) Upon receipt of an application for certificate of approval, the fire marshal or his representative shall conduct an inspection of the proposed day care center, and shall promptly thereafter issue his findings, indicating whether or not fire safety rules have been met. In addition to compliance with the Uniform Fire Code, all day care centers shall comply with the following provisions of the building code which are hereby incorporated by reference: Secs. 802(c), 803, 808, 809, chapter 33, section 3802(e), and chapter 42. Day care centers must also comply with the following additional requirements:

(a) A single, fixed space heater (wood, coal or fuel oil) may be used, provided it is properly installed and surrounded by a suitable barrier to prevent contact by children and is so located as to not obstruct egress. Installation shall be in accordance with the Uniform Mechanical Code.

(b) Portable unvented oil-fueled heating appliances are prohibited.

(c) No extension cords shall be used in lieu of permanent wiring. All appliance and lamp cords shall be suitably protected to prevent pulling or chewing by children.

(d) All unused electrical receptacles shall be properly capped.

(e) Every closet door latch shall be fixed so that the door is capable of being opened by a child inside the closet.

(f) Every bathroom door lock shall be installed to permit the locked door to be opened from the outside.

(g) In sleeping rooms, windows having a minimum of 5.7 square feet of clear, unobstructed opening shall be readily accessible for rescue or fire suppression. Windows shall be capable of being opened from the inside without the use of tools or special knowledge. Clear opening shall not be less than 20 inches in width or 24 inches in height. The bottom of the window shall not be more than 44 inches from the floor.

(h) Every day care center shall provide operational smoke detectors in locations designated by the chief. Smoke detectors shall be tested at least every thirty days and a log of such tests maintained on the premises.

(i) Portable fire extinguishers shall be installed and maintained in accordance with UFC Standard 10-1 or NFPA 10.

(j) A telephone shall be provided for emergency notification. Emergency phone numbers shall be posted in close proximity to the telephone.

(k) House numbers, no less than 6 inches in height, shall be placed in such a position as to be plainly visible and legible from the street or road fronting the property. Numbers shall contrast with their background.

(l) Space under stairwells shall not be used for storage of any kind except as permitted by UFC Sec. 12.106(c).

(4) If the proposed day care center is in compliance with these rules, the fire marshal shall issue a certificate of approval. If the center is not in compliance, the fire marshal shall issue a notice of corrective action needed to bring the center into compliance. Additional inspections may be conducted as needed until compliance is achieved.

(5) For the purposes of this rule, the definitions contained in section 52-2-703, MCA, are applicable.

(6) Inspection of any day care facility shall be done upon receipt of a request from the department of family services or as a part of an inspection performed by a fire department under other provisions of state law. Findings of any inspection conducted at the request of the department of family services shall be reported to that department.

AUTH: 52-2-734 MCA. IMP: 52-2-734, 52-2-733(5) MCA.

RULE X CERTIFICATE OF APPROVAL FOR COMMUNITY HOMES (1) This rule shall govern certification for fire and life safety of all community homes for the developmentally disabled, in accordance with section 53-19-204, MCA, and of all community homes for persons with severe disabilities, in accordance with section 53-19-204.

(2) All community homes must be certified annually for fire and life safety by the state fire marshal.

(3) Applicants for certification shall submit to the state fire marshal in writing the following information:

(a) Name and address of applicant and location of proposed community home; and

(b) Number of residents for which proposed community home will provide care.

(4) Upon receipt of an application for certificate of approval, the fire marshal or his representative shall conduct an inspection of the proposed community home, and shall promptly thereafter issue his findings, indicating whether or not fire safety rules have been met.

(5) For purpose of determining compliance with fire safety rules, all community homes shall comply with Uniform Fire Code and with all other rules promulgated by the fire marshal bureau.

(6) If the proposed community home is in compliance with these rules, the fire marshal shall issue a certificate of approval. If the home is not in compliance, the fire marshal shall issue a notice of corrective action needed to bring the home into compliance. Additional inspections may be conducted as needed until compliance is achieved.

(7) The state fire marshal shall notify the department of social and rehabilitation services and the department of family services when a community home has been certified.

AUTH: 53-20-307, 53-19-204 MCA.
IMP: 50-20-307, 53-19-204 MCA.

RULE XI THREAT OF EXPLOSIVES IN STATE BUILDINGS (1) In any building housing state offices, each department director or official in charge shall assign one individual for each building housing members of the department, whose responsibilities shall be to coordinate evacuation and to practice proper procedures involving a threat of explosive materials in the assigned building or building area. The designated individual shall have responsibility to ensure that appropriate fire and law enforcement authorities are notified of a threat of explosives.

(2) In the event a building houses more than one state agency, each agency shall designate a responsible individual. Where the threatened explosive device is located in a particular agency's area of the building, that agency's designated individual shall be primarily responsible for evacuation and notification of proper authorities.

AUTH: 50-3-102(1)(j) MCA. IMP: 50-3-102(1)(j) MCA.

RULE XII RENEWAL OF PERMIT, LICENSE, OR CERTIFICATE (1) Each person or firm who receives a permit, license or certificate of registration from the state fire prevention and investigation bureau in accordance with these rules must submit an application for renewal every two years.

(2) The application for renewal shall contain the following information:

(a) applicant's name and address;

(b) business address;

(c) business name used;

(d) type of work to be performed, or products to be sold;

(e) whether the applicant is employed by a fire protection agency of the state or of any local government unit;

(f) Whether the applicant is a member of the personnel of a non-profit fire department;

(g) Whether any of the above information has changed since the date of first issuance of the license, permit, or certificate, or since the date of last renewal;

(h) Whether the applicant has been continuously engaged in installation, sale, or service of fire protection equipment since the date of first issuance of the license, permit, or certificate, or since the date of last renewal.

(3) Upon receipt of the application, the state fire marshal shall grant a renewal of the permit, license or certificate if it appears that the applicant meets all of the requirements under ARM 23.7.121, has committed no act which would constitute ground for suspension or revocation under ARM 23.7.122, and remains properly equipped and staffed to provide the services intended to be performed. The fire marshal may require retesting if the applicant fails to meet any of the requirements of this section or if the applicant has not, for a period of two years, engaged in the business for which the original permit, license or certificate was issued.

(4) Each application for renewal shall be accompanied by a fee of $5.

AUTH: 50-3-102(2) MCA. IMP: 50-39-101 through 105 MCA.

4. The following rules are proposed to be amended as follows:

23.7.121 APPLICATION FOR PERMIT, LICENSE, OR CERTIFICATE (1) through (2)(d) remain the same.

(e) Whether the applicant is employed by a fire protection agency of the state or of any local government unit;

(f) Whether the applicant is a member of the personnel of a non-profit fire department and, if so, for what purpose the certificate, license or permit is being obtained; and

(2)(e) remains the same but is renumbered to (2)(g).

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.122 SUSPENSION OR REVOCATION OF PERMIT, LICENSE OR CERTIFICATE (1) through (5) remain the same.

(6) ~~A licensed firm who has an employee that while employed by the firm,~~ Employed an individual who, while employed by the holder of the license, permit, or certificate, installs or services fire protection equipment improperly or who installs or services fire protection equipment without the required certificate of registration;

(7) ~~Violated any provisions of this chapter.~~ Violated any of the conditions, qualifications, or limitations set forth in the permit, license, or certificate, or allowed the permit, license, or certificate to be used by anyone other than the person or firm to whom the same was issued.

(8) Violated the provisions of section 2-2-121(2)(b) or 2-5-125(2)(b), MCA.

(9) Violated any provisions of this chapter.

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.124 DENIAL OF A CERTIFICATE, PERMIT OR LICENSE (1) The state fire marshal may deny a permit, license, or certificate to an applicant if the granting of one would adversely affect public safety or welfare~~.~~, or if the applicant fails to satisfy the applicable requirements of section 50-39-102, MCA, or these rules.

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.125 INVESTIGATION OF IMPROPER INSTALLATION OR SERVICE (1) Upon the request of a local authority or other person, the state fire marshal ~~shall~~ may conduct an inspection of the installation or service of fire protection equipment;

(2) remains the same.

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.131 WHO MUST OBTAIN A CERTIFICATE OF REGISTRATION (1) through (2)(a) remain the same.

(b) An apprentice, ~~must perform~~ so long as he or she performs the installation or service of fire protection equipment under the immediate personal supervision of a qualified registrant.

(c) and (d) remain the same.

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.133 EXAMINATION FOR CERTIFICATE (1) remains the same.

(2) The written examination may include information from the latest edition of the Fire Protection Handbook, the latest editions of the Uniform Fire Code Standard No. 10.1, and the National Fire Protection Association (NFPA) Pamphlets Number 10, 13, 13A, 13D, 13R, 72A, 72B, 72C, 72D, 72E, and 74.

(3) and (4) remain the same.

(5) A passing grade for the written examination is a score of 70 or better. An applicant who fails may reapply after 30 days to take another examination. The examination may be taken no more than three times during a one-year period.

AUTH: 50-3-102(2), 50-3-103 MCA.
IMP: 50-39-101 through 105 MCA.

23.7.134 ENDORSEMENT OF QUALIFICATIONS (1) through (2)(c)(i) remain the same.

(ii) automatic fire extinguishing systems;

(iii) fire alarms; ~~or~~

(iv) automatic fire alarm systems~~.~~; or

(v) other fixed fire protection systems.

AUTH: 50-3-102 MCA. IMP: 50-3-102 MCA.

5. The following rules are proposed to be amended as follows and will be transferred to new rule numbers if amended:

23.2.111 RULES RELATING TO THE BUILDING CODE (1) A notice of adoption or amendment by the state fire marshal of a rule relating to building and equipment standards covered by the state or a municipal building code must be signed by the ~~head of the~~ director of the ~~Department of Administration~~ department of commerce. ~~These~~ Such rules "are effective upon approval of the department of ~~administration~~ commerce and filing with the secretary of state." Section 50-3-103(2) MCA.

AUTH: 52-4-201(1) MCA. IMP: 50-3-103(2) MCA.

23.7.101 ~~ENFORCEMENT OF FIRE MARSHAL BUREAU RULES~~ HOLDER NOT ENTITLED TO RIGHT OF ENTRY ~~(1) The fire marshal bureau shall enforce this chapter in every area of Montana. The chief fire official or the appropriate local fire authority having jurisdiction in each area shall assist the bureau. Where no such local fire authority exists, the sheriff shall assist. The local authorities shall notify the fire marshal bureau of any violations.~~

(1) ~~(2)~~ A permit, license, or certificate does not authorize any person to enter any property or building or to enforce this chapter.

AUTH: 50-3-102(2) MCA. IMP: 50-3-102 MCA.

6. The rules proposed to be repealed are as follows: ARM 23.2.131, 23.7.111. These rules may be found on pages 23-33 and 23-361 of the Administrative Rules of Montana.

7. Proposed rules regarding this same subject matter were initially published for proposed adoption on November 29, 1990, at 2078, issue no. 22, of the 1990 Montana Administrative Register. On December 20, 1990, a public hearing was held to

receive comments on the proposed rules. Extensive public comment was received, warranting a new hearing on the rules pertaining to regulation of fireworks. A second public hearing on the proposed fireworks rules was held on April 11, 1991.

In the proposed rules published last November, the fire marshal intended to adopt certain parts of the 1988 Uniform Fire Code and tailor the Code to the needs of Montana and the requirements of Montana law. The fire marshal and staff also undertook a comprehensive review of the existing rules, together with the statutory requirements, and proposed to adopt new rules to carry into effect a fire prevention law of Montana that would better serve the function of the state fire marshal as well as safeguard life and property from the hazards of fire.

In light of the extensive comments received from the initial proposed rules and because of recent legislative changes, a new review of the Uniform Fire Code is necessary. For this reason, the previous revisions and supplement to the 1988 Uniform Fire Code are not being adopted.

Nonetheless, the proposed rules contained in the present notice are necessary in order to follow through with the comprehensive review and revision of the earlier proposed rules that were not affected by adoption of the Uniform Fire Code and the Montana Supplement to the Code. The current proposed rules, as previously stated in the earlier notice, thus serve to update and clarify existing rules and statutory provisions relating to fire safety in Montana.

8. Interested parties may submit their data, views or arguments concerning the proposed rules in writing to the Fire Prevention and Investigation Bureau, 303 North Roberts, Helena, MT 59620, no later that August 30, 1991.

9. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to the Fire Prevention and Investigation Bureau, 303 North Roberts, Helena, MT 59620, no later than August 30, 1991.

10. If the agency receives requests for a public hearing on the proposed adoption from 25 persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not 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. It has been determined that 25 is less than 10 percent of the persons directly affected.

11. The authority of the department to make the proposed rules is based on section 50-3-102, MCA, and the rules implement section(s) 50-3-102 and 50-3-103, and Title 50, Chapter 61, MCA.

Marc Racicot
Marc Racicot
Attorney General

Certified to the Secretary of State 7/15/91.

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

In the matter of the proposed amendment of ARM 36.16.117 pertaining to water reservation applications in the Upper Missouri Basin	))))	NOTICE OF PROPOSED AMENDMENT OF RULE 36.16.117 PERTAINING TO WATER RESERVATION APPLICATIONS IN THE UPPER MISSOURI BASIN

NO PUBLIC HEARING CONTEMPLATED

TO: ALL INTERESTED PERSONS

1. On August 24, 1991, the Board of Natural Resources and Conservation proposes to amend ARM 36.16.117 pertaining to water reservation applications in the Upper Missouri Basin.

2. The proposed amended rule will read as follows: (New matter underlined, deleted matter interlined) (full text of the rule is located at pages 36-346.6 and 36-346.7, Administrative Rules of Montana.)

"36.16.117 APPLICATIONS IN THE MISSOURI RIVER BASIN AND THE LITTLE MISSOURI RIVER BASIN (1) Applicants seeking a reservation of water for instream purposes or diversionary uses with points of diversion in the Missouri River basin above Fort Peck Dam pursuant to 85-2-331, MCA, shall submit ~~correct and complete~~ applications on or before July 1, 1989~~91~~. The board shall make a final determination on all applications for water reservations above Fort Peck Dam on or before ~~December 31, 1991~~ July 1, 1992. ~~Correct and complete a~~Applications for the reservation of water for instream purposes or diversionary uses with points of diversion below Fort Peck Dam and the Little Missouri River Basin must be submitted on or before July 1, 1991. The board shall make a final determination on applications for water reservations below Fort Peck Dam on or before December 31, 1993. For the purposes of this rule, the Missouri River basin below Fort Peck Dam includes all drainages that would enter the Missouri River downstream of Fort Peck Dam, including the Milk River basin, the Little Missouri River Basin and any groundwater therein. An application to reserve water below Fort Peck Dam may be filed as an amendment to an application to reserve water above Fort Peck Dam, if filed by the same applicant for the same purpose.

(2) The priority date of Missouri reservations applied for and granted in accordance with the deadlines provided in (1) is July 1, 1985 in the Missouri River basin and July 1, 1989 in the Little Missouri basin. Applications for water reservations in the ~~Missouri~~ basins submitted after the deadlines provided in (1) will be accepted, but the priority date shall be the date the order reserving water is adopted by the board. Separate environmental impact statements and board hearings may be required for such late applications.

(3) The use of reserved water with a July 1, 1985 priority

date may, at the discretion of the board, be subordinated to the use of water under permits with priority dates after July 1, 1985 which are issued before the date of the board order granting such reservations. The use of reserved water with a July 1, 1989 priority date may, at the discretion of the board, be subordinate to the use of water under permits with priority dates after July 1, 1989 which are issued before the date of the board order granting such reservations. The board may provide for subordination only if it finds that such permits would not substantially interfere with the purpose of a reservation. The board may consider subordination after issuing its order reserving water. The hearing convened in the matter of objections to the reservations may be bifurcated to separately consider the establishment of the water reservations and the subordination of those reservations.

(4)..."

Auth: 85-2-113, MCA Imp: 85-2-316, 331, MCA;

The Board is proposing this amendment in response to a legislative amendment to the statute. The rule amendment originally was noticed in December, 1990, but was inadvertently not adopted.

3. The 1989 legislature amended 85-2-331, MCA, changing the board's deadline for making a final determination on reservation applications in the basin above Fort Peck Dam from December 31, 1991 to July 1, 1992, including the Little Missouri River basin in the reservation proceeding below Fork Peck Dam, and establishing a July 1, 1989 priority date for any reservation granted in the Little Missouri River basin.

ARM 36.6.117 of the rules requires the applicants to submit correct and complete applications for the reservation of water in the basin below Fort Peck Dam by July 1, 1991. The proposed amendments would require applicants to simply submit applications to reserve water in the basin below Fort Peck Dam by July 1, 1991. This would give the department 90 days to determine reservation applications correct and complete. The applicants would then have 60 days to re-submit applications returned as not being correct and complete.

The proposed amendments to ARM 36.16.117 reflect the changes made by the legislature to the reservation statute and give the department flexibility in reviewing reservation applications.

4. Interested parties may present their data, views, and arguments concerning the proposed amendment in writing to the Board of Natural Resources and Conservation, 1520 East Sixth Avenue, Helena, MT 59620-2301, no later than August 22, 1991.

5. If a person who is directly affected by the proposed adoption 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 written comments to the Board of Natural Resources and Conservation, 1520 East Sixth Avenue, Helena, MT 59620-2301 no later than August 22, 1991.

6. If the board receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the 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 not 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 more than 25 persons.

BOARD OF NATURAL RESOURCES
AND CONSERVATION

By: Donald D. MacIntyre
Chief Legal Counsel

Certified to the Secretary of State July 15th, 1991

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

In the Matter of Proposed Adoption of New Rules Requiring Two-way, end-of-train telemetry devices on trains operating in Montana within mountain grade territory.	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF NEW RULES I THROUGH IV REGARDING REAR-END TELEMETRY DEVICES ON TRAINS

TO: All Interested Persons

1. On August 22, 1991 at 9:00 a.m. in the Conference Room of the Public Service Commission at 2701 Prospect Avenue, Helena, Montana, the Commission will hold a public hearing to consider the proposed rules regarding rear-end telemetry systems on trains operating within mountain grade territory in the state of Montana.

2. The proposed rules do not replace or modify any section currently found in the Administrative Rules of Montana.

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

RULE I. GENERAL PROVISIONS FOR TELEMETRY DEVICES

(1) Any railroad operating trains in the state of Montana is required to install a rear-end telemetry system on each of its trains operating within mountain grade territory within the state, except as provided in subsection (2) following.

(2) A telemetry system as required in subsection (1) preceding is not required on a train equipped with a caboose that meets the requirements of state law, is placed on the last car of the train, and is occupied by a member of the train crew.

(3) Any train operating in the area defined under Rule III may not depart a crew change point or its local point of origin unless the train is equipped with the telemetry system required under these rules, or alternatively, with a caboose meeting the requirements in sec. 69-14-232(2), MCA.

(4) A train equipped with a rear-end telemetry device as required by these rules shall not depart from the point provided in subsection (3) preceding unless all components of the rear-end telemetry system are properly functioning.

(5) Upon failure of any component or function of a rear-end telemetry device, while en route, a cabooseless train shall proceed to the next crew change point at a speed not exceeding 25 mph, unless the device is repaired so that all functions are operational.

(6) A railroad operating cabooseless trains pursuant to these rules shall provide a distance measuring device, such as a measured distance, at the crew change point preceding mountain grade territory so that the telemetry device may be calibrated. AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

RULE II. REAR-END TELEMETRY SYSTEM (1) A rear-end telemetry system required by these rules shall be a radio transmitter and receiver system with one device placed on the last car of a train and a second device placed in the cab of the controlling locomotive. The device in the locomotive shall be visible to the locomotive engineer and capable of indicating through electronic communication with the device on the last car the following information:

(a) brake pipe pressure at the rear of the train, in increments of one pound per square inch;

(b) rear car movement;

(c) operation or nonoperation of the rear marker light;

(d) remaining battery life powering the telemetry system;

(e) interruption of the communication link between the device located on the last car of the train and the device located in the cab of the controlling locomotive; and

(f) total distance travelled in feet by the locomotive to which the device is attached.

(2) A rear-end telemetry system installed pursuant to these rules must be capable of an emergency application of the brakes of the train initiated from the device placed in the cab of the controlling locomotive by activation of the device placed on the last car of the train. AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

RULE III. MOUNTAIN GRADE TERRITORY (1) "Mountain grade territory" is geographically defined and designated by mile posts in the railroad's official timetable and operating rules on file with the commission. AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

RULE IV. REPORTING AND FILING REQUIREMENTS (1) A railroad operating in the state of Montana must file with the commission its most current official timetables and operating rules including designations by mile posts indicating mountain grade. AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

RULE V. NO DISCIPLINARY ACTION FOR REPORTING VIOLATIONS (1) A railroad, including its officers, employees and/or other agents, shall not institute disciplinary action, adverse administrative or other employment action against a person for reporting a violation of these rules or for acting to enforce the provisions of these rules. AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

RULE VI. ENFORCEMENT AND PENALTIES (1) Enforcement of these requirements for rear-end telemetry systems on trains operating within mountain grade territory in the state shall be by the public service commission.

(2) Any person, corporation or company operating any railroad in this state in violation of any requirements provided in these rules shall be subject to penalties and fines of not less than $500 or more than $1,000 for each offense.

AUTH: Sec. 69-14-116, MCA; IMP, (Sec. 1, ch. 487, L. 1991), Sec. 69-14-116, MCA

4. Rationale: The Public Service Commission proposes the adoption of these rules on rear-end telemetry devices in order to implement and enforce the provisions of the amendments to Section 69-14-116, MCA, as enacted by the 1991 Legislature under HB 271. The Montana Legislature has determined that this equipment is necessary to remedy the safety hazard of mountain grade territory in Montana. These rules are necessary to establish the requirements for railroads operating trains within mountain grade territory in Montana to have this specified equipment. Alternatively, these railroads may use a caboose occupied by train crews on mountain grade in lieu of the required rear-end telemetry devices, provided that the caboose meets statutory requirements.

5. 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 Denise Peterson, 2701 Prospect Avenue, Helena, Montana 59620-2601 no later than August 23, 1991.

6. Denise Peterson, staff attorney, Public Service Commission, has been designated to preside over and conduct the hearing.

7. The Montana Consumer Counsel, 34 West Sixth Avenue, Helena, Montana, (406) 444-2771, is available and may be contacted to represent consumer interests in this matter.

Howard L. Ellis

HOWARD L. ELLIS, Chairman

CERTIFIED TO THE SECRETARY OF STATE JULY 15, 1991.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.21.151 relating to Television Cable Systems for Personal Property Taxes	NOTICE OF PROPOSED AMENDMENT of ARM 42.21.151 relating to Television Cable Systems for Personal Property Taxes

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On September 13, 1991, the Department of Revenue proposes to amend ARM 42.21.151 relating to television cable systems for personal property taxes.

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

42.21.151 TELEVISION CABLE SYSTEMS (1) through (4) remains the same.

(5) This rule is effective for tax years beginning after December 31, ~~1991~~ 1990.

3. The authority to amend this rule is found at 15-1-201, MCA and the implementing section is 15-6-140, MCA.

4. This amendment is necessary to correct a clerical error.

5. Interested parties may submit their data, views, or arguments concerning the proposed adoption in writing to:

Cleo Anderson
Department of Revenue
Office of Legal Affairs
Mitchell Building
Helena, Montana 59620

no later than August 23, 1991.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than August 23, 1991.

6. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision, or agency; 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 25.

DENIS ADAMS, Director
Department of Revenue

Certified to Secretary of State July 15, 1991.

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

In the matter of the amendment of Rule 46.10.404 pertaining to Title IV-A day care increase	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.10.404 PERTAINING TO TITLE IV-A DAY CARE INCREASE

TO: All Interested Persons

1. On August 15, 1991, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.10.404 pertaining to Title IV-A day care increase.

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

46.10.404 TITLE IV-A DAY CARE FOR CHILDREN OF RECIPIENTS IN TRAINING OR IN NEED OF PROTECTIVE SERVICES (1) Unless otherwise provided, in addition to the basic AFDC grant, day care payment will be provided for children of recipients who are attending employment-related training or for children in need of protective services day care. AFDC recipients who attend ~~WIN~~ JOBS training shall be referred for ~~WIN~~JOBS-related day care. AFDC recipients who are employed shall have their day care expenses deducted from earned income when testing net monthly income and when determining grant amount as provided in ARM 46.10.512.

Subsections (2) through (2)(b) remain the same.

~~(c) Title IV-A day care needs will be taken into consideration for eligibility determination of an applicant. If an applicant requires Title IV-A day care, this need will be considered in addition to the AFDC grant amount to determine eligibility.~~

(~~d~~c) Title IV-A day care payment may be made ~~directly to the recipient or~~ through a vendor or two-party payment. ~~The recipient must volunteer in writing to have the day care payment made through a vendor or two-party payment.~~

Original subsection (2)(e) remains the same in text but will be renumbered as subsection (2)(d).

~~(f) Day care payments shall not exceed $207 per month per child except in unusual circumstances when additional day care is approved by the department for the protection of children.~~

(~~g~~e) The maximum rate for fFull-day care ~~services are paid at a rate of $8.00~~ in day care homes is $11.25 per day per child ~~in care in day care homes~~ for children 24 months of age or older and $12.00 per day per child for infants under 24 months of age. The maximum rate for full-day care in group

day care homes is ~~$8.50~~ $11.25 per child per day ~~of care~~ for children 24 months of age or older and $12.00 per child per day for infants under 24 months of age. The maximum rate for full-day care in day care centers is ~~$9.00~~ $12.00 per child per day ~~of care~~ for children 24 months of age or older and $13.00 per child per day for infants under 24 months of age.

(i) "Full-day care" means care provided for a continuous period of not less than six (6) hours per day.

(~~h~~f) The maximum rate for ~~P~~part-time care ~~is paid at a rate of 90¢~~ in day care homes is $1.50 per hour per child ~~in day care homes, 95¢~~. The maximum rate for part-time care in group day care homes is $1.50 per hour per child ~~in group day care homes and $1.00~~. The maximum rate for part-time care in day care centers is $2.00 per hour per child ~~up to a maximum of a~~. Part-time care payments may not exceed the full-day or night care rate.

Original subsection (2)(i) remains the same in text but will be renumbered as subsection (2)(g).

(i) extra meals at a rate of ~~75¢~~ $1.10 per meal per child; and

(ii) exceptional child care, as defined in ARM ~~46.5.903~~ 11.14.101(6)(d), at a maximum of ~~$11.00~~ $12.00 per day per child for full-time care or ~~$1.25~~1.75 per hour per child for part-time care in day care homes or group day care homes and $2.00 per hour per child in day centers.

(~~i~~h) Title IV-A day care is available only for care provided ~~in~~ by licensed or registered day care facilities ~~only~~ or by a day care provider who is legally operating pursuant to Montana law as set forth in 52-2-703 (2)(a) and (b) and 52-2-721(1)(a) and (b), MCA. Title IV-A payments are available for in-home care furnished by a provider who is licensed or registered or is not required to be licensed or registered, including care provided by a person related to the child by blood or marriage. However, no payments shall be made to any person who is in the AFDC assistance unit for which care is being provided.

(~~k~~i) The recipient shall choose his day care provider.

AUTH: Sec. 53-4-212 MCA
IMP: Sec. 53-4-211 and 53-4-716 MCA

3. The Family Support Act of 1988 requires that the State IV-A agency guarantee child care to permit an AFDC eligible family member to accept employment or participate in an approved education or training activity under JOBS. The maximum day care rates are being increased based on a market rate survey completed in 1990. Payment for in-home care and legally unlicensed care are mandated in 45 CFR 255.3(c), which provides that if more than one type of child care is available, the state must provide the caretaker relative an opportunity to choose the arrangement, e.g. center, group family

care, family day care or in-home care. Several references to WIN in the rule have been changed to JOBS because the WIN program has been replaced by JOBS. Several other minor changes in language have been made for the sake of clarity and do not change the substance of the rule.

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 the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604-4210, no later than August 22, 1991.

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

Julia E. Peters

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 15, 1991.

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

In the matter of the amendment of Rules 46.25.725, 46.25.726 and 46.25.744 pertaining to general relief medical income and resources	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.25.725, 46.25.726 AND 46.25.744 PERTAINING TO GENERAL RELIEF MEDICAL INCOME AND RESOURCES

TO: All Interested Persons

1. On August 15, 1991, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.25.725, 46.25.726 and 46.25.744 pertaining to general relief medical income and resources.

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

46.25.725 INCOME Subsections (1) and (1)(a) remain the same.

(b) Depreciation is not allowed as a deduction when computing self-employment income.

Subsections (2) through (2)(c) remain the same.

AUTH: Sec. 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-3-205 MCA

46.25.726 RESOURCES Subsections (1) through (3)(f) remain the same.

(4) It is presumed that a client owns one hundred percent (100%) of any joint bank account, certificate of deposit or savings bond which the client holds jointly with another person or persons, and to which the client has unrestricted access. One hundred percent (100%) of the value of such account, certificate of deposit or savings bond shall be counted as a resource to the client.

(a) A client may rebut the presumption of one hundred percent (100%) ownership by:

(i) filling out and signing the form designated by the department;

(ii) obtaining corroborating statements from all other co-owners or from a knowledgeable third party if the co-owner is a minor or is incompetent; and

(iii) providing proof of a change of designation removing the client's name from the account, certificate or bond or restricting client's access.

(b) If a client rebuts the presumption of 100% percent ownership, then only that portion of the jointly held account,

certificate of deposit or bond which client owns, if any, shall be counted as a resource.

Subsections (4) through (10)(d) remain the same in text but will be renumbered as subsections (5) through (11)(d).

AUTH: Sec. 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-3-205 and 53-2-803 MCA

46.25.744 INCOME FOR GENERAL RELIEF MEDICAL Subsections (1) through (1)(a)(i) remain the same.

(ii) Depreciation is not allowed as a deduction when computing self-employment income.

Subsections (2) through (5) remain the same.

AUTH: Sec. 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-3-205 and 53-3-206 MCA

3. A recent Fair Hearing decision determined that a General Relief applicant could rebut the presumption that all of the funds in a joint checking or savings account were available for the applicant's use and should be counted as a resource. The Department, therefore, reviewed its policy with regard to such jointly held resources and has determined that the rule should be changed in order to be more equitable to the client and to conform to the holdings of several Montana judicial decisions regarding ownership of jointly titled accounts. ARM 46.25.726 is, therefore, being amended to allow General Relief clients to rebut the presumption that all of the funds in a jointly held bank account, certificate of deposit, or U.S. Savings bond are accessible to the client and countable as a resource to the client.

