MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 20

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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 STATE COMPENSATION MUTUAL INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the proposed adoption of new rule pertaining to the medical deductible plan and amendments of rules pertaining to the assignment of classifications and premium ratesetting	NOTICE OF PUBLIC HEARING FOR PROPOSED ADOPTION OF NEW RULE PERTAINING TO THE MEDICAL DEDUCTIBLE PLAN AND AMENDMENTS OF RULES 2.55.301 and 2.55.305

TO: All Interested Persons:

1. On November 20, 1991, the State Compensation Mutual Insurance Fund will hold a public hearing at 10 a.m., in Room 303 of the State Compensation Mutual Insurance Fund Building, 5 South Last Chance Gulch, Helena, Montana, to consider the adoption of new rule I, and amendment of rules 2.55.301 and 2.55.305 pertaining to the State Compensation Mutual Insurance Fund.

2. The proposed new rule does not replace or modify any section currently found in the Administrative Rules of Montana. The proposed new rule implements the medical deductible plan offered by the State Compensation Mutual Insurance Fund to its policyholders.

3. The proposed new rule is as follows:

RULE I. MEDICAL DEDUCTIBLE (1) The state fund offers an annual medical deductible plan in increments of $500, $1,000, $1,500, $2,000 and $2,500 per claim. This plan allows qualified employers to reimburse the state fund for a selected deductible amount of the medical costs of each claim in exchange for a premium discount.

(2) To qualify for the plan, an employer must:

(a) file an endorsement form, provided by the state fund; and

(b) have annual premium which equals or exceeds the chosen deductible amount; and

(c) demonstrate the ability to promptly pay the deductible amounts by not having a poor premium payment history with the state fund.

(3) The state fund is responsible for initial payment of medical benefits; then bills the employer for reimbursement up to the chosen deductible amount. The state fund may cancel the employer's policy for failure to reimburse the state fund for expended medical deductible amounts.

AUTH: 39-71-2316, MCA; IMP: 39-71-434 and 39-71-2311, MCA.

Rationale: To describe the statutorily required medical deductible plan offered by the State Fund and set forth qualifying criteria for individual insureds.

4. The proposed amendment to 2.55.301 updates the rule to reflect the latest issuance date of the classification section of the state fund underwriting manual. The proposed amendments to 2.55.305 allow a fee-based method of determining premium rates, rather than a payroll-based method; clarifies the method of calculating the premium rate of a classification which does not have sufficient state fund experience to allow for an experienced-based rate; and provides for an interim premium rate adjustment.

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

2.55.301 METHOD FOR ASSIGNMENT OF CLASSIFICATIONS OF EMPLOYMENTS (1) and (2) remain the same.

(3) The state fund shall assign its insureds to classifications contained in the classifications section of the State Compensation Insurance Fund Policy Services Underwriting Manual issued ~~July 1, 1991~~ January 1, 1992. That section of the manual is hereby incorporated by reference. Copies of the classification section of the manual may be obtained from the Underwriting Department of the State Fund, 5 South Last Chance Gulch, Helena, Montana 59604-4759.

AUTH: 39-71-2316 MCA; IMP, 39-71-2311 and 39-71-2316 MCA.

Rationale: Amends the issuance date of the classification section of the state fund underwriting manual to include new additions and modifications.

2.55.305 PREMIUM RATESETTING (1) Except as provided in subsections (2) through ~~(4)~~(5), to establish a premium rate for a classification for the following fiscal year, the state fund shall apply a factor to each credibility weighted rate in an amount sufficient to ensure that the aggregate of the premium for all classifications provides an amount sufficient to meet the actuarily determined aggregate revenue projections.

(2) The state fund shall evaluate an individual classification to determine whether the process for setting the premium rate results in an equitable rate based on an analysis of the losses and the premium amount and, if the rate is not equitable, may adjust it so that it is equitable. If this analysis determines payrolls are not sufficiently verifiable for an industry, a method other than payroll, such as a fee basis, may be used.

(3) If appropriate, the state fund may ~~review~~ set a classification's rate at a percentage of the National Council on Compensation Insurance (NCCI) ~~rates for the same classification in determining a premium~~ rate based on a factor recommended by the state fund actuary or at the rate of an equivalent class code recommended by NCCI or the state fund actuary. These situations include, but are not limited to:

(a) a new industry or occupation;

(b) an industry or occupation without state fund experience;

(c) an industry or occupation which has changed significantly; or

(d) an industry or occupation with significant changes in class code definition or application.

(4) Remains the same.

(5) The state fund may, with concurrence of the state fund board of directors, implement interim premium rate changes. The interim adjustment of the premium rates for classifications may be either experience based as set forth in ARM 2.55.302 through 2.55.305(1) or the same percentage increase or decrease may be applied to each classification's rate.

AUTH: 39-71-2316 MCA; IMP, 39-71-2311 and 39-71-2316 MCA.

Rationale: To use a method, other than payroll, such as a fee basis to determine the premium rate when payroll cannot be sufficiently verified to allow for an equitable rate in a classification.

To define a rate setting method for a new or changed industry or occupation by using NCCI rates as a basis or by following the State Fund actuary's recommendations when the industry or occupation is new, lacks sufficient state fund experience, has changed significantly or has undergone a significant change in class code description or application.

To allow for an interim premium rate adjustment which could be either experienced based or on a percentage increase or decrease applied to each classification rate.

6. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written testimony may be submitted to state fund attorney Nancy Butler, Legal Department, State Compensation Mutual Insurance Fund, 5 South Last Chance Gulch, Helena, Montana 59604-4759, no later than November 28, 1991.

7. The State Fund Legal and Underwriting Departments have been designated to preside over and conduct the hearing.

8. The authority of the state fund to make the proposed rules is based on section 39-71-2316, MCA, and the rules implement 39-71-434 and 39-71-2311.

State Compensation Mutual Insurance Fund

By: Dal Smilie
Rule Reviewer

By: Patrick J. Sweeney, President

Certified to the Secretary of State October 21, 1991

MAR Notice No. 2-55-5

20-10/31/91

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the proposed)
amendment of rule relating to) NOTICE OF PROPOSED AMENDMENT
supervisors of special educ.) OF ARM 10.16.1705

NO PUBLIC HEARING CONTEMPLATED

To: All interested persons

1. On November 30, 1991, the Superintendent of Public Instruction proposes to amend Rule 10.16.1705.

2. The rule, as proposed to be amended, new material underlined, provides as follows:

10.16.1705 SUPERVISORS OF SPECIAL EDUCATION TEACHERS (1) Supervisors of special education teaching personnel must have a Class III administrator's certificate with a principal's endorsement or a supervisor's endorsement in special education.

(AUTH: Sec. 20-7-403, MCA; IMP: 20-7-403, MCA)

3. As the result of a complaint filed with the Office of Public Instruction, the proposed rule change is presented. Specifically, the complaint alleged that ARM 10.16.1705 is not implemented as it is currently written.

4. Interested persons may submit their data, views or arguments concerning the proposed rule changes in writing to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on November 29, 1991.

5. If a person who is directly affected by the proposed amendment wishes to express his/her data, views and arguments orally or in writing at a public hearing, s/he must make written request for a hearing and submit this request along with any written comments s/he may have to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on November 29, 1991.

6. If OPI receives requests for a public hearing 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 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.

Nancy Keenan
Nancy Keenan
Superintendent
Office of Public Instruction

Rule Reviewer

Certified to the Secretary of State October 21, 1991

BEFORE THE STATE LIBRARY COMMISSION
STATE OF MONTANA

In the matter of the adoption of Rule I pertaining to direct state aid to public libraries for per capita and per square mile served and the amendment of ARM 10.102.4001 pertaining to reimbursement to libraries for interlibrary loans	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I PERTAINING TO DIRECT STATE AID TO PUBLIC LIBRARIES FOR PER CAPITA AND PER SQUARE MILE SERVED AND ON THE PROPOSED AMENDMENT OF ARM 10.102.4001 FOR REIMBURSEMENT TO LIBRARIES FOR INTERLIBRARY LOANS

TO: All Interested Persons

1. On November 20, 1991, at 2:00 p.m., a public hearing will be held in the conference room of the Montana State Library, 1515 E. Sixth Avenue, Helena, Montana to consider the proposed adoption of Rule I pertaining to direct state aid to public libraries for per capita and per square mile served, and the proposed amendment of the rule pertaining to reimbursement to libraries for interlibrary loans under the provisions of H.B. 193.

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

Rule I DIRECT STATE AID TO PUBLIC LIBRARIES FOR PER CAPITA AND FOR PER SQUARE MILE SERVED (1) Definitions used in this section include:

(a) "Public library" means those libraries as defined in 22-1-303 through 22-1-317 MCA, and in Title 7 MCA.

(b) "Population" means those official, final figures from the most recent decennial census of population produced by the U.S. bureau of the census.

(c) "Leftover population" means the population count remaining in each county after the population counts of each municipality with library service are subtracted.

(d) "Additional population" means the population count which is to be credited to each public library based on the proportion of that municipality's population to the total population of the county.

(e) "Leftover square miles" means the number of square miles left in each county after the square miles of each municipality with public library service are subtracted from the total number of square miles in the county.

(f) "Additional square miles" means the number of square miles credited to each public library, based on the proportion of that municipality's population to the total population of the county.