It has been a long-standing policy of the Department to disallow depreciation as a deduction in computing self-employment income for purposes of determining eligibility for General Relief Assistance. This policy has never been stated in a rule, however. ARM 46.25.725 and 46.25.744 are being amended to specifically provide that depreciation is not an allowable deduction.

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 the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604-4210, no later than August 22, 1991.

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

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 15, 1991.

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

In the matter of the adoption of Rules I through XXV, the amendment of Rules 46.12.1208 through 46.12.1210 and the repeal of Rules 46.12.1201 through 46.12.1207 pertaining to medicaid nursing facility services and reimbursement, and appeal procedures for certain other medicaid providers	))))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES I THROUGH XXV, THE AMENDMENT OF RULES 46.12.1208 THROUGH 46.12.1210 AND THE REPEAL OF RULES 46.12.1201 THROUGH 46.12.1207 PERTAINING TO MEDICAID NURSING FACILITY SERVICES AND REIMBURSEMENT, AND APPEAL PROCEDURES FOR CERTAIN OTHER MEDICAID PROVIDERS

TO: All Interested Persons

1. On August 15, 1991, at 1:30 p.m. a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of Rules I through XXV, the amendment of Rules 46.12.1208 through 46.12.1210 and the repeal of Rules 46.12.1201 through 46.12.1207 pertaining to medicaid nursing facility services and reimbursement, and appeal procedures for certain other medicaid providers.

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

[RULE I] SCOPE, APPLICABILITY AND PURPOSE (1) [Rules I through XXV] specify requirements applicable to provision of and reimbursement for medicaid nursing facility services, including intermediate care facility services for the mentally retarded. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Unless otherwise provided, [Rules I through XXV] apply to rate years beginning on or after July 1, 1991. Reimbursement and other substantive nursing facility requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption.

(4) The purpose of the department's rules relating to medicaid reimbursement of nursing facility services is to provide, as required by federal law, for payment for nursing

facility services through rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE II] DEFINITIONS (1) Unless the context requires otherwise, in sub-chapter 12 the following definitions apply:

(a) "Abstracts" mean patient assessment abstracts submitted by providers to the department each month, in accordance with the requirements of [Rule VIII], which report to the department the care requirements for each medicaid recipient in the facility on forms provided and according to the patient assessment manual and instructions supplied by the department.

(b) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for 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 a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(c) "Closely held corporation" is defined as a corporation having 15 or fewer shareholders.

(d) "Department" means the Montana department of social and rehabilitation services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(e) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

(f) "Estimated economic life" means the estimated remaining period during which property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(g) "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.

(h) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax year.

(i) "Licensed to non-licensed ratio" means the ratio computed when the sum of all hourly registered and licensed practical nurse wages, including benefits, paid or accrued by all providers, as identified by the department in its survey of providers for the month of March in the most current year, divided by the total number of registered and licensed practical nurse hours included in the survey, is divided by the sum of all hourly nurse aide wages, including benefits, paid or accrued by all providers, as identified by the department in its survey of providers for the month of March in the most current year, divided by the total number of nurse aide hours included in the survey.

(j) "Maintenance therapy and rehabilitation services" mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(k) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(l) "Monitor" means a review performed by the department or its agents on a statistical sample of a specific month's medical records, including chart documentation, to determine whether such records support the patient management minutes claimed by the provider for the same month.

(m) "Nonemergency routine transportation" means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists or other medical providers. This definition includes such transportation when it is provided within the community served by the facility or within 20 miles of the facility, whichever is greater.

(n) "Nursing facility services" means nursing facility services provided in accordance with 42 CFR, Part 483, Subpart B, or intermediate care facility services for the mentally retarded provided in accordance with 42 CFR, Part 483, Subpart C. The department hereby adopts and incorporates herein by reference 42 CFR, Part 483, Subparts B and C, which define the participation requirements for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) providers, copies of which may be obtained from the Medicaid Services Division, 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". 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. Payment for the services listed in this subsection is included in the per diem rate determined by

the department under [Rule IV or XVI] and no additional reimbursement is provided for such services. Nursing facility services include but are not limited to the following or any similar items:

(i) all general nursing services, including but not limited to administration of oxygen and medications, handfeeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitis treatment;

(ii) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;

(iii) services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each medicaid recipient who is a resident in the facility;

(iv) items furnished routinely to all residents without charge, such as resident gowns, water pitchers, basins and bed pans;

(v) items distributed or used individually in small quantities including but not limited to:

(A) anti-bacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;

(B) cotton;

(C) denture cups;

(D) deodorizers (room-type);

(E) routine incontinence care items appropriate for the resident's individual medical needs;

(F) distilled water;

(G) enema equipment and/or solutions;

(H) facial tissues and paper toweling;

(I) finger cots;

(J) first aid supplies;

(K) foot soaks;

(L) gloves (sterile and unsterile);

(M) hot water bottles;

(N) hypodermic needles (disposable and non-disposable);

(O) ice bags;

(P) incontinence pads;

(Q) linens for bed and bathing;

(R) lotions (for general skin care);

(S) medication - dispensing cups and envelopes;

(T) ointments for general protective skin care;

(U) ointments (anti-bacterial);

(V) safety pins;

(W) sanitary pads;

(X) sterile water and normal saline for irrigating;

(Y) sheepskins and other fleece-type pads;

(Z) soaps (hand or bacteriostatic);

(AA) supplies necessary to maintain infection control, including those required for isolation-type services;

(BB) surgical dressings;

(CC) surgical tape;
(DD) the following over-the-counter medications (or their equivalents):
(I) acetaminophen (regular and extra-strength);
(II) aspirin (regular and extra-strength);
(III) milk of magnesia;
(IV) mineral oil;
(V) suppositories for evacuation (dulcolax and glycerine);
(VI) maalox;
(VII) mylanta;
(EE) straw/tubes for drinking;
(FF) suture removal kits;
(GG) swabs (including alcohol swab);
(HH) syringes (disposable or non-disposable hypodermic; insulin; irrigating);
(II) thermometers, clinical;
(JJ) tongue blades;
(KK) water pitchers;
(LL) waste bags;
(MM) wound-cleansing beads or paste;
(vi) items used by individual residents which are reusable and expected to be available, including but not limited to:
(A) bathtub accessories (seat, stool, rail);
(B) beds, mattresses, and bedside furniture;
(C) bedboards, foot boards, cradles;
(D) bedside equipment, including bedpans, urinals, emesis basins, water pitchers, serving trays;
(E) bedside safety rails;
(F) blood-glucose testing equipment;
(G) blood pressure equipment, including stethoscope;
(H) canes, crutches;
(I) cervical collars;
(J) commode chairs;
(K) enteral feeding pumps;
(L) geriatric chairs;
(M) heat lamps, including infrared lamps;
(N) humidifiers;
(O) isolation cart;
(P) IV poles;
(Q) mattress (foam-type and water);
(R) patient lift apparatus;
(S) physical examination equipment;
(T) postural drainage board;
(U) room (private or double occupancy as provided in [RULE XV]);
(V) raised toilet seat;
(W) sitz baths;
(X) suction machines;
(Y) tourniquets;
(Z) traction equipment;
(AA) trapeze bars;

(BB) vaporizers, steam-type;
(CC) walkers (regular and wheeled);
(DD) wheelchairs (standard);
(EE) whirlpool bath;

(vii) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and

(viii) transportation of residents for routine services as defined in subsection (1)(m).

(o) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with ARM 46.12.3804.

(p) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the 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 resident 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.

(q) "Provider" means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to medicaid recipients.

(r) "Rate year" means a 12-month period beginning July 1. For example, rate year 1992 means a period corresponding to state fiscal year 1992.

(s) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(t) "Total allowable remodeling costs" means those remodeling costs which are supported by adequate documentation. These costs include, but are not limited to, all costs of construction. These costs do not include costs of moveable equipment, supplies, furniture, appliances or other similar items.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE III] PROVIDER PARTICIPATION REQUIREMENTS

(1) Nursing facility service providers, as a condition of participation in the Montana medicaid program must meet the following requirements:

(a) comply with and agree to be bound by all laws, rules, regulations and policies generally applicable to medicaid providers, including but not limited to the provisions of ARM 46.12.301 through 309;

(b) maintain a current license issued by the department of health and environmental sciences under Montana law for the

category of care being provided, or, if the facility is located outside the state of Montana, maintain a current license under the laws of the state in which the facility is located for the category of nursing facility care being provided;

(c) maintain a current certification for Montana medicaid issued by the department of health and environmental sciences under applicable state and federal laws, rules, regulations and policies for the category of care being provided, or, if the facility is located outside the state of Montana, maintain current medicaid certification in the state in which the facility is located;

(d) maintain a current agreement with the department to provide the care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of [Rule XVII];

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules or policies may require;

(f) for providers maintaining resident trust accounts, insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds which do not exceed $50 must be maintained in a non-interest bearing account or petty cash fund. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(h) comply with ARM 46.12.1101 through 1106 and 46.12.1301 through 1310, regarding screening for nursing facility services;

(i) comply with all applicable federal and state laws, rules, regulations and policies 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 Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604-4210.

(2) A provider which fails to meet any of the requirements of this section may be denied medicaid payments, refused further participation in the medicaid program or otherwise sanctioned or made subject to appropriate department action,

according to applicable laws, rules, regulations or policies.

AUTH: Sec. 53-6-108, 53-6-111 and 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-106 and 53-6-107 MCA

[RULE IV] NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this section, minus the amount of the medicaid recipient's patient contribution. The per diem rate shall not exceed the limitation specified in subsection (3). Except as provided in subsection (4), the per diem rate is the sum of the following components:

(a) an operating cost component, individually determined for each provider in accordance with [Rule VI];

(b) a direct nursing personnel cost component, individually determined for each provider in accordance with [Rule VII];

(c) an OBRA cost component, individually determined for each provider in accordance with [Rule IX]; and

(d) a calculated property cost component, individually determined for each provider in accordance with [Rule X], or a grandfathered property component determined in accordance with [Rule X], if the provider is entitled to a grandfathered property rate under the provisions of [Rule XI].

(2) For purposes of subsection (1), medicaid patient days include bed hold days to the extent allowable under [Rule XVIII].

(3) A provider's per diem rate for rate year 1992 shall not exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus $9.50 per diem.

(4) For providers which, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in [Rule XII], the per diem rate shall be as provided in [Rule XIII].

(5) For ICF/MR services provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider as provided in [Rule XVI].

(6) In addition to the per diem rate provided under subsection (1) or the reimbursement allowed to an ICF/MR provider under subsection (5), the Montana medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with [Rule XIV].

(7) For nursing facility services, including ICF/MR services, provided by nursing facilities located outside the state of Montana, the Montana medicaid program will pay a provider only as provided in [Rule XVII].

(8) The Montana medicaid program will not pay any provider for items billable to residents under the provisions of [Rule XV].

(9) Reimbursement for medicare co-insurance days will be limited to the per diem rate, as determined under subsection (1) or [Rule XVI], or the medicare co-insurance rate, whichever is lower, minus the medicaid recipient's patient contribution.

(10) Providers must bill for all services and supplies in accordance with the provisions of ARM 46.12.303. The department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized medicaid recipients during the billing period.

(a) Authorized medicaid recipients are those residents determined eligible for medicaid and authorized for nursing facility services as a result of the screening process described in ARM 46.12.1101 through 1106 and 46.12.1301, et seq.

(11) Payments provided under this section are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or non-payment, as specifically provided in these rules.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE V] RATE EFFECTIVE DATES (1) Except as specifically provided in these rules, per diem rates and interim rates are set only once a year, effective July 1, and remain in effect through June 30 of the following year. Revised rates based on new calculations are effective only on July 1 of each year, except as specifically otherwise provided in these rules.

(2) The department will change a provider's operating cost component on a date other than July 1 of the rate year only upon the department's notice of final settlement of a cost report based upon a desk review or audit which results in adjustment of the base period costs used by the department to calculate the provider's rate or as provided in [Rule XIII)(2)(c)].

(3) The department will change a provider's direct nursing personnel cost component on a date other than July 1 of the rate year only:

(a) as of January 1 of the rate year as provided in [Rule VIII(7)(a)];

(b) upon the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period costs used by the department to calculate the provider's rate; or

(c) as provided in [Rule XIII(2)(c)].

(4) The department will change a provider's property cost component on a date other than July 1 of the rate year only upon a change in provider's calculated property cost component as provided in [Rule X(2)(c)], upon loss of a grandfathered property cost component as provided in [Rule XI(2)(d)], or as provided in [Rule XIII(2)(c)].

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE VI] OPERATING COST COMPONENT (1) This section specifies the method used by the department to calculate the operating cost component for a specific provider. Such operating cost component is expressed in dollars and cents per patient day.

(2) As used in this section, the following definitions apply:

(a) "Base period" means the provider's cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the operating cost component for a given year.

(i) Except as otherwise specified in [Rule XIII], for rate years beginning on or after July 1, 1991, the base period is the provider's cost report period of at least six months with a fiscal year ending between January 1, 1989 and December 31, 1989 inclusive, if available or, if not available, the provider's cost report period of at least six months on file with the department before July 1, 1991.

(b) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

(c) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule.

(d) "Median operating costs" means the median amount calculated by arraying the inflated per diem base period operating cost of each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have per diem costs less than or equal to the median and one-half of the licensed beds in the array have per diem costs greater than or equal to the median.

(i) For purposes of setting state fiscal year 1992 rates, if a provider has not filed a cost report for a period of at least six months with a fiscal year ending between January 1, 1989 and December 31, 1989 inclusive, such provider

shall not be included in the array for purposes of calculating the median.

(e) "Operating costs" means allowable patient-related administrative costs (including home office and management fees), dietary, laundry, housekeeping, plant operation, and other allowable patient service costs not included in the direct nursing personnel cost component or the property cost component.

(f) "Per diem operating costs" means the provider's total operating costs divided by the number of provider's patient days for the base period.

(3) The provider's operating cost component is the lesser of the provider's inflated base period per diem operating costs or the operating cost limit calculated in accordance with subsection (4), plus an incentive allowance, if applicable, as provided in subsection (5).

(4) The operating cost limit is 115% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with subsection (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of 5% of median operating costs or 40% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE VII] DIRECT NURSING PERSONNEL COST COMPONENT

(1) This section specifies the method used by the department to calculate the direct nursing personnel cost component for a specific provider. Such nursing cost component is expressed in dollars and cents per patient day.

(2) As used in this section, the following definitions apply:

(a) "Base period" means the provider's same cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the provider's operating cost component for a given year.

(i) Except as otherwise specified in [Rule XIII], for rate years beginning on or after July 1, 1991, the base period is the provider's cost report period of at least six months with a fiscal year ending between January 1, 1989 and December 31, 1989 inclusive, if available or, if not available, the provider's cost report period of at least six months on file with the department before July 1, 1991.

(b) "Composite nursing wage rate" means the total base period direct nursing personnel cost divided by the product of the provider's base period average patient assessment score, determined in accordance with [Rule VIII], and the provider's patient days for the base period.

(c) "Direct nursing personnel cost" means allowable direct nursing personnel wages, salaries and benefits, to the extent such are direct costs of patient-related services actually rendered within the facility and are separately identifiable, rather than merely allocable, as such. Direct nursing personnel costs include the accrued wages, salaries and benefits of registered nurses, licensed practical nurses, nurse aides, and director of nursing, if any, to the extent such wages, salaries and benefits meet the other requirements of this definition.

(d) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

(e) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule.

(f) "Statewide median average wage" means the amount calculated by arraying the inflated base period average wage rate for each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have average wage rates less than or equal to the median and one-half of the licensed beds in the array have average wage rates greater than or equal to the median.

(i) For purposes of setting rate year 1992 rates, if a provider has not filed a cost report for a period of at least six months with a fiscal year ending between January 1, 1989 and December 31, 1989 inclusive, such provider shall not be included in the array for purposes of calculating the median.

(3) The provider's direct nursing personnel cost component is the lesser of the provider's inflated base period composite nursing wage rate multiplied by the provider's most recent average patient assessment score, determined in accordance with [Rule VIII], or the direct nursing personnel cost limit calculated in accordance with subsection (4).

(4) The direct nursing personnel cost limit is 140% of the statewide median average wage, multiplied by the provider's most recent average patient assessment score, determined in accordance with [Rule VIII].

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE VIII] PATIENT ASSESSMENT SCORING AND STAFFING REQUIREMENTS (1) Each provider must report to the department each month the care provided for each medicaid

resident in the facility on the forms provided and in accordance with the patient assessment manual and instructions supplied by the department. The patient assessment manual dated July 15, 1991 is hereby adopted and incorporated herein by reference. A copy of this manual is available from the Medicaid Services Division, Department of Social and Rehabilitation Services, 111 Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) The completed patient (resident) assessment forms and staffing report forms required by this section must be received by the department within ten days following the end of each calendar month. Each report must be executed by the nursing facility administrator or his designee and must include a certification that the report, to the best of his knowledge and belief, is complete, accurate, and prepared in accordance with all applicable rules and departmental instructions.

(3) If the complete, accurate and certified forms are not received within the ten-day period, the department may withhold all payments for nursing facility services until such time as the complete, accurate and certified forms are received.

(4) Based upon the monthly patient (resident) assessment form submitted the provider in accordance with subsection (2) and considering such hours as are allowable under the patient assessment manual, the department will determine the provider's hourly patient assessment score for the month as follows:

(a) Using the licensed to non-licensed ratio as defined in [Rule II], all registered and licensed practical nurse hours, referred to herein as licensed hours, will be converted into non-licensed hours. All licensed hours so converted will be added to all nurse aide (nonlicensed) hours. The total of the converted licensed hours and the nonlicensed hours will be divided by the number of residents served in the period. The result is the provider's hourly patient assessment score for the month.

(5) Once a year, for purposes of determining the direct nursing personnel cost component as provided in [Rule VII], the department will determine the provider's average patient assessment score, using the methodology described in subsection (4)(a), considering such hours as are allowable under the patient assessment manual and based upon all patient assessment information for the provider from a survey period consisting of not less than three nor more than six of the months in the previous period October through March inclusive.

(a) The department will use the same survey period for all providers.

(b) The department may determine a provider's average patient assessment score more than once a year and recalculate the provider's direct nursing personnel cost limit according to the provisions of and as required by subsection (7).

(c) For purposes of determining the provider's direct nursing personnel cost limit as provided in [Rule VII], the provider's average patient assessment score will be as determined in accordance with subsection (5) or, if applicable, as provided in subsection (6), (6)(e)(i) or (7).

(6) At least once annually, the department or its agents will monitor the monthly patient assessment abstracts for accuracy and consistency with medical records maintained by the provider. If the department's monitor team finds that the abstracts, as supported and verified by the provider's chart documentation, are significantly different, as defined in subsection (6)(a), than the abstracts as submitted to the department by the provider for the same month, the provider's average patient assessment score, for purposes of determining the direct nursing personnel cost limit under [Rule VII], will be the provider's hourly patient assessment score for the monitor month, calculated using the methodology described in subsection (4)(a) and based upon the abstracts as verified by the monitor team.

(a) For purposes of these rules, "significant difference" and "significantly different" mean a ten percent or greater variance.

(b) Within a reasonable time after completion of the monitor, the department will notify the provider of the monitor results. Such notice will include the provider's patient assessment score as determined by the department from the monitor findings, the provider's patient assessment score for the same month as determined based upon the abstracts submitted by the provider, and a statement of whether or not there is a "significant difference" which will affect the provider's per diem rate.

(c) Subject to the provisions of subsection (d), if the department determines that a significant difference exists, the provider may request administrative review and fair hearing regarding the determination of significant difference in accordance with [Rule XXV]. For purposes of administrative review and fair hearing under [Rule XXV], documentation which was not made available to the monitor team at the time of the initial monitor is inadmissible and may not be considered by the department or the hearing officer.

(d) For providers who object to the monitor team's sampling technique used to select the abstracts to be monitored, the 100% monitor procedure described in subsection (e) through (e)(ii) will be the only appeal available with respect to the sampling technique issue.

(i) A provider wishing to object to both the sampling technique and to other issues relating to the determination of a significant difference, must first timely request a 100% monitor as provided below. The provider may request administrative review and fair hearing regarding other issues relating to the determination of a significant difference in accordance with [Rule XXV] only after the department has made

a determination based upon the 100% monitor as provided in this section.

(A) For purposes of administrative review regarding other issues after a determination based upon the 100% monitor, the deadline for requesting such review shall begin running on the date of mailing of the department's written determination on the 100% monitor. If the provider does not request a 100% monitor, the deadline for requesting administrative review on issues other than the sampling technique is as provided in [Rule XXV].

(B) If the provider fails to request a 100% monitor within the time specified in this section, the provider waives the right to object to or appeal the sampling technique used to select the abstracts to be monitored.

(e) Within thirty (30) days of the department's mailing of the monitor findings as required under subsection (6)(b), the provider may request a monitor of 100% of the monthly patient assessment abstracts for the month originally monitored.

(i) If the monitor team finds, based upon the 100% monitor, that the abstracts submitted by the provider are significantly different than the abstracts monitored, the provider must reimburse the department for the cost of the 100% monitor, as determined by the department, and the provider's average patient assessment score will be the provider's hourly patient assessment score for the 100% monitor month, calculated using the methodology described in subsection (4)(a) and based upon the abstracts as verified by the monitor team during the 100% monitor.

(A) Unless the department receives payment from the provider for the cost of the 100% monitor within 30 days after the department mails to the provider notice of the costs of the monitor, the department may recover such cost by offset against amounts otherwise payable by the department to the provider.

(ii) If, following a monitor under subsection (6) which resulted in a determination that a significant difference exists, the monitor team finds, based upon the 100% monitor, that the abstracts submitted by the provider are not significantly different than the abstracts monitored, the department will bear the cost of the 100% monitor and the provider's average patient assessment score will be determined in accordance with subsection (5).

(iii) Documentation which was not made available to the monitor team at the time of the 100% monitor may not be considered by the department in an administrative review proceeding or by a hearing officer in a fair hearing regarding the provider's average patient assessment score determination.

(7) A provider whose direct nursing personnel cost component, effective July 1, has been determined using a provider's average patient assessment score determined in accordance with subsection (6) or (6)(e)(i), may request that a new monitor be performed. In the event of such a request,

the monitor will be performed on a month from the period May through October, as selected by the department or its agents.

(a) If the department determines, based upon the new monitor, that there is no significant difference between the new monitor findings and the abstracts submitted by the provider for the month of the monitor, the provider's direct nursing personnel cost limit shall be recalculated using the provider's average patient assessment score calculated using the methodology described in subsection (5), based upon the average from the entire period May through October and the abstracts as verified by the monitor team. If the recalculated limit changes the provider's direct nursing personnel cost component, as calculated under the provisions of [Rule VII], the provider's per diem rate shall be revised accordingly, effective January 1 of the rate year, regardless of whether such revision results in an increased or a decreased rate.

(i) Providers who acquire a new patient assessment score under this subsection must staff in relation to the new patient assessment score as required by subsection (8).

(b) the new monitor findings indicate that a significant difference exists there will be no change in the provider's rate.

(8) Providers must provide staffing at levels which, at a minimum, equal the staffing requirements indicated by the provider's hourly patient assessment score for the month, determined in accordance with this section.

(a) Each provider must report to the department each month, as required in subsection (2), the staffing provided at the facility on forms provided and according to instructions supplied by the department.

(b) If the department determines that a provider's average patient assessment care requirement was ten percent or more in excess of actual provider nursing care staffing for two or more consecutive months, the department may:

(i) schedule and conduct an audit of the provider's cost report within 180 days of receipt of the cost report covering the fiscal year in which the deficiency occurred; and

(ii) determine allowable costs in accordance with [Rule XX] and recover, in accordance with [Rule XXII], all amounts paid in excess of allowable medicaid costs, or 10% of the total amount paid to the facility for the period for nursing facility services, whichever is greater.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-108 MCA

[RULE IX] OBRA COST COMPONENT (1) For rate years beginning on or after July 1, 1991, the OBRA cost component for a provider is the sum of the OBRA increment, as provided in subsection (2), and a facility-specific certified nurse aide wage increment, as provided in subsection (3).

(2) For all providers, the OBRA increment will be $1.90 per patient day.

(a) The OBRA increment covers the medicaid share of nurse aide certification training costs incurred to meet OBRA requirements and all other fiscal year 1992 costs of complying with the requirements of the Omnibus Budget Reconciliation Acts of 1987, 1989 and 1990, public laws 100-203 and 101-239, 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 costs of actual testing required for nurse aides.

(b) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training costs incurred at the facility. The required information must be submitted quarterly on the nurse aide certification/training survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel, supplies and equipment, and subcontracted services. The reporting form must include a brief description of the items included in each of the three categories.

(c) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in [Rule XXI], such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with [Rule XVIII]. This documentation must be maintained by the facility for three years from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(d) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold the OBRA increment from the provider's reimbursement for the following month. If the report remains overdue for a second consecutive month, the department may withhold the provider's total reimbursement for the month. All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) The certified nurse aide wage increment is the amount, if any, for a particular provider calculated in accordance with this subsection.

(a) A certified nurse aide wage increment will be computed for each facility which:

(i) provided the department with monthly reporting /billing forms for the previous reporting periods of July 1, 1990 through April 30, 1991; and

(ii) received certified nurse aide wage increase payments for the reporting periods July 1, 1990 through April 30, 1991 under the department's rules then in effect.

(b) The per diem nurse aide wage increment for a provider is the sum of nurse aide wage increase payments to the

provider for the reporting periods July 1, 1990 through April 30, 1991, which have been actually paid as of June 14, 1991, divided by the facility's total medicaid bed days for the period July 1, 1990 through April 30, 1991, as identified in the department's medicaid bed day report for fiscal year 1991, dated June 12, 1991.

(i) Payments for the period July 1, 1990 through April 30, 1991 processed after June 14, 1991 will not be considered for calculation of the nurse aide wage increment.

(ii) Calculated amounts ending in fractions of cents will be rounded to the nearest cent, with amounts of .5 cent or higher being rounded up to the next cent.

(c) Providers must continue to keep the original documentation to support hours, wages, and employer contributions reported to the department regarding nurse aide wage increases for the period July 1, 1990 through April 30, 1991. This documentation is subject to audit and evaluation in accordance with [Rule XXI]. This documentation must be maintained by the facility for 3 years from the date the forms were submitted to the department, or until final resolution of any dispute to which the documentation relates, whichever is later.

(i) If the department determines that the documentation is not adequate to support the claim for certified nurse aide wage increases or employer contributions, or that an overpayment has occurred, the nurse aide wage increment as determined in this subsection will be recalculated and overpayments under this subsection will be subject to recovery in accordance with [Rule XXII].

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE X] CALCULATED PROPERTY COST COMPONENT (1) This section specifies the formula used by the department to determine the calculated property cost component for a specific facility for rate years beginning on or after July 1, 1991. The calculated property cost component is expressed in dollars and cents per patient day.

(2) A provider's calculated property cost component (M) for rate years beginning on or after July 1, 1991, in dollars and cents per patient day, is calculated according to the formula specified in subsection (a) using the terms as specified and defined in subsection (b).

(a) The provider's calculated property cost component (M) is as follows:

(i) $M = N \times Z$ except for facilities extensively remodeled or with new beds constructed after July 1, 1984;

(ii) $M = N(1)$ for facilities with new beds constructed after July 1, 1984; or

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

(b) As used in this section, the following definitions apply:

(i) "A" is the total square footage of the original nursing facility structure.

(ii) "B" is the square footage added to the nursing facility with the construction of new beds.

(iii) "D" is the property rate as of June 30, 1985 for the original structure.

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

(v) "H" is the total number of licensed beds in the nursing facility after extensive remodeling.

(vi) "G" is total allowable remodeling costs.

(vii) "M" is the calculated property cost component per patient day.

(viii) "N" is the provider's property rate as of June 30, 1985. For entire facilities built after June 30, 1985, N is $7.60. For facilities new to the medicaid program, but constructed prior to June 30, 1982, a June 30, 1985 rate will be computed according to property rules effective as of June 30, 1985. That rate will be indexed forward to the current rate year using the formula M = N x Z.

(ix) "N(1)" equals the lower of 8.90 or ((((A x D) + (B x 7.60)) divided by (A + B)) x 1.171).

(x) "N(2)" equals the lower of 8.90 or ((D x 1.171) + ((F x 12) divided by 365)).

(xi) "Z" is 1.171.

(c) The department will increase or decrease a provider's calculated property cost component on a date other than July 1 of the rate year only upon:

(i) certification of newly constructed beds; or

(ii) completion of an extensive remodeling, as defined in [Rule II].

(d) Subsection (c) shall not be construed to prevent the department from assigning to a provider a calculated property cost component and revising the provider's per diem rate accordingly on a date other than July 1 of the rate year upon loss of a grandfathered rate as provided in [Rule XI].

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XI] GRANDFATHERED PROPERTY COST COMPONENT

(1) This section specifies the circumstances under which the property cost component for a provider will be based upon a historical rate rather than calculated under the provisions of [Rule X]. When a provider's property rate is not a calculated property cost component, it is referred to as a "grandfathered" property cost component.

(2) A provider shall be entitled to a grandfathered property cost component only as specified in this section.

(a) No provider who is delivering services in a nursing facility newly constructed after June 30, 1982 shall be entitled to a grandfathered property cost component under this section.

(b) Nursing facilities located within the state of Montana and providing intermediate care facility services for the mentally retarded shall be reimbursed under the provisions of [Rule XVI] and may not receive a grandfathered property cost component under this section.

(c) Nursing facilities located outside the state of Montana shall be reimbursed under the provisions of [Rule XVII] and may not receive a grandfathered property cost component under this section.

(d) Any grandfathered property cost component to which a provider, facility or owner may otherwise be entitled under this section shall immediately expire if there is a change in the June 30, 1982 provider, as defined in [Rule XII]. The new provider's per diem rate will be as determined under the provisions of [Rule XIII], beginning upon the effective date of any change in provider.

(3) A provider not disqualified under subsection (2) is entitled to a grandfathered property cost component only if:

(a) the provider was providing services in the same nursing facility on June 30, 1982;

(b) the property cost component calculated in accordance with [Rule X] is less than the interim property rate in effect for the provider on June 30, 1982, except that, if property costs to a provider have decreased since June 30, 1982, this requirement is met only if the property cost component calculated in accordance with [Rule X] is less than actual costs; and

(c) the calculated property rate in effect on June 30, 1985, multiplied by 1.171, does not exceed:

(i) the interim property rate in effect for the provider on June 30 1982; or

(ii) if property costs to a provider have decreased since June 30, 1982, actual costs.