(2) The per capita portion of the direct state aid to public libraries will be distributed annually based on the following:

(a) In counties which have county-wide library service from one public library, or in which only one municipal public library exists, the most recent decennial census figure will be multiplied by the amount of state aid available per capita in each year.

(b) In each county with more than one municipal public library, the following procedure will be employed:

(i) The population counts of all municipalities with public libraries are added together and subtracted from the total county population resulting in the leftover population figure.

(ii) Each year all monies received by these libraries from the county commission are added together; each year each library's total is divided by the total amount received by all the libraries to determine the percentage of money given to each library by the county.

(iii) The leftover population figure is multiplied by the percentage of money each library receives from the county in order to determine the additional population figure which will be credited to each library.

(iv) The municipal population and additional population figures are added together to determine the total population which will be credited to each library.

(v) For each library the total population credited to each library is multiplied by the amount of per capita state aid available in each year to determine the total per capita support.

(vi) In the case of counties in which no county aid is provided to municipal libraries, the additional population credited to each library is based solely on the ratio of each municipal library's service area population to the total county population.

(vii) In the case of counties in which only one of two or several municipal libraries receives county aid, the library receiving county aid is credited with the entire county population exclusive of the population present in the service area populations of any other municipal libraries.

(viii) The population counts of legally annexed areas, as determined by the latest decennial U.S. census, will be credited to the municipality annexing the area the year following the annexation.

(3) The per square mile portion of the direct state aid to public libraries will be distributed annually based on the following:

(a) In counties which have county-wide library service from one public library, or in which only one municipal public library exists, the total square miles of each county will be multiplied by the amount of state aid available per square mile in each year.

(b) In each county with more than one municipal public library, the following procedure will be employed:

(i) The number of square miles of all municipalities with

BEFORE THE STATE LIBRARY COMMISSION
STATE OF MONTANA

In the matter of the adoption of Rule I pertaining to direct state aid to public libraries for per capita and per square mile served and the amendment of ARM 10.102.4001 pertaining to reimbursement to libraries for interlibrary loans	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I PERTAINING TO DIRECT STATE AID TO PUBLIC LIBRARIES FOR PER CAPITA AND PER SQUARE MILE SERVED AND ON THE PROPOSED AMENDMENT OF ARM 10.102.4001 FOR REIMBURSEMENT TO LIBRARIES FOR INTERLIBRARY LOANS

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(a) "Public library" means those libraries as defined in 22-1-303 through 22-1-317 MCA, and in Title 7 MCA.

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(c) "Leftover population" means the population count remaining in each county after the population counts of each municipality with library service are subtracted.

(d) "Additional population" means the population count which is to be credited to each public library based on the proportion of that municipality's population to the total population of the county.

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(2) The per capita portion of the direct state aid to public libraries will be distributed annually based on the following:

(a) In counties which have county-wide library service from one public library, or in which only one municipal public library exists, the most recent decennial census figure will be multiplied by the amount of state aid available per capita in each year.

(b) In each county with more than one municipal public library, the following procedure will be employed:

(i) The population counts of all municipalities with public libraries are added together and subtracted from the total county population resulting in the leftover population figure.

(ii) Each year all monies received by these libraries from the county commission are added together; each year each library's total is divided by the total amount received by all the libraries to determine the percentage of money given to each library by the county.

(iii) The leftover population figure is multiplied by the percentage of money each library receives from the county in order to determine the additional population figure which will be credited to each library.

(iv) The municipal population and additional population figures are added together to determine the total population which will be credited to each library.

(v) For each library the total population credited to each library is multiplied by the amount of per capita state aid available in each year to determine the total per capita support.

(vi) In the case of counties in which no county aid is provided to municipal libraries, the additional population credited to each library is based solely on the ratio of each municipal library's service area population to the total county population.

(vii) In the case of counties in which only one of two or several municipal libraries receives county aid, the library receiving county aid is credited with the entire county population exclusive of the population present in the service area populations of any other municipal libraries.

(viii) The population counts of legally annexed areas, as determined by the latest decennial U.S. census, will be credited to the municipality annexing the area the year following the annexation.

(3) The per square mile portion of the direct state aid to public libraries will be distributed annually based on the following:

(a) In counties which have county-wide library service from one public library, or in which only one municipal public library exists, the total square miles of each county will be multiplied by the amount of state aid available per square mile in each year.

(b) In each county with more than one municipal public library, the following procedure will be employed:

(i) The number of square miles of all municipalities with

public libraries are added together and subtracted from the total number of square miles in the county to determine the leftover square miles.

(ii) The population counts of all municipalities with public libraries are added together, and each library's population is divided by the total county population to determine the percentage of the county population credited to each library.

(iii) The leftover square miles figure is multiplied by the percentage of the county population credited to each library in order to determine the additional square miles to be credited to each library.

(iv) Each municipality's square miles are added to their appropriate additional square miles to determine the total square miles credited to each library.

(v) For each library the total square miles credited to each library is multiplied by the amount of per square mile state aid available in each year to determine the total per capita support.

(4) In the case of library districts which are not defined by municipal or county boundaries, but by boundaries such as school districts, both the per capita and the per square mile state aid will be distributed using the appropriate boundaries and population figures as if they were municipal or county boundaries and counts.

(5) In each county which has no public libraries, the state library will contact the county commission indicating that the county will qualify for per capita and per square mile state aid if the county commission establishes county-wide library service as provided for in state statute, or if the county commission contracts for library services with another county or municipal library as provided for in state statute. If such means are not established within a six-month period following written notice received from the state library, the state aid which would have gone to the county will be distributed according to guidelines approved by the state library commission.

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

AUTH: Sec. 22-1-330 MCA
IMP: Sec. 22-1-327 MCA

3. H.B. 193, passed by the 51st Legislature, recognized the need to provide state support for Montana's libraries. The portion of this bill with which this rule deals, provides for the following: (1) state direct support of local public libraries on a per capita basis; and (2) state direct support of local public libraries on a per square mile basis. This rule will provide an equitable means to distribute such aid in recognition of the contribution such libraries make to the total information resources of the state, and to help insure equitable

library services for all its citizens.

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

10.102.4001 REIMBURSEMENT TO LIBRARIES FOR INTERLIBRARY LOANS

(1) Section (1) remains as in the current rule.
(2) Reimbursements will be made on a quarterly basis based on the following:

(a) Reimbursement will be made at ~~the~~ a rate ~~of $5.50 per item loaned~~ determined by the state library. This will be effective July 1, 1992.

(2)(a) through (2)(h) remain as in the current rule.

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

REASON: The proposed amendment will allow the reimbursement rate to be set based upon the number of prior years' transactions and will result in a more equitable rate being set for the entire year.

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 Richard Miller, State Librarian, Montana State Library, 1515 East 6th Avenue, Helena, Montana 59620, no later than December 5, 1991.

6. Mary Doggett, Chair of the State Library Commission, will preside over and conduct the hearing.

7. Rule I pertaining to direct state aid to public libraries for per capita and per square mile served will be applied retroactively to July 1, 1991.

Richard T. Miller, Jr.
State Librarian
Rule Reviewer

Mary Doggett, Chairman
Montana State Library
Commission

Certified to the Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of rules implementing laws adopted by the 52nd Legislature, amendments of Rules 24.29.1401 to 24.29.1405, 24.29.1415, and 24.29.1425; repeal of Rule 24.29.1420 relating to Workers' Compensation Medical Services	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULES, AMENDMENT AND REPEAL OF RULES RELATING TO WORKERS' COMPENSATION MEDICAL SERVICES

TO ALL INTERESTED PERSONS:

1. On November 22, 1991, at 10:00 a.m., a public hearing will be held at first floor conference room, Department of Labor and Industry, 1327 Lockey, Helena, Montana to consider the proposed adoption of new rules I and II; amendments to rules 24.29.1401 to 24.29.1405, 24.29.1415, and 24.29.1425; and the repeal of rule 24.29.1420.

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

3. The proposed new rules are as follows:

RULE I APPLICABILITY OF DATE OF INJURY, DATE OF SERVICE (1) Sections of the Workers' Compensation and Occupational Disease Acts and the Administrative Rules of Montana relating to medical payments or medical benefits, including section 39-71-704(1)(c), MCA, and ARM 24.29.1409, apply only to claims for which the date of injury is on or after the effective date of the section in question, except that for all pharmacy services rendered on or after July 1, 1991, an insurer is liable only for the purchase of generic-name drugs according to the provisions of section 39-71-704(1), MCA, regardless of the date of injury.

(2) The amounts of the following types of payments are determined according to the specific department rates in effect on the date the medical service is provided, regardless of the date of injury: medical fees; hospital charges; travel reimbursements for mileage, meals, and lodging; generic-name drugs. The rate for a specific generic-name drug is the price customarily charged by the pharmacist for that drug.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA
39-71-727, MCA

RULE II MONTANA MEDICAL FEE SCHEDULE (1) The department's annual schedule of fees for medical nonhospital services is known as the Montana Medical Fee Schedule and is effective January 1 of each year. An insurer is not obligated to pay more than the fee listed in the schedule for a service rendered.

(2) The Montana Medical Fee Schedule comprises the following:

(a) The relative value scales given in the most current edition or updates of the publication Relative Values for Physicians (RVP), published by SysteMetrics/McGraw-Hill, for the following specialty areas:

(i) anesthesia,
(ii) surgery,
(iii) radiology,
(iv) pathology,
(v) medicine.

The relative value scales are the listings of unit values, procedure codes, and descriptions for all listed services, as well as the follow-up days for surgery services.

(b) The most current relative value scale issued by the department for dental services. The scale must include procedure codes, descriptions, and unit values.

(c) The most current conversion factors issued by the department for the specialty areas listed in subsection (2)(a) and for the dental specialty area.

(d) All instructions, definitions, guidelines, and other explanations given in the most current edition or updates of the RVP, affecting the determination of individual fees, except as specifically revised or deleted by the department.

(e) Any additions, deletions, or revisions issued by the department to the relative value scales or to the information listed in subsection (2)(d).

(3) Conversion factors effective January 1, 1992, for anesthesia, surgery, radiology, pathology, and medicine shall be established by the department according to the following methodology, to be applied separately for each specialty area:

(a) Identify the ten most common (frequently billed) procedures in the specialty area, using the most recently available data from the state compensation mutual insurance fund (SCMIF).

(b) For each of the ten procedures identified in subsection (3)(a) identify the current (1987) fee.

(c) Multiply the 1987 fee by 1.0402 to produce an increased fee for each of the ten procedures.

(d) Identify the current RVP unit value for each of the ten procedures.

(e) Find the individual procedure conversion factor for each of the ten procedures by dividing the increased fee by the RVP unit value.

(f) Determine the overall conversion factor for the specialty area by calculating the weighted average of the ten individual procedure conversion factors. Weight each procedure conversion factor according to the number of transactions shown in the SCMIF data.

(4) The conversion factor and relative value scale effective January 1, 1992, for the dental specialty area shall be established by the department according to the following methodology:

(a) Identify the ten most common (frequently billed)

procedures in the specialty area using the most recently available SCMIF data.

(b) For each of the ten procedures identify the current (1987) fee.

(c) Multiply the 1987 fee by 1.0402 to produce an increased fee for each of the ten procedures.

(d) Determine the median amount billed for each of the ten procedures using the SCMIF data.

(e) Divide the increased fee by the median amount billed to produce a procedure discount factor for each of the ten procedures.

(f) Determine the overall discount factor for dental fees by calculating the weighted average of the ten individual procedure discount factors. Weight each procedure discount factor according to the number of transactions shown in the SCMIF data.

(g) Determine the median amounts billed for all remaining dental procedures, using the SCMIF data. Update procedure codes or descriptions, and delete procedures, as necessary to retain only currently recognized dental procedures.

(h) Establish approved fees for all dental procedures described in subsection (4)(g) by multiplying each procedure's median amount billed by the overall dental discount factor.

(i) Define the conversion factor in the dental specialty area as the approved fee for the most common procedure.

(j) Establish unit values for all dental procedures by dividing approved fees by the dental conversion factor.

(5) Conversion factors for the anesthesia, surgery, radiology, pathology, medicine, and dental specialty areas shall be established annually by the department beginning January 1, 1993, by increasing the conversion factors from the preceding year by the percentage increase in the state's average weekly wage. Beginning in 1993 the dental relative value scale may be updated by the department on January 1 of any year as necessary to maintain the most current dental procedural terminology. Updates may include the addition or deletion of individual procedures or the revision of individual procedure codes or descriptions.

(6) The department may, in its discretion and upon evidence received from Montana insurers or providers, adjust any of the conversion factors or dental unit values determined according to the methodologies given in subsections (3) and (4).

(7) The department shall make available to all users of the Montana Medical Fee Schedule order forms for obtaining directly from the publisher, at a discounted price, copies of the 1991 edition of Relative Values for Physicians. Subsequent editions of RVP may be obtained directly from the publisher. Users may contact the department to inquire about possible discounts for these editions.

(8) The Montana Medical Fee Schedule applies uniformly to the charges of all health care practitioners authorized to provide medical services under the Workers' Compensation or Occupational Disease Acts.

(9) Insurers shall make reasonable payments for medical services rendered. Services for which no fees are contained in the Montana Medical Fee Schedule are determined on a case-by-case basis, subject to the provisions of section 39-71-704(1)(a), MCA.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

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

24.29.1401 INITIAL LIABILITY (1) Remains the same.

(2) Remains the same.

(3) The injured worker is responsible for charges incurred for treatment of conditions which were not the result of the injury~~,~~ or for treatment when medical benefits have terminated according to section 39-71-704(1)(d), MCA.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) Payment of medical claims ~~will~~shall be made in accordance with ~~a~~the schedule of nonhospital medical fees and the hospital rates~~charges~~ adopted by the ~~division~~department.

(2) Remains the same.

(3) Payment of private room charges ~~will~~shall be made only if ordered by the treating physician.

(4) Special nurses ~~will~~shall be paid only if ordered by the treating physician.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

24.29.1403 SELECTION OF PHYSICIAN (1) Remains the same.

(2) Remains the same.

(3) Except in an emergency, approval of the insurer ~~must~~shall be obtained before referral of a worker to a medical specialist for consultation. The report of the consultant shall be available to the insurer upon request. Insurers may request consultation and evaluation by a physician of their choice.

(4) Remains the same.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

24.29.1404 DISPUTED MEDICAL CLAIMS (1) Disputes arising over ~~medical claims shall be~~the following issues are resolved by a hearing before the ~~division~~department upon written application of a party to the dispute or the injured worker~~,~~:

(a) Amounts payable to medical providers, when benefits available directly to claimants are not an issue,

(b) Access to medical records,

(c) Timeliness of payments to medical providers.

All other disputes arising over medical claims, including travel expense reimbursement to injured workers, shall be brought before a department mediator as provided in part 24 of the

Workers' Compensation Act.

(2) Remains the same.

(3) Remains the same.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

24.29.1405 PHYSICIAN'S REPORTS (1) Immediately after treatment of an injured worker, the physician shall complete ~~form 39, attending physician's report,~~ form ERD-462, attending physician's first report and initial treatment bill, and submit it to the appropriate insurer. Delay in filing the report delays payment of medical and compensation benefits. Incomplete or partially completed reports ~~must~~may be returned for proper completion.

(2) Remains the same.

(3) Routine medical reports are considered as a service to the injured worker and ~~there shall be~~ no charge is allowed for the report.

(4) Physicians' bills may be presented on the physician's statement form, providing the bill is properly identified with the name of the injured worker, employer, and date of accident. Each bill ~~shall~~must contain a short explanation of the status of the injured worker's case, his progress or prognosis, if feasible at the time, and the worker's ability to work. Bills shall be submitted every 30 days.

(5) Remains the same.

(6) Remains the same.

~~(7) Permanent impairments are rateable in percentages and ratings should be based on the American Medical Association Guide to Evaluation of Permanent Impairments.~~

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

24.29.1415 IMPAIRMENT RATING DISPUTE PROCEDURE (1) This section applies to dates of injury beginning July 1, 1987, through June 30, 1991. An evaluator must be a qualified physician licensed to practice in the state of Montana under Title 37, chapter 3, MCA, and board certified or board eligible in his area of specialty appropriate to the injury of the claimant, except that if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an impairment evaluator under Title 37, chapter 12, MCA. The claimant's treating physician may not be one of the evaluators to whom the claimant is directed by the department.

(2) through (6) will remain the same.

AUTH: 39-71-203, MCA IMP: 39-71-711, MCA

24.29.1425 RATES FOR HOSPITAL SERVICES (1) Beginning January 1, 1988, through December 31, 1991, hospital rates payable by workers' compensation insurers shall not exceed those rates prevailing in the hospital in effect on January 1, 1988.

~~(2) Rates for hospital services must be furnished to the division no later than December 31, 1987, on division approved~~

~~forms.--All-rate-filings-will-be-subject-to-division-approval.~~

~~(3)--An-insurer-is-not-obligated-to-pay-more-than-the maximum-rate-filed-with-the-division-for-the-particular-services rendered,-or-the-prevailing-rates-in-the-hospital-in-effect-on January-1,-1980,-for-services-not-provided-for-in-the-hospital's rate-filing.--Any-new-service-not-being-provided-on-or-before January-1,-1980,-must-be-filed-with-the-division-accompanied-by a-detailed-explanation-of-such-service.~~

(2) Beginning January 1, 1992, hospital rates payable shall not exceed the product of the rates prevailing in the hospital on the date of service and the discount factor issued by the department for the corresponding date of service. The department shall establish discount factors according to the following methodology:

(a) The discount factor in effect for a hospital beginning January 1, 1992, is the discount factor in effect on December 31, 1991, multiplied by 1.0402, and divided by the quantity 1 + ORI, where ORI is the overall percent rate increase, if any, adopted by the hospital for January 1, 1992, divided by 100. Discount factors in effect December 31, 1991, are those established by the department in accordance with subsection (1). These discount factors are available from the department upon request.

(b) The discount factor in effect for a hospital beginning July 1, 1992, is the discount factor in effect on June 30, 1992, multiplied by the quantity 1 + AWW93, and divided by the quantity 1 + ORI, where AWW93 is the percent increase in the state's average weekly wage over fiscal year 1992, divided by 100, and ORI is the overall percent rate increase, if any, adopted by the hospital for July 1, 1992, divided by 100. The discount factor in effect beginning July 1, 1993, is determined according to the equivalent formula for fiscal year 1993.