(4) For purposes of subsection (3), a decrease in costs includes a decrease which results from provider activities, including but not limited to refinancing of a debt or renegotiation of a lease. Decreased costs resulting from normal changes in interest and principal payments over the terms of an existing mortgage or lease will not be considered a decrease in costs for purposes of this section.

(5) If a provider is entitled to a grandfathered property cost component under this section, such rate shall be as follows:

(a) for providers providing services in facilities which have completed construction of new beds after July 1, 1984, the amount derived, subject to the definitions in subsection (b), by the following calculation:

(i) [(V x S) + (Y x 8.90)] divided by (V + Y).

(b) in subsection (a)(i), the following definitions apply:

(i) "V" is the total square footage of the original structure before construction of new beds.

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

(iii) "S" is the interim property rate in effect for the provider on June 30, 1982, or, if property costs to a provider have decreased since June 30, 1982, actual costs. For purposes of this definition, a decrease in costs includes a decrease which results from provider activities, including but not limited to refinancing of a debt or renegotiation of a lease. Decreased costs resulting from normal changes in interest and principal payments over the terms of an existing mortgage or lease will not be considered a decrease in costs for purposes of this definition.

(c) for providers providing services in facilities which have completed an extensive remodeling after July 1, 1984, the amount derived, subject to the definitions in subsection (d), by the following calculation:

(i) the lower of $8.90 or [S + ((F x 12) divided by 365)].

(d) in subsection (c)(i), the following definitions apply:

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

(ii) "D" is the number of licensed beds in the facility.

(iii) "B" is the total allowable remodeling costs as defined in [Rule II].

(iv) "S" is as defined in subsection (b)(iii).

(e) for all other providers entitled to a grandfathered property rate, the grandfathered property rate shall equal S, as defined in subsection (b)(iii).

(6) Regardless of any other provision of these rules, if the provider's calculated property cost component for the new rate year equals or exceeds the provider's grandfathered property cost component for the new rate year, the provider's per diem rate for the new rate year and for all subsequent years shall be based upon the provider's calculated property cost component. Such a provider shall not be entitled to any further grandfathering protection.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XII] CHANGE IN PROVIDER DEFINED (1) A change in provider will be deemed to have occurred under any one of the following circumstances:

(a) the addition or substitution of a partner having a twenty-five or greater percent interest in the partnership as permitted by applicable state law;

(b) the sale of an unincorporated sole proprietorship or the transfer of title to, or possession of, a facility used in the provision of nursing facility services from the provider to another party or entity;

(c) 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 under this subsection (c), unless the provider corporation is closely held as defined in [Rule II] and stock representing a twenty-five or greater percent interest in the corporation is transferred from one party or entity to another party or entity; or

(d) the lease of all or part of a provider-owned facility used in the provision of nursing facility services or the transfer of a lease from the provider to another party or entity.

(2) In determining whether a change in provider has occurred within the meaning of this section, the provisions of federal medicare law, regulation or policy or related caselaw regarding changes in ownership under the medicare program is not applicable.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XIII] INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This section specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in [Rule XII].

(2) For in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in [Rule XII], the interim per diem rate shall be the bed-weighted median per diem rate for all nursing facility providers. The interim rate shall be determined based upon all non-interim provider rates determined by the department and effective as of July 1 of the rate year.

(a) The provider's interim rate shall become effective on the date a provider begins providing medicaid services in a newly constructed facility or on the effective date of a change in provider as defined in [Rule XII].

(b) The provider's interim rate shall remain in effect until the provider has filed with the department a complete and accurate cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in [Rule XII].

(c) After the provider files a complete and accurate cost report as specified in subsection (b), the department

will determine a per diem rate based upon such cost report according to the provisions of [Rules VI, VII and X]. Such per diem rate shall be determined using the period covered by the cost report as the provider's base period. The per diem rate determined in accordance with this subsection shall be effective retroactive to the date the interim rate set under subsection (2) became effective. Any overpayment or underpayment shall be adjusted in accordance with the cost settlement rules specified in [Rule XXII].

(3) For purposes of calculating a per diem rate as provided in subsection (2)(c), the following shall apply with respect to patient assessment scores used to calculate the direct nursing personnel cost component:

(a) For providers who have received an interim rate under the provisions of this section based upon a change in provider, the provider's direct nursing personnel cost component shall be calculated based upon the average patient assessment score for the previous provider, as though no change in provider had occurred.

(b) For providers who have received an interim rate under the provisions of this section based upon provision of services in a new facility, the provider's direct nursing personnel cost component shall be calculated based upon a patient assessment score determined as follows:

(i) The department or its agents will monitor the provider's abstracts from a month during the provider's first three months in the medicaid program.

(ii) If the department's monitor team finds that the abstracts, as supported and verified by the provider's chart documentation, are significantly different, as defined in [Rule VIII], than the abstracts as submitted to the department by the provider for the same month, the provider's average patient assessment score, for purposes of calculating the provider's direct nursing personnel cost component, shall be the provider's hourly patient assessment score for the monitor month, calculated using the methodology described in [Rule VIII(4)(a)] and based upon the abstracts as verified by the monitor team.

(iii) If the department's monitor team finds that the abstracts, as supported and verified by the provider's chart documentation, are not significantly different, as defined in [Rule VIII], than the abstracts as submitted to the department by the provider for the same month, the provider's average patient assessment score, for purposes of calculating the provider's direct nursing personnel cost component, shall be the provider's average patient assessment score, calculated using the methodology described in [Rule VIII(4)(a)] and based upon all patient assessment information for the provider from the first six months of the provider's participation in the medicaid program.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XIV] SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the provisions of [Rule VI(1) or (4)], the department will reimburse nursing facilities located in the state of Montana for separately billable items listed in the following subsections (a) through (nnnnn):

(a) colostomy set;
(b) ostomy face plate;
(c) ostomy skin barrier;
(d) ostomy liquid barrier;
(e) ostomy skin bond or cement;
(f) ostomy bag, disposable/closed;
(g) ostomy bag, reusable or drainable;
(h) ostomy belt;
(i) stoma wicks;
(j) tail closures;
(k) ostomy skin bond or cement, remover;
(l) ileostomy set;
(m) ileal bladder set;
(n) irrigation set for irrigation of ostomy;
(o) ostomy lubricant;
(p) ostomy rings;
(q) ostomy supplies not otherwise listed;
(r) ureterostomy set;
(s) ureterostomy supplies not otherwise listed;
(t) colon tube;
(u) disposable colostomy appliances and accessories;
(v) colostomy irrigation appliance;
(w) colostomy irrigation accessory;
(x) colostomy appliance, non-disposable;
(y) colostomy appliance;
(z) disposable ileostomy accessory;
(aa) disposable urostomy bags;
(bb) piston irrigation set;
(cc) blood or urine control strips or tablets;
(dd) dextrostick or glucose test strips;
(ee) implantable vascular access portal/catheter (venous arterial or peritoneal);
(ff) indwelling catheter, foley type, two-way, teflon;
(gg) indwelling catheter, foley type, two-way, latex;
(hh) indwelling catheter, foley type, two-way, latex with teflon coating;
(ii) indwelling catheter, foley type, two-way, all silicone;
(jj) indwelling catheter, foley type, two-way, silicone with elastomer coating;
(kk) indwelling catheter, foley type, three-way, latex or teflon for continuous irrigation;
(ll) external catheter, condom type;
(mm) urinary collection and retention system, drainage bag with tube;
(nn) urinary collection and retention system, drainage bag with tube;

(oo) urinary collection and retention system, leg bag with tube;
(pp) catheter care kit;
(qq) catheter insertion tray, without tube and drainage bag;
(rr) 3-way irrigation set for catheter;
(ss) uretheral catheter;
(tt) catheter miscellaneous supplies;
(uu) uretheral catheter with tray;
(vv) caudi-tip catheter;
(ww) male mentor catheter;
(xx) incontinence clamp;
(yy) urinary drainage bag;
(zz) urinary leg bag;
(aaa) bedside drainage bag;
(bbb) tracheostomy care kit;
(ccc) nasopharyngeal/tracheal suction kit;
(ddd) oxygen contents, gaseous, per cubic feet;
(eee) oxygen contents, gaseous, per 100 cubic feet;
(fff) oxygen contents, liquid, per pound;
(ggg) oxygen contents, liquid, per 100 pounds;
(hhh) cannula;
(iii) tubing, unspecified length, per foot;
(jjj) regulator;
(kkk) mouth piece;
(lll) stand/rack;
(mmm) face tent;
(nnn) IPPB kit;
(ooo) portable aspirator;
(ppp) connectors;
(qqq) face mask;
(rrr) nasal catheter;
(sss) disposable IPPB tubing;
(ttt) disposable humidifier(s);
(uuu) extension hoses;
(vvv) MADA plastic nebulizer with mask and tube;
(www) nasal O2 kit;
(xxx) O2 contents, linde reservoir;
(yyy) O2 contents, liberator;
(zzz) O2 contents, LV 160;
(aaaa) O2 contents, PCU reservoir;
(bbbb) O2 contents, GP-45;
(cccc) O2 contents, D cylinder;
(dddd) O2 contents, E cylinder;
(eeee) O2 cylinder contents, GDL-K;
(ffff) cylinder rental, one month;
(gggg) piped in oxygen;
(hhhh) oxygen cart for portable tank (purchase);
(iiii) enteral feeding supply kit; syringe (monthly);
(jjjj) enteral feeding supply kit; pump fed (monthly);
(kkkk) enteral feeding supply kit; gravity fed (monthly);

(llll) nasal gastric tubing with thin wire or cotton (e.g., travasorb, entriflex, dobb huff, flexiflow, etc.);

(mmmm) nasogastric tubing without stylet;

(nnnn) stomach tube - levine type;

(oooo) enteral supply kit for prepackaged delivery system (monthly);

(pppp) nasogastric tubing with or without stylet (e.g., travasorb);

(qqqq) enteric feeding set;

(rrrr) flex-flo feeding set;

(ssss) nutrition container;

(tttt) IV intercath;

(uuuu) IV tubing;

(vvvv) IV piggyback tubing;

(wwww) parenteral nutrition supply kit for one month - premix;

(xxxx) parenteral nutrition supply kit for one month - homemix;

(yyyy) parenteral nutrition administration kit for one month;

(zzzz) parenteral supplies not elsewhere classified;

(aaaaa) enteral supplies not elsewhere classified;

(bbbbb) feeding syringe;

(ccccc) gavage feeding set;

(ddddd) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for residents who, because of chronic illness or trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;

(eeeee) routine nursing supplies used in extraordinary amounts and prior authorized by the department;

(fffff) effective October 1, 1989, oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.

(i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:

(A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.

(B) The provider maintains a certificate of medical necessity indicating the PO2 level or oxygen saturation level. This certificate of medical necessity must meet or exceed medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with [Rule XIX].

(ii) The provider must attach to its billing claim a copy of the prior authorization form.

(iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.

(ggggg) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(i) If the items listed in subsections (a) through (fffff) are also covered by the medicare program and provided to a medicaid recipient who is also a medicare recipient, reimbursement will be limited to the lower of the medicare prevailing charge or the amount allowed under subsection (a). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

(ii) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by a physician.

(hhhhh) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.

(i) Maintenance therapy and rehabilitation services within the definition of nursing facility services in [Rule II], are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.

(ii) If the therapist is employed by or under contract with the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.

(iiiii) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.

(jjjjj) All prescribed medication, including flu shots and tine tests, may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs.

(kkkkk) Non-emergency transportation for activities other than those described in [RULE II(1)(m)], may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed

separately by an ambulance service in accordance with department rules applicable to such services.

(llllll) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.

(mmmmm) The provisions of subsections (hhhhh) through (llllll) apply to all nursing facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana.

(nnnnn) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under [Rule IV].

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XV] ITEMS BILLABLE TO RESIDENTS (1) The department will not pay a provider for any of the following items or services provided by a nursing facility to a resident. The provider may charge these items or services to the nursing facility resident:

(a) vitamins, multivitamins;
(b) calcium supplements;
(c) nasal decongestants and antihistamines;
(d) shaving soap;
(e) toothpaste, toothbrush;
(f) cosmetics;
(g) hair combs;
(h) brushes;
(i) tobacco products and accessories;
(j) personal dry cleaning;
(k) beauty shop services;
(l) television rental;
(m) less-than-effective drugs (exclusive of stock items);
(n) for items usually reimbursed under the per diem rate or which the resident requests a specific item or brand different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers); and
(o) over-the-counter drugs other than routine stock items such as acetaminophen, aspirin, milk of magnesia, mineral oil, suppositories for evacuation, maalox and mylanta.

(2) Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(a) A provider must provide a medically necessary private room at no additional charge and may not bill the

recipient any additional charge for the medically necessary private room.

(b) A provider may bill a resident for the extra cost of a private room if the private room is not medically necessary and is requested by the resident. The provider must clearly inform the resident that additional payment is strictly voluntary.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XVI] REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (1) For intermediate care facility services for the mentally retarded provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined in accordance with [Rules XX and XXI], divided by the total patient days of service during the provider's fiscal year, subject to the limits specified in subsection (2).

(2) Payments under subsection (1) may not exceed the following limits:

(a) For fiscal years ending on or before June 30, 1987, the payment rate will not exceed the final rate in effect on June 30, 1982, as indexed to the mid-point of the rate year by 9% per 12 month year.

(b) For fiscal years ending after June 30, 1987 and on or before June 30, 1988, the payment rate will not exceed the final rate in effect on June 30, 1987 indexed by 5.1% to June 30 of the rate year.

(c) For fiscal years ending after June 30, 1988 and on or before June 30, 1989, the payment rate will not exceed total allowable costs per day for the 12-month period ended June 30, 1989, with increases in subsequent years indexed to June 30 of the rate year by an index not to exceed the final medicare market basket index applicable to the rate year.

(d) For fiscal years ending after June 30, 1990 and on or before June 30, 1991, the payment rate will not exceed total allowable costs per day for the 12-month period ending June 30, 1991, with increases in subsequent years indexed to June 30 of the rate year by an index not to exceed the final medicare market basket index applicable to the rate year.

(e) For fiscal years ending after June 30, 1991 and on or before June 30, 1992, the payment rate will not exceed total allowable costs per day for the 12-month period ended June 30, 1992, with increases in subsequent years indexed to June 30 of the rate year by an index not to exceed the final medicare market basket index applicable to the rate year.

(3) Providers having a 1989 or 1991 cost reporting period ending on a date other than June 30 must submit detailed cost information supplemental to the cost report within 90 days after June 30. This cost information must be

for the period July 1 through June 30 of the respective reporting year and must include, at a minimum, worksheet A and the medicaid long term care facility trial balance (form MA-2), which are standard cost report forms.

(4) Prior to the billing of July services each year the department will compute an interim payment rate which is the department's estimate of actual allowable cost divided by estimated patient days. The department may determine estimated costs based upon provider cost estimates, subject to the provisions of [Rule XX].

(5) The difference between actual includable cost allocable to services to medicaid residents, as limited in subsection (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in [Rule XIX].

(6) Following the sale of an intermediate care facility for the mentally retarded after April 5, 1989, the new provider's property costs will be the lesser of historical costs or the rate used for all other intermediate care facilities, subject to the limitations in 42 U.S.C. § 1396a(a)(13)(C).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XVII] REIMBURSEMENT TO OUT OF STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana medicaid individuals at the medicaid rate and upon the basis established by the medicaid agency in the state in which the facility is located.

(2) The Montana medicaid program will pay for nursing facility services or related supplies provided to eligible Montana medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana medicaid program. Enrollment information and instructions may be obtained from the department's

fiscal intermediary, Consultec, at P.O. Box 4286, Helena, MT 59604-4286.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state medicaid agency establishing or stating the facility's medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state medicaid agency establishing or stating the medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by ARM 46.12.1302, et seq.;

(i) 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 resident's need for active treatment. A Level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for medicaid during the period services were provided; and

(h) assurances that, during the period the billed services were provided, the facility was not operating under sanctions imposed by medicare or medicaid which would preclude payment.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XVIII] BED HOLD PAYMENTS (1) Except as provided in subsections (6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident for whom the bed is held is temporarily receiving medical services outside the facility, except in

another nursing facility, and is expected to return to the provider;

(c) 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; and

(d) the provider has received written approval from the department's medicaid services division as provided in subsection (4).

(2) For purposes of subsection (1), a provider will be considered full if:

(a) all medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) 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.

(3) For purposes of subsection (1), the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of the anticipated duration of the absence. Temporary absences which are of indefinite duration must be documented at least weekly by the provider to assure that the absence is indeed temporary.

(4) A provider's request for the department's written approval of bed hold days as required in subsection (1) must be submitted to the department's medicaid services division on the form provided by the department within 90 days after the first day of the requested bed hold period. The request must include a copy of the waiting list applicable to each bed hold day claimed for reimbursement.

(5) Where the conditions of subsections (1) through (4) 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's medicaid services division. 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 bed hold day until all conditions of billing are met.

(6) Payment will be made to a provider for holding a bed for a resident during a therapeutic home visit only if:

(a) the recipient's plan of care provides for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit; and

(c) the resident is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence.

(7) The department may allow therapeutic home visits for trial placement in the home and community services (medicaid waiver) program.

(8) No more than 24 days per resident in each rate year will be allowed for therapeutic home visits.

(9) The provider must submit to the department's medicaid services division a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the department's medicaid services division.

(10) Approvals or authorizations of bed hold days obtained from county offices will not be valid or effective for purposes of this section.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XIX] MEDICARE HOSPICE BENEFIT - REIMBURSEMENT (1) In accordance with section 9435(b) of the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509, the department may not pay a nursing facility provider for services provided to an eligible medicaid/medicare individual who has elected the medicare hospice benefit.

(a) This section applies where the hospice provider and the nursing facility provider have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual.

(b) When this section applies, the department will pay the hospice provider in accordance with the department's rules governing medicaid reimbursement to hospice providers.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XX] ALLOWABLE COSTS (1) This section applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for includable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the health insurance manual 15 (HIM-15), published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

A copy of the HIM-15 may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210. Applicability of the HIM-15 is subject to the exceptions and limitations specified in this section.

(a) The term "allowable costs" means costs which are reportable and which are considered in determining the costs of providing medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in [Rule XXI], allowable costs will be determined in accordance with the HIM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for the mentally retarded which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers from established lending institutions at the date of asset acquisition or at the inception of the lease.

(iii) Leases must be capitalized according to generally accepted accounting principles.

(iv) Depreciation of real property and movable equipment must be in accordance with American hospital association guidelines. Depreciation of real property and movable equipment based upon accelerated cost recovery guidelines is not an allowable cost.

(v) In accordance with sections 1861(v)(1)(O) and 1902(a)(13) of the Social Security Act, includable property costs shall not be increased on the basis of a change in ownership which takes place on or after July 18, 1984. Sections 1861(v)(1)(O) and section 1902(a)(13) are hereby adopted and incorporated herein by reference. Copies of these sections may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

(c) Administrator compensation is allowable only as determined according to the HIM-15 provisions relating to owner compensation, and as specifically limited in this section.

(i) For purposes of reporting and determining allowable administrator compensation, administrator compensation includes:

(A) all salary paid to the administrator for managerial, administrative, professional or other services;

(B) all employee benefits except employer contributions required by state or federal law for FICA, workers' compensation insurance (WCI), federal unemployment insurance (FUI), and state unemployment insurance (SUI);

(C) all deferred compensation either accrued or paid;

(D) the value of all supplies, services, special merchandise, and other valuable items paid or provided for the personal use or benefit of the administrator;

(E) wages of any provider employee to the extent such employee works in the home of the administrator;

(F) the value of use of an automobile owned by the provider business to the extent used by the administrator for uses not related to patient care;

(G) personal life, health, or disability insurance premiums paid by the provider on the administrator's behalf;

(H) the rental value of any portion of the facility occupied by the administrator as a personal residence;

(I) the value of any other remuneration, compensation, fringe or other benefits whether paid, accrued, or contingent.

(d) Allowable costs include employee benefits as follows:

(i) Employee benefits are defined as amounts accrued on behalf of an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death, if uniformly applicable to all employees. An item is an employee benefit only if it directly benefits an individual employee and does not directly benefit the owner, provider or related parties.

(ii) Employee benefits include all employer contributions which are required by state or federal law, including FICA, WCI, FUI, SUI.

(iii) Costs of recreational activities or facilities available to employees as a group, including but not limited to condominiums, swimming pools, weight rooms and gymnasiums, are not allowable.

(iv) For purposes of this section, an employee is one from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, and sole proprietors and partners owning or operating a facility are not employees even if FICA is withheld for them.

(v) Accrued vacation and sick leave are employee benefits if the facility has in effect a written policy uniformly applicable to all employees within a given class of employees, and are allowable to the extent they are reasonable in amount.

(e) Bad debts, charitable contributions and courtesy allowances are deductions from revenue and are not allowable costs.

(f) Revenues received for services or items provided to employees and guests are recoveries of cost and must be deducted from the allowable cost of the related items.

(g) Dues, membership fees and subscriptions to organizations unrelated to the provider's provision of nursing facility services are not allowable costs.

(h) Charges for services of a chaplain are not an allowable cost.

(i) Subject to subsection (3)(l), fees for management or professional services (e.g., management, legal, accounting or consulting services) are allowable to the extent they are identified to specific services and the hourly rate charged is reasonable in amount. In lieu of compensation on the basis of an hourly rate, allowable costs may include compensation for professional services on the basis of a reasonable retainer agreement which specifies in detail the services to be performed. Documentation that such services were in fact performed must be maintained by the provider. If the provider elects compensation under a retainer agreement, allowable costs for services specified under the agreement are limited to the agreed retainer fee.

(j) Travel costs related to resident care are allowable to the extent such costs are allowable under sections 162 and 274 of the internal revenue code and section 1.162-2 of the federal income tax regulations, which are federal statutes and regulations dealing with allowable travel expenses and transportation costs. The above-cited sections of the internal revenue code and income tax regulations are hereby adopted and incorporated herein by reference. A copy of the statutes and regulations may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

(i) Vehicle operating costs will be allocated between business and personal use based on actual mileage logs, a percentage derived from a sample mileage log and pre-approved by the department, or any other method pre-approved by the department.

(ii) For vehicles used primarily by an administrator, any portion of vehicle costs allocated to personal use shall be included as administrator compensation and subject to the limits specified in subsection (3)(c).

(iii) Allowable costs include automobile depreciation calculated on a straight-line basis, subject to salvage value, with a minimum of a 3-year useful life. The total of automobile depreciation and interest, or comparable lease costs will not be allowable in excess of $3200 per year. Other reasonable vehicle operating expenses are allowable.

(iv) Public transportation costs will be allowable only at tourist or other available commercial rate (not first class).

(k) Allowable costs for purchases, leases or other transactions between related parties are subject to the following limitation:

(i) Allowable cost of services, facilities and supplies furnished to a provider by a related party or parties shall not exceed the lower of costs to the related party or the price of comparable services, facilities or supplies obtained from an unrelated party. A provider must identify such related parties and costs in the annual cost report.

(l) Costs, including attorney's fees, in connection with court or administrative proceedings are allowable only to the extent that the provider prevails in the proceeding. Where such proceedings are related to specific reimbursement amounts, the proportion of costs which are allowable shall be the percentage of costs incurred which equals the percentage derived by dividing the total cost or reimbursement on which the provider prevails by the total cost or reimbursement at issue.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XXI] COST REPORTING, DESK REVIEW AND AUDIT

(1) Providers must use generally accepted accounting principles to record and report costs. The provider must, in preparing the cost report required under this section, adjust such costs in accordance with [Rule XX] to determine allowable costs.

(2) Providers must use the accrual method of accounting, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(3) Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain the provider's costs of the various services provided. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 (1990 ed.), which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210. Notwithstanding the above, distinctions between skilled nursing and intermediate care need not be made in cost finding.

(4) All providers must report allowable costs based upon the provider's fiscal year and using the financial and statistical report form provided by the department. Reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) A provider must file its cost report within 90 days after the end of its fiscal year.

(b) If a provider files an incomplete cost report or reported costs are inconsistent, the department may return the

cost report to the facility for completion or correction, and may withhold payment as provided in subsection (c).

(c) If a provider does not file its cost report within 90 days of the end of its fiscal year, or if a provider files an incomplete cost report, the department may withhold from payment to the provider an amount equal to 10 percent of the provider's total reimbursement for the month following the due date of the report or the filing of the incomplete report. If the report is overdue or incomplete a second month, the department may withhold 20 percent of the provider's total reimbursement for the following month. For each succeeding month for which the report is overdue or incomplete, the department may withhold the provider's entire medicaid payment for the following month. If the provider fails to file a complete and accurate cost report within six months after the due date, the department may recover all amounts paid to the provider by the department for the fiscal period covered by the cost report. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(d) The department may grant a provider one 30-day extension for filing the cost report if the provider's written request for the extension is received by the department prior to expiration of the filing deadline and if, based upon the explanation in the request, the department determines that the delay is unavoidable.

(e) Cost reports must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports must sign, under penalties of false swearing, upon an affirmation that he has examined the report, including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared in accordance with applicable laws, regulations, rules, policies and departmental instructions.

(5) A provider must maintain records of financial and statistical information which support cost reports for three years after the date a cost report is filed, the date the cost report is due, or the date upon which a disputed cost report is finally settled, whichever is later.

(a) Each provider must maintain, as a minimum, a chart of accounts, a general ledger and the following supporting ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable, cash disbursements, payroll, general journal, resident census records identifying the level of care of all residents individually, all records pertaining to private pay residents and resident trust funds.

(b) To support allowable costs, the provider must make available for audit at the facility all business records of any related party, including any parent or subsidiary firm, which relate to the provider under audit. To support allowable costs, the provider must make available at the facility

for audit any owner's or related party's personal financial records relating to the facility. Any costs not so supported will not be allowable.

(c) Cost information and documentation developed by the provider must be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedure. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks, invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. The provider must make and maintain contemporaneous records to support labor costs incurred. Documentation created after the fact will not be sufficient to support such costs.

(d) The provider must make all of the above records and documents available at the facility at all reasonable times after reasonable notice for inspection, review or audit by the department or its agents, the federal department of health and human services, the Montana legislative auditor, and other appropriate governmental agencies. Upon refusal of the provider to make available and allow access to the above records and documents, the department may recover, as provided in [Rule XXII], all payments made by the department during the provider's fiscal year to which such records relate.

(6) Department audit staff may perform a desk review of cost statements or reports and may conduct on-site audits of provider records. Such audits will be conducted in accordance with audit procedures developed by the department.

(a) Department audit staff may determine adjustments to cost reports or reported costs through desk review or audit of cost reports. Department audit staff may conduct a desk review of a cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) Department audit staff may conduct on-site audits of a provider's records, information and documentation to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.

(c) The department shall notify the provider of any adverse determination resulting from a desk review or audit of a cost report and the basis for such determination. Failure of the department to complete a desk review or audit within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

(d) The department, in accordance with the provisions of [Rule XXII], may collect any overpayment and will reimburse a provider for any underpayment identified through desk review or audit.

(e) For providers receiving per diem rates determined in accordance with [Rules VI and VII], if based upon desk review or audit of the provider's base period cost information used to determine the per diem rate, the department adjusts such

costs upward or downward, the department shall adjust rates retroactively for the period of the per diem rate in accordance with adjusted costs and shall use adjusted cost information in any subsequent calculations for which such base period cost information is used. The provider shall not be entitled to any adjustment until the department has mailed notice of final settlement to the provider. Any overpayment or underpayment shall be paid or collected in accordance with the cost settlement procedures in [Rule XXII].

(7) A provider may request administrative review and a fair hearing regarding adverse audit findings according to the provisions of [RULE XXV].

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

[RULE XXII] COST SETTLEMENT PROCEDURES (1) The department will notify the provider of any overpayment discovered. The provider may contact the department to seek an agreement providing for repayment of the full overpayment within 60 days of mailing of the overpayment notice.

(2) Unless, within 30 days of mailing of overpayment notice to the provider, the provider enters into an agreement with the department which provides for full repayment within 60 days of mailing of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete full recovery as soon as possible.

(3) The department may recover the full overpayment amount regardless of whether the provider disputes the department's determination of the overpayment in whole or in part. A request for administrative review or fair hearing does not entitle a provider to delay repayment of any overpayment determined by the department.

(4) The department will notify the provider of any underpayment discovered. In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of the amount of the underpayment.

(5) Court or administrative proceedings for collection of overpayment or underpayment must be commenced within five years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.

(6) The amount of any overpayment constitutes a debt due the department as of the date the department mails notice of overpayment to the provider. The department may recover the overpayment from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets.

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

[RULE XXIII] THIRD PARTY PAYMENTS AND PAYMENT IN FULL

(1) Regardless of any other provision of these rules, a provider may not bill the medicaid program for any patient day, item, service or other amount which could have been or could be paid by any other payer, including but not limited to a private or governmental insurer, or medicare, regardless of whether the facility participates in such coverage or program. If the department finds that medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with [Rule XXII].

(a) This section does not apply to payment sources which by law are made secondary to medicaid.

(2) The payments allowed under [Rule IV] constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill or collect any amount from a medicaid recipient, other than the resident's patient contribution and any items billable to residents under [Rule XV].

(3) This section applies in addition to ARM 46.12.309.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

[RULE XXIV] UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456.250 through 456.522, may evaluate the necessity of nursing facility care for each medicaid resident. 42 CFR 456.250 through 456.522 are federal regulations which specify utilization review criteria for nursing facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456.250 through 456.522. A copy of these regulations may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

(2) As frequently as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456.600 through 456.614, may evaluate the quality of medical care provided to each medicaid resident in an intermediate care facility for the mentally retarded or an institution for mental diseases. 42 CFR 456.600 through 456.614 are federal regulations which specify medical review criteria for nursing facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456.600 through 456.614. A copy of these regulations may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142 MCA

[RULE XXV] ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Administrative review. Within 30 days of mailing of the department's written determination, including a rate or audit determination, a provider may request an administrative review. The request must be in writing, must state the provider's objections in detail and must include any substantiating information and documentation.

(a) Within the period specified in subsection (1), a provider may request in writing an extension of up to 15 days for submission of an administrative review request. The request for extension must be received by the department within the 30-day period specified in subsection (1).

(b) The department may grant further extensions for good cause shown. Requests for such further extensions must be written and must state the cause for the request. The request for extension must be received by the department within the period of any previous extension granted.

(c) The provider's request may also include a request for a conference as part of the administrative review. If requested, the conference shall be held no later than 30 days after the department receives the provider's written administrative review request, detailed objections and substantiating information and documentation. The conference shall be based upon the department's determination and the provider's written request, detailed objections and substantiating information and documentation.