(c) In addition to the dates given in subsections (2)(a) and (2)(b), the discount factor for a hospital is also updated on any date(s) through December 31, 1993, for which a rate change is adopted by the hospital. The discount factor in effect beginning the date of rate adoption is the previous discount factor divided by the quantity 1 + ORI, where ORI is the overall percent rate increase adopted by the hospital, divided by 100.

(3) The overall rate increase adopted by a hospital shall be reported to the department on a department-approved form within thirty (30) days after the effective date of any rate change. Notification by the Montana Hospitals Rate Review System of the amount and date of an overall rate increase shall be accepted in lieu of direct rate change reporting by the hospital.

~~(4)--The-division~~The department may in its discretion conduct audits of any hospital's financial records, ~~for-hospitals required-to-file-rates-with-the-division,~~ to determine proper reporting of rate filings. ~~Each-hospital-filing-rates-with-the division-must-retain-records-for-at-least-five-(5)-years substantiating-such-rates-were-those-in-effect-on-January-1, 1980.~~

~~(5)--The-division-may-develop-new,-amended-or-modified rules-governing-rates-for-hospital-services.~~

(4) Charges billed by a hospital are not subject to reduction under the Montana Medical Fee Schedule, except that hospital professional fees may be paid according to either the fee schedule or the applicable hospital rates, but not both.

(5) Insurers shall make timely payments of hospital bills as follows:

(a) Within thirty (30) days of receipt of a hospital's charges an insurer shall either pay the charges according to the rates established in subsection (2), or notify the hospital that there will be a delay in payment. Notification must include the reasons for the delay.

(b) In cases where an insurer elects to conduct an audit of a hospital's charges with no dispute over liability, the insurer shall pay, within thirty (30) days of receipt of charges, seventy (70) percent of the amount determined according to the rates established in subsection (2) for the charges being audited.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

5. The following rule is to be repealed:

24.29.1420 RELATIVE VALUE FEE SCHEDULE can be found on pages 24-2157 to 24-2159 of the Administrative Rules of Montana. The repeal will be effective January 1, 1992.

AUTH: 39-71-203, MCA IMP: 39-71-704, MCA

6. Rationale. Pursuant to Workers' Compensation case law, the general rule is that amendments to statute or rules, or new laws or rules, including those for travel reimbursement, apply only to claims for which the date of injury is on or after the effective date of the section in question. Rule I is necessary to identify those areas where the date of service, rather than the date of injury applies. Payment for medical services are determined according to the specific department rate in effect on the date the medical services is provided, regardless of the date of injury. Ch. 131, L. 1991, amended section 39-71-704(1)(a), MCA, and added section 39-71-727, MCA. These sections limit the payment of prescription drugs to the purchase of generic-name products unless a physician specifies no substitution or the generic-name drug is unavailable. Payment for a prescription drug has always been at the rate at the time the prescription is filled, regardless of the date of injury.

Rule II implements the 1991 amendments to section 39-71-704, MCA. The legislative amendments removed the requirement that the medical fee schedule be based on the California Relative Value Studies and limit the increase in medical cost payable to no more than the annual percentage increase in the state's average weekly wage. Also, **ARM 24.29.1420 RELATIVE**

VALUE FEE SCHEDULE will be repealed.

Amendments to ARM 24.29.1401 implements the 1991 amendment to section 39-71-704, MCA, allowing termination of medical benefits when they are not used for a period of 60 consecutive months.

Amendments to ARM 24.29.1415 implements the 1991 amendments to section 39-71-1415, MCA, which removed the impairment disputes procedure from the Department's administrative process and subjects the disputes to mediation.

Amendments to ARM 24.29.1425 implement the 1991 amendments limiting medical cost increase to the percentage increase in the state's average weekly wage to hospital rates. Also, the amendment will implement recommendations of the Department's advisory committee on timely payment.

The other amendments make minor changes to language and style, and replace references to obsolete forms.

7. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to:

Dennis A. Zeiler, Chief
Department of Labor and Industry
P.O. Box 1728
Helena, MT 59624

no later than November 29, 1991.

8. The Hearings Unit, Legal Services Division, has been designated to preside over and conduct the hearing.

William E. O'Leary, Chief Counsel
Rule Reviewer

Mario A. Micone, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: October 21, 1991

BEFORE THE BOARD OF LAND COMMISSIONERS
AND THE DEPARTMENT OF STATE LANDS
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 26.4.1301A pertaining to the modification of existing coal and uranium permits	)))))	NOTICE OF PROPOSED AMENDMENT OF RULE 26.4.1301A NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On December 16, 1991 the Board of Land Commissioners proposes to amend rule 26.4.1301A which provides that each strip mine operating permit and coal test pit prospecting permit be revised by January 13, 1992.

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

26.4.1301A MODIFICATION OF EXISTING PERMITS: ISSUANCE OF REVISIONS AND PERMITS (1) By July 13, 1991 each operator and each test pit prospector shall submit to the department:

(a) an index to the existing permit cross-referencing each section of the permit to sub-chapters 3 through 12, as they read on January 12, 1989 and as they read on January 13, 1989;

(b) a modified table of contents for the existing permit;

(c) maps showing each portion of the permit area on which each of the following had been completed as of 11:59 p.m. on January 12, 1989:

(i) removal of overburden only;

(ii) removal of overburden and coal only;

(iii) removal of overburden and coal and backfilling and grading only;

(iv) removal of overburden and coal, backfilling and grading, and soiling only; and

(v) removal of overburden and coal, backfilling and grading, soiling and seeding and planting;

(d) an application for all permit revisions necessary to bring the permit and operations conducted thereunder into compliance with this rule and ARM 26.4.414 through 26.4.1122.

(2) A permit revision application submitted solely for purposes of subsection (1)(d) above is a minor revision for purposes of sub-chapter 4. The department shall issue written findings granting or denying the application within 5 months of its receipt.

(3) No permittee may continue to mine under an operating permit after ~~January 13, 1992~~ July 16, 1992, unless the permit has been revised to comply with subchapters 3 through 12, as amended January 13, 1989.

(4) As of the date that a permit is revised to comply with sub-chapters 3 through 12, as amended on January 13,

1989, the permittee shall conduct all operations in compliance with the permit and sub-chapters 3 through 12, as amended, except that:

(a) any area in which backfilling and grading operations had been completed on January 12, 1989 is subject to the backfilling and grading requirements as they read on that date;

(b) any area in which soiling operations had been completed on January 12, 1989 is subject to the soiling requirements as they read on that date; and

(c) any area for which the final minimum period of responsibility for establishing vegetation, as provided in ARM 26.4.725(1), had commenced on or before May 17, 1990 of ARM 26.4.724 through 26.4.735, as amended is subject to:

(i) the seeding and planting and related requirements as they read on that date; or

(ii) the seeding and planting requirements on or after May 18, 1990 of ARM 26.4.724 through 26.4.735, as amended.

(5) Each new permit and each amendment to an existing permit applied for and issued on or after January 13, 1989 must be in compliance with sub-chapters 3 through 12 as they read on January 13, 1989.

3. All strip mine permit holders have recently submitted permit modifications to the Department pursuant to ARM 26.4.1301A. Under that rule, these modifications require processing by January 13, 1992. Because of workload, the Department would have difficulty reviewing all modifications by that date. The proposed rule amendment would allow the Department more time for review of the modifications. This amendment is necessary to allow thorough processing of those strip mine permit modifications.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment in writing to Bonnie Lovelace, Montana Department of State Lands, Capitol Station, Helena, Montana, 59620, no later than December 1, 1991. To guarantee consideration, mailed comments must be postmarked no later than December 1, 1991.

5. If a person 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 or she must make written request for a hearing and submit this request along with any written comments to Bonnie Lovelace, Montana Department of State Lands, Capitol Station, Helena, Montana, 59620 no later than December 1, 1991.

6. If the agency receives requests for a public hearing 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 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 have been determined to be one person based on fewer than ten active coal mines.

7. The authority of the agency to make the proposed amendment is based on section 82-4-205, MCA, and the rule implements section 82-4-221, MCA.

Dennis D. Casey, Commissioner

Reviewed by:

John F. North
Chief Legal Counsel

Certified to the Secretary of State October 21, 1991.