(d) No later than 60 days following receipt of the provider's written request, detailed objections and substantiating information and documentation, or the conference, whichever is later, the department shall mail a written determination concerning the provider's objections.

(2) Fair hearing. In the event the provider does not agree with the department's determination following administrative review by the department, the following fair hearing procedures will apply. The hearings officer may dismiss a fair hearing request if the provider fails to meet any of the requirements set forth in subsections (2)(a) through (e).

(a) The written request for a fair hearing must be mailed or delivered to the Department of Social and Rehabilitation Services, Hearings Officer, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604-4210.

(b) The request must be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of mailing of the department's written administrative review determination.

(d) The fair hearing request must state in detail the individual items and amounts in disagreement and the reasons for the disagreement, and must include substantiating information and documentation.

(e) The provider must provide a copy of the hearing request and substantiating materials to the department's medicaid services division.

(f) The hearings officer will conduct the fair hearing and may hold a pre-hearing conference and grant extensions of time as he deems necessary.

(g) The hearings officer will render a written proposed decision within ninety calendar days of final submission of the matter to him.

(3) Appeal. In the event the provider or department disagrees with the hearings officer's proposed decision, a request for appeal may be made by filing a notice of appeal with the Department of Social and Rehabilitation Services, Office of Fair Hearings, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604-4210. The appeal shall be to the Board of Social and Rehabilitative Services Appeals.

(a) The notice of appeal must be received within 15 days of mailing of the hearings officer's written proposed decision. The provider must serve a copy of the notice of appeal upon the department's medicaid services division.

(b) The notice of appeal must state the specific grounds for appeal. If no notice of appeal is filed within 15 days, the hearings officer's proposed decision shall become the final agency decision.

(c) Upon receipt of a notice of appeal, the notice and all evidence in the record and offers of proof shall be transmitted to the Board of Social and Rehabilitative Services Appeals by the hearings officer.

(d) The decision of the board shall be based solely on the record transmitted by the hearings officer. Written briefs and oral arguments based on the record may be presented personally or through a representative of the provider or the department.

(e) The board director shall render its written decision and mail copies to the parties within ninety days of final submission of the matter to it. The board shall notify the parties of the right to judicial review under the provisions of Title 2, chapter 4, part 7, MCA.

(4) This section applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings occurring on or after [the effective date of this rule].

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-2-606, 53-6-111 and 53-6-113 MCA

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

46.12.1208 COST REPORTING Subsections (1) and (2) remain the same.

(3) Cost Finding. Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain its costs of the various services provided. In preparing cost reports, all providers shall utilize the methods of cost finding described at 42 CFR 413.24 which the department hereby adopts and incor-

porates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210. ~~Notwithstanding the above, distinctions between skilled nursing and intermediate care need not be made in cost finding.~~

Subsections (4) through (5)(d) remain the same.

~~(6) Audits. Department audit staff may perform a desk review of cost statements and may conduct on-site audits of provider records. Such audits shall be conducted in accordance with audit procedures developed by the department.~~

~~(a) Desk review of cost reports will determine the adjustments to be applied to reported costs. Incomplete reports, or inconsistency in reported costs will cause the return of the cost report to the facility for correction and may result in withholding payment as set forth in ARM 46.12.1208(4)(b). Department audit staff may conduct a desk review of each cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.~~

~~(b) On-site audits of provider detailed records shall be made to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.~~

~~(c) On conclusion of a review of a cost report, the department shall send the provider the results of the review. 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.~~

~~(d) Upon conclusion of each on-site audit the department audit staff will submit an audit report to the medicaid bureau. The report will meet generally accepted auditing standards. The department will keep audit reports on file for at least 3 years after receipt.~~

~~(7) A provider may object to audit findings through the administrative review process according to ARM 46.12.1210.~~

(6) This section shall not apply to providers of nursing facility services which are subject to [Rules I through XXV].

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

46.12.1209 OVERPAYMENT AND UNDERPAYMENT Subsection (1) remains the same.

(2) Within 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 ~~nursing facility services~~ medical assistance or by repayments by the provider.

Subsections (3) through (6) remain the same.

(7) This section shall not apply to providers of nursing facility services which are subject to [Rules I through XXV].

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

46.12.1210 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Administrative Rreview. Within ~~15~~ 30 days of mailing ~~receipt~~ of the department's written ~~findings, recommendations, or rate~~ determination, the provider may ~~detail in writing any objections or justifications concerning the findings and may also~~ request an administrative ~~conference or~~ review. The request must be in writing, must state in detail the provider's objections, and must include substantiating documents and information. Within the ~~15~~ 30 days a provider may request in writing an extension of up to ~~30~~ 15 days for submission of ~~objections and justifications~~ a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the medicaid services division within the period of any previous extension, and must demonstrate good cause for the extension. ~~The conference or review shall be held no later than 30 days after the department receives the provider's written objections and justifications and the request for a conference or review. The department's medicaid bureau shall conduct the conference or review based on its findings and recommendations and the provider's written objections and justifications. No later than 60 days following receipt of the written objections and justifications, or the conference or review, whichever is later, the department's medicaid bureau, after consultation with the office of legal affairs, shall mail a written determination concerning the provider's objections and justifications and the position the department takes concerning the findings.~~

(a) The provider may also request a conference as part of the administrative review. If the provider requests an administrative review conference, the conference must be held no later than 30 days after the department or its designee receives the provider's written objections and substantiating materials and the request for a conference. The conference may be conducted by the department or its designee and shall be based on the department's determination and the provider's written objections and justifications.

(b) No later than 60 days following receipt of the written objections and justifications, or the conference, whichever is later, the department must mail a written determination concerning the provider's objections and justifications and the position the department takes concerning the finding.

(2) Fair Hhearing. In the event the provider does not agree with the department's determination following administrative review ~~by the department~~, the following fair hearing procedures will apply. The hearings officer may dismiss a fair hearing request if a provider fails to meet any of the requirements of subsections (2)(a) through (e).

(a) The written request for a fair hearing ~~shall~~ must be mailed or delivered to the Department of Social and Rehabilitation Services, Hearings Officer, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604-4210.

(b) The request ~~shall~~ must be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of ~~receipt~~ mailing of the department's written administrative review determination.

(d) The fair hearing request ~~shall~~ must identify the individual items and amounts in disagreement, give the reasons for the disagreement, and furnish substantiating materials and information.

(e) The ~~hearings officer will~~ provider must provide copies of hearing requests~~, notices and written decisions~~ and substantiating information to the department's ~~director,~~ medicaid ~~bureau and office of legal affairs~~ services division.

Subsections 2(f) and (g) remain the same.

(3) Appeal. In the event the provider or department disagrees with the hearings officer's proposed decision, ~~a notice of appeal may be submitted to the hearings officer for forwarding to the department director within ten days of the receipt of the hearings officer's decision. The notice of appeals shall set forth the specific grounds for appeal. If no notice of appeal is filed within ten days, the hearings officer's proposed decision shall become the final agency decision.~~ a request for appeal to the board of social and rehabilitation appeals may be made by filing notice of appeal with the Montana Department of Social and Rehabilitation Services, Office of Fair Hearings, P.O. Box 4210, Helena, Montana 59604-4210.

(a) The notice of appeal must be received in the office of fair hearings within fifteen (15) days of mailing of the hearings officer's written proposed decision. The provider must serve a copy of the notice of appeal upon the medicaid services division.

(b) The notice of appeal must set forth the specific grounds for appeal. If no notice of appeal is filed within 15 days, the hearings officer's proposed decision shall become the final agency decision.

(~~a~~c) All evidence in the record and offers of proof shall be transmitted to the ~~department director~~ board of social and rehabilitation appeals by the hearings officer. The decision of the ~~department director~~ board shall be based solely on the record transmitted by the hearings officer. Written briefs and oral arguments based on the record may be presented personally or through a representative of the provider or the department to the ~~department director~~ board.

(~~b~~d) The ~~department director~~ board shall reduce ~~his~~ its decision to writing and mail copies to the parties within ninety days of final submission of the matter to ~~him~~ it. The provider shall be notified of its right to judicial review under the provisions of Title 2, chapter 4, part 7, MCA.

(4) This section applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings occurring on or after the [effective date of this rule amendment].

(5) This section shall not apply to providers of nursing facility services which are subject to [Rules I through XXV].

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-2-606, 53-6-111 and 53-6-113 MCA

4. Rules 46.12.1201, 46.12.1202, 46.12.1203, 46.12.1204, 46.12.1205, 46.12.1206 and 46.12.1207 as proposed to be repealed are on pages 46-1535 through 46-1575 of the Administrative Rules of Montana.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

5. The proposed changes to the medicaid nursing facility rules are necessary to (1) implement authorized increases in aggregate nursing facility reimbursement for state fiscal year (FY) 1992; (2) revise the methodology for determining reimbursement in the operating and direct nursing areas to more equitably reimburse individual nursing facilities; (3) index current property rates to account for inflation; (4) incorporate patient assessment manual revisions regarding resident assessments; (5) establish FY 1992 as a new base period for purposes of calculating reimbursement limits for intermediate care facilities for the mentally retarded; (6) reorganize and rewrite the rules for clarity and readability, and update the rules to conform with current department practice; and (7) revise the rules governing administrative review and fair hearing procedures to address current practice problems and to conform with general legal practice. These proposed changes are contained in new Rules I through XXV.

The proposed changes to existing ARM 46.12.1208 through 1210 are also necessary to (8) maintain and adapt these sections for application to the inpatient psychiatric services program. These sections are referenced in the rules governing that program. These sections will no longer apply to nursing facilities. The changes to ARM 46.12.1210 are also necessary to revise and update administrative review and fair hearing procedures for inpatient psychiatric facilities to conform to general legal practice.

These changes are described below in further detail.

1. The proposed rule is necessary to implement authorized increases in aggregate nursing facility reimbursement.

The proposed rule is necessary to implement several increases in aggregate reimbursement to nursing facilities. These increases cannot be implemented under the current rule.

Sections 53-6-101(5) and 53-6-113(3), MCA authorize the department to establish rates for medical services provided under the medicaid program. In establishing rates, the department may consider the availability of appropriated funds, among other factors. Section 53-2-201(1)(f), MCA requires the department to do all things necessary, in conformity with state and federal law, for the proper fulfillment of public assistance purposes.

House Bill 93 (1991 Legislature) appropriated certain funds for increases in medicaid rates to nursing facilities. The proposed rule would implement the funding increases appropriated under HB 93. HB 2, in addition to the base funding for nursing facility reimbursement, appropriated increases for "rebasing" of the nursing facility reimbursement system. These increases are effective October 1, 1991 and October 1, 1992. On the last day of the 1991 legislative session, rebase funds for the period July 1, 1991 through September 30, 1991 and July 1, 1992 through September 30, 1992 were cut from HB 2. The proposed rule would implement the rebase increases as provided in HB 2.

In addition, the department has determined that it is necessary to provide additional increases in aggregate funding for the periods July 1, 1991 through September 30, 1991 and July 1, 1992 through September 30, 1992. The current reimbursement system is based upon 1982 actual costs, which have been indexed forward each year. Industry representatives have contended for several years that reimbursement has not taken into consideration increases in necessary provider costs resulting from inflation, patient acuity, new legal requirements, and other causes. They have contended that rates consequently have failed to meet federal statutory and regulatory standards for medicaid reimbursement.

Each fiscal year the department must submit to the federal government a state plan, together with assurances that the plan meets federal requirements, including assurances that reimbursements meet federal standards. Because the department's reimbursement system is antiquated and based upon old cost data and because of more stringent standards and federal review, the department has had increasing difficulty obtaining federal approval of its state plan for nursing facility reimbursement. As recently as May 15, 1991, the department had not yet obtained federal approval of its plan for state fiscal year 1991. Industry representatives had written to the federal government opposing approval and the federal government had delayed action on the plan and had requested additional justification. Disapproval of the state plan would have resulted in the loss of all federal matching payments for FY 1991. Federal payments constitute approximately 71% of all medicaid payments to nursing facilities.

One provider association presented to the department a proposed letter to the federal government detailing its arguments that the plan failed to meet federal requirements. The association indicated that it would send the letter if increases for the periods July 1, 1991 through September 30, 1991 and July 1, 1992 through September 30, 1992, equivalent to the cut rebase funding was not granted. In addition, the association threatened to file suit to challenge the adequacy of FY 1991 rates and to challenge the constitutionality and legality of HB 93. The department concluded that these threatened actions were serious and posed a significant risk of loss of substantial federal funds and would require the expenditure of substantial funds for legal costs.

The department determined that HB 2 base funding for nursing facility reimbursement is sufficient to provide the requested increases. Additional funding is available for this purpose because of anticipated increases in patient contributions to the cost of care. These increased contributions will occur independently of and regardless of whether the department provides the additional increase requested.

After determining that the department is legally authorized to grant the requested increases using HB 2 base funding and that the department has independent statutory authority to determine rates, the department has determined that it will provide the requested increase in funding for the periods July 1, 1991 through September 30, 1991 and July 1, 1992 through September 30, 1992. The provider association, in response has written to the federal government to request approval of the state plan and has resolved not to take legal action. The federal government has now approved the FY 1991 state plan. The proposed rule will implement the increase for the period July 1, 1991 through September 30, 1991.

2. The proposed rule is necessary to revise the reimbursement methodology in the operating and direct nursing cost areas to more equitably reimburse individual nursing facilities.

The 1991 legislature appropriated substantial new funds for the purpose of increasing medicaid reimbursement to nursing facilities. The department worked closely with provider representatives, the Governor's Office of Budget and Program Planning and the legislature in developing and passing the nursing facility budget and appropriation. The department believes that the increases provided under the proposed rule are appropriate and adequate to provide reimbursement in accordance with all legal requirements.

However, if the additional funds simply were distributed under the current methodology, any reimbursement inequities existing under the present system would be exacerbated rather than alleviated. Providers have contended that the current system

fails to address costs which must be incurred to provide nursing facility services. If the current methodology is not revised, the state may be vulnerable to the risks of federal disapproval of its medicaid state plan and to lawsuits to force expenditures beyond funds appropriated by the legislature. Further, quality of care in nursing facilities may suffer.

The proposed rule is therefore necessary to adopt a revised nursing facility reimbursement methodology to meet the following requirements and goals: (1) to comply with applicable federal standards for medicaid reimbursement to nursing facilities; (2) to encourage providers to provide high quality care to nursing facility residents; and (3) to provide reimbursement rates that are fair and equitable to individual providers, yet consistent with efficiency and economy. The department believes that a methodology which meets these goals will also result in a reduction of cost shifting by providers to private pay patients.

(a) Description of the proposed reimbursement methodology.

The proposed rule would revise the methodology for determining reimbursement levels for what is referred to as the operating rate under the current rule. The proposed rule would not change the methodology for determining property rates (see section (3) below for discussion of proposed property rate indexing). The proposed rule would not change the methodology for determining reimbursement rates for intermediate care facilities for the mentally retarded (but see section (5) below for discussion of new base year for ICF/MR reimbursement) or for out of state providers.

Under the proposed rule, a provider would receive a per diem rate that is a total of the following components: an operating cost component, a direct nursing personnel cost component, a property cost component, and an OBRA cost component. The amount of increase in a provider's per diem rate from FY 1991 to FY 1992 would be limited to $9.50. This limit is intended as a transitional measure to mitigate wide fluctuations in rates from rate year 1991 to 1992 and to achieve fairer rates to providers as a whole.

The operating component would be the lesser of the provider's actual operating cost or a limit set at 115% of the median bed-weighted operating cost. Operating costs are defined in the rule and would not include direct nursing personnel costs. The provider's cost would be base period cost inflated from the midpoint of the base year to the midpoint of the rate year by the DRI-HC Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

In addition, an incentive payment would be included in the operating cost component for those providers whose actual costs are less than the operating cost limit (115% of the median bed-weighted operating cost). The incentive would be the lesser of 40% of the difference between the provider's actual cost and the operating cost limit, or 5% of median operating cost. The incentive is intended to encourage providers to reduce operating costs such as administrative costs.

The direct nursing personnel cost component would be the lesser of the provider's inflated base period composite nursing wage rate multiplied by the provider's most recent average patient assessment score, or a limit set at 140% of the statewide median average wage multiplied by the provider's most recent average patient assessment score. Direct nursing personnel costs are defined in the rule. The provider's composite nursing wage rate would be determined based upon base period costs, patient assessment score and patient days. The direct nursing personnel component is intended to encourage providers to direct resources toward direct nursing care to residents, thereby improving the quality of care provided.

For purposes of determining both the operating and direct nursing personnel cost components for rate year 1992, the base period generally would be the provider's fiscal year ending during calendar year 1989. Although it is generally preferable to base rates upon the most recent available cost information, the preference for more recent data must be balanced against other important considerations. The department has determined that on balance, 1989 cost data provides a more complete and consistent basis for determination of equitable rates. Use of 1990 cost data is problematic because OBRA costs are not consistently or completely reflected in the data for all providers and these costs are extremely difficult to identify and isolate. Because the department would separately reimburse for OBRA costs, some providers would receive double payment. Moreover, the potentially detrimental effects of use of the older 1989 data can be adequately mitigated by use of the more generous DRI-HC index to index the data to account for inflation. Further, the department anticipates that 1991 cost data will be used to set FY 1993 rates, thus limiting use of the slightly older data to only one rate year.

If no cost report were available for a fiscal year ending in 1989, the components would be determined based upon a cost report for a later period which includes at least 6 months participation by the provider. If no such cost report were available, the provider would receive an interim per diem rate set at the bed-weighted median per diem rate for all facilities. After a cost report covering at least a 6 month period, a per diem rate would be determined based upon such cost information and would be effective retroactively to the date the interim rate became effective. The difference between

interim rate payments and the amount payable at the rate determined based upon actual cost information would be collected from or paid to the provider. This process would insure that a provider's payment is related to its actual cost experience, subject to the applicable limitations.

Patient assessment scores would be determined as under the current system. However, the direct nursing personnel component, including the limit, would be based upon the individual provider's patient assessment score rather than upon a comparison of the provider's score to the statewide average. This will insure that reimbursement relates more directly to the acuity level of the individual provider's residents.

The OBRA cost component would be $1.90 per patient day plus a facility-specific certified nurse aide wage increment. This component is described in new rule IX.

Under the proposed rule, if the department, through audit or desk review, adjusts costs in a base period cost report upward or downward, the department would adjust the provider's rate retroactive to the rate effective date and recover or pay the difference between the adjusted rate and the original rate. The adjusted cost information would be used in any subsequent calculations for which that base period cost information is used.

(b) The proposed system will be effective and benefits of the new system will be granted retroactively to July 1, 1991.

The department proposes that the new reimbursement system would be applied retroactively to July 1, 1991, to coincide with the new rate year. This would allow the department to distribute retroactive to July 1, 1991 increases in funding appropriated by the legislature. Those providers entitled to rate increases under the new system would receive those increases retroactive to July 1, 1991. Such providers would receive an adjustment payment without interest for the difference between the old rate and the new rate for the period between July 1, 1991 and the effective date of this rule. Those few providers whose rate will decrease under the new system would not receive decreases until the effective date of this rule. Such providers would not be required to repay the difference between the old rate and the new rate for the period between July 1, 1991 and the effective date of this rule.

(c) Adoption of the proposed reimbursement system is necessary to meet legal requirements.

The department has worked closely in consultation with the accounting firm of Myers and Stauffer to develop the proposed reimbursement system. Based upon the analysis conducted by

that firm and by the department, the department believes that adoption of the proposed system is necessary to provide rates which meet the requirements of federal law and which equitably reimburse individual providers. The department believes that the proposed system is necessary to encourage and enhance the quality of care provided to nursing facility residents as required by federal law. By providing rates which meet applicable legal requirements and which fairly reimburse providers, the department believes that the necessity of cost shifting will be minimized. The department believes that adoption of the proposed system is reasonably necessary to conform medicaid nursing facility reimbursement with current legal requirements and industry conditions.

3. The proposed rule is necessary to index current property rates to account for inflation.

The proposed rule would not change the methodology for reimbursement of property costs. However, current calculated property rates would be increased by 3% to account for inflation in acquisition costs for capital items. Grandfathered property rates would not be increased.

4. The proposed rule is necessary to incorporate patient assessment manual provisions regarding resident assessments.

OBRA 1987 requires the department to designate a resident assessment tool for use by nursing facilities. The department has designated the federal minimum data set as the assessment tool. Because the minimum data set duplicates much of the information currently required to be reported in the department's patient assessment reporting form, the department has revised the patient assessment reporting form to eliminate this duplication. The current rule incorporates by reference the patient assessment manual dated January 1990, which contains the current form. The proposed rule is necessary to incorporate the revised form.

5. The proposed rule is necessary to establish FY 1992 as a new base year for purposes of calculating reimbursement limits for intermediate care facilities for the mentally retarded (ICFs/MR).

The proposed rule is necessary to allow the department to reimburse ICFs/MR for actual allowable costs during FY 1992. Rebasing is necessary to take into account increasing and changing costs. Without rebasing, ICFs/MR would be subject to reimbursement limits based upon significantly different operating conditions in prior years.

6. The proposed rule is necessary to reorganize and rewrite the nursing facility rules for clarity and readability, and to update the rule to conform with current department practice.

The current nursing facility rules are extremely difficult to use and understand. The lack of organization of the rules is confusing and makes it difficult to locate rules governing a particular subject. The current rules rely upon mathematical formulas to specify reimbursement methodology, without detailed explanation. The proposed rule is intended to remedy many of these problems.

The proposed rule represents a reorganization of the current rule. The department has organized the rule into sections according to subject matter. The sections have been ordered in a more logical sequence. Unnecessary or duplicate material has been deleted. Material has been added to address issues not adequately addressed in the current rule.

An attempt has been made to eliminate or reduce reliance upon mathematical formulas. Where mathematical formulas have been retained, an attempt has been made to better organize the material and to include definitions or explanatory language to aid the reader in understanding the significance and details of the formula.

The revision is not intended primarily to enact substantive changes, but rather to clarify existing requirements. However, in some cases substantive changes have been made where necessary to more accurately reflect department practice, to address unresolved issues or to provided a more workable rule. The substantive changes are as follows:

(a) Rule I - Scope, Applicability and Purpose. Subsection (2) is new and is intended to state the general rule that in case of conflict, federal law supersedes these rules. Subsection (3) specifies that these rules apply to rate years beginning on or after July 1, 1991.

(b) Rule II - Definitions. Definitions relating to the geographic wage factor have been eliminated along with the factor itself. The definition of nursing facility services has been revised to update incorporations of federal regulations and to incorporate the OBRA 1990 requirement to provide services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each medicaid resident.

(c) Rule III - Provider Participation Requirements. Subsection (1)(f) has been revised to incorporate new federal requirements relating to maintaining certain resident funds in an interest-bearing account.

(d) Rule IV - Nursing Facility Reimbursement. This section is mostly new and is intended to provide an overview of how the various reimbursement sections of the rule fit together. The new substantive provisions relating to reimbursement are discussed above in section (2).

(e) Rule V - Rate Effective Dates. This section maintains the general rule that rates are set only once a year, and specifies the exceptions to that rule. Under the proposed reimbursement system, desk review or audit of base period cost reports will result in appropriate retroactive rate revisions and recovery or payment of the difference.

(f) Rule VI - Operating Cost Component. This section is all new and is discussed above in section (2).

(g) Rule VII - Direct Nursing Personnel Cost Component. This section is all new and is discussed above in section (2).

(h) Rule VIII - Patient Assessment Scoring and Staffing Requirements. This section more completely and accurately specifies the methodology used to determine patient assessment scores, monitor procedures, and appeal procedures related to patient assessment score issues. The proposed section clarifies that if a provider objects to the sampling technique used by the monitor team to select the abstracts to be monitored, the only appeal will be to request a 100% monitor. This must be done before other issues may be appealed and failure to request a 100% monitor results in a waiver of objections to the sampling technique.

(i) Rule IX - OBRA Cost Component. The provisions of this section are discussed in section (2) above.

(j) Rule X - Calculated Property Cost Component. The substantive change to this section is discussed in section (3) above.

(k) Rule XI - Grandfathered Property Cost Component. This section clarifies in subsection (6) that once a provider's calculated property cost component equals or exceeds the grandfathered rate, the provider is no longer entitled to grandfathering protection. This is so even if the component subsequently falls below the prior grandfathered rate. This is consistent with the original intent of grandfathering as a temporary transitional measure.

(l) Rule XII - Change in Provider Defined. This section contains no substantive change.

(m) Rule XIII - Interim Per Diem Rates For Newly Constructed Facilities and New Providers. This section is all new and is discussed in part in section (2) above. All providers who have not filed a cost report covering a period of at least 6 months participation in the program will receive an interim rate. This includes newly constructed facilities and new providers, such as a provider providing services in a facility after a change in provider which results in a loss of grandfathered property cost component. This section specifies how interim rates are set and retroactively adjusted, and how

patient assessment scores are calculated for such facilities for purposes of retroactive rate adjustment.

(n) Rule XIV - Separately Billable Items. This section contains no substantive change.

(o) Rule XV - Items Billable to Residents. This section contains no substantive change.

(p) Rule XVI - Reimbursement For Intermediate Care Facilities For The Mentally Retarded. This section contains no substantive change, except as described in section (5) above.

(q) Rule XVII - Reimbursement to Out Of State Facilities. This section contains no substantive change.

(r) Rule XVIII - Bed Hold Payments. This section clarifies that for purposes of bed hold days for temporary absences, a provider must document at least weekly that the absence is temporary. This section also clarifies that approvals must be obtained from the medicaid services division in Helena, and that approvals obtained from county offices will not be valid.

(s) Rule XIX - Medicare Hospice Benefit. This section contains no substantive change.

(t) Rule XX - Allowable Costs. This section contains no substantive change.

(u) Rule XXI - Cost Reporting, Desk Review And Audit. This section revises the rule governing the length of time for which records must be maintained by a provider. The current rule requires that records must be maintained for three years after the date of filing the cost report or the due date of the cost report, whichever is later. The proposed rule requires that records be maintained for three years after filing, due date or final settlement of a disputed cost report, whichever is later. This change will assure the availability of records for a longer period if a dispute regarding the report has not been settled.

This section also clarifies that the provider must make and maintain contemporaneous records to support labor costs incurred. Documentation created after the fact will not be accepted.

Subsection (6)(e) is new. If the department adjusts costs in a base period cost report upward or downward, the department will adjust the provider's rate retroactive to the rate effective date and will recover or pay the difference between the adjusted rate and the original rate. The adjusted cost infor-

mation will be used in any subsequent calculations for which that base period cost information is used.

(v) Rule XXII - Cost Settlement Procedures. This section clarifies that, for purposes of the 30-day negotiation period, notice of an overpayment is complete upon mailing of notice by the department.

(w) Rule XXIII - Third Party Payments And Payment In Full. This section contains no substantive change.

(x) Rule XXIV - Utilization Review And Quality Of Care. This section contains no substantive change.

(y) Rule XXV - Administrative Review And Fair Hearing Procedures. This section contains several substantive changes. These are discussed in section (7) below.

7. The proposed rule is necessary to revise the rules governing administrative review and fair hearing procedures to address current practice problems and to conform with general legal practice.

These changes are contained in new rule section XXV.

The time periods stated would begin to run upon the date of mailing of the department's determination or the hearing officer's decision, rather than upon receipt of such determination or decision as provided in the current rule. The date of receipt of a document is difficult or impossible for the department to ascertain, whereas the date of mailing can be ascertained with certainty. This rule is more consistent with general legal practice. The time periods would be lengthened to eliminate any reduction in time for the provider to act which would result from this change.

The initial period within which a provider may request in writing administrative review of a department determination would be extended from 15 to 30 days. The provider would be required to state its objections in detail and to include substantiating information and documentation. The length of an initial extension for submission of the request would be reduced from 30 to 15 days. The rule would provide that the extension request must be received in writing within the original 30-day request deadline. Further extension requests would have to be in writing, received by the department during the period of any prior extension granted, and demonstrate good cause for the extension. These changes would allow the provider more initial time to consider whether to seek administrative review of a department determination, but will require a provider to diligently pursue that course once chosen.

This section would clarify that a conference is an optional part of an administrative review. It will not be held unless requested by the provider.

Subsection (2) would provide that a hearings officer may dismiss the hearing request if the provider fails to follow the requirements stated in the rule. For example, the provider must state in detail the issues and the reasons for disagreement with the department's determination, and must include substantiating information and documentation. This rule would insure that providers carefully consider hearing requests before invoking the formal hearing process, which is very time-consuming and costly to all parties.

The section would add the requirement that the provider provide a copy of the complete hearing or appeal request to the medicaid services division. This is consistent with general legal practice.

This section would change the appeal procedure to provide that appeal from a decision of a hearings officer is to the Board of Social and Rehabilitation Services Appeals, rather than to the department director. This procedure would provide a more independent forum for consideration of the appeal.

This section also would provide that it applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings occurring on or after the effective date of the rule.

8. The proposed changes to ARM 46.12.1208 through 46.12.1210 are necessary to maintain and adapt these sections for other program rules which reference these sections.

Because the nursing facility rules have been reorganized and rewritten, this notice proposes repeal of the current nursing facility program rules. However, other program rules refer to certain sections of the current nursing facility rules to provide cost reporting, cost settlement and appeal procedures. Specifically, the inpatient psychiatric services program described in ARM 46.12.590 through 46.12.599 refers to ARM 46.12.1208 through 46.12.1210 for rules governing cost reporting, cost settlement and administrative review and fair hearing procedures. Therefore, it is necessary to maintain rules to govern these procedures for the psychiatric program. Some changes are also necessary to adapt these rules to the psychiatric program and to conform appeal procedures to general legal practice.

Changes to ARM 46.12.1208 would remove material not referenced by the psychiatric program rules and not relevant to that program. The changes would also clarify that the section no longer applies to the nursing facility program.

Changes to ARM 46.12.1209 would remove material not relevant to the psychiatric program. The changes would also clarify that the section no longer applies to the nursing facility program.

Changes to ARM 46.12.1210 are necessary to adapt the rule more closely to the psychiatric program, to clarify the rule and to conform the rule more closely to general legal practice.

Throughout this rule section, the time periods stated would begin to run upon the date of mailing of the department's determination or the hearing officer's decision, rather than upon receipt of such determination or decision as provided in the current rule. The date of receipt of a document is difficult or impossible for the department to ascertain, whereas the date of mailing can be ascertained with certainty. This rule is more consistent with general legal practice. The time periods would be lengthened to eliminate any reduction in time for the provider to act which may result from this change.

The initial period within which a provider may request in writing administrative review of a department determination would be extended from 15 to 30 days. The provider would be required to state its objections in detail and to include substantiating information and documentation. The length of an initial extension for submission of the request would be reduced from 30 to 15 days. The rule would require that the extension request be received in writing within the original 30-day request deadline. Under the proposed rule, further extension requests must be in writing, must be received by the department during the period of any prior extension granted, and must demonstrate good cause for the extension. These changes would allow the provider more initial time to consider whether to seek administrative review of a department determination, but would require a provider to diligently pursue that course once chosen.

This section would clarify that a conference is an optional part of an administrative review. It will not be held unless requested by the provider.

Subsection (2) would provide that a hearings officer may dismiss the hearing request if the provider fails to follow the requirements stated in the rule. For example, the provider must state in detail the issues and the reasons for disagreement with the department's determination, and must include substantiating information and documentation. This rule would insure that providers carefully consider hearing requests before invoking the formal hearing process, which is very time-consuming and costly to all parties.

The section would add the requirement that the provider provide a copy of the complete hearing or appeal request to

the medicaid services division. This is consistent with general legal practice.

This section would change the appeal procedure to provide that appeal from a decision of a hearings officer is to the Board of Social and Rehabilitation Services Appeals, rather than to the department director. This procedure would provide a more independent forum for consideration of the appeal.

This section would also provide that it applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings occurring on or after the effective date of the rule. The changes would also clarify that the section no longer applies to the nursing facility program.

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 the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604-4210, no later than August 22, 1991 at 5:00 p.m..

7. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 15, 1991.

BEFORE THE DEPARTMENT OF AGRICULTURE

OF THE STATE OF MONTANA

In the matter of the adoption of rules pertaining to the honeybee hourly inspection fee	))))	NOTICE OF ADOPTION OF A NEW RULE 4.12.108 PERTAINING TO THE HONEYBEE HOURLY INSPECTION FEE

TO: All Interested Persons

1. On June 13, 1991, the Department of Agriculture published a notice of proposed adoption of the above-stated rule at page 880 of the 1991 Montana Administrative Register, Issue number 11.

2. The Department of Agriculture has adopted the rule exactly as proposed.

3. No comments or testimony were received.

E. M. Snortland, Director
Department of Agriculture

Certified to the Secretary of State, July 15, 1991.

BEFORE THE BOARD OF HEARING AID DISPENSERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees and record retention	NOTICE OF AMENDMENT OF 8.20.402 FEES AND 8.20.407 RECORD RETENTION

TO: All Interested Persons

1. On May 16, 1991, the Board of Hearing Aid Dispensers published a notice of proposed amendment of the above-stated rules at page 575, 1991 Montana Administrative Register, issue number 9.

2. The Board has amended the rules exactly as proposed.

3. No comments or testimony were received.

BOARD OF HEARING AID DISPENSERS
BYRON RANDALL, CHAIRMAN

BY: _____
ANDY POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 15, 1991.

BEFORE THE FINANCIAL DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to dollar amounts to which consumer loan rates are to be applied	NOTICE OF AMENDMENT OF 8.80.307 DOLLAR AMOUNTS TO WHICH CONSUMER LOAN RATES ARE TO BE APPLIED

TO: All Interested Persons

1. On May 30, 1991, the Financial Division published a notice of proposed amendment of the above-stated rule at page 766, 1991 Montana Administrative Register, issue number 10.

2. The Division amended the rule exactly as proposed.

3. No comments or testimony were received.

FINANCIAL DIVISION

BY: _____
ANDY POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, July 15, 1991.

BEFORE THE DEPARTMENT OF FISH, WILDLIFE AND PARKS
OF THE STATE OF MONTANA

In the matter of the adoption of new Rules I through VI pertaining to fish health and importation and the repeal of ARM 12.7.501	))))	NOTICE OF ADOPTION OF NEW RULES I THROUGH VI AND REPEAL OF ARM 12.7.501

TO: All interested persons

1. On June 13, 1991, in the Montana Administrative Register Issue No. 11, the department published notice of proposed adoption of new rules I through VI (12.7.502 through 12.7.507) pertaining to fish health and importation, and repeal of ARM 12.7.501 at page 895.

2. The department has adopted the new rules as proposed with no changes, and has repealed ARM 12.7.501.

3. No comments or testimony were received.

Patrick Graham
Deputy Director

Certified to the Secretary of State July 15, 1991

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

In the matter of the amendment of 16.18.201, 16.18.203 - 205, 16.18.207 - 208 and the adoption of new rule I relating to water and wastewater operators	NOTICE OF AMENDMENT OF RULES AND ADOPTION OF NEW RULE I (16.18.209) (Water Quality Bureau)

To: All Interested Persons

1. On May 30, 1991, the department published notice at page 776 of the Montana Administrative Register, Issue No. 10, of amendment and adoption of rules which would amend minimum requirements for water and wastewater operator certification, adjust fee requirements, and provide procedures for license revocation for water and wastewater operators.

2. After consideration of the comments received on the proposed rules, the department has amended the rules as proposed with the following changes:

16.18.208 CONTINUING EDUCATION REQUIREMENTS (1) A continuing education credit or portion thereof must be earned by all class I, II, III, and IV fully certified operators during a two-year period commencing on July 1, 1986, and July 1 of even-numbered years thereafter. One continuing education credit per water distribution and/or water plant certificate and one continuing education credit per wastewater certificate must be earned by a class I certified operator during each two-year period. A one-half (1/2) continuing education credit per water distribution and/or water plant certificate and one-half (1/2) continuing education credit per wastewater certificate must be earned by a class II, III, and IV certified operator. Beginning July 1, 1992, ~~class~~ class V certified operators must attend a minimum of ~~two~~ four contact hours of seminar training per two-year period. A credit consists of ten (10) contact hours, and one-half credit consists of five (5) contact hours. A contact hour is defined as a sixty-minute participation in an approved classroom program or sixty-minute participation in an approved program not requiring classroom participation. On and after July 1, 1992, the credit requirements shall double for each classification except class V.

(2) through (7) Remain the same.

AUTH: 37-42-202, MCA; IMP: 37-42-202, MCA

RULE I DISCIPLINARY ACTIONS -- DESCRIPTION OF GROUNDS -- PROCEDURES FOR REVOCATION, PROBATION, SUSPENSION, OR REPRIMAND OF LICENSE (1)(a)-(b) Remain the same.

(c) The department shall deem an operator incompetent or unable to properly perform his duties when he repeatedly, and without explanation, fails to:

(i) Remains the same.

(ii) ~~repeatedly, and without adequate explanation, fails to~~ take the corrective action specified in an inspection report completed by the department for the water distribution system, water supply system, wastewater treatment plant, or water

treatment plant for which he is the certified operator in responsible charge.

(2) Remains the same.

AUTH: 37-42-202, MCA; IMP: 37-42-321, MCA

3. The department has thoroughly considered the comments received on the proposed rules. The following is a summary of the comments received from the public and the department's responses:

COMMENT -- 16.18.204(7) EXAMINATIONS:

In a written statement, the Montana Rural Water Systems Board of Directors disagreed with the deletion of the oral examinations saying that one meeting of the state board could be devoted to oral examinations. Harry Whalen, who attended the hearing as circuit rider for MRW, testified that oral examinations are needed for those who "just can't take tests."

RESPONSE:

Examination stress is relieved by the provisions that the examinations may be repeated whenever offered, that examinations are not timed, and that they may be reviewed in department offices.

COMMENT -- 16.18.205 EXPERIENCE/EDUCATION:

Montana Rural Water Board of Directors said the high school graduation or equivalent requirement restricts the ability of city councils to hire personnel who have incidental duties as an operator and would force Hutterite Colonies to request special exceptions. In addition, they expressed concern that special exceptions may not be granted uniformly.

RESPONSE:

In today's world even small communities must invest considerable money in water or wastewater systems. To operate such systems for protection of the public health, the environment, and large financial investments as well, operators must have basic reading comprehension, computing, and reporting skills normally gained by a high school education. The Department intends to develop uniform guidelines to ensure that special exceptions are granted where appropriate. Currently certified operators are not affected by this requirement.

COMMENT -- 16.18.207(1) and (3) FEES:

Daniel L. Hembd, certified operator for the National Park Service in Glacier National Park, believes that water and wastewater operators should not be forced to compensate for bureau shortages and that a fee increase from 122 to 1000 percent is very drastic.

RESPONSE:

Bureau shortages are not being made up by the water and wastewater operators. As required by law, the program budget is entirely self-supporting and fees must be set to cover the

program costs. The budget has been exceeded for the last four years. The shortages have been covered by a small reserve that is now depleted. The last fee increase was in 1983. Uniform application and renewal fees per certificate will now reflect uniform administration costs as is equitable. The calculated range of the fee increase is 11 to 200 percent, depending on classification.

COMMENT -- 16.18.208(1) CONTINUING EDUCATION REQUIREMENTS:

Montana Rural Water Board of Directors felt the Class V continuing education requirement should be increased to one-half day every two years so that when doubled on July 1, 1992, a full day's training would be required with one hour devoted to system requirements of extensive federal regulations. Montana Rural Water also feels the current CEC system set down (but not amended) in this rule should be simplified by eliminating decimals now used in CEC unit calculations.

Art Adamson, Class 1 operator from Devon, felt doubling the continuing education requirements after July 1, 1992, will be an expense of time and money for small rural systems which is not justified by the risk to public health nor applicability of continuing education readily available to the rural operator and system.

RESPONSE:

Class 5 operators are required for well water systems serving under 100 people. Typically these systems serve trailer courts and subdivisions skirting larger Montana communities. Typical operators of such systems are volunteers with full-time jobs in the community. The Department considers that expecting operators to take annual leave to attend a day-long seminar would be unenforceable. However, the Department feels a half-day continuing education requirement is desirable, and intends to offer evening seminars as an alternative time to encourage compliance. Thus, the rule is changed to require a minimum of four contact hours of seminar training per two-year period for Class V certified operators beginning July 1, 1992.

The Department feels Montana must continue following national guidelines for continuing education units (CEUs) which use 10 contact hours for 1 CEU and 5 contact hours for .5 CEUs in order to be comparable with the system and standards set down by the Association of Boards of Certification and most other states.

Mr. Adamson has a choice of seminars which will be enlarged through a broader array of offerings approved by the Department. The quality and quantity of seminars are being improved. The seminars will provide useful information on new state and federal regulations, as well as ongoing developments in relevant technology.

DENNIS IVERSON, Director

Certified to the Secretary of State July 15, 1991 .

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

In the matter of the amendment of rules 16.38.105, 16.38.111-112, 16.38.115 and 16.38.126 dealing with licensure and requirements for analysis of public water supplies	)))))	NOTICE OF AMENDMENT OF RULES

(Water Quality Bureau)

To: All Interested Persons

1. On May 16, 1991, the Board published notice at page 587 of the Montana Administrative Register, Issue No. 9, to consider the amendment of the above-captioned rules, which would incorporate changes in analytical methodology and reporting requirements for laboratories approved to analyze water samples for microbiological contaminants and also to allow the department to assess an annual fee to recover the costs of implementing the laboratory approval process.

2. The Board has amended the rules as proposed with no changes.

3. No comments were received.

DENNIS IVERSON, Director

Certified to the Secretary of State July 15, 1991.

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

In the matter of the amendment of rules 16.45.1219, 16.45.1220, 16.45.1230 and 16.45.1232 relating to inspection requirements for small farm and residential tanks	NOTICE OF AMENDMENT OF RULES

(Underground Storage Tanks)

To: All Interested Persons

1. On June 13, 1991, the Department published notice at page 900 of the Montana Administrative Register, Issue No. 11, to consider the adoption of the above-captioned rules which would provide less costly inspection fees for owners of small farm and residential underground storage tanks and home heating oil tanks. Application of the existing fee schedule would result in charges beyond what is necessary to provide adequate inspection of small tank closures and is contrary to the intent of the Legislature.

2. The department has amended the rules as proposed with no changes.

3. No comments were received.

DENNIS IVERSON, Director

Certified to the Secretary of State July 15, 1991 .

BEFORE THE DEPARTMENT OF JUSTICE
DIVISION OF FORENSIC SCIENCE
OF THE STATE OF MONTANA

In the matter of the amendment of Rules 23.4.201 and 23.4.209, the repeal of Rules 23.4.202 and 23.4.204 through 23.4.208 and adoption of new rules.	NOTICE OF THE AMENDMENT OF RULES 23.4.201 and 23.4.209, REPEAL OF RULES 23.4.202 and 23.4.204 through 23.4.208 AND ADOPTION OF NEW RULES, ALCOHOL ANALYSIS

TO: All Interested Persons.

1. On May 30, 1991, the department of justice published notice of a proposed amendment of rules, repeal of rules, and the adoption of new rules, all relating to alcohol analysis performed under Title 61, chapter 8, part 4, MCA, at page 785 of the 1991 Montana Administrative Register, issue number 10.

2. The agency has amended the rules with minor editorial changes but substantially as proposed, as follows:

23.4.201 DEFINITIONS

(1) remains the same.

(2) "Alcohol" means an organic hydrocarbon molecule which contains a hydroxyl (oxygen, hydrogen) as its primary functional group, such compounds to include such common alcohols as: ~~menthol~~ METHANOL, ethanol, isopropanol and all other compounds chemically classed as an alcohol.

(3) remains the same.

(4) "Alveolar air" means that air which is located in the alveoli region of the lungs and IS responsible for the exchange of gases between the blood and the lung. This is the type of breath upon which THE 2100:1 breath blood ratio is established.

(5) remains the same.

(6) "Authorized designee" means a breath test specialist/operator selected by the breath test specialist/senior operator to perform the ~~supervisor's~~ SENIOR OPERATOR'S duties in the event of the ~~supervisor's~~ SENIOR OPERATOR'S absence.

(7) through (23) remain the same.

(24) "Test", in reference to a breath analysis, means a full and complete analysis of a properly delivered breath sample. Such analysis is to be considered complete when the breath analysis instrument has executed its prescribed program, a final analysis is obtained and a report is generated. All breath analysis must be performed in accordance with the procedures set forth by the forensic science division. In reference to other biological sample analysis, a test shall be defined as a full and complete analysis of the received sample or samples. A test of the sample may consist of more than one analysis of the submitted sample or samples in accordance with the procedures set forth by the forensic science division.

~~(h)(24)~~(25) "Testing device" means any instrument or device used to determine the presence and/or concentration of alcohol ~~concentration~~ in blood, breath, urine or tissue pursuant to this subchapter.

~~(25)~~(26) "Vendor means any company or representative of a manufacturer responsible or involved in the sale and/or marketing of ~~breath test~~ breath analysis instrumentation, associated equipment, accessories, and/or supplies.

23.4.209 ~~BREATH TESTING~~ BREATH ANALYSIS INSTRUMENTS

(1) All models of ~~breath testing~~ breath analysis instruments used to administer testing according to section 61-8-402, MCA, must be approved by the division. The models operated by certified operators and/or ~~operator supervisors~~ senior operators prior to and on the effective date of this rule are deemed approved by the division.

The agency has repealed rules 23.4.202 and 23.4.204 through 23.4.208, designated new Rules I through X as Rules 23.4.212 through 23.4.221 and has adopted the new Rules as proposed with the following minor editorial change:

RULE VI RECERTIFICATION OF BREATH TEST PERSONNEL

(1) through (8) remain the same.

(9) A notice will be issued to all individuals successfully completing the ~~supervisor's~~ senior operator's recertification training. Such notification shall have the specialist's expiration date displayed. Certification expires the last day of the month, in the following year, in which the specialist was certified.

(10) through (13) remain the same.

3. At the public hearing, Sergeant Dick Lewis, Missoula Police Department, testified that the definitional rule (23.4.201) should include a definition of the word "test", as that word is used in section 61-8-402, MCA. The department agrees with this comment and has provided such a definition as shown in paragraph 2 above.

By: Judy Browning
JUDY BROWNING
Deputy Attorney General

Certified to the Secretary of State July 15, 1991.

BEFORE THE FIRE ~~MARSHAL~~ PREVENTION AND INVESTIGATION BUREAU
OF THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the adoption of Rules of the fire prevention and investigation bureau, pertaining to the regulation of fireworks.	))))	NOTICE OF THE ADOPTION OF ARM 23.7.201, 23.7.202 AND 23.7.203 (RULES V THROUGH VII).

TO: All Interested Persons:

1. On November 29, 1990, at page 2078 of issue number 22 of the 1990 Montana Administrative Register, the Department published notice of the proposed adoption of Rules I through XVI; amendment of ARM 23.7.121, 23.7.122, 23.7.124, 23.7.125, 23.7.131, 23.7.133, and 23.7.134, the amendment and transfer of ARM 23.2.111, 23.7.101, and the repeal of ARM 23.2.131 and 23.7.111.

2. On March 1, 1991, at page 291 of issue number 5 of the Montana Administrative Register, the Department published notice of a second public hearing on the proposed adoption of Rules V, VI, and VII, pertaining to the regulation of fireworks.

3. Two public hearings were held in Helena regarding the proposed rules. The first hearing was held on December 20, 1990, at which testimony was received. Numerous written comments were also received. In light of the written comments concerning the proposed rules on regulation of fireworks, a second public hearing was held April 11, 1991, at which further oral testimony was received. Comments and responses are addressed in paragraph 8 of this notice.

4. Based upon the comments received, rules are being adopted as proposed with those changes given below.

NEW RULE V (23.7.201) RETAIL FIREWORKS SALE (1) Anyone engaged in the retail sale of permissible fireworks, as defined in section 50-37-105, MCA, must obtain ~~any~~ permit if required by the applicable local jurisdiction. The provisions of this rule do not apply if a local ordinance has been adopted pursuant to section 7-33-4206, MCA, regulating or prohibiting the retail sale of fireworks.

(2) No person under the age of eighteen shall be employed to sell or offer for sale permissible fireworks, ~~or be allowed to accompany an employee for the purpose of selling or offering for sale permissible fireworks.~~

(3) No fireworks may be discharged within 100 feet of a fireworks retail sales location.

(4) No smoking shall be allowed within the fireworks stand. At any place where permissible fireworks are sold or displayed, a sign reading "NO SMOKING" must be posted in letters at least four inches in height and 1/2 inch in stroke where customers are most likely to read it.

(5) Except as provided in subsection (12) of this rule, retail sale of fireworks shall be conducted from stands

~~separated from gas stations, inhabited buildings, public ways, property lines, other fireworks stands, and hospitals or churches by the following distances:~~

~~Area of Stand (in sq. ft.)~~	~~Other Fireworks Stands~~	~~Inhabited Buildings~~	~~Public Ways~~	~~Property Lines~~	~~Flammable Liquid Tanks/Dispenser~~	~~Hospital or Church~~
~~300 or less~~	~~60~~	~~60~~	~~30~~	~~30~~	~~1500~~	~~300~~
~~301 to 600~~	~~95~~	~~95~~	~~60~~	~~60~~	~~1500~~	~~300~~
~~601 to 900~~	~~130~~	~~130~~	~~90~~	~~90~~	~~1500~~	~~300~~
~~Over 900~~	~~Prohibited~~					

located at least 300 feet from a church or hospital, 50 feet from any flammable liquid dispensing device or installation, 50 feet from other inhabited buildings, and 30 feet from any public roadway.

(6) Parking of vehicles used to transport Class A or B explosives or flammable and combustible liquids is prohibited within ~~1500~~ 100 feet of a retail fireworks stand.

(7) Stands ~~over 30 feet in length~~ shall be equipped inside with at least ~~two~~ one pressurized water extinguishers with a minimum rating of 2A or ~~two~~ one garden hoses. ~~Stands 30 feet or less in length shall be provided with at least one such extinguisher or hose.~~

(8) Any stand constructed to admit members of the public inside shall have a minimum of two unobstructed exits remotely located from each other.

(9) ~~All vegetation within a 50-foot radius of each exterior wall of a retail fireworks stand shall be cut to a maximum of two inches in height. The area within this radius shall be raked clean of any dead vegetation. Any trees within the radius shall be trimmed of dead branches and may be subject to removal if determined by the chief to pose a fire hazard.~~ All weeds, dry grass, and combustible material shall be cleared for a minimum distance of 25 feet in all directions from the stand.

(10) Electrical wiring shall be ~~installed in accordance with the most recent version~~ in a safe condition, and if found upon inspection to be unsafe shall be upgraded to comply with the applicable provisions of the National Electrical Code adopted by the building codes bureau of the department of commerce.

(11) Open flame devices of any kind are prohibited in retail fireworks stands~~.~~, and within 25 feet of the stand.

(12) Retail sale of fireworks from occupancies other than those authorized by this rule is prohibited~~.~~, except that fireworks may be sold out of an existing retail business establishment under the following conditions:

(a) The amount of fireworks on display in the customer service area contains an aggregate of no more than one pound of black powder; and

(b) Remaining quantities of fireworks are stored in a cabinet or room designed and constructed to restrict smoke travel that is separate from the customer service area, that has a self-closing door, and that conforms to one of the following:

(i) It is constructed of material sufficient to achieve a one-hour fire resistant-rated barrier between the storage area and the customer service area. The fireworks must be stored in cabinets made of wood or equivalent material that is at least one inch thick, and each cabinet must contain no more than an aggregate of 5 pounds of black powder;

(ii) It is protected by a fire suppression sprinkler system approved by the fire prevention and investigation bureau or by a fire marshal of the local jurisdiction; or

(iii) The fireworks are contained in a cabinet with casters and constructed of wood at least one inch thick that is covered on all sides with 5/8-inch sheetrock.

(13) All retail fireworks stands shall be subject to inspection by the chief in accordance with section 2.201 of the Uniform Fire Code. Violations shall be handled in accordance with section 50-61-115, MCA. If immediate action is necessary to safeguard life and property, the chief may issue an order to remedy in accordance with section ~~50-62-108~~ 50-62-102, MCA~~, and, if there is no compliance within 24 hours after service of the order, may take any action authorized by section 50-62-109, MCA~~.

AUTH: 50-3-102(3) MCA. IMP: 50-3-102(3) MCA.

NEW RULE VI (23.7.202) FIREWORKS REPACKAGING, STORAGE AND SHIPPING

(1) All buildings where fireworks are stored, opened for repacking, repackaged or prepared for shipping shall conform to the provisions ~~of NFPA pamphlet 1124 (1988 ed.) in addition to any other requirements~~ of the Building Code and the Uniform Fire Code. Where those codes are silent, NFPA pamphlet 1124 shall be applied. ~~or other applicable law.~~ NFPA pamphlet 1124 is incorporated by reference. Copies may be obtained from the Fire Prevention and Investigation Bureau, 303 North Roberts, Helena, Montana 59620.

~~(2) All buildings in which fireworks are opened for repacking, repackaged, or prepared for shipping are considered to be process buildings as defined by NFPA pamphlet 1124 (1998 ed.).~~

~~(3) Any conflict between NFPA pamphlet 1124 and the Building Code shall be resolved by application of the highest standard of safety.~~

AUTH: 50-3-102(3) MCA. IMP: 50-3-102(3) MCA.

NEW RULE VII (23.7.203) OUTDOOR DISPLAY OF FIREWORKS ~~(1) NFPA pamphlet 1123 (1990 ed.) is adopted as the standard for conducting supervised public displays of fireworks.~~

~~(2) The local jurisdiction shall be consulted for any permit requirements and on all other occasions where NFPA pamphlet 1123 refers to the "authority having jurisdiction."~~

(1) Unless prohibited by local ordinance, supervised public displays of fireworks shall be conducted in accordance with section 50-37-107 and applicable local ordinances. Where no local ordinance is in effect, the governing body of the city,

town, or county shall be notified at least 15 days in advance of any outdoor display.

AUTH: 50-3-102(3), 50-37-107, 50-37-108 MCA.
IMP: 50-3-102(3), 50-37-107 MCA.

5. There were no comments on these proposed rules at the December 20, 1990, hearing. However, in view of the extensive written comments received on proposed Rules V, VI, and VII, regarding fireworks, an additional hearing was held April 11, 1991, on those rules, at which time the following comments were received, response to which is set out following summary of all comments on Rules V, VI, and VII:

COMMENT: Steve Brown, an attorney representing R & S Marketing, voiced concern for a need to eliminate ambiguities in rules, and to eliminate exercise of broad discretion by local officials. In particular, he was concerned with the following: Rule V(2) - no one under 18 can sell fireworks, but the proposed rule goes beyond statutory requirements, "accompany" is too broad; Rule V(5) - distances are unreasonable, would like to know what authority there is for separation from "inhabited buildings," no factual basis for the 1500 foot separation requirement; Rule V(6) - prohibition against parking vehicles, who will enforce this and who will get the citation if there is a violation?; Rule V(9) - clearing of vegetation, not clear what is required, inconsistency between 50-foot vegetation requirement and 30-foot property line requirement; Rule V(10) - electrical requirements are too broad, need clarification, minimum requirements are fine, but referencing entire Electrical Code is unreasonable; Rule VI - "process" building is too restrictive for this type of facility, suggests grandfather clause for existing buildings.

COMMENT: Dennis Schweitzer, R & S Marketing, indicated his primary concern is with the 1500-foot setback requirement in Rule V, no similar requirement is imposed in other states. He suggested limiting the setback requirement to 100 feet or eliminating it altogether. He also expressed concern with the definition of "process" buildings in Rule VI, and suggested that it should be limited to manufacturing buildings only.

COMMENT: Mike Brown, Class C fireworks importer/wholesaler, expressed concern with Rule VI, asserting that adoption of NFPA requirements here would put him out of business. The rule is too restrictive, his facility would be a "process" building under this rule; also concerned about the 1500-foot setback requirement.

COMMENT: Judy Cline, stand operator from Great Falls, was concerned with the 1500-foot setback and with the vegetation requirements.

COMMENT: John Peterson, Fox Marketing, Missoula, expressed concern with electrical requirements, would be costly to require compliance with most recent edition of national code; also concerned that these new rules would affect property owners who lease ground for stands, requirements are too stringent.

COMMENT: Michael Thomas, stand operator from Helena, was concerned with setback requirements, including distance from road; suggests regional hearings throughout state.

COMMENT: Debbie Clevidence, Missoula, questioned Rule V(2) regarding children "accompanying" adults in stand, also challenged 1500-foot setback. Local zoning ordinances will make it impossible to find a place to locate.

COMMENT: Roger Baker, Butte Kiwanis, was concerned primarily with setback requirements, children accompanying parents in stand, and vegetation requirements. Contracts with Safeway to sell in parking lots would no longer be feasible. Rules have too many ambiguities.

COMMENT: Anna Marie Clouse, Missoula Pink Grizzly Fireworks, was concerned with 1500-foot setback and suggested that each local area should have its own regulations.

COMMENT: Brook Lincoln, Mineral County, was concerned with setback requirements, particularly harsh in small rural areas where everything is in one place. He also questioned whether the bureau could enforce rules on reservations.

COMMENT: Rich Vaughn, Spokane, Washington, questioned whether or not state is adopting NFPA pamphlet 1123 in Rule VII, concerned with distance requirements and with setback requirements in Rule V.

COMMENT: John Thompson suggested that the rules must be clarified, concerned with lack of ability to enforce on reservations, suggests regional hearings throughout state.

WRITTEN COMMENTS TO FIREWORKS RULES (Rules V, VI, and VII): The following persons submitted comments that expressed particular concern with the setback requirements: Steve Brown, George Mahoney, Rick Henningson (also concerned with electrical requirements), Todd Reichenbach, Marlene M. Taylor, Randy and Sue Boyson, Dianne Kay, Ralph and Darlene Robinson, Victor Reichenbach, Cindy Turner, Mike and Kaylee Nussbaum, Randy R. Riley, Bobbie Kay Beach, Jan Schweitzer (also concerned with requirement of separated stand), Mike Rich, Stan and Debra Clevidence, James, Kathy and Heather Hutchison, Stephen C. Stanley, Tom Huffman, David B. Wright, Mike Brown (also concerned with electrical wiring requirements and lack of enforceability on Indian reservations), Roger Baker (also concerned with requirement that fireworks be sold only from

stands, and concerned with electrical requirements), Dan Oakland, Marlene M. Taylor and Larry Morley.

Comments were received from the following individuals expressing general concern with the restrictiveness of the rules: Joan Huie, Regina B. Hendrickson, Ron Hrubes, Amelia Heidema, Mrs. G. W. Mullaney, Charles Farina (request for hearing from citizens), Doug Plauffe, Kathy Huttinga, Les Green, Sheila Arensmeyer, Anna Marie Clouse and Ferris E. Clouse, Dave Brandon, Robert Crandall, John E. Adams, Linda J. Gardner, Tom Huffman, Regina Hendrickson.

Comments received regarding the potential restrictiveness of Rule VI were sent by Marlene M. Taylor, Dianne Kay, Steve Brown, Mike Brown, Larry E. McCann, and Gary Reid.

Finally, these individuals expressed concern with Rule VII, indicating that the separation distances required by NFPA 1123 are too restrictive: Todd Reichenbach, Dianne Kay, Victor Reichenbach, Steve Brown, Fred Smart, and Gary Reid.

Many opponents also expressed concern about lack of notice of the rules and of the hearing prior to January 1991.

RESPONSE: In response to the extensive written comments, a second hearing was held on April 11, 1991, and notice was sent to all who had submitted written comments. Additionally, comments asked that the new rules not go into effect for the 1991 fireworks season. Many changes have been made in Rules V, VI, and VII, as a result of comments received. Rule V now specifically provides that this rule does not apply if a local ordinance has been adopted. The requirement that a child may not accompany an adult has been removed. Setback requirements have been dramatically changed in response to the comments; rules and ordinances of other states also were consulted in determining the new setback requirements. Subsection (6) has been modified to prohibit parking of vehicles transporting explosives or flammable liquids within 100 feet of the stand. Compliance with this section is the responsibility of the vehicle operator, but the posting of a sign in the fireworks stand is recommended. Subsection (9) of Rule V, regarding clearing of vegetation, was modified and clarified to address the comment that it was too broad. Subsection (10) was modified to meet concern that it was too restrictive. Its requirements are now similar to those applied by the building codes bureau of the department of commerce: so long as the wiring is in a safe condition, technical compliance with electrical codes will be unnecessary. However, if the wiring is unsafe, it must be upgraded to standard. In response to the concern expressed about selling fireworks from existing retail businesses, the rule has been adapted to allow limited sale from an existing business. Chapter 9 of the Uniform Building Code requires that any building storing, handling, using or selling any quantity of black powder in excess of one pound must meet the requirements

for a Group H occupancy; therefore, the rule has been amended to reflect the one-pound maximum, but allows storage in excess thereof if certain precautionary measures are taken. This is similar to the requirements for storage of smokeless powder contained in section 50-61-121, MCA. Rules VI and VII also have been modified as a result of the comments received.