BEFORE THE DEPARTMENT OF STATE LANDS
AND BOARD OF LAND COMMISSIONERS
OF THE STATE OF MONTANA

In the matter of the adoption of New Rules I through XIV implementing a recreational access program for state lands and amendment of ARM 26.3.156 pertaining to weeds, pests, and fire protection on state lands	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RECREATIONAL ACCESS RULES AND AMENDMENT OF ARM 26.3.156 RELATING TO WEEDS, PESTS, AND FIRE PROTECTION

TO: All Interested Persons:

1. From December 2, 1991 through December 5, 1991, the Department of State Lands and Board of Land Commissioners will hold hearings to consider adoption of Rules I through XIV pertaining to implementation of a recreational access program for state lands and amendment of ARM 26.3.156 pertaining to weeds, pests, and fire protection on state lands. The hearings will be held at the following locations on the following dates and at the following times :

- Glendive at the Best Western Holiday Lodge, 222 N. Kendrick Avenue on December 2, 1991 at 7:00 p.m.
- Havre at the Northern Montana College in Room 101, Hagener Science Center on December 2, 1991 at 7:00 p.m.
- Great Falls at the CMR High School Auditorium, 228 17th Ave. NW on December 2, 1991 at 7:00 p.m.
- Miles City at the Eagles Club, 24 North 8th on December 3, 1991 at 7:00 p.m.
- Glasgow at the Elks Lodge Meeting Room, 302 2nd Ave. S. on December 3, 1991 at 7:00 p.m.
- Helena at the Department of Social and Rehabilitation Services Auditorium, 111 Sanders Ave. on December 3, 1991 at 7:00 p.m.
- Billings at the Lincoln School Auditorium, corner of 4th Ave. N. and 29th St. on December 4, 1991 at 7:00 p.m.
- Lewistown at the Fergus High School Cafeteria, 201 Casino Creek Drive on December 4, 1991 at 7:00 p.m.
- Butte at the Montana Tech Library Auditorium, West Park Street, on December 4, 1991 at 7:00 p.m.
- Bozeman at the Courthouse Community Room, 311 W. Main on December 5, 1991 at 7:00 p.m.
- Missoula at the Lewis and Clark School Gymnasium, 2901 Park St. on December 5, 1991 at 7:00 p.m.
- Kalispell at Cavanaugh's Motor Inn, Ballroom B, 20 North Main on December 5, 1991 at 7:00 p.m.

2. The proposed new rules do not replace or modify any section found in the Administrative Rules of Montana except for ARM 26.3.156, which is expressly modified.

3. The proposed new rules read as follows:

RULE I. OVERVIEW OF RECREATIONAL USE RULES (1) Rules IV through XIV regulate the recreational use of state lands administered by the department of state lands. These lands are commonly referred to as "trust lands" and appear in light blue on most land status maps.

(2) Recreational use is divided into two categories as follows:

(a) General recreational use - This use is generally defined as hunting and related activities and fishing and is more specifically defined in Rule III (10). It requires purchase of a recreational use license. Detailed procedures and restrictions are contained in Rules IV through XIII.

(b) Special recreational use - This use is defined in Rule III (19) and requires a special recreational use license. These kinds of uses include commercial or concentrated use as defined in 77-1-101(5), MCA. Detailed provisions are contained in Rule XIV. (AUTH: Secs. 77-1-209, 77-1-804, 77-1-806, MCA; IMP, Secs. 77-1-801 through 77-1-810, MCA.)

RULE II. ADMINISTRATION OF RECREATION ON STATE LANDS ADMINISTERED BY THE DEPARTMENT OF STATE LANDS (1) Under Article X, Section 4 of the Montana Constitution, the board of land commissioners has the duty and authority to manage state trust lands under regulations provided in law. Under 77-1-301, MCA, the department of state lands manages state lands under the direction of the board. Section 77-1-203(3), MCA, opens state lands administered by the board to general recreational use subject to legal access and to closures and restrictions.

(2) Lands owned by the state that are not subject to [these rules] are:

(a) lands owned by the department of fish, wildlife and parks, including:

(i) those portions of game ranges and game management areas that are owned by the department of fish, wildlife and parks;

(ii) state parks;

(iii) fishing access sites; and

(iv) lands leased by the department of fish, wildlife and parks to private individuals as cabinsites;

(b) lands subject to lease, license, or easement from the department to the department of fish, wildlife and parks for the following purposes:

(i) state parks, and

(ii) fishing access sites;

(c) the surface, beds and banks of rivers, streams, and lakes that are navigable for recreational purposes;

(d) highways and highway rights-of-way;

(e) lands administered by the department of corrections and human services [formerly the department of institutions];

(f) campus grounds, experiment station grounds, and other lands owned by the university system;

(g) department of state lands administrative sites;

(h) lands in which the department of state lands does not own the surface, including lands where the department owns the mineral estate only and private lands over which the department has acquired an easement; and

(i) other lands owned by any other state agency.

(3) The main office of the department of state lands is located in Helena. To administer its field functions, the department has divided the state into six geographic "areas," each administered by an "area land office", the head of which is the "area manager." Areas are further divided into units, each administered by a "unit office." A listing of those offices is:

Area	Office Location
Central Area	
Central Land Office	Helena
Helena Unit Office	Helena
Bozeman Unit Office	Bozeman
Conrad Unit Office	Conrad
Dillon Unit Office	Dillon
Eastern Area	
Eastern Land Office	Miles City
Northeastern Area	
Northeastern Land Office	Lewistown
Glasgow Unit Office	Glasgow
Lewistown Unit Office	Lewistown
Northwestern Area	
Northwestern Land Office	Kalispell
Kalispell Unit Office	Kalispell
Libby Unit Office	Libby
Plains Unit Office	Plains
Stillwater Unit Office	Olney
Swan River Unit Office	Swan Lake
Southern Area	
Southern Land Office	Billings
Southwestern Area	
Southwestern Land Office	Missoula
Missoula Unit Office	Missoula
Hamilton Unit Office	Hamilton
Clearwater Unit Office	Greenough
Anaconda Unit Office	Anaconda

(4) Whenever in [these rules], the submission of a document, such as a petition, is required to be filed at an area or unit office, the document must be submitted to the area or unit office listed above that administers the state land to which the document pertains. Persons may contact any department office to determine the appropriate office for any tract of land.

(5) Whenever in [these rules], a formal or informal hearing is required to be held in an "area," the term "area" refers to the department area in which the land to which the hearing pertains is located. The hearing may be held, at the department's discretion, at any location within that area. (AUTH: Secs. 77-1-209, 77-1-804, 77-1-806, MCA; IMP, Secs. 77-1-801 through 77-1-810, MCA.)

RULE III. DEFINITIONS

Wherever used in [these rules], unless a different meaning clearly appears from the context:

(1) "Affidavit" means a signed statement, the truth of which has been sworn to or affirmed before a notary public, as evidenced by the signature and seal of the notary public.

(2) "Board" means the board of land commissioners provided for in Article X, section 4 of the Montana Constitution.

(3) "Closure" means prohibition of all general recreational use.

(4) "Commissioner" means the commissioner of state lands, provided for in 2-15-3202, MCA. The commissioner is the chief administrative officer of the department of state lands.

(5) "Dedicated county road" means a county road that has been created by means of donation of a landowner and acceptance by a county under statutory or common law dedication procedures.

(6) "Dedicated public road" means a road useable by the public under state or federal law. The term includes dedicated county roads.

(7) "Department" means the department of state lands provided for in Title 2, Chapter 15, part 32, MCA.

(8) "Drop box" means a receptacle in which a person making general recreational use of state lands may leave notice required pursuant to Rule IX(3) and (4).

(9) "Emergency" means, for the purposes of Rule VII and VIII, a situation that:

(a) creates an imminent threat to personal safety or of significant property damage or significant environmental harm;

(b) would be substantially lessened or alleviated by closure to general recreational access of a state tract; and

(c) requires closure more expeditiously than could be implemented through the normal closure procedure.

(10) "General recreational use" means hunting and fishing. Day horseback use in conjunction with hunting and fishing is included as general recreational use. Hunting for non-game species, such as rodents and coyotes, is general

recreational use. Scouting for game that can be legally hunted only during a certain season is hunting if conducted no more than 30 days before the beginning of the season.

(11) "Growing crop" means a crop, as defined below, between the time of planting and harvest, except that winter wheat is not considered to be a growing crop between November 1 and February 28. "Crop" means such products of the soil as are planted and intended for harvest, including but not limited to cereals, vegetables, and grass, including alfalfa that is intended for harvest for hay or seed production. The term does not include grass used for pasturage or trees.

(12) "Lessee" means a person who holds a lease or land use license, other than a general or special recreational use license issued pursuant to [these rules], issued by the department for use of the surface of the land. The term does not include mineral lessee unless it is preceded by the word "mineral."

(13) "Legally accessible state lands" means state lands that can be accessed by dedicated public road, right-of-way, or easement; by public waters such as lakes, rivers and streams that are recreationally navigable under 23-2-302, MCA; by adjacent federal, state, county or municipal land if the land is open to public use; or by adjacent private land if permission to cross the land has been secured from the landowner. Accessibility by aircraft does not render lands legally accessible under this definition. The granting of permission by a private landowner to cross private property in a particular instance does not subject the state land that is accessed to general recreational use by members of the public other than those granted permission.

(14) "Livestock" means cattle, sheep, swine, goats, horses, llamas, mules and donkeys and other animals used for the protection of these animals.

(15) "Motorized vehicle" means a vehicle propelled by motor power, including, but not limited to, an automobile, truck, motorcycle, moped, all terrain vehicle and snowmobile.

(16) "Recreational use account" means the account established by 77-1-808, MCA, in which revenues generated from general recreational use of state lands are deposited and from which expenses of the general recreational use program are paid.

(17) "Recreational use license" means the license issued pursuant to Rule IV that authorizes a person to engage in general recreational use as defined in (10) above.

(18) "Restriction" means a limitation on the manner in which recreational use may be conducted.

(19) "Special recreational use" means:

(a) commercial recreational activities, such as outfitting, in which a private person, corporation, group or other entity charges a fee or obtains other consideration;

(b) non-commercial recreational activities conducted by an organization, such as a lodge, business, church, union, or club;

(c) family reunions; and

(d) camping by one or more persons at other than designated campgrounds.

(AUTH: Secs. 77-1-209, 77-1-804, 77-1-806, MCA; IMP, Secs. 77-1-801 through 77-1-806, MCA.)