6. As required by 50-3-103, MCA, these rules have been approved by the Department of Commerce.

Marc Racicot
Attorney General

Certified to the Secretary of State 7-12-91.

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

In the matter of the amendment of Rules 46.12.545 and 46.12.547 pertaining to occupational therapy	)))	NOTICE OF THE AMENDMENT OF RULES 46.12.545 AND 46.12.547 PERTAINING TO OCCUPATIONAL THERAPY

TO: All Interested Persons

1. On May 16, 1991, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.545 and 46.12.547 pertaining to occupational therapy at page 658 of the 1991 Montana Administrative Register, issue number 9.

2. The Department has amended Rule 46.12.545 as proposed.

3. The Department has amended Rule 46.12.547 as proposed with the following changes:

46.12.547 OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT
Subsections (1) through (2)(c) remain as proposed.
(43) Occupational therapy fee schedule:

EVALUATION AND INSTRUCTION

H5240	Occupational therapy evaluation Each 15 minute unit (maximum 4 units PER VISIT).....	~~8.32~~ 8.66
Z9210	Home instruction including design of maintenance plans Each 15 minute unit (maximum 4 units PER VISIT).....	~~8.32~~ 8.66

ACTIVITIES OF DAILY LIVING (ADL)

(Physical & Psychological)

Z9217	Each 15 minute unit.....	~~7.50~~ 7.80

~~MODALITIES~~

~~Modality is the employment, or method of employment, of a therapeutic agent (used in conjunction with occupational therapy procedures)~~

~~H5300 Modalities, initial 15 minutes .... 13.31~~
~~Z9216 Each additional 15 minutes ..... 3.00~~

~~MEDICARE CROSSOVER CLAIMS~~
~~(Billing procedure codes to be used when medicare payments are also available)~~

REHABILITATIVE SERVICES

H5300	Occupational Therapy 1 unit equals 15 ~~30 minutes or 2 medicaid units~~	~~13.31~~	13.85
H5300-52	Occupational therapy additional 15 minute unit(s)	~~3.00~~	3.17

TRAINING PROCEDURES

All Procedures

Each 15 minute unit	~~7.50~~	7.80

Z9211	Prosthetic training (upper extremity only)
Z9212	Orthotics training (upper extremity dynamic bracing, splinting)

Neuromuscular Procedures

Z9218	Reflex integration
Z9219	Range of motion
Z9220	Gross and fine coordination
Z9221	Strength and endurance

Cognitive Integration Procedures

Z9213	Orientation to environment
Z9214	Conceptionalization/comprehension
Z9215	Cognitive integration

Sensory Integration Procedures

Z9222	Sensory awareness
Z9223	Visual spatial awareness
Z9224	Body integration

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: What will be the effect of the rule on hospitals and home health agencies? Will services performed by these groups

be subject to the language in the Occupational Therapy Practices Act?

RESPONSE: Occupational therapists who perform services through a hospital or home health agency are subject to the same legal restrictions, including those provided in sections 37-24-101 et seq., MCA, and those professional standards of practice required of private practitioners.

COMMENT: Will occupational therapists be subject to the unit of service limit, as physical therapists are limited?

RESPONSE: Limits are set on specific procedure codes for both physical and occupational therapy which limit the number of units of service which can be performed during a specific visit. These limits are noted in the rule notice and will appear in the administrative rule. To avoid confusion the words "per visit" have been added to be consistent with physical therapy.

COMMENT: Will the program establish specific codes and reimbursement rates for the therapy agents which have been authorized for use?

RESPONSE: Separate procedure codes will not be established for the treatment agents. The treatment agent will be considered to be part of the procedure billed by the therapist.

COMMENT: The program has changed the codes used for modalities to codes for Medicare services. The services covered for these codes need to be defined.

RESPONSE: The Department's intent is to cover services defined in state law. Medicare describes occupational therapy to include the types of activities necessary to restore function. Medicare's list of activities parallel the language in state law and include items such as evaluation and treatment, teaching of task oriented activities, activities to restore sensory integrated function, and the teaching of compensatory techniques.

All services billed under this code must be within the scope of practice as defined by state law. The Department reserves the right to review any claim to determine whether it was medically necessary and within the scope of practice.

The Department has chosen to retain the code H5300 in an attempt to facilitate payment to the occupational therapists by Medicaid after Medicare has either paid or rejected a claim. This procedure is referred to as a crossover claim

where the claim is transferred, or crossed over, from the Medicare program to the Medicaid program for payment.

COMMENT: The occupational therapists commented that code H5300 should not be limited to Medicare crossovers. They also questioned the unit measurement which would be one unit in the Medicare system and two units in the Medicaid system. The unit problem will cause difficulty when the claim is processed by Medicaid.

RESPONSE: The Department will remove the reference to the medicare crossover that is associated with procedure code H5300. The code will remain in the system so that it can be used for Medicare crossover claims. The Department has chosen to retain this code because it is a national code and it can be used for both Medicare and Medicaid claims. The H5300 series is now entitled "Rehabilitative Services."

COMMENT: The rules appear to lower the number of services and the amount of reimbursement. In addition, it was indicated that even if code H5300 is treated as two units by Medicaid or $26.61 it will still be less than the $30.00 allowed by Medicare.

RESPONSE: The intent of the rule proposal is to modify the definition of occupational therapy so that it is in conformity with state law. It is not our intent to limit the number of services beyond the current limits nor to change the amount of reimbursement. The previous rule allowed a 4% general increase effective July 1, 1990. These rules incorporate that 4% increase into each reporting code. The proposed rule, however, failed to take into account the previously allowed 4% increase for rehabilitative services. That has been corrected in this second notice.

COMMENT: Do occupational therapy services include the use of superficial heat and cold, including hot packs, cold packs, ice, paraffin, and water? Are these specific services limited to application to the elbow, forearm and hand?

RESPONSE: Yes, these services may be provided to Medicaid recipients by occupational therapists but only to the elbow, forearm and hand.

COMMENT: SRS must expressly enumerate in this rule the specific OT treatment and services that constitute occupational therapy and appropriate coding. This list must be consistent with Senate Bill 54 passed by the 52nd Montana Legislature.

RESPONSE: Section 2-4-305, MCA specifically prohibits state agencies from unnecessarily repeating statutory language. Therefore, the Department did not repeat those treatments and services stated in SB 54. The proposed rule authorizes those services as provided in 37-24-103, MCA. It is more appropriate for the Board of Occupational Therapy to further define what is permitted according to Montana law. Coding for these services are enumerated under general categories in the proposed rule and have been modified in this adopted rule to follow generally accepted national coding practices. More specific enumeration is not required by law for purposes of Medicaid reimbursement.

COMMENT: Since the OT Board has not yet approved therapeutic devices, they cannot be reimbursed under the Medicaid program. A later SRS hearing will be required after the OT Board approves therapeutic devices.

RESPONSE: In order to avoid unnecessary and repetitious hearings, the Department has simply chosen to provide reimbursement for those services that are expressed in 36-24-103, MCA. The statute, as amended by SB 54 requires the OT Board to approve the use of therapeutic devices other than those specifically listed. Therefore, the Department agrees that occupational therapists cannot provide or be reimbursed for those services requiring prior Board approval. It is not required, however, that the Medicaid reimbursement rule be more specific on this issue.

COMMENT: A sunset or termination provision must be added to the rule so that it is consistent with SB 54.

RESPONSE: The Department, by referencing the applicable statute defining "occupational therapy", does not need to make further changes if the statute is amended or certain provisions within that statute sunset as the result of SB 54. It is automatically accomplished by process of law. This will once again avoid time consuming and costly hearings which are an expense for all parties as well as the Department.

Julia E. Hansen

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 11, 1991.

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

In the matter of the adoption of Rules I through XXI pertaining to targeted case management	))))	NOTICE OF THE ADOPTION OF RULES I THROUGH XXI PERTAINING TO TARGETED CASE MANAGEMENT

TO: All Interested Persons

1. On May 30, 1991, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rules I through XXI pertaining to targeted case management at page 797 of the 1991 Montana Administrative Register, issue number 10.

2. The Department has adopted [RULE VI] 46.12.1917, CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, COVERAGE; [RULE XVIII] 46.12.1937, CASE MANAGEMENT FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, COVERAGE; and [RULE XIX] 46.12.1938, CASE MANAGEMENT FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, GEOGRAPHICAL COVERAGE as proposed.

3. The Department has adopted the following Rules as proposed with the following changes:

[RULE I] 46.12.1901 CASE MANAGEMENT SERVICES, GENERAL PROVISIONS ~~(1) Case management includes activities which assist clients in the designated populations to:~~

~~(a) identify their needs; and~~

~~(b) manage and gain access to necessary medical, social, educational and other services through assessment, case plan development, and ongoing monitoring and service coordination.~~

(~~2~~1) Case management services are available to persons who are determined by the department or its designees in accordance with ~~{~~these ~~R~~Rules~~}~~ to be within the covered groups set forth in ARM 46.12.1902.

Original subsections (3) and (4) remain as proposed in text but will be renumbered as subsections (2) and (3).

(~~5~~4) Case management services must be delivered by a case manager whose primary responsibility is the delivery of case management services to one or more of the populations identified in ARM 46.12.1902. EXCEPTIONS TO THIS REQUIREMENT MAY BE APPROVED BY THE DEPARTMENT OR ITS DESIGNEE.

(~~6~~5) Referral and arrangements for treatment of a client are a case management service, but the direct provision of medical ~~and other~~ services to the client is not part of the case management service.

(~~7~~6) Except as otherwise provided for in ~~{~~these ~~R~~Rules~~}~~, a client may select a case management service provider and OTHER ~~the~~ SERVICE providers ~~of the care~~ WHOSE SERVICES ARE received with the assistance of case management.

(7) A CASE MANAGEMENT PLAN MUST BE DEVELOPED JOINTLY BY THE CASE MANAGER AND THE CLIENT.

(a) THE PLAN SHOULD BE SIGNED BY THE CLIENT. IF THE CLIENT DOES NOT SIGN THE PLAN, THE REASON FOR THE LACK OF SIGNATURE SHOULD BE DOCUMENTED.

(b) A CLIENT'S REFUSAL TO SIGN THE PLAN WILL NOT RESULT IN A DENIAL OF CASE MANAGEMENT SERVICES.

~~(8) The case manager must document the name of the client, verification of the client's eligibility for medicaid and for case management services, the date of service, the services provided, the name of the persons or agencies providing services, and the location of the service.~~

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE II] 46.12.1902 CASE MANAGEMENT SERVICES, GENERAL ELIGIBILITY Subsections (1) and (1)(a) remain as proposed.

(b) ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS; and

Subsection (1)(c) remains as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE III] 46.12.1903 CASE MANAGEMENT SERVICES, GENERAL DEFINITIONS (1) "Case management" means the process of planning and coordinating care and services to meet individual needs OF A CLIENT and to ~~facilitate access to~~ ASSIST THE CLIENT IN OBTAINING necessary medical, social, nutritional, educational and other services. CASE MANAGEMENT INCLUDES ASSESSMENT, CASE PLAN DEVELOPMENT, MONITORING AND SERVICE COORDINATION.

(2) "Case management provider" or "provider" means an entity that as provided for in ~~(~~these ~~R~~Rules~~)~~ may provide case management services to clients.

Subsections (3) through (4) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE IV] 46.12.1915 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, ELIGIBILITY Subsections (1) through (2)(a) remain as proposed.

(b) HAS MEDICAL FACTORS WHICH INDICATE THE POTENTIAL FOR A POOR PREGNANCY OUTCOME;

(~~b~~c) OR someone in the person's immediate environment ~~uses~~ ABUSES alcohol or drugs;

(d) IS CURRENTLY IN AN ABUSIVE RELATIONSHIP;

Original subsections (2)(c) and (2)(d) remain as proposed but will be renumbered as subsections (2)(e) and (2)(f).

(i) has ~~been~~ A HISTORY OF physical~~ly~~ or sexual~~ly~~ abuse~~d~~;

(ii) has no support system or involvement of a spouse or other supporting person;

~~(iii) has medical factors which indicate the potential for a poor pregnancy outcome;~~

(~~iv~~iii) has two or more children under age five;

(~~v~~iv) is not educated beyond the ~~eighth~~ TWELFTH grade level;

Original subsections (2)(d)(vi) through (2)(d)(x) remain as proposed but will be renumbered as subsections (2)(f)(v) through (2)(f)(ix).

Subsections (3) through (4)(b) remain as proposed.

(c) the newborn ~~remains eligible for~~ RECEIVES medicaid.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE V] 46.12.1916 CASE MANAGEMENT FOR HIGH RISK PREGNANT WOMEN, DEFINITIONS (1) "Assessment" means an evaluation to identify a client's physical, medical, nutritional, ~~environmental,~~ psychosocial, developmental, AND educational~~, behavioral, emotional and mobility~~ status to determine if the person meets the "high risk" criteria. This is an ongoing process updated at each contact.

Subsections (2) and (3) remain as proposed.

~~(4) "Low birth weight prevention project" means a facility operated by the Montana department of health and environmental sciences perinatal program that provides low birth weight prevention services.~~

Original subsection (5) remains the same in text but will be renumbered as subsection (4).

(6~~5~~) "Presumptive eligibility" means, as provided at ARM 46.12.3401, the ~~temporary~~ process of determining ~~medicaid~~ eligibility FOR PREGNANT WOMEN TO RECEIVE ~~and providing limited~~ ambulatory prenatal care SERVICES UNDER THE MEDICAID PRESUMPTIVE ELIGIBILITY PROGRAM.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE VII] 46.12.1918 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, PROVIDER REQUIREMENTS Subsections (1) through (2)(a) remain as proposed.

~~(b) be under contract with the Montana department of health and environmental sciences to provide low birthweight prevention services for the Montana perinatal program;~~

(e~~b~~) meet the requirements in subsections (3) through (7);

(~~d~~c) have experience in the delivery of HOME AND COMMUNITY services to high risk pregnant women;

Original subsections (2)(e) and (2)(f) remain the same in text but will be renumbered as subsections (2)(d) and (2)(e).

Subsections (3) through (3)(a)(B)(ii) remain as proposed.

(iii) nutrition SERVICES must be provided by a registered dietitian who is licensed as a nutritionist in Montana and has ~~two~~ ONE years experience in public health and/or maternal-child health.

(b) To accommodate special agency and geographic needs and circumstances, exceptions to the staffing requirements may be allowed if approved by the department ~~of health and environmental sciences~~.

Subsection (4) remains as proposed.

(5) Where services are provided through a subcontractor, the subcontract must be submitted to the department OR DESIGNEE for review and approval.

Subsection (6) remains as proposed.

(a) conduct activities to inform the target population, AND health care and social service providers in the geographic area to be served of its prenatal care coordination services;

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

(f) ~~educate~~ INFORM clients regarding whom and when to call for pregnancy emergencies;

Subsections (6)(g) through (7)(b)(ii) remain as proposed.

(iii) ~~educate~~ INFORM a client regarding health conditions and implications of risk factors;

Subsections (7)(b)(iv) through (7)(b)(vii) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE VIII] 46.12.1919 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, FINANCIAL RECORDS AND REPORTING

(1) A case management provider FOR HIGH RISK PREGNANT WOMEN must maintain adequate financial and statistical records, in the form and containing the information required by the department, to allow the department and its agents to determine payment for services provided to medicaid recipients and to provide a record that is auditable through the application of generally accepted audit procedures.

(2) Financial data must be maintained on an accrual basis. The provider must file a cost report for each of the provider's fiscal years.

(3) Financial records must be maintained for a period of three years after a cost report is filed with respect to the period covered by the records or until the cost report is finally settled, whichever is later.

Original subsections (2) through (6) remain as proposed but will be renumbered as subsections (4) through (8).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE IX] 46.12.1920 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, REIMBURSEMENT (1) A provider of case management services for high risk pregnant women will be reimbursed ~~for the allowable costs, determined~~, in accordance with subsection (3), FOR THE ALLOWABLE COSTS of providing case management services to eligible medicaid recipients.

Subsections (1)(a) through (4) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE X] 46.12.1925 CASE MANAGEMENT SERVICES FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, ELIGIBILITY (1) A person is eligible for case management as ~~a chronically mentally ill person~~ AN ADULT WITH SEVERE AND DISABLING MENTAL ILLNESS if the person:

Subsections (1)(a) through (3)(c) remain as proposed.

(d) BECAUSE OF MENTAL ILLNESS maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XI] 46.12.1926 CASE MANAGEMENT SERVICES FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, DEFINITIONS (1) "Assessment" means an integrated examination of the client's strengths, status, aspirations, needs and goals in the life domains of ~~residential~~ RESIDENCE, health, vocation, education, community participation, leisure time and economics.

Subsection (2) remains as proposed.

(3) "Case planning" means the development of a written individualized case management plan by the case manager and the client. ~~The plan must be signed by the client and the case manager.~~

(4) "Care coordination, referral, and advocacy" means ~~the~~ providing access to and mobilizing resources to meet the needs of a client. This may include but is not limited to:

(a) advocating on behalf of a client with a local human services system, THE social security system, THE disability determination unit, judges, etc.;

(b) making APPROPRIATE referrals, INCLUDING TO ADVOCACY ORGANIZATIONS AND SERVICE PROVIDERS, and insuring that needed services are provided; and

(c) ~~intervention~~ INTERVENING on behalf of a client who otherwise could not negotiate or access complex systems without assistance and support.

(5) "Crisis intervention and stabilization" means immediate action ~~taken for a specific client or other persons in relation to a specific client~~ BY A CASE MANAGER FOR THE PURPOSE OF SUPPORTING OR ASSISTING A CLIENT OR OTHER PERSON IN RESPONSE TO A CLIENT'S MENTAL HEALTH CRISIS. CRISIS ~~Inter-~~

vention AND STABILIZATION SHOULD BE CONSISTENT WITH THE CONCEPT OF LEAST RESTRICTIVE ALTERNATIVE. CRISIS INTERVENTION AND STABILIZATION may include contacts with a client's family members IF NECESSARY AND APPROPRIATE.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XII] 46.12.1927 CASE MANAGEMENT SERVICES ~~TO~~ FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, COVERAGE (1) Reimbursable case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS are:

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

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XIII] 46.12.1928 CASE MANAGEMENT SERVICES FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, GEOGRAPHICAL COVERAGE (1) Case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS are available only in the following counties of the community health regions designated by the Montana department of ~~institutions~~ CORRECTIONS AND HUMAN SERVICES:

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

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XIV] 46.12.1929 CASE MANAGEMENT FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, PROVIDER REQUIREMENTS Subsection (1) remains as proposed.

(2) Case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS must be provided by a licensed mental health center as specified in ARM 46.12.571 that is contracting with the Montana department of ~~institutions~~ CORRECTIONS AND HUMAN SERVICES to provide mental health services~~.~~ OR IN CASES WHERE A MENTAL HEALTH CENTER IS UNWILLING OR UNABLE TO PROVIDE THE REQUIRED CASE MANAGEMENT SERVICES, THE SERVICES MAY BE PROVIDED BY A PROVIDER DESIGNATED BY AND UNDER CONTRACT WITH THE DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES.

Subsection (3) remains as proposed.

(a) BE DEVELOPED JOINTLY BY THE CASE MANAGER AND THE CLIENT.

Original subsections (3)(a) through (3)(d) remain as proposed in text but will be renumbered as subsections (3)(b) through (3)(e).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XV] 46.12.1930 CASE MANAGEMENT SERVICES FOR ~~CHRONICALLY MENTALLY ILL~~ ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS, REIMBURSEMENT (1) Case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS are reimbursed based on a cost per service unit. A service unit is a fifteen minute increment.

(2) The department will pay the lower of the following for case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS:

Subsections (2)(a) and (2)(b) remain as proposed.

(3) The fee schedule for case management services for ~~chronically mentally ill~~ adults WITH SEVERE AND DISABLING MENTAL ILLNESS is the following:

(a) FOR INDIVIDUAL CASE MANAGEMENT SERVICES:

~~E~~Each 15 minute unit.....~~8.74~~ 9.54

(b) FOR GROUP CASE MANAGEMENT SERVICES:

EACH 15 MINUTE UNIT.....3.18

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XVI] 46.12.1935 CASE MANAGEMENT SERVICES FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, DEFINITIONS Subsections (1) through (3) remain as proposed.

(4) "Level III case management service" means ~~the placement of~~ ASSISTING a client IN ENTRY into the services identified in Levels I and II.

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

(10) "Individual service plan (ISP)" means a written plan DEVELOPED WITH THE CLIENT'S PARTICIPATION FOR THE PROVISION AND MANAGEMENT OF SERVICES IN THE LEAST RESTRICTIVE MANNER TO RECIPIENTS. THE PLAN MUST ~~which~~ contains:

Subsections (10)(a) through (10)(f) remain as proposed

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XVII] 46.12.1936 CASE MANAGEMENT FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES, ELIGIBILITY Subsections (1) through (2) remain as proposed.

(a) a person residing in an intermediate care facility for the mentally retarded (ICF/MR)~~,~~ OR IN A MEDICAID CERTIFIED NURSING FACILITY EXCEPT AS PROVIDED FOR IN SUBSECTION (3); AND

~~(b) an otherwise qualified person residing in a medicaid certified nursing facility or intermediate care facility for~~

~~the developmentally disabled, except as provided for in subsection (3); and~~

(~~a~~b) a person receiving case management services under a home and community-based waiver program authorized under Section 1915 (c) of the Social Security Act.

(3) ~~An otherwise qualified~~ A person residing in a medicaid certified nursing facility or intermediate care facility for the mentally retarded may receive case management services during the 30-day period immediately preceding the scheduled discharge from a nursing facility in order to coordinate post-discharge services in a non-institutional setting.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XX] 46.12.1939 CASE MANAGEMENT FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, PROVIDER REQUIREMENTS Subsections (1) through (8) remain as proposed.

(9) A CASE MANAGEMENT PROVIDER MUST:

(a) HAVE A SYSTEM FOR HANDLING CLIENT GRIEVANCES; AND

(b) PROTECT THE CONFIDENTIALITY OF CLIENT RECORDS.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

[RULE XXI] 46.12.1940 CASE MANAGEMENT FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, REIMBURSEMENT Subsection (1) remains as proposed.

(2) During fiscal years 1992 and 1993, the reimbursement rate per unit of service will be determined by dividing the estimated total costs on a statewide basis for the delivery of case management services during the fiscal year by the estimated total number of ~~clients~~ UNITS OF SERVICE to be ~~served~~ DELIVERED on a statewide basis during that fiscal year.

(3) For fiscal years subsequent to fiscal year 1993, the reimbursement rate will be based upon actual case management data from the previous year. The reimbursement rate per unit of service will be determined by dividing the total costs on a statewide basis for the delivery of case management services during the prior fiscal year by the total number of ~~clients provided~~ UNITS OF SERVICE PROVIDED on a statewide basis during that year.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: Case managers should be graduate social workers.

RESPONSE: While graduate social workers are qualified to perform the role of case manager, there are other persons who

by virtue of other combinations of training and experience are also qualified. Standards will be kept at a high level by encouraging the hiring of qualified persons and by providing pre-service and in-service training.

COMMENT: The qualifications for case management providers are not provided in the proposed rules.

RESPONSE: 46.12.1918, 1929, 1939 and 46.12.571 contain specific language regarding the qualifications of providers.

COMMENT: The language in 46.12.1901(6) could be interpreted to mean that the case manager assists the client in selecting a case manager.

RESPONSE: The language has been modified.

COMMENT: 46.12.1901(1) appears to be duplicative of the definition of case management provided in 46.12.1903(1) though it differs in its language.

RESPONSE: The Department agrees. 46.12.1901(1) has been deleted and the definition in 46.12.1903(1) modified.

COMMENT: The documentation requirements set forth in 46.12.1901(8) need not be in rule.

RESPONSE: The Department agrees. 46.12.1901(8) has been deleted.

COMMENT: In some areas of the state case management services may not be available from a person whose primary responsibility is the delivery of case management services.

RESPONSE: The Department agrees. 46.12.1901(4) has been modified to allow for approved exceptions to the requirement.

COMMENT: Case management for high risk pregnant women should include infants for one year because a high risk pregnant woman might deliver a high risk infant.

RESPONSE: The Department agrees and has changed 46.12.1915 to provide that infants receive case management services through the month of the first birthday.

COMMENT: What do the terms "rural" and "urban" used in the fee schedule for reimbursement of case management services for high risk pregnant women mean.

RESPONSE: Reimbursement based on "urban" and "rural" distinctions was not provided in the rules as proposed.

COMMENT: The definition for high risk pregnancy should be changed to incorporate persons with severe and disabling mental illness.

RESPONSE: The Department has added medical factors as a condition that defines high risk in 46.12.1915(2).

COMMENT: Women who are in an abusive relationship or have medical factors that indicate the potential for a poor pregnancy outcome should as such without consideration of other factors qualify for case management for high risk pregnant women.

RESPONSE: The Department agrees. 46.12.1915 has been modified to provide for such eligibility.

COMMENT: Under the federal authority for the targeted case management program, the state may not designate a single entity for the case management of high risk pregnant women.

RESPONSE: The Department agrees. 46.12.1916 and 46.12.1918 have been modified to remove the low birth weight program as the designated case manager.

COMMENT: The definition of presumptive eligibility in 46.12.1916(5) needs clarification.

RESPONSE: The definition in 46.12.1916(5) has been revised.

COMMENT: The two year experience requirement in 46.12.1918 (3)(B)(iii) for registered nutritionists delivering services to high risk pregnant women should be one year.

RESPONSE: The requirement has been modified as suggested.

COMMENT: Federal authority would not allow the use of targeted case management services for education purposes. The word educate in certain provider requirements in 46.12.1918 is inappropriate.

RESPONSE: The word educate will not be used.

COMMENT: Eligibility should be expanded to include children with mental illness.

RESPONSE: The need for case management for severely emotionally disturbed children and adolescents is recognized and may be developed through the Department of Family Services in the near future.

COMMENT: "Chronically mentally ill adults" should be identified as "adults with severe and disabling mental illness."

RESPONSE: The Department has accepted this recommendation and has revised the rules.

COMMENT: Effective July 1, 1991, the Department of Institutions will be called the Department of Corrections and Human Services.

RESPONSE: The rules have been revised to reflect the Department's new name.

COMMENT: The definition of "crisis intervention and stabilization" for adults with severe and disabling mental illness in 46.12.1926(5) should be clarified.

RESPONSE: The Department agrees and has changed the rule.

COMMENT: The definition of "severe mental illness" in 46.12.1925 requires prior hospitalization for a minimum of 30 days and could eliminate people who received service in other settings.

RESPONSE: 46.12.1925(a), (b) and (c) are a series any one of which can constitute severe mental illness. Consequently, the rule does not limit eligibility to persons with prior hospitalization.

COMMENT: The processes for determining eligibility and appealing eligibility determination for persons with severe and disabling mental illness should be described.

RESPONSE: Eligibility is provided for in 46.12.1925. The appeal process is that provided in ARM 46.12.201 et seq.

COMMENT: 46.12.1926(3) should be clarified to state clearly that services will not be denied if client does not sign the plan.

RESPONSE: The Department agrees and has added the language as subsection (7) of 46.12.1901.

COMMENT: The definition of "care coordination referral and advocacy" in 46.12.1926(4) should specifically include making referral to advocacy organization.

RESPONSE: All appropriate referrals will be made. The rule has been changed to include mention of advocacy organizations.

COMMENT: The definition of "crisis intervention and stabilization" in 46.12.1926(5) should include contacts with family members only when such contacts are necessary and should specify that action taken be the least restricted alternative. The rule has been revised accordingly.

RESPONSE: The Department agrees in principle that crisis intervention and stabilization should be focused on the client and should include the family only when necessary. The Department also agrees that action taken by the case should be consistent with the concept of least restrictive alternative.

COMMENT: The geographical coverage provided in 46.12.1928 should be expanded to statewide coverage.

RESPONSE: Due to the limited amount of state matching funds, case management for persons with severe and disabling mental illness must be limited to certain areas.

COMMENT: Case management should not be provided by mental health centers which are contracting with the Department of Corrections and Human Services.

RESPONSE: After two years of experience with intensive case management in the mental health system, the Department of Corrections and Human Services believes that the conflicts in the circumstances of its contracted for services can be minimized. While the concerns expressed in comment are legitimate, the problem appears to be manageable. The issues raised in comment will be monitored and provider selection reconsidered if indicated.

COMMENT: 46.12.1929(3) should state the requirement that the case management plan is developed jointly by the client and the case manager.

RESPONSE: The Department agrees and has added the language as subsection (7) of 46.12.1901.

COMMENT: 46.12.1929 should describe in more detail the services to be provided, and should include provisions for handling client grievances and maintaining confidentiality of records.

RESPONSE: The Department of Corrections and Human Services in administrating targeted case management for adults with severe and disabling mental illness will use the model of intensive case management. The principles and standards of that existing service model with minor fine tuning will be applied to targeted case management. Community mental health centers are required by contract to have a client grievance procedure and a system for maintaining confidentiality of records.

COMMENT: 46.12.1929(2) should be changed to allow the Department of Corrections and Human Services to designate providers other than licensed mental health centers.

RESPONSE: The Department agrees and has changed 46.12.1929(2).

COMMENT: There should be a fee for group case management activities for adults with severe and disabling mental illness.

RESPONSE: A group rate has been incorporated into 46.12.1930.

COMMENT: 46.12.1939(7) precludes a provider of direct care services to persons with developmental disabilities from acting as the case management provider for clients for whom the provider delivers services. A provider of direct care services should be allowed to provide case management services to its own clients as well.

RESPONSE: This requirement is being retained as proposed. Administrative separateness is encouraged by the Health Care Financing Administration. The Developmental Disabilities Division of the Department and the Department of Family Services believe that a case manager who is employed by an agency different from that providing the direct care or training service can be more independent and objective in the role as advocate for the recipient.

COMMENT: In 46.12.1935 there is no discernable difference between the definition of Level II and Level III developmental disabilities case management services.

RESPONSE: The policy manual being developed by the Department of Family Services will describe in detail the particulars of these levels. During Level I activities the needs of a person must be identified. A person may be found to need new eye glasses, home-delivered meals, or a senior activity program for individuals with developmental disabilities. Level II activities could include arranging for an eye appointment, transportation to the appointment, or contacting the Area Aging office to arrange for the "meals on wheels" program. Level III activities would involve the development of a referral to a DDD-contracted senior program.