RULE IV. GENERAL RECREATIONAL USE OF STATE LANDS: LICENSE REQUIREMENT (1) Subject to restrictions imposed pursuant to Rule V and closures imposed pursuant to Rules VI, VII, and VIII, state lands administered by the department, except those lands described in Rule II(2)(g) and (h), are open to general recreational use to a person under the age of 12 years or a person 12 years old and older who obtains a recreational use license, signs that license, and has a valid signed license in his or her possession. Under 77-1-801, MCA, general recreational use without a license is a misdemeanor.

(2) A general recreational use license is issued for a 12-month period beginning on March 1 of each year and expiring on the last day of February of the next year. The license is personal and non-transferable. It may be purchased at any outlet that sells conservation licenses issued by the department of fish, wildlife and parks. Any person may purchase a recreational use license for another person, but the license is not valid until signed by the person in whose name it is issued.

(3) A person who uses state lands for general recreational use shall abide by the restrictions imposed pursuant to Rule V and may not use for general recreational purposes state lands that have been closed pursuant to Rule VI, VII or VIII. Violation of this provision subjects the violator to civil penalties pursuant to Rule X.

(4) No lessee or other person may interfere with a person who is making or attempting to make lawful general recreational use of state lands in accordance with this rule. Violation of this provision subjects the violator to civil penalties pursuant to Rule X or loss of lease pursuant to 77-6-210(1)(e), MCA. (AUTH: Secs. 77-1-209, 77-1-804, MCA; IMP, 77-1-801, 77-1-802, 77-1-804, 77-6-210, MCA.)

RULE V. GENERAL RECREATIONAL USE OF STATE LANDS: RESTRICTIONS (1) Following restrictions apply to persons engaging in general recreational use of state lands:

(a) Motorized vehicle use on state lands by recreationists is restricted to federal roads, state roads, dedicated county roads and other county roads and those roads that are designated by the department as open for motor vehicle use.

(b) A recreationist shall use firearms in a careful and prudent manner. A recreationist may not discharge a firearm within one-quarter mile of an inhabited dwelling or of an outbuilding in close proximity to an inhabited dwelling without permission of an inhabitant. Temporary absences of inhabitants do not render a dwelling uninhabited.

(c) Camping is restricted to campgrounds designated by the department for public camping. No person may camp in a campground for more than 14 consecutive days.

(d) Open fires are prohibited except in designated campgrounds.

(e) Recreationists may not interfere with legitimate activities of the lessees or their agents conducted pursuant to the lease or license. For example, the discharge of firearms that would interfere with the authorized use of the tract for livestock operations is prohibited.

(f) For state lands included within a game management or block management area administered by the department of fish, wildlife and parks, recreational access and activities must be conducted in accordance with rules, regulations, and procedures specific to that management area.

(g) Littering on state lands is prohibited.

(2) The department may impose additional site specific restrictions on general recreational use to protect public safety, property or the environment. (AUTH: Secs. 77-1-209, 77-1-804, MCA; IMP, Secs. 77-1-804, MCA.)

RULE VI. GENERAL RECREATIONAL USE OF STATE LANDS; CATEGORICAL CLOSURES (1) Except as provided in (2), the following state lands are closed to general recreational use by the public:

(a) all lands leased or licensed for cabinsites or homesites;

(b) all lands on which growing crops as defined in Rule III(11) are located;

(c) military leases while military activities are taking place;

(d) active commercial leases; and

(e) lands on which the department has declared the threat of wildfire to be extreme.

(2)(a) Any person, corporation, organization or agency of local, state, or federal government may petition to exclude a specific tract from a categorical closure imposed pursuant to (1) above.

(b) The petition must be submitted in writing to the area or unit office, must be signed by the petitioner, and must contain the following information:

(i) name, mailing address, and telephone number of petitioner;

(ii) description of lands to which petition applies by legal description, lease or license number, or description of the location;

(iii) reason that the categorical closure should be terminated for that tract and supporting documentation; and

(iv) duration of period for which termination is sought.

(c) The department may summarily dismiss a petition with a brief statement of the reasons for dismissal whenever:

(i) the petition is unsupported by specific substantial factual allegations, data, or documentation; or

(ii) a petition requesting substantially the same exclusion has been denied within the preceding 365 days.

(d) To be considered during a particular calendar year, the petition must be submitted by January 31 of that year. Upon receipt of a valid petition, the department shall notify the lessee that a petition has been filed and he or she may submit an objection or have an informal hearing, or both, on the petition at the area or unit office on or before March 1. The petitioner may also request an informal hearing.

(e) If an informal hearing is requested, the department shall notify the petitioner of the informal hearing and the petitioner may attend and participate. The informal hearing must be conducted by the area manager or his designee.

(f) The area manager or designee may conduct further investigation and shall, on or before April 1, make a written decision whether to grant the petition. The written decision must contain the reason for granting or denying the petition. Copies of the decision must be mailed to the petitioner and the lessee.

(g) The lessee or petitioner may appeal the decision to the commissioner or his designee by filing a written notice of appeal with the area office within 15 days of receipt of the decision. The area office shall immediately forward the appeal to the department's main office in Helena. The appeal shall, in the discretion of the commissioner, proceed by written argument, oral argument, or both at the main office of the department in Helena or other location designated by the commissioner. The opposing party is entitled to notice of the appeal and the opportunity to respond, including the right to appear at any appellate hearing. Neither party may submit evidence or information that was not submitted at the informal hearing. The commissioner or his designee shall issue a written decision affirming, reversing or modifying the decision on or before June 15.

(3) Except for closure for fire danger pursuant to (1)(e), the lessee shall post categorically closed lands at all customary access points with signs purchased from the department at cost. (AUTH: Secs. 77-1-209, 77-1-804, MCA; IMP, Sec. 77-1-804, MCA.)

RULE VII, GENERAL RECREATIONAL USE OF STATE LANDS; PROCEDURE FOR SITE SPECIFIC CLOSURES PRIOR TO SEPTEMBER 2, 1992 (1) The department may close specific tracts of state land pursuant to this rule prior to September 2, 1992, for any of the following reasons:

(a) damage attributable to recreational use diminishes the income generating potential of the state lands;

(b) damage to surface improvements of the lessee;

(c) the presence of threatened, endangered, or sensitive species or plant communities;

(d) the presence of unique or special natural or cultural features;

(e) wildlife protection;

(f) noxious weed control;

(g) the presence of buildings, structures, or facilities;

(h) protection of public safety;

(i) prevention of significant environmental impact; or

(j) substantial disruption of livestock management on the tract, such as calving, lambing, or shipping activities.

(2) Closures made pursuant to this rule may be of a seasonal, temporary or permanent nature.

(3)(a) Any person, corporation, organization or agency of local, state, or federal government may petition to close a specific tract of land for any reason listed in (1).

(b) The petition must be submitted to the area or unit office in which the state land is located and must be in writing. To be considered during a calendar year, the petition must be submitted by May 1, 1992, be signed by the petitioner, and must contain the following information:

(i) name, mailing address, and telephone number of petitioner;

(ii) description of lands to which petition applies by legal description, lease or license number, or other description of the location;

(iii) reason that the land should be closed and supporting documentation; and

(iv) period for which closure is sought.

(c) The department may summarily dismiss a petition with a brief statement of the reasons for the dismissal if:

(i) the petition is not based on a grounds for closure listed in (1);

(ii) the petition is not supported by specific factual allegations, data, or documentation; or

(iii) a petition requesting essentially the same closure has been rejected in the past 365 days.

(d) The department may also initiate a closure proceeding by preparing on or before May 1, 1992, a written statement containing the information described in (b)(ii)(iii), and (iv). The department shall follow the procedures contained in (4) through (9) below.

(4) The department shall by May 15, 1992, post public notice of the petition at the county courthouse and the area and unit offices and by making a list of all petitions filed statewide available at the department's main office in Helena.

(5) Any person may object to the closure. Written objections must be submitted to the office in the area or unit in which the land is located by June 15, 1992. The objection must contain the reasons why the petition should not be granted and supporting documentation. The objection may not be considered if it does not. In addition, the department shall hold, in the area in which the state land is located, a public hearing on each petition for which an objection has been filed. At the hearing, the petitioner and any objector may submit testimony, orally or in writing. The public notice required in (4) must provide notice of the right to object in writing and the public hearing.

(6) The department may conduct further investigation. On or before September 1, 1992, the commissioner shall grant, grant with modifications, or deny the petition and shall prepare a written document stating his reasons for the decision. He shall immediately send a copy of the decision to the petitioner and any person who filed an objection.

(7) If the petition is granted, the lessee shall post the closed lands at all customary access points with signs purchased from the department at cost. For temporary closures, the lessee shall remove closure signs at the end of the closure period.

(8) In an emergency, as defined in Rule III(9), any person or entity that is qualified to file a petition pursuant to (3)(a) may request an emergency closure by filing a written request with the area office or by making a telephone call and filing a written request within 24 hours. When possible, the area manager or his designee shall notify and consult with the lessee. The area manager or his designee shall grant or deny the petition as soon as possible, but in no case in more than five days. If the petition is granted, the closure must be for a specific period of time and may be extended for a period not exceeding the initial term. The area manager or his designee shall terminate the closure as soon as the emergency ceases. Upon request of any person, the commissioner or his designee shall review any emergency closure in effect for more than 5 days and shall approve, modify, or terminate the closure in writing.

(9) The department may also, on its own initiative, after consulting or attempting to consult with the lessee, close a tract of state land in an emergency. (AUTH: Secs. 77-1-209, 77-1-804, MCA; IMP, Sec. 77-1-804, MCA.)

RULE VIII. GENERAL RECREATIONAL USE OF STATE LANDS: PROCEDURE FOR SITE SPECIFIC CLOSURES AFTER SEPTEMBER 1, 1992

(1) The department may close specific tracts of state land pursuant to this rule after September 1, 1992 for any of the following reasons:

(a) damage attributable to recreational use diminishes the income generating potential of the state lands;

(b) damage to surface improvements of the lessee;

(c) the presence of threatened, endangered, or sensitive species or plant communities;

(d) the presence of unique or special natural or cultural features;

(e) wildlife protection;

(f) noxious weed control;

(g) the presence of buildings, structures, or facilities;

(h) protection of public safety;

(i) prevention of significant environmental impact; or

(j) substantial disruption of livestock management on the tract, such as calving, lambing, or shipping activities.

(2) Closures made pursuant to (1) may be of a seasonal, temporary or permanent nature.

(3)(a) Any person, corporation, organization or agency of local, state, or federal government may petition to close a specific tract of land for any reason listed in (1).

(b) The petition must be submitted to the area or unit office in which the state land is located and must be in writing. To be considered during a calendar year, the petition must be submitted by January 31 of that year, be signed by the petitioner, and must contain the following information:

(i) name, mailing address, and telephone number of petitioner;

(ii) description of lands to which petition applies by legal description, lease or license number, or other description of the location;

(iii) reason that the land should be closed and supporting documentation; and

(iv) period for which closure is sought.

(c) The department may summarily dismiss a petition with a brief statement of the reasons for the dismissal if:

(i) the petition is not based on a grounds for closure listed in (1);

(ii) the petition is not supported by specific factual allegations, data, or documentation; or

(iii) a petition requesting essentially the same closure has been rejected in the past 365 days.

(d) The department may also initiate a closure proceeding by preparing on or before January 31, a written statement containing the information described in (b)(ii)(iii), and (iv). The department shall follow the procedures contained in (4) through (9) below.

(4) The department shall by March 1 post public notice of the petition at the county courthouse and the area and unit offices and by making a list of all petitions filed statewide available at the department's main office in Helena.

(5) The public notice must give the public an opportunity to object to the closure and objector and the petitioner an opportunity to request, on or before April 1, a public hearing on the closure. The objection must be submitted to the office in the area or unit in which the land is located. The objection must contain the reasons why the petition should not be granted and supporting documentation. The objection may not be considered if it does not. If a hearing is requested, the department shall hold the hearing in the area of the proposed closure.

(6) Notice of hearing must be given by publication in a newspaper of general circulation in the area of the proposed closure on or before May 1. The notice must contain the name of the petitioner, location of the land, reason for proposed closure and reasons that the hearing has been requested.

(7) The hearing must be held in the area of the proposed closure and be an open public hearing at which any interested party may give comments and submit information. The hearing must be held before June 1.

(8) The department may conduct further investigation and shall prepare a written decision to grant, grant with modifications, or deny the petition, stating its reasons for the decision. On or before July 1, it shall send a copy of the decision to the petitioner and any person who filed objections pursuant to (5) above.

(9) The objector or petitioner may appeal the decision to the commissioner or his designee by filing a written appeal with the area office within 15 days of receipt of the decision. The department shall give the opposing party notice of the appeal and the opportunity to respond, including the right to appeal at any appellate hearing. The appeal shall, in the discretion of the commissioner, proceed by written argument, oral argument, or both, at the main office of the department in Helena or other location designated by the commissioner. No party may submit evidence or information that was not submitted at the hearing. The commissioner or his designee shall issue a written decision affirming, reversing, or modifying the decision on or before September 1.

(10) If the petition is granted, the lessee shall post the closed lands at all customary access points with signs purchased from the department at cost. For temporary closures, the lessee shall remove closure signs at the end of the closure period.

(11) In an emergency, as defined in Rule III(9), any person or entity that is qualified to file a petition pursuant to (3)(a) may request an emergency closure by filing a written request with the area office or by making a telephone call and filing a written request within 24 hours. When possible, the area manager or his designee shall notify and consult with the lessee. The area manager or his designee shall grant or deny the petition as soon as possible, but in no case in more than five days. If the petition is granted, the closure must be for a specific period of time and may be extended for a period not exceeding the initial term. The area manager or his designee shall terminate the closure as soon as the emergency ceases. Upon request of any person, the commissioner or his designee shall review any emergency closure in effect for more than 5 days and shall approve, modify, or terminate the closure in writing.

(12) The department may also, on its own initiative, after consulting or attempting to consult with the lessee, close a tract of state land in an emergency.

(13) The department shall periodically review each closure made pursuant to Rule VII or this rule to determine whether the closure is still necessary. This review must occur at least at lease expiration or renewal for leased tracts and at least every ten years for unleased tracts. After public notice and an opportunity for public comment and hearing, the department may terminate a closure it determines to no longer be necessary. (AUTH: Secs. 77-1-209, 77-1-804, MCA; IMP, 77-1-804, MCA.)

RULE IX. GENERAL RECREATIONAL USE OF STATE LANDS; NOTICE TO LESSEES (1) If a lessee wishes to be notified prior to anyone entering upon the leasehold for general recreational purposes, the lessee shall post, at all customary access points, signs purchased from the department at cost or constructed, in accordance with design and content specifications developed by the department. The lessee must include on the sign the following information:

(a) name of the lessee or lessee's agent who must be notified;

(b) telephone number of lessee or lessee's agent;

(c) directions to the location at which lessee or the lessee's agent may be contacted; and

(d) location of closest drop box.

If the lessee does not wish to be notified in person or by telephone, the sign must so indicate and need not contain the information required in (b) and (c). The information must be legible and legibility must be maintained.

(2) A lessee who posts land pursuant to (1) shall provide a clearly identified drop box for each single tract at a customary access point to the tract, except that a lessee of 2 or more contiguous tracts may provide one drop box for those tracts to which the access point provides convenient access. In cases in which a customary access point cannot be easily identified or question of the convenience of an access point is raised by the public, the area manager shall make a determination and the lessee shall install drop boxes in accordance with that determination.

(3) If the lessee or agent wishes to be notified in person or by telephone, the lessee or his or her agent shall be available to receive notice from recreational users by telephone or in person from the hours of 6:00 A.M. until 10:00 P.M. A person wishing to make general recreational use of state lands shall attempt to contact the lessee or lessee's agent in person or by telephone during those hours if the recreationist's access point to the state land is five miles or less by the shortest road from the nearest public telephone or the location at which the lessee or lessee's agent is available. The recreationist may determine which method of contact to employ. If the recreationist contacts the lessee or agent in person or by telephone, the recreationist shall, upon request, provide his or her name, the name of all recreationists in his or her party and the dates of the use. If the recreationist attempts to contact the lessee by telephone or in person but the lessee or agent is not available, or if the shortest road distance from the recreationist's access point to the nearest public telephone or the location at which the lessee or lessee's agent is available is greater than five miles, the recreationist shall leave a notice in the drop box provided pursuant to (2).

(4) If the lessee wishes to be notified by drop box only, the recreationist shall leave notice in the drop box provided pursuant to (2). The notice must provide the recreationist's name, and the names of each person in his or

her party, and the dates of use. The recreationist is responsible for providing paper and pencil or pen to prepare the notice.

(5) The department shall, after notice and opportunity for informal hearing at the main office of the department in Helena, revoke the general recreational use license of any person who violates (3) or (4) above. In addition, the department may prohibit the person from obtaining a recreational use license for a period not exceeding 2 years from the effective date of the revoked license. (AUTH: 77-1-209, 77-1-806, MCA; IMP, 77-1-806, MCA.)

RULE X. GENERAL RECREATIONAL USE OF STATE LANDS: CIVIL PENALTIES (1) Pursuant to 77-1-804(8), MCA, the department may assess against a recreationist, lessee or other person a civil penalty of up to $1,000 for each day of violation of Rules IV(3) or (4), VI, VII, or VIII. The department may waive the civil penalty for minor or technical violations.

(2) In determining the amount of civil penalty, the department shall consider the following factors:

(a) number of previous violations;

(b) severity of the infraction; and

(c) whether the violation was intentional or unintentional.

(3) A person against whom the department proposes to assess a civil penalty is entitled to a contested case hearing in accordance with Montana Administrative Procedure Act, Title 2, Chapter 4, part 6, MCA, on the questions of whether a violation was committed and the amount of the penalty. The hearing must be conducted by a hearing officer appointed by the commissioner. The department shall notify the individual of the violation, setting forth in the notice the specific facts which the department alleges to constitute the violation. The notice shall be served by certified mail or in person by a department employee, sheriff or deputy, fish and game warden, or registered process server. The notice must give the person at least 15 days to respond to the violation notice. Upon receipt of the response or expiration of the period allotted for response, the department shall either withdraw the notice of violation or provide its rationale for pursuing the violation and a proposed penalty. Service of the response and proposed penalty must be made in the same manner as the notice of violation. The person is entitled to a hearing on the existence of the violation, the amount of proposed penalty, or both, if he or she requests a hearing within 30 days of receipt of the department's response and proposed penalty. The request for hearing must set forth a statement of the reasons that the person is contesting assessment of the penalty.

(4) Upon conclusion of the hearing, the department shall, within 60 days, issue its findings of fact and conclusions of law and order dismissing the violation or assessing a penalty. If a civil penalty is assessed, the

person shall pay the penalty within 30 days of receipt of the order or such additional time as is granted by the department.

(5) The assessment of the civil penalty is appealable to district court pursuant to Title 2, Chapter 4, part 7, MCA. (AUTH: 77-1-209, 77-1-804, MCA; IMP, 77-1-804, MCA.)

RULE XI. GENERAL RECREATIONAL USE OF STATE LANDS: DAMAGE REIMBURSEMENT (1) As provided in 77-1-809, MCA, a lessee may apply to the department for reimbursement of costs resulting from repair to or replacement of the lessee's improvements, growing crops, or livestock damaged by recreationists.

(2) The application must be submitted to the area or unit office within 30 days of the time that the lessee discovers the damage, must be in affidavit form, and must contain:

(a) the date of discovery of the damage;

(b) the nature of the damage;

(c) reasonable proof that the loss was caused by a recreationist;

(d) documentation of repair or replacement costs, and

(e) whether the claimant has submitted a claim to his private insurance carrier and, if so, the status of the claim.

(3) No reimbursement may be paid to the extent the lessee's costs have been reimbursed by the lessee's insurance carrier.

(4) Upon review of the application and, if necessary, additional investigation, the department shall grant the claim in whole or in part or deny the claim. The department shall issue its decision within 60 days of receipt of the application.

(5) Whenever the lessee has submitted an insurance claim, the department shall delay payment of the claim until the action on the claim is completed.

(6) The department shall, on or before July 1 of each fiscal year, designate a portion of the recreational use account for damage reimbursement. Claims that are granted may be paid only to the extent that funds are available for damage reimbursement in the recreational use account and must be paid in the order they have been filed with the department. (AUTH: 77-1-209, 77-1-804, MCA; IMP, 77-1-809, MCA.)

RULE XII. GENERAL RECREATIONAL USE OF STATE LANDS: WEED CONTROL (1) The lessee is responsible for weed control on leased state land. However, weed control cost share funds designated pursuant to (2) are available to lessees from the recreational use account for control of noxious weed infestations caused by general recreational use. "Noxious weeds" are those weeds designated as noxious weeds by the Montana department of agriculture.

(2) The department shall, on or before July 1 of each fiscal year, designate a portion of the general recreational use account for weed control.

(3) A lessee may apply in writing for weed control funds, equipment, or supplies to treat a weed infestation caused by general recreational use. The application must:

(a) describe the location and size of the infestation and type of weed;

(b) demonstrate that the infestation was caused by general recreational use of the tract;

(c) contain a weed management plan, including the cost of carrying out the plan.

(4) The area land office shall process applications in the order received and shall approve an application if it finds that the application reasonably proves that the infestation was caused by general recreational use of state lands, that the plan provides an effective method of control, and that the plan is cost effective. In its approval, the area office shall designate the amount of funding approved. That amount may be less than the amount applied for. Before providing funding, supplies or materials, the department shall enter into a written agreement with the lessee specifying how the funding, supplies or materials must be used.

(5) Projects remain eligible for funding for the fiscal year in which the approval was granted and for two additional fiscal years. At the end of this period, the department may terminate the approval if it determines that the project no longer meets the criteria in (4). (AUTH: Secs. 77-1-209, 77-1-810, MCA; IMP, 77-1-810, MCA.)

RULE XIII. GENERAL RECREATIONAL USE OF STATE LANDS: OTHER PROVISIONS (1) Nothing in [these rules] authorizes a recreationist to enter private land to reach state lands or to enter private land from state lands. A recreationist may not enter private land from adjacent state lands, regardless of the absence of fencing or failure of the owner to provide notice, without permission of the landowner or his agent.

(2) Under section 77-1-806(2), entry onto private land from state land by a recreationist without permission of the landowner is a misdemeanor, whether or not the recreationist knows he or she is on private land.

(3) Recreationists are responsible for determining whether state lands are legally accessible.

(4) Before designating roads on state lands as open for public access pursuant to Rule V(1)(a), the department shall mail notice of the proposed designation to the lessee.

(5) Any person may petition the board to include within the definition of general recreational use any type of recreation other than hunting and fishing. The petition must be in writing, be signed, and include a statement of the reasons why the use petitioned for should be included subject to the general recreational use license. It must be filed with the commissioner, who shall bring the petition before the board. (AUTH: 77-1-209, 77-1-804; IMP, 77-1-804, 77-1-806, MCA.)

RULE XIV. SPECIAL RECREATIONAL USE OF STATE LANDS

(1) No special recreational use of state lands may occur without first obtaining a special recreational use license from the department. This requirement applies whether or not any or all of the persons involved in the special recreational use have obtained general recreational use license pursuant to Rule IV.

(2) To obtain a special recreational use license, a person must be at least 18 years of age and apply to the area or unit office on a form prescribed by the department. The applicant shall provide a description of or a map showing the area intended for use.

(3) To obtain a special recreational use license, a person must pay to the department the amount that the department determines to be the full market value of that use. A license granted pursuant to this rule may be subject to competitive bidding.

(4) A license granted pursuant to this rule may be exclusive, except the department shall reserve the right to grant other licenses for different uses on the same land. Issuance of an exclusive license does not prohibit general recreational use of state lands that have not been closed pursuant to Rules VI, VII, or VIII.

(5) A license issued pursuant to this rule shall include provisions regulating motor vehicle use and may include other restrictions on the activity.

(6) The holder of a special recreational use license shall comply with all provisions of that license.

(7) Pursuant to 77-1-804(8), MCA, the department may assess a civil penalty of up to $1,000 for each day of violation of this rule. The department may waive the civil penalty for minor or technical violations. The penalty assessment standards and procedures contained in Rule X are applicable to civil penalty proceedings under this rule.
(AUTH: 77-1-209, 77-1-804, MCA; IMP, 77-1-804, MCA.)

ARM 26.3.156, as proposed to be amended, would read as follows:

26.3.156 WEEDS, PESTS AND FIRE PROTECTION (1) A lessee or licensee of state land shall keep the land free of noxious weeds and pests and assume responsibility for fire prevention and suppression necessary to protect the forage, trees and improvements. The lessee or licensee shall perform these duties at his own cost and in the same manner as if he or she owned the land. The lessee or licensee is not responsible for the suppression of or damages resulting from a fire caused by a general recreational user, except that he or she shall make reasonable efforts to suppress the fire or report it to the proper firefighting authority or both, as circumstances dictate.
(AUTH: 77-1-209, MCA; IMP, 77-1-805, MCA)

4. The Board is requesting comments on two provisions that the Department considered but did not place in the proposed rules:

(3) A lessee may apply in writing for weed control funds, equipment, or supplies to treat a weed infestation caused by general recreational use. The application must:

(a) describe the location and size of the infestation and type of weed;

(b) demonstrate that the infestation was caused by general recreational use of the tract;

(c) contain a weed management plan, including the cost of carrying out the plan.

(4) The area land office shall process applications in the order received and shall approve an application if it finds that the application reasonably proves that the infestation was caused by general recreational use of state lands, that the plan provides an effective method of control, and that the plan is cost effective. In its approval, the area office shall designate the amount of funding approved. That amount may be less than the amount applied for. Before providing funding, supplies or materials, the department shall enter into a written agreement with the lessee specifying how the funding, supplies or materials must be used.

(5) Projects remain eligible for funding for the fiscal year in which the approval was granted and for two additional fiscal years. At the end of this period, the department may terminate the approval if it determines that the project no longer meets the criteria in (4). (AUTH: Secs. 77-1-209, 77-1-810, MCA; IMP, 77-1-810, MCA.)

RULE XIII, GENERAL RECREATIONAL USE OF STATE LANDS: OTHER PROVISIONS (1) Nothing in [these rules] authorizes a recreationist to enter private land to reach state lands or to enter private land from state lands. A recreationist may not enter private land from adjacent state lands, regardless of the absence of fencing or failure of the owner to provide notice, without permission of the landowner or his agent.

(2) Under section 77-1-806(2), entry onto private land from state land by a recreationist without permission of the landowner is a misdemeanor, whether or not the recreationist knows he or she is on private land.

(3) Recreationists are responsible for determining whether state lands are legally accessible.

(4) Before designating roads on state lands as open for public access pursuant to Rule V(1)(a), the department shall mail notice of the proposed designation to the lessee.

(5) Any person may petition the board to include within the definition of general recreational use any type of recreation other than hunting and fishing. The petition must be in writing, be signed, and include a statement of the reasons why the use petitioned for should be included subject to the general recreational use license. It must be filed with the commissioner, who shall bring the petition before the board. (AUTH: 77-1-209, 77-1-804; IMP, 77-1-804, 77-1-806, MCA.)

RULE XIV. SPECIAL RECREATIONAL USE OF STATE LANDS

(1) No special recreational use of state lands may occur without first obtaining a special recreational use license from the department. This requirement applies whether or not any or all of the persons involved in the special recreational