COMMENT: For developmental disabilities case management, is there a difference between an individual service plan (ISP) and an individual habilitation plan (IHP)? If not, the individual habilitation plan should be used.

RESPONSE: An individual service plan would be developed to cover Level I, II, and III activities. At Level IV, entry into DDD-contracted services, an individual habilitation plan would be developed. While an ISP is a case management plan, it is different from an IHP because it includes services of a generic nature, as well as those delivered under a contract with the Developmental Disabilities Division.

COMMENT: For developmental disabilities case management, the individual service plan (ISP) should identify and specify the least restrictive service alternatives.

RESPONSE: The definition of individual service plan, 46.12.1935(10) has been amended to provide that case management be based on the least restrictive alternatives.

COMMENT: Eligibility for developmental disabilities case management, should be expanded to include persons under the age of 16 years.

RESPONSE: While children are not eligible for targeted case management, they may receive case management services under other programs:

1. when assigned a case worker as a part of a child protective service action;

2. when receiving child and family services under contract with DDD; or

3. when receiving specialized family care under the Medicaid waiver through a contract with DDD.

COMMENT: If a person meets the eligibility criteria in 46.12.1936 for developmental disabilities case management services, does that person qualify for all levels of case management services?

RESPONSE: Yes.

COMMENT: What is the process for determining eligibility for developmental disabilities case management and how are appeals of those determinations made?

RESPONSE: Eligibility is provided for in 46.12.1936. The appeal process is that provided in ARM 46.2.201 et seq..

COMMENT: The entities with whom the Department of Family Services will contract for developmental disabilities case management and the areas of the state for those contracts should be described in rule.

RESPONSE: In House Bill 2 the 52nd legislature authorized the Department of Family Services to contract for case management. Service requirements and areas to be served are included in DFS's Request for Proposals for Case Management Services. A case management provider under contract will have to meet the requirements of 46.12.1939. There is no need in rule to distinguish whether the case management services in a particular area are under contract or not.

COMMENT: For developmental disabilities case management services, what is the interrelationship of the individual service plan (ISP) with the rule on individual habilitation planning? Will there be two case managers?

RESPONSE: There will be only one case manager. The IHP rule applies to Level IV service provision. This will be described further in the Department of Family Services handbook.

COMMENT: The individual service plan (ISP) for developmental disabilities case management should be developed with the client's participation.

RESPONSE: The definition of individual service plan at 46-12-1935(10) has been amended to provide for participation of the recipient.

COMMENT: For developmental disabilities case management, additional provisions should be added to address client grievances and the confidentiality of client records.

RESPONSE: The Department of Family Services case management handbook contains details of the service to be provided. Provisions for client grievance and confidentiality have been added to 46.12.1939.

COMMENT: The exclusions from case management for persons with developmental disabilities in 46.12.1936 are confusing.

RESPONSE: The language relating to the exclusions has been modified.

COMMENT: The reimbursement formulas in 46.12.1240 for case management for persons with developmental disabilities appear to be incorrectly stated.

RESPONSE: The Department agrees. The formulas have been corrected.

COMMENT: The rate of reimbursement for case management services for adults with severe and disabling mental illness is not adequate.

RESPONSE: The Department of Corrections and Human Services has reviewed the reported costs of the current case management system. The rate has been changed based on that review to provide more appropriate reimbursement.

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 12, 1991.

VOLUME NO. 44 OPINION NO. 13

COUNTIES - Scope of authority of county to spend cash donations made in lieu of park land dedication;
PARKS - Improvement of municipal, county and state parks with funds received by county government through donations made in lieu of park land dedication under section 76-3-606;
SUBDIVISION AND PLATTING ACT - Interpretation of what type of projects are appropriately funded with cash donations in lieu of park land dedication under section 76-3-606;
MONTANA CODE ANNOTATED - Section 76-3-606, 76-3-606(2);
OPINIONS OF THE ATTORNEY GENERAL - 42 Op. Att'y Gen. No. 42 (1987), 40 Op. Att'y Gen. No. 49 (1984).

HELD: Cash donations received by Ravalli County in lieu of park land dedication under section 76-3-606, MCA, may be used by the county park board to fund restroom construction on the grounds of the Marcus Daly Mansion.

July 12, 1991

George H. Corn
Ravalli County Attorney
Courthouse Box 5008
Hamilton MT 59840

Dear Mr. Corn:

You have requested my opinion on the following questions:

> May cash donations made in lieu of park lands be spent to build restroom facilities on state land that is located within the county, used as a park by county residents, and managed by a nonprofit organization? If so, for what other projects may these funds be used?

The questions you ask stem from the potential allocation of county park funds for the development of restrooms at the Marcus Daly Mansion. The Daly Mansion and the statute which controls the disbursement of the funds at issue are unique and have both been the subject of prior opinions of this office.

The legal status of the Daly Mansion was discussed in a 1987 opinion which determined that state open meeting laws pertained to this nonprofit private corporation. 42 Op. Att'y Gen. No. 42 (1987). That opinion recognized that the mansion and the 40 acres of grounds surrounding it were deeded to the Montana Historical Society on December 31, 1986. While a private trust administers the estate, the lands are now state-owned and the property is open to the public. A nominal admittance fee is

charged to members of the public for entry to the grounds of the mansion. A separate fee is charged for tours of the mansion and the trust rents the home and grounds for private events such as weddings, concerts, and plays. The trust itself sponsors events and charges admittance fees. These events include dinners, concerts, tours, and holiday celebrations.

The utility of the Daly Mansion for the various types of events that have been held on its grounds since its conveyance to the Historical Society in 1986 is limited by the absence of restroom facilities. Ravalli County questions whether cash donations it has received under section 76-3-606, MCA, may be appropriated for such a project. The cited statute is part of the Subdivision and Platting Act and establishes a requirement of park land dedication by the developers of residential subdivisions. In certain situations the dedication of park land is excused, provided the developers make specified cash donations to the local governing body. The statute provides in relevant part:

> Where the dedication of land for parks or playgrounds is undesirable because of size, topography, shape, location, or other circumstances, the governing body may, for good cause shown, make an order to be endorsed and certified on the plat accepting a cash donation in lieu of the dedication of land and equal to the fair market value of the amount of land that would have been dedicated. For the purpose of this section, the fair market value is the value of the unsubdivided, unimproved land. Such cash donation shall be paid into the park fund to be used for the purchase of additional lands or for the initial development of parks and playgrounds. [Emphasis added.]

§ 76-3-606(2), MCA. Resolution of your questions involves interpretation of the last sentence of the above quotation. Two issues are present: (1) whether the Marcus Daly Mansion may be considered a "park" for purposes of the statute, and (2) whether the construction of restrooms may be considered the "initial development" of parks.

Resolution of the issues presented is not difficult in light of the facts presented. The Subdivision and Platting Act does not define the word "parks." As a practical matter, the Act does not limit use of the park funds to a particular type of park, e.g., municipal or county, because the Act is applicable to both types of local government. In fact, the Montana Supreme Court has tacitly endorsed the use of county park funds received under section 76-3-606(2), MCA, for the development of a municipal golf course. Burgess v. Gallatin County Commission, 215 Mont. 503, 698 P.2d 862 (1985). In that case an individual unsuccessfully challenged the discretion of Gallatin County in allocating funds received through cash donations made in lieu

of park land dedication for the development of a golf course on property acquired by the city of Three Forks and managed by a private nonprofit corporation. See Burgess, supra, Brief of Respondent at 6.

Generally where a word is not defined in a statute, its commonly accepted meaning is applied. 2A Sutherland Statutory Construction § 47.07 at 133 (4th ed. 1984). Webster's defines "park" as follows:

> 1. in English law, an enclosed area of land, held by authority of the king or by prescription, stocked and preserved for hunting.
>
> 2. an area of land containing pasture, woods, lakes, etc., surrounding a large country house or private estate.
>
> 3. an area of public land; specifically, (a) an area in or near a city, usually laid out with walks, drives, playgrounds, etc., for public recreation; (b) an open square in a city, with benches, trees, etc.; (c) a large area known for its natural scenery and preserved for public recreation by a state or national government.
>
> 4. a level, open area surrounded by mountains or forest.
>
> 5. in military usage, (a) an area set aside for vehicles, supplies, and other equipment; (b) things kept in such an area; as, a *park* of tanks.

Webster's New Twentieth Century Dictionary, Unabridged at 1303 (2d ed. 1979). This definition comports with definitions set out in case law whereby a park is defined as a place for recreation and enjoyment of the public. County of San Benito v. Copper Mountain Mining Co. of California, 45 P.2d 428, 430 (Cal. 1935).

The concept of a park need not be restricted to open space or playgrounds. As an early New York decision recognized:

> A park may be devoted to any use which tends to promote popular enjoyment and recreation. Although primarily involving the idea of open air and space, the sentiment for artistic adornment of public places is such that the occupation in part by monuments, statues to heroes, art, museums, gallerys [sic] of painting and sculpture, free public libraries, and other agencies contributing to the aesthetic enjoyment of eye and ear is not a perversion of the lands from park purposes.

In re Central Parkway, City of Schenectady, 251 N.Y.S. 577, 579-80 (N.Y. 1931). See also Aquamsi Land Co. v. City of Cape Girardeau, 142 S.W.2d 332, 335 (Mo. 1940) (a "park" includes "buildings of architectural pretension which attract the eye and divert the mind of the visitor").

The Marcus Daly Mansion is a significant historical and architectural resource that Ravalli County residents, in conjunction with the Montana Historical Society, have seen fit to preserve for the future enjoyment of all visitors. It is, based upon the foregoing, a park for purposes of section 76-3-606(2), MCA. The fact that the property is owned by a state agency does not defeat its status as a park located within and used by the residents of Ravalli County.

The second issue that must be resolved is whether the construction of restroom facilities constitutes "initial development of parks" for purposes of section 76-3-606, MCA. This phrase has never been judicially interpreted in Montana. In Burgess, supra, the Montana Supreme Court commented that the statute only tells the county commissioners in general terms how the "in lieu" donations are to be spent for park and recreation purposes: they are not told how each dollar is to be spent. In 40 Op. Att'y Gen. No. 49 at 199 (1984), an opinion which predated the Burgess decision, the Attorney General addressed the administration of those park revenues that are restricted pursuant to section 76-3-606, MCA. In addition to the cash donations received in lieu of dedication of land for park purposes, revenues received by a county from the sale, exchange, or disposal of dedicated park land must also be used in the manner prescribed by section 76-3-606(2), MCA. § 7-16-2324(4), MCA. The 1984 Attorney General's Opinion concluded that:

> Revenues from these sources are restricted in use to the sole purpose of the purchase of additional lands or the initial development of parks and playgrounds. [Statutory citations omitted.] While these revenues are a part of the park fund, they should be separated from unrestricted park fund revenues, either through separate bank accounts or through acceptable accounting procedures, so that the restricted revenues are used solely for the authorized purpose.

40 Op. Att'y Gen. No. 49 at 202.

The phrase "initial development" implies planning for new improvement or the actual construction thereof. The park dedication requirement found within section 76-3-606, MCA, and similar provisions found in the subdivision regulation statutes of other states, are designed in part to require subdivision developers to ease the burden that additional residents bring to existing parks. 4 Anderson, American Law of Zoning 3d § 25.39 (1986). The statutory intent of providing new facilities and park lands for increased population would clearly

not be served if a county used restricted revenues for paying its general operating costs. However, the construction and provision of new facilities such as restrooms within a park, where none have previously existed, may be considered "initial development" consistent with the statutory language and intent of section 76-3-606(2), MCA. The expenditure of cash donations received by Ravalli County in lieu of park land dedication upon the Daly Mansion serves to develop the park and provide facilities that allow for more opportunities for county residents and others to enjoy its amenities. Under the circumstances, the provision of facilities not previously in existence, as part of a long-term plan to improve the park, falls within the definition of "initial development" as that phrase is used in section 76-3-606, MCA.

You have further requested that I determine what other types of projects might be appropriately funded with cash donations made in lieu of park land dedication. Apart from the general guidance offered above I am unable to offer a definitive list of those types of projects for which the restricted park funds may be allocated. Consistent with the reasoning expressed above, initial park development clearly includes the provision of a capital improvement, e.g., picnic shelter, softball field, or swimming pool, where such permanent facility is being added, as opposed to being replaced, in a park. When local governments are in doubt as to the appropriateness of a particular disbursement, they should examine whether the recreational and cultural opportunities for its residents are increased by the project under consideration.

THEREFORE, IT IS MY OPINION:

> Cash donations received by Ravalli County in lieu of park land dedication under section 76-3-606, MCA, may be used by the county park board to fund restroom construction on the grounds of the Marcus Daly Mansion.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

VOLUME NO. 44 OPINION NO. 14

CORRECTIONAL FACILITIES - Voter approval requirements for imposition of levy for operational costs of juvenile detention facilities;
COUNTY GOVERNMENT - Voter approval requirements for imposition of levy for operational costs of juvenile detention facilities;
ELECTIONS - Voter approval requirements for imposition of levy for operational costs of juvenile detention facilities;
JUVENILES - Voter approval requirements for imposition of levy for operational costs of juvenile detention facilities;
TAXATION AND REVENUE - Voter approval requirements for imposition of levy for operational costs of juvenile detention facilities;
MONTANA CODE ANNOTATED - Sections 7-6-2501, 7-6-2523, 7-6-2526, 7-6-2531, 7-6-2531(2), 15-10-402(1), 15-10-412, 15-10-412(9);
MONTANA LAWS OF 1991 - Chapter 745, section 2;
OPINIONS OF THE ATTORNEY GENERAL - 39 Op. Att'y Gen. No. 34 (1981).

HELD: House Bill 74 does not require that the levy for juvenile detention facilities be approved by the voters subsequent to the initial voter approval unless there is a proposal to increase the amount of the previously approved levy.

July 15, 1991

Dr. Gordon Browder, Chairman
Board of Crime Control
Scott Hart Building
303 North Roberts
Helena MT 59620

Dear Dr. Browder:

You have requested my opinion on the following question:

> Does House Bill 74, which allows counties upon the approval of the voters to impose a levy for the operational costs of juvenile detention facilities, require annual or biennial voter approval?

House Bill (hereinafter HB) 74, passed by the Montana Legislature during the 1991 session, authorizes a county to impose a levy for the purpose of providing juvenile detention programs. The bill also requires approval by a majority of the qualified electors voting on the question prior to the imposition of the levy. 1991 Mont. Laws, ch. 745, § 2. The bill is silent as to whether an election is required subsequent to initial voter approval of the levy.

I conclude that HB 74 does not require that the levy for juvenile detention facilities be approved by the voters subsequent to initial voter approval unless there is a proposal to increase the amount of the previously approved levy.

Two statutes address procedures for voter approval when a county seeks to either exceed the levy or levies allowed by law, § 7-6-2531, MCA, or to exceed the limit set on the amount of taxes levied by a taxing unit against any particular property, § 15-10-412(9), MCA.

Section 15-10-412(9), MCA, provides a procedure whereby a county may exceed the limitations set by section 15-10-402(1), MCA, and clarified in section 15-10-412, MCA, on the amount of taxes that may be levied against various classes of property. The levy for juvenile detention programs, however, is specifically exempted from the limits imposed in sections 15-10-402(1) and 15-10-412, MCA. 1991 Mont. Laws, ch. 745, §§ 3, 4. Therefore, the election procedures of section 15-10-412(9), MCA, do not apply to HB 74.

Section 7-6-2531, MCA, provides a procedure whereby a county may exceed the maximum mill levies "allowed by law." A county may impose a levy for the purpose of defraying the general expenses of the county up to the maximum levy set by section 7-6-2501, MCA, or the county may impose an all-purpose levy as defined in section 7-6-2523, MCA. If a county elects to impose a levy greater than the maximum mills allowed by statute it must follow the procedures provided in section 7-6-2531, MCA. 39 Op. Att'y Gen. No. 34 at 135 (1981). However, these statutes do not limit a county's authority to levy other taxes authorized by statute for special purposes and, as a result, do not limit the county's ability to impose a levy for juvenile detention programs if such a levy is approved by the voters under HB 74. § 7-6-2526, MCA.

HB 74 does not set a maximum mill levy. Rather it requires that a majority of the qualified voters approve the mill levy which the governing body determines is necessary. The voters of the county, therefore, are authorized by the Legislature to set the maximum mill levy for the provision of a juvenile detention program. Once this maximum mill levy is set by the voters, the county need not bring the issue before the electorate again unless the governing body of the county proposes to raise the mill levy beyond that set by the voters, i.e., beyond that "allowed by law."

In order to raise the number of mills beyond the maximum initially set by the voters, the governing body must comply with the procedures set forth in section 7-6-2531, MCA, and bring the requested increase in the amount of mills before the voters. Section 7-6-2531(2), MCA, allows the county to impose the increased mill levy, if authorized by a majority of the qualified voters, "for a period not to exceed 2 years." § 7-6-2531(2), MCA. Therefore, should the governing body decide

at any time that an increase in the amount of mills is necessary, it must follow the procedures outlined in section 7-6-2531, MCA.

In conclusion, House Bill 74 requires that the qualified electors of a county approve a maximum mill amount to be levied for the purpose of providing a juvenile detention program. This issue need only be brought before the voters one time, unless additional increases in the approved levy are sought thereafter.

THEREFORE, IT IS MY OPINION:

> House Bill 74 does not require that the levy for juvenile detention facilities be approved by the voters subsequent to the initial voter approval unless there is a proposal to increase the amount of the previously approved levy.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

VOLUME NO. 44 OPINION NO. 15

INDIANS - Applicability of Uniform Enforcement of Foreign Judgments Act to tribal court judgments;
JUDGMENTS - Applicability of Uniform Enforcement of Foreign Judgments Act to tribal court judgments;
MONTANA CODE ANNOTATED - Sections 25-9-501 to 25-9-508, 26-3-203;
UNITED STATES CODE - 25 U.S.C. § 1911(D), 28 U.S.C. § 1738;
UNITED STATES CONSTITUTION - Article IV, section 1.

HELD: A judgment, decree, or order of an Indian tribal court may not be filed as a foreign judgment under the provisions of the Uniform Enforcement of Foreign Judgments Act, unless the judgment, decree, or order concerns an Indian child custody proceeding.

July 16, 1991

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

Dear Mr. Nelson:

You have requested my opinion on the following question:

> May a judgment, decree, or order of an Indian tribal court be filed as a foreign judgment under the provisions of the Uniform Enforcement of Foreign Judgments Act?

In 1989 the Montana Legislature enacted the Uniform Enforcement of Foreign Judgments Act, which is codified at sections 25-9-501 to 508, MCA. The Act provides a procedure for the filing of a foreign judgment with the clerk of the district court and permits the clerk to treat the foreign judgment in the same manner as a judgment of the district court. § 25-9-503, MCA. If a judgment creditor utilizes this registration procedure, the creditor does not need to bring an action or special proceeding under section 26-3-203, MCA, in order to enforce the judgment in Montana.

Your inquiry requires me to determine whether a judgment, decree, or order of an Indian tribal court may be considered a "foreign judgment" as that term is used in the Uniform Enforcement of Foreign Judgments Act. Section 25-9-502, MCA, defines "foreign judgment" for purposes of the Act as "a judgment, decree, or order of a court of the United States or of any other court which is entitled to full faith and credit in this state." The inquiry thus narrows to the question of

whether a tribal court judgment, decree, or order is entitled to full faith and credit in Montana.

The "full faith and credit" that is referred to in section 25-9-502, MCA, is the full faith and credit that is required by the Constitution of the United States, Art. IV, § 1, which provides in pertinent part:

> Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State.

This clause applies by its own terms only to judicial proceedings of a state and makes no reference to judgments of other entities or jurisdictions. See Multibanco Comermex, S.A. v. Gonzalez, 630 P.2d 1053 (Ariz. Ct. App. 1981).

However, the full faith and credit clause also authorizes Congress to enact laws to implement its provisions, and Congress has legislatively extended the application of the clause to judgments of courts "within the United States and its Territories and Possessions." 28 U.S.C. § 1738. As you have noted in your inquiry, state courts have not agreed on whether an Indian tribe should be viewed as a "territory" or "possession" of the United States for purposes of this federal statute. See Jim v. CIT Financial Services Corp., 533 P.2d 751 (N.M. 1975); In re Buehl, 555 P.2d 1334 (Wash. 1976); Sheppard v. Sheppard, 655 P.2d 895 (Idaho 1982). Cf. Brown v. Babbitt Ford, Inc., 571 P.2d 689 (Ariz. Ct. App. 1977). See also Felix S. Cohen's Handbook of Federal Indian Law 384-85 (R. Strickland ed. 1982); W. Vetter, Of Tribal Courts and "Territories" Is Full Faith and Credit Required?, 23 Cal. W.L. Rev. 219 (1987).

The Montana Supreme Court has not expressly addressed the issue of the application of 28 U.S.C. § 1738 to tribal judgments. However, the Court has observed that a tribe is not the equivalent of a state and that the full faith and credit clause is not applicable to a tribe. Little Horn State Bank v. Stops, 170 Mont. 510, 555 P.2d 211 (1976). Rather, the Court has stated that tribal court judgments are treated with the same deference shown decisions of foreign nations as a matter of comity. Wippert v. Blackfeet Tribe, 201 Mont. 299, 654 P.2d 512 (1982). See also In re Marriage of Limpy, 195 Mont. 314, 636 P.2d 266 (1981).

In view of these statements by the Montana Supreme Court, I conclude that in Montana, tribal court judgments, decrees, and orders may not be filed as "foreign judgments" under the provisions of the Uniform Enforcement of Foreign Judgments Act.

It is generally agreed that judgments of foreign countries cannot be registered under the Uniform Enforcement of Foreign Judgments Act. See Multibanco Comermex, S.A. v. Gonzalez, supra; In re Marriage of Agathos, 550 N.E.2d 1161 (Ill. Ct. App.

1990). Since the Montana Supreme Court treats tribal court judgments as decisions of foreign nations, it follows that such judgments are also precluded from utilizing the simplified registration procedures of the Act. However, as you point out, although that simplified process cannot be utilized, the holder of a tribal court judgment still retains the right to bring an action or special proceeding to enforce the judgment. §§ 25-9-507, 26-3-203, MCA; Wippert v. Blackfeet Tribe, supra. Under the principles of comity, the tribal court judgment may be recognized and given effect by the state court in such an action or special proceeding, not as a matter of obligation but out of deference and mutual respect. See Leon v. Numkena, 689 P.2d 566 (Ariz. Ct. App. 1984); Mexican v. Circle Bear, 370 N.W.2d 737 (S.D. 1985); In re Marriage of Red Fox, 542 P.2d 918 (Or. Ct. App. 1975).

My conclusion is subject to one exception created by the Indian Child Welfare Act, which requires the states to give full faith and credit to the "public acts, records, and judicial proceedings of any Indian tribe applicable to Indian child custody proceedings to the same extent that such entities give full faith and credit to the public acts, records, and judicial proceedings of any other entity." 25 U.S.C. § 1911(d).

THEREFORE, IT IS MY OPINION:

> A judgment, decree, or order of an Indian tribal court may not be filed as a foreign judgment under the provisions of the Uniform Enforcement of Foreign Judgments Act, unless the judgment, decree, or order concerns an Indian child custody proceeding.

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, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code 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 lists 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 Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1991. This table includes those rules adopted during the period April 1, 1991 through June 30, 1991 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, 1991, 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 1990 and 1991 Montana Administrative Register.

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BOARD APPOINTEES AND VACANCIES

House Bill 424, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of HB 424 was that the Secretary of State publish monthly in the ***Montana Administrative Register*** a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments made in June, 1991, are published. Vacancies scheduled to appear from August 1, 1991, through October 31, 1991, are also listed, as are current recent vacancies due to resignations or other reasons.

Individuals interested in serving on a new board should refer to the bill that created the board for details about the number of members to be appointed and qualifications necessary.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of July 15, 1991.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES: JUNE, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Natural Resources and Conservation (Natural Resources and Conservation)			
Mr. Gerald Feda Glasgow Qualifications (if required): informed and experienced in natural resources & conservation	Governor	Roskie	6/11/1991 1/1/1995
Board of Respiratory Care (Commerce)			
Mr. Mike Biggins Missoula Qualifications (if required): respiratory care practitioner	Governor	new appointment	6/26/1991 7/1/1995
Dr. Richard Dyer Blevins Great Falls Qualifications (if required): doctor member	Governor	new appointment	6/26/1991 7/1/1995
Mr. Phillip J. Grainey Polson Qualifications (if required): public member	Governor	new appointment	6/26/1991 7/1/1995
Ms. Pat Johnson Helena Qualifications (if required): respiratory care practitioner	Governor	new appointment	6/26/1991 7/1/1995
Mr. Richard Lundy Billings Qualifications (if required): respiratory care practitioner	Governor	new appointment	6/26/1991 7/1/1995
Board of Veterans' Affairs (Military Affairs)			
Mr. Thaddeus Mayer Missoula Qualifications (if required): honorably discharged from military service	Governor	Durkee	6/11/1991 5/18/1996

BOARD AND COUNCIL APPOINTEES: JUNE, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Capitol Finance Advisory Council (Administration)			
Mr. Dennis Iverson	Governor	Pizzini	6/25/1991
Helena			1/23/1992
Qualifications (if required): Director of Department of Health and Environmental Sciences			
Dr. Amos Little	Governor	Munger	6/25/1991
Helena			1/23/1992
Qualifications (if required): Chairman of Montana Health Facility Authority Board			
Mr. Bob Marks	Governor	Ashley	6/25/1991
Helena			1/23/1992
Qualifications (if required): Director of Department of Administration			
Mr. John Rothwell	Governor	Larson	6/25/1991
Helena			1/23/1992
Qualifications (if required): Director of Department of Highways			
Mr. Steve Yeakel	Governor	Hunter	6/25/1991
Helena			1/23/1992
Qualifications (if required): Budget Director for Governor's Budget Office			
Committee for the Humanities (Governor)			
Ms. Ann Cogswell	Governor	Elting	6/27/1991
Great Falls			1/1/1993
Qualifications (if required): public member			

BOARD AND COUNCIL APPOINTEES: JUNE, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Flathead Basin Commission (Governor)			
Ms. Jean Cumming	Governor	not listed	6/30/1991
Columbia Falls			6/30/1995
Qualifications (if required): public member			
Ms. Joann Speelman	Governor	not listed	6/30/1991
Kalispell			6/30/1995
Qualifications (if required): public member			
Health Facility Authority Board (Commerce)			
Ms. Gayle Carpenter	Governor	Munger	6/30/1991
Helena			1/1/1995
Qualifications (if required): public member			
Petroleum Tank Release Compensation Board (Health and Environmental Sciences)			
Mr. Ron Guttenberg	Governor	not listed	6/30/1991
Glasgow			6/30/1994
Qualifications (if required): public member			
Mr. Gary Tschache	Governor	not listed	6/30/1991
Bozeman			6/30/1994
Qualifications (if required): representative of service station dealers			

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Board of Medical Examiners (Commerce)		
Dr. John R. Jacobson, Butte	Governor	9/1/91
Qualifications (if required): has degree of doctor of medicine		
Dr. Thomas J. Malee, Glendive	Governor	9/1/91
Qualifications (if required): has degree of doctor of medicine		
Board of Private Security Patrolmen and Investigators (Commerce)		
Mr. Robert F. Ash, Hysham	Governor	8/1/91
Qualifications (if required): rep: County Sheriff's Department		
Mr. David J. Collings, Deer Lodge	Governor	8/1/91
Qualifications (if required): rep: County Sheriff's Department		
Mr. Al Murphy, Missoula	Governor	8/1/91
Qualifications (if required): licensed private investigator		
Mr. Jack F. Samson, Billings	Governor	8/1/91
Qualifications (if required): rep: City Police Department		
Mr. Joseph H. Servel, Missoula	Governor	8/1/91
Qualifications (if required): licensed private investigator		
Board of Psychologists (Commerce)		
Dr. Michael J. McLaughlin, Great Falls	Governor	9/1/91
Qualifications (if required): licensed psychologist		
Clark Fork Rehabilitation Advisory Council (Governor)		
Mr. Vic Andersen, Helena	Governor	9/8/91
Qualifications (if required): none specified		
Mr. Ray Beck, Helena	Governor	9/8/91
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Clark Fork Rehabilitation Advisory Council . (Governor)		
Mr. Frank Bennett, Anaconda Qualifications (if required): none specified	Governor	9/8/91
Mr. Bob Fox, Helena Qualifications (if required): none specified	Governor	9/8/91
Mr. Pat Graham, Helena Qualifications (if required): none specified	Governor	9/8/91
Mr. Dick Hafer, Helena Qualifications (if required): none specified	Governor	9/8/91
Mr. Frank Munshower, Bozeman Qualifications (if required): none specified	Governor	9/8/91
Mr. Peter Nielson, Missoula Qualifications (if required): none specified	Governor	9/8/91
Mr. Steve Pilcher, Helena Qualifications (if required): none specified	Governor	9/8/91
Mr. Joe Roberts, Butte Qualifications (if required): none specified	Governor	9/8/91
Mr. Ray Tilman, Butte Qualifications (if required): none specified	Governor	9/8/91
Mr. Bill Williams, Anaconda Qualifications (if required): none specified	Governor	9/8/91
Sen. Thomas Beck, Deer Lodge Qualifications (if required): none specified	Governor	9/1/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Criminal Justice and Corrections Advisory Council (Institutions)		
Ms. Margaret L. Borg, Missoula Qualifications (if required): none specified	Governor	9/1/91
Rep. Vivian M. Brooke, Missoula Qualifications (if required): member	Governor	9/1/91
Mr. Henry E. Burgess, Helena Qualifications (if required): none specified	Governor	9/1/91
Sen. B. F. "Chris" Christiaens, Great Falls Qualifications (if required): none specified	Governor	9/1/91
Ms. Colleen Conroy, Hardin Qualifications (if required): none specified	Governor	9/1/91
Mr. Donald D. Dupuis, Pablo Qualifications (if required): none specified	Governor	9/1/91
Ms. Sheryl Hoffarth, Billings Qualifications (if required): none specified	Governor	9/1/91
Rep. Betty Lou Kasten, Brockway Qualifications (if required): none specified	Governor	9/1/91
Mr. Mike Lavin, Helena Qualifications (if required): none specified	Governor	9/1/91
Mr. Ted O. Lympus, Kalispell Qualifications (if required): none specified	Governor	9/1/91
Mr. Walter J. Moore, Roundup Qualifications (if required): none specified	Governor	9/1/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Criminal Justice and Corrections Advisory Council (Institutions)		
Rep. Helen O'Connell, Great Falls Qualifications (if required): none specified	Governor	9/1/91
Judge Thomas A. Olson, Bozeman Qualifications (if required): none specified	Governor	9/1/91
Ms. Pat Regan, Billings Qualifications (if required): none specified	Governor	9/1/91
Mr. Daniel D. Russell, Helena Qualifications (if required): none specified	Governor	9/1/91
Mr. Mike Schafer, Billings Qualifications (if required): none specified	Governor	9/1/91
Ms. Debbie Swanson, Havre Qualifications (if required): none specified	Governor	9/1/91
Rep. Bob Thoft, Stevensville Qualifications (if required): none specified	Governor	9/1/91
Data Processing Advisory Council (Administration)		
Mr. Dave Ashley, Helena Qualifications (if required): none specified	Director	10/15/91
Auditor Andrea "Andy" Bennett, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Peter Blouke, Helena Qualifications (if required): none specified	Director	10/15/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Data Processing Advisory Council (Administration)		
Mr. Phil Brooks, Helena Qualifications (if required): none specified	Director	10/15/91
Ms. Judy Browning, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. David Darby, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Jack Ellery, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Gregg Groepper, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Larry Larsen, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Mike Micone, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Richard Miller, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Douglas M. Mitchell, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Bob Mullen, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. William J. Opitz, Helena Qualifications (if required): none specified	Director	10/15/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Data Processing Advisory Council (Administration)		
Mr. Jim Oppedahl, Helena Qualifications (if required): member	Governor	10/15/91
Mr. Robert Person, Helena Qualifications (if required): none specified	Director	10/15/91
Andrew Poole, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Wayne Wetzel, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Keith Wolcott, Helena Qualifications (if required): none specified	Director	10/15/91
Mr. Steve Yeakel, Helena Qualifications (if required): none specified	Director	10/15/91
Education Commission for the Nineties (Education)		
Mr. Dennis Burr, Clancy Qualifications (if required): none specified	Governor	10/6/91
Mr. Terry Cosgrove, Helena Qualifications (if required): none specified	Governor	10/6/91
Ms. Nancy Davidson, Great Falls Qualifications (if required): none specified	Governor	10/6/91
Mr. Jack Dietrich, Billings Qualifications (if required): none specified	Governor	10/6/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Education Commission for the Nineties (Education)		
Mr. Bill Fuglevand, Havre Qualifications (if required): none specified	Governor	10/6/91
Ms. Verna Green, Helena Qualifications (if required): none specified	Governor	10/6/91
Ms. Jean Hagan, Big Fork Qualifications (if required): none specified	Governor	10/6/91
Sen. Howard W. "Swede" Hammond, Malta Qualifications (if required): none specified	Governor	10/6/91
Rep. Mike Kadas, Missoula Qualifications (if required): none specified	Governor	10/6/91
Ms. Charlene Loge, Dillon Qualifications (if required): none specified	Governor	10/6/91
Mr. Jim Moore, Bozeman Qualifications (if required): none specified	Governor	10/6/91
Mr. Jack Mudd, Missoula Qualifications (if required): none specified	Governor	10/6/91
Mr. John Olson, Sidney Qualifications (if required): none specified	Governor	10/6/91
Mr. Don Peoples, Butte Qualifications (if required): none specified	Governor	10/6/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Family Support Services Advisory Council (Social and Rehabilitation Services)		
Ms. Alicia Pichette, Helena Qualifications (if required): member	Governor	9/29/91
Flathead Basin Commission (Governor)		
Mr. Edgar Brannon, Kalispell Qualifications (if required): none specified	Director	8/5/91
Mr. Kenneth Krueger, Kalispell Qualifications (if required): none specified	Commissioners	8/1/91
Historic Preservation Review Board (Education)		
Mr. Richard D. King, Havre Qualifications (if required): none specified	Governor	10/1/91
Mr. Ross Plambeck, Kalispell Qualifications (if required): public member	Governor	10/1/91
Ms. Ellen M. Sievert, Great Falls Qualifications (if required): none specified	Governor	10/1/91
Lewis and Clark Trail Advisory Council (Governor)		
Mr. John C. Austin, Hamilton Qualifications (if required): none specified	Governor	9/5/91
Mr. Joe Belgum, Great Falls Qualifications (if required): none specified	Governor	9/5/91
Mr. Arthur W. Dickhoff, Great Falls Qualifications (if required): none specified	Governor	9/5/91
Mr. Robert Doerk, Jr., Great Falls Qualifications (if required): none specified	Governor	9/5/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Lewis and Clark Trail Advisory Council (Governor)		
Mr. Harry W. Fritz, Missoula Qualifications (if required): none specified	Governor	9/5/91
Mr. Jack Hane, Lewistown Qualifications (if required): none specified	Governor	9/5/91
Mr. Jack Hayne, Dupuyer Qualifications (if required): none specified	Governor	9/5/91
Mr. Don D. Hyyppa, Helena Qualifications (if required): none specified	Governor	9/5/91
Ms. Ruth Kvaalen, Lambert Qualifications (if required): none specified	Governor	9/5/91
Mr. Mike Letson, Helena Qualifications (if required): none specified	Governor	9/5/91
Mr. Donald F. Nell, Bozeman Qualifications (if required): none specified	Governor	9/5/91
Mr. Robert A Saindon, Helena Qualifications (if required): none specified	Governor	9/5/91
Ms. Jane Schmoyer Weber, Great Falls Qualifications (if required): none specified	Governor	9/5/91
Mr. William P. Sherman, Portland Qualifications (if required): none specified	Governor	9/5/91
Ms. Gladys V. Silk, Glasgow Qualifications (if required): none specified	Governor	9/5/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Lewis and Clark Trail Advisory Council (Governor)		
Mr. Lawrence Sommer, Helena Qualifications (if required): none specified	Governor	9/5/91
Mr. Harold G. Stearns, Helena Qualifications (if required): none specified	Governor	9/5/91
Mr. Andy A. Van Teylingen, Bozeman Qualifications (if required): none specified	Governor	9/5/91
Ms. Margaret S. Warden, Great Falls Qualifications (if required): none specified	Governor	9/5/91
Mr. John A. Willard, Billings Qualifications (if required): none specified	Governor	9/5/91
Local Youth Services Advisory Council, Billings (Family Services)		
Ms. Elaine K. Allestad, Big Timber Qualifications (if required): Billings	Director	10/26/91
Mr. James F. Canan, Billings Qualifications (if required): Billings	Director	10/26/91
Ms. Dollean Lind, Hardin Qualifications (if required): Billings	Director	10/26/91
Mr. Cliff Murphy, Billings Qualifications (if required): Billings	Director	10/26/91
Mr. Vern Peterson, Lewistown Qualifications (if required): Billings	Director	10/26/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Billings	(Family Services)	
Ms. Karen Smith, Billings	Director	10/26/91
Qualifications (if required): Billings		
Local Youth Services Advisory Council, Bozeman	(Family Services)	
Mr. Bruce Becker, Bozeman	Director	10/26/91
Qualifications (if required): Bozeman		
Mr. Robert Brown, Bozeman	Director	10/26/91
Qualifications (if required): Bozeman		
Mr. Jerry Churchill, White Sulphur Springs	Director	10/26/91
Qualifications (if required): Bozeman		
Mr. Carlo Cieri, Livingston	Director	10/26/91
Qualifications (if required): Bozeman		
Sen. Dorothy Eck, Bozeman	Director	10/26/91
Qualifications (if required): Bozeman		
Mr. Ray Hokanson, Bozeman	Director	10/26/91
Qualifications (if required): Bozeman		
Local Youth Services Advisory Council, Butte	(Family Services)	
Mr. Pat Clark, Dillon	Director	10/26/91
Qualifications (if required): Butte		
Dr. William Hickey, Anaconda	Director	10/26/91
Qualifications (if required): Butte		
Ms. Charlotte Kilroy, Butte	Director	10/26/91
Qualifications (if required): Butte		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Butte (Family Services)		
Mr. Mike Mahoney, Deer Lodge Qualifications (if required): Butte	Director	10/26/91
Rep. William T. "Red" Menahan, Anaconda Qualifications (if required): Butte	Director	10/26/91
Ms. Rosemary G. Rawls, Butte Qualifications (if required): Butte	Director	10/26/91
Local Youth Services Advisory Council, Glasgow (Family Services)		
Mr. Ed Amestoy, Malta Qualifications (if required): Glasgow	Director	10/26/91
Mr. Ron Arneson, Wolf Point Qualifications (if required): Glasgow	Director	10/26/91
Mr. Arthur Arnold, Hinsdale Qualifications (if required): Glasgow	Director	10/26/91
Mr. Pastor John Bent, Nashua Qualifications (if required): Glasgow	Director	10/26/91
Rep. Dorothy Cody, Wolf Point Qualifications (if required): Glasgow	Director	10/26/91
Mr. Jim Halverson, Wolf Point Qualifications (if required): Glasgow	Director	10/26/91
Ms. Harriet McCoy, Plentywood Qualifications (if required): Glasgow	Director	10/26/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Glasgow	(Family Services)	
Mr. Larry Wahl, Scobey	Director	10/26/91
Qualifications (if required): Glasgow		
Local Youth Services Advisory Council, Glendive	(Family Services)	
Mr. Pete Degel, Glendive	Director	10/26/91
Qualifications (if required): Glendive		
Ms. Carol Friederichs, Glendive	Director	10/26/91
Qualifications (if required): Glendive		
Mr. Bob Jensen, Circle	Director	10/26/91
Qualifications (if required): Glendive		
Mr. Derry S. Long, Circle	Director	10/26/91
Qualifications (if required): Glendive		
Ms. Gloria Paladichuk, Sidney	Director	10/26/91
Qualifications (if required): Glendive		
Ms. Judy Reddig, Glendive	Director	10/26/91
Qualifications (if required): Glendive		
Sen. Larry J. Tveit, Fairview	Director	10/26/91
Qualifications (if required): Glendive		
Local Youth Services Advisory Council, Great Falls	(Family Services)	
Mr. Russell R. Andrews, Choteau	Director	10/26/91
Qualifications (if required): Great Falls		
Mr. Earl Arkinson, Box Elder	Director	8/15/91
Qualifications (if required): Great Falls		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Great Falls (Family Services)		
Mr. Joe Gottfried, Shelby Qualifications (if required): Great Falls	Director	8/15/91
Ms. Gini Onstad, Fort Benton Qualifications (if required): Great Falls	Director	10/26/91
Rep. Ray Peck, Havre Qualifications (if required): Great Falls	Director	10/26/91
Judge John Warner, Havre Qualifications (if required): Great Falls	Director	10/26/91
Local Youth Services Advisory Council, Helena (Family Services)		
Dr. Thomas D. Carlin, Helena Qualifications (if required): Helena	Director	10/26/91
Ms. Bonnie Holman, Townsend Qualifications (if required): Helena	Director	10/26/91
Ms. Joyce Janacaro, Whitehall Qualifications (if required): Helena	Director	10/26/91
Mr. Wally Jewell, Helena Qualifications (if required): Helena	Director	10/26/91
Rep. Jim Rice, Helena Qualifications (if required): Helena	Director	10/26/91
Mr. Bob Stockton, Helena Qualifications (if required): Helena	Director	10/26/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Helena (Family Services)		
Ms. Margaret Stuart, Helena Qualifications (if required): Helena	Director	10/26/91
Local Youth Services Advisory Council, Kalispell (Family Services)		
Mr. Roy R. Delong, Thompson Falls Qualifications (if required): Kalispell	Director	10/26/91
Mr. Howard W. Gipe, Kalispell Qualifications (if required): Kalispell	Director	10/26/91
Ms. June Hermanson, Polson Qualifications (if required): Kalispell	Director	10/26/91
Mr. Melvin R. Mohler, Swan Lake Qualifications (if required): Kalispell	Director	10/26/91
Ms. Gretchen Otto, Kalispell Qualifications (if required): Kalispell	Director	10/26/91
Mr. Scott Spencer, Libby Qualifications (if required): Kalispell	Director	10/26/91
Local Youth Services Advisory Council, Miles City (Family Services)		
Sen. Hubert Abrams, Wibaux Qualifications (if required): Miles City	Director	10/26/91
Mr. Ernest Big Horn, Miles City Qualifications (if required): Miles City	Director	8/15/91
Ms. Carmelita Birdinground, Lame Deer Qualifications (if required): Miles City	Director	10/26/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Miles City (Family Services)		
Mr. Garry Bunke, Miles City Qualifications (if required): Miles City	Director	8/15/91
Ms. Theresa Harris, Lame Deer Qualifications (if required): Miles City	Director	10/26/91
Mr. Gerald Himelspach, Broadus Qualifications (if required): Miles City	Director	10/26/91
Ms. Colleen Kohn, Miles City Qualifications (if required): Miles City	Director	10/26/91
Ms. Julie Krutzveldt, Miles City Qualifications (if required): Miles City	Director	10/26/91
Mr. Steven D. Rice, Miles City Qualifications (if required): Miles City	Director	10/26/91
Local Youth Services Advisory Council, Missoula (Family Services)		
Mr. Jerry Allen, Hamilton Qualifications (if required): Missoula	Director	10/26/91
Mr. Jon Ellingson, Missoula Qualifications (if required): Missoula	Director	10/26/91
Ms. Mary Ann Moon, Missoula Qualifications (if required): Missoula	Director	10/26/91
Rep. Barry "Spook" Stang, St. Regis Qualifications (if required): Missoula	Director	10/26/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Local Youth Services Advisory Council, Missoula	(Family Services)	
Ms. Mary Taylor, Missoula Qualifications (if required): Missoula	Director	10/26/91
Ms. Judy Wing, Missoula Qualifications (if required): Missoula	Director	10/26/91
Prison Ranch Advisory Council (Institutions)		
Rep. Francis Bardanouve, Harlem Qualifications (if required): none specified	Director	9/1/91
Mr. Don Davis, Deer Lodge Qualifications (if required): none specified	Director	9/1/91
Rep. Edward J. "Ed" Grady, Canyon Creek Qualifications (if required): none specified	Director	9/1/91
Sen. Francis Koehnke, Townsend Qualifications (if required): none specified	Director	9/1/91
Sen. Ray Lybeck, Kalispell Qualifications (if required): none specified	Director	9/1/91
State Employee Group Benefits Advisory Council	(Administration)	
Ms. Cindy Anders, Helena Qualifications (if required): none specified	Governor	9/1/91
Ms. Laurie Ekanger, Helena Qualifications (if required): none specified	Governor	9/1/91
Ms. Nancy Ellery, Helena Qualifications (if required): member	Governor	9/1/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
State Employee Group Benefits Advisory Council	(Administration)	
Mr. David H. Evenson, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Mr. Ken Givens, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Ms. Nadiean Jensen, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Mr. Tom McCarthy, Warm Springs	Governor	9/1/91
Qualifications (if required): none specified		
Mr. Curt Nichols, Helena	Governor	9/1/91
Qualifications (if required): member		
Mr. William Salisbury, Helena	Governor	9/1/91
Qualifications (if required): member		
Mr. Thomas Schneider, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Mr. Scott Seacat, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Ms. Lois Steinbeck, Helena	Governor	9/1/91
Qualifications (if required): none specified		
Mr. Dennis M. Taylor, Missoula	Governor	9/1/91
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Water Plan Advisory Council (Natural Resources and Conservation)		
Mr. Ed Azure, Harlem Qualifications (if required): none specified	Governor	8/23/91
Mr. Byron Bayers, Twin Bridges Qualifications (if required): none specified	Governor	8/23/91
Sen. Esther Bengtson, Shepherd Qualifications (if required): none specified	Governor	8/23/91
Mr. Stan Bradshaw, Helena Qualifications (if required): none specified	Governor	8/23/91
Mr. Dueane Calvin, Ballantine Qualifications (if required): none specified	Governor	8/23/91
Mr. K. L. Cool, Helena Qualifications (if required): none specified	Governor	8/23/91
Sen. Jack Galt, Helena Qualifications (if required): none specified	Governor	8/23/91
Sen. Lorents Grosfield, Big Timber Qualifications (if required): none specified	Governor	8/23/91
Mr. Brian Kahn, Helena Qualifications (if required): none specified	Governor	8/23/91
Mr. Jess Kilgore, Three Forks Qualifications (if required): none specified	Governor	8/23/91
Mr. Glenn Marx, Helena Qualifications (if required): none specified	Governor	8/23/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Water Plan Advisory Council (Natural Resources and Conservation)		
Mr. Donald E. Pizzini, Great Falls Qualifications (if required): none specified	Governor	8/23/91
Mr. Chris Risbrudt, Missoula Qualifications (if required): none specified	Governor	8/23/91
Mr. Jim Wedeward, Billings Qualifications (if required): none specified	Governor	8/23/91
Mr. Mike Zimmerman, Butte Qualifications (if required): none specified	Governor	8/23/91
Water and Waste Water Operators Advisory Council (Health and Environmental Sciences)		
Mr. Robert L. Butcher, Billings Qualifications (if required): holds Class 1C license	Governor	10/16/91
Wheat and Barley Committee (Agriculture)		
Mr. Richard E. Sampsen, Dagmar Qualifications (if required): represents District I	Governor	8/29/91
Women in Employment Advisory Council (Governor)		
Ms. Jeanne C. Amsberry, Helena Qualifications (if required): none specified	Governor	8/9/91
Ms. Judy Birch, Helena Qualifications (if required): none specified	Governor	8/9/91
Ms. Virginia Bliss, Conrad Qualifications (if required): none specified	Governor	8/9/91
Ms. Aubyn Curtiss, Fortine Qualifications (if required): none specified	Governor	8/9/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Women in Employment Advisory Council (Governor)		
Ms. Ilene "Mike" Dallum, Cascade Qualifications (if required): none specified	Governor	8/9/91
Ms. Dolores Havdahl, Helena Qualifications (if required): member	Governor	8/9/91
Ms. Darlene Johnson, Wolf Point Qualifications (if required): none specified	Governor	8/9/91
Ms. Blanche Proul, Anaconda Qualifications (if required): none specified	Governor	8/9/91
Ms. Antoinette Fraser Rosell, Billings Qualifications (if required): none specified	Governor	8/9/91
Ms. Rosemarie Strope, Helena Qualifications (if required): none specified	Governor	8/9/91
Ms. Sue Weingartner, Helena Qualifications (if required): none specified	Governor	8/9/91
Youth Placement Advisory Council, 1st Judicial District (Family Services)		
Mr. James K. Benish, Helena Qualifications (if required): 1st Judicial District	Director	8/15/91
Mr. Lowell H. Luke, Helena Qualifications (if required): 1st Judicial District	Director	8/15/91
Mr. Richard L. Meeker, Helena Qualifications (if required): 1st Judicial District	Director	8/15/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 1st Judicial District (Family Services)		
Ms. Rosemary Miller, Helena	Director	8/15/91
Qualifications (if required): 1st Judicial District		
Mr. Norman Waterman, Helena	Director	8/15/91
Qualifications (if required): 1st Judicial District		
Youth Placement Advisory Council, 2nd Judicial District (Family Services)		
Ms. Sue Bennett, Butte	Director	8/15/91
Qualifications (if required): 2nd Judicial District		
Mr. Jim Fay, Anaconda	Director	8/15/91
Qualifications (if required): 2nd Judicial District		
Mr. Ed Heard, Butte	Director	8/15/91
Qualifications (if required): 2nd Judicial District		
Mr. Dave Manning, Butte	Director	8/15/91
Qualifications (if required): 2nd Judicial District		
Mr. Don Puich, Butte	Director	8/15/91
Qualifications (if required): 2nd Judicial District		
Youth Placement Advisory Council, 3rd Judicial District (Family Services)		
Ms. Jean S. Duncan, Deer Lodge	Director	8/15/91
Qualifications (if required): 3rd Judicial District		
Mr. Tim Hamm, Anaconda	Director	8/15/91
Qualifications (if required): 3rd Judicial District		
Ms. Frieda Howery, Deer Lodge	Director	8/15/91
Qualifications (if required): 3rd Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 3rd Judicial District (Family Services)		
Dr. Minott E. Pruyn, Missoula	Director	8/15/91
Qualifications (if required): 3rd Judicial District		
Mr. Jackie Sperry, Anaconda	Director	8/15/91
Qualifications (if required): 3rd Judicial District		
Ms. Bernie Sturm, Anaconda	Director	8/15/91
Qualifications (if required): 3rd Judicial District		
Youth Placement Advisory Council, 4th Judicial District (Family Services)		
Mr. Rodney C. Bates, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Mr. Gregory N. Burham, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Mr. John Contway, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Mr. Steve Gibson, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Ms. Carole Graham, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Mr. Bill Houchin, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Mr. Jim Parker, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 4th Judicial District (Family Services)		
Mr. Jack Rudio, Missoula	Director	8/15/91
Qualifications (if required): 4th Judicial District		
Youth Placement Advisory Council, 5th Judicial District (Family Services)		
Mr. Frank Hull, Dillon	Director	8/15/91
Qualifications (if required): 5th Judicial District		
Reverend Mary Jacques, Dillon	Director	8/15/91
Qualifications (if required): 5th Judicial District		
Mr. Dennis Kimzey, Dillon	Director	8/15/91
Qualifications (if required): 5th Judicial District		
Ms. Marj Montrose, Dillon	Director	8/15/91
Qualifications (if required): 5th Judicial District		
Mr. Emery Smith, Twin Bridges	Director	8/15/91
Qualifications (if required): 5th Judicial District		
Youth Placement Advisory Council, 6th Judicial District (Family Services)		
Ms. Kathy Ellison, Livingston	Director	8/15/91
Qualifications (if required): 6th Judicial District		
Mr. Mike G. Fleming, Livingston	Director	8/15/91
Qualifications (if required): 6th Judicial District		
Ms. Juanita M. Freeman, Livingston	Director	8/15/91
Qualifications (if required): 6th Judicial District		
Mr. Steve Hoppes, Livingston	Director	8/15/91
Qualifications (if required): 6th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 6th Judicial District (Family Services)		
Mr. Gerald S. Spalding, Livingston	Director	8/15/91
Qualifications (if required): 6th Judicial District		
Youth Placement Advisory Council, 7th Judicial District (Family Services)		
Mr. Craig J. Anderson, Glendive	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Ms. Audrey Crook, Sidney	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Mr. Rod Huisman, Miles City	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Ms. Vicki Metcalfe, Sidney	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Ms. Bonne Lu Perry, Sidney	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Ms. Joan Ritter, Sidney	Director	8/15/91
Qualifications (if required): 7th Judicial District		
Youth Placement Advisory Council, 8th Judicial District (Family Services)		
Ms. Lynette Bolender, Great Falls	Director	8/15/91
Qualifications (if required): 8th Judicial District		
Ms. Marsha Brunett, Great Falls	Director	8/15/91
Qualifications (if required): 8th Judicial District		
Mr. Dennis Dronen, Great Falls	Director	8/15/91
Qualifications (if required): 8th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 8th Judicial District (Family Services)		
Dr. Renee Johnson, Great Falls Qualifications (if required): 8th Judicial District	Director	8/15/91
Ms. Sharon Lindstrom, Great Falls Qualifications (if required): 8th Judicial District	Director	8/15/91
Ms. Ingrid Wagner, Great Falls Qualifications (if required): 8th Judicial District	Director	8/15/91
Youth Placement Advisory Council, 9th Judicial District (Family Services)		
Ms. Eva Burney, Cut Bank Qualifications (if required): 9th Judicial District	Director	8/15/91
Ms. Rita Christiaens, Conrad Qualifications (if required): 9th Judicial District	Director	8/15/91
Mr. James Richard Gunlikson, Cut Bank Qualifications (if required): 9th Judicial District	Director	8/15/91
Ms. Mary Meis, Shelby Qualifications (if required): 9th Judicial District	Director	8/15/91
Mr. Matt Shearer, Cut Bank Qualifications (if required): 9th Judicial District	Director	8/15/91
Ms. Sue Walley, Cut Bank Qualifications (if required): 9th Judicial District	Director	8/15/91
Ms. Linda Warden, Browning Qualifications (if required): 9th Judicial District	Director	8/15/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 10th Judicial District (Family Services)		
Mr. Michael L. Ikard, Lewistown Qualifications (if required): 10th Judicial District	Director	8/15/91
Mr. Michael F. Otto, Lewistown Qualifications (if required): 10th Judicial District	Director	8/15/91
Mr. Mike Steuhm, Lewistown Qualifications (if required): 10th Judicial District	Director	8/15/91
Mr. Joseph Cahill, Lewistown Qualifications (if required): 10th Judicial District	Director	8/15/91
Ms. Boni Braunbeck, Lewistown Qualifications (if required): 10th Judicial District	Director	8/15/91
Youth Placement Advisory Council, 11th Judicial District (Family Services)		
Ms. Ruth Davis, Kalispell Qualifications (if required): 11th Judicial District	Director	8/15/91
Mr. Bill Harris, Kalispell Qualifications (if required): 11th Judicial District	Director	8/15/91
Mr. Patrick C. Lee, Kalispell Qualifications (if required): 11th Judicial District	Director	8/15/91
Ms. Mary Schulze, Kalispell Qualifications (if required): 11th Judicial District	Director	8/15/91
Mr. Patrick Warnecke, Kalispell Qualifications (if required): 11th Judicial District	Director	8/15/91

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 12th Judicial District (Family Services)		
Mr. Bryce Johnson, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Ms. Nancy Neibauer, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Ms. Judy Rominger, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Dr. Laurence C. Stineford, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Mr. Keith Turck, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Mr. Joe Uhl, Havre	Director	8/15/91
Qualifications (if required): 12th Judicial District		
Youth Placement Advisory Council, 13th Judicial District (Family Services)		
Mr. Corum Cunninham, Billings	Director	8/15/91
Qualifications (if required): 13th Judicial District		
Mr. Gary Huffmaster, Billings	Director	8/15/91
Qualifications (if required): 13th Judicial District		
Mr. Ted Lechner, Billings	Director	8/15/91
Qualifications (if required): 13th Judicial District		
Mr. Leonard Orth, Billings	Director	8/15/91
Qualifications (if required): 13th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 13th Judicial District	(Family Services)	
Ms. Betty Petek, Billings	Director	8/15/91
Qualifications (if required): 13th Judicial District		
Youth Placement Advisory Council, 14th Judicial District	(Family Services)	
Ms. Boni Braunbeck, Lewistown	Director	8/15/91
Qualifications (if required): 14th Judicial District		
Mr. Joseph Cahill, Billings	Director	8/15/91
Qualifications (if required): 14th Judicial District		
Mr. Mike Ikard, Lewistown	Director	8/15/91
Qualifications (if required): 14th Judicial District		
Mr. Mike Otto, Lewistown	Director	8/15/91
Qualifications (if required): 14th Judicial District		
Mr. Mike Steuhm, Lewistown	Director	8/15/91
Qualifications (if required): 14th Judicial District		
Youth Placement Advisory Council, 15th Judicial District	(Family Services)	
Mr. James Allen, Plentywood	Director	8/15/91
Qualifications (if required): 15th Judicial District		
Mr. J. T. Brownlee, Wolf Point	Director	8/15/91
Qualifications (if required): 15th Judicial District		
Ms. Wilma Desjarlais, Poplar	Director	8/15/91
Qualifications (if required): 15th Judicial District		
Mr. William E. Lumpkin, Wolf Point	Director	8/15/91
Qualifications (if required): 15th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 15th Judicial District (Family Services)		
Mr. Michael Preyer, Wolf Point	Director	8/15/91
Qualifications (if required): 15th Judicial District		
Youth Placement Advisory Council, 16th Judicial District (Family Services)		
Mr. Ernest "Sonny" Butts, Miles City	Director	8/15/91
Qualifications (if required): 16th Judicial District		
Mr. Jim Hunter, Miles City	Director	8/15/91
Qualifications (if required): 16th Judicial District		
Ms. Gordon Jackson, Miles City	Director	8/15/91
Qualifications (if required): 16th Judicial District		
Ms. Sue Matthews, Miles City	Director	8/15/91
Qualifications (if required): 16th Judicial District		
Mr. Nolan Mickelson, Miles City	Director	8/15/91
Qualifications (if required): 16th Judicial District		
Youth Placement Advisory Council, 17th Judicial District (Family Services)		
Mr. Mike Boyer, Glasgow	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Mr. Robert E. Brown, Glasgow	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Mr. Dain Christianson, Glasgow	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Mr. Bob McNeel, Harlem	Director	8/15/91
Qualifications (if required): 17th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 17th Judicial District (Family Services)		
Ms. Carolyn Nyquist, Glasgow	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Ms. Darlene Pomeroy, Chinook	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Mr. Preston L. Stiffarm, Harlem	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Ms. Lori Tresch, Glasgow	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Ms. Linda Uhl, Chinook	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Mr. Tim Whitney, Chinook	Director	8/15/91
Qualifications (if required): 17th Judicial District		
Youth Placement Advisory Council, 18th Judicial District (Family Services)		
Ms. Joan Davies, Bozeman	Director	8/15/91
Qualifications (if required): 18th Judicial District		
Ms. Dorothy Filson, Bozeman	Director	8/15/91
Qualifications (if required): 18th Judicial District		
Mr. David Gates, Bozeman	Director	8/15/91
Qualifications (if required): 18th Judicial District		
Ms. Sharon Hanton, Bozeman	Director	8/15/91
Qualifications (if required): 18th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 18th Judicial District (Family Services)		
Mr. Mark Salo, Bozeman	Director	8/15/91
Qualifications (if required): 18th Judicial District		
Youth Placement Advisory Council, 19th Judicial District (Family Services)		
Ms. Nancy Chalgren, Libby	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Mr. John P. Freemole, Polson	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Mr. Gordon F. Gerrish, Ronan	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Ms. Susan Smith, Libby	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Ms. Catherine L. Spencer, Libby	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Ms. Marie Studebaker, Libby	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Ms. Lee Tonner, Libby	Director	8/15/91
Qualifications (if required): 19th Judicial District		
Youth Placement Advisory Council, 20th Judicial District (Family Services)		
Ms. Marilyn C. Becker, Polson	Director	8/15/91
Qualifications (if required): 20th Judicial District		
Mr. Dennis Jones, Pllson	Director	8/15/91
Qualifications (if required): 20th Judicial District		

VACANCIES ON BOARDS AND COUNCILS -- August 1 through October 31, 1991

Board/current position holder	Appointed by	Term end
Youth Placement Advisory Council, 20th Judicial District (Family Services)		
Mr. David W. McDougall, Polson	Director	8/15/91
Qualifications (if required): 20th Judicial District		
Youth Services Advisory Council (Justice)		
Mr. Donald Wetzel, Harlem	Governor	9/27/91
Qualifications (if required): none specified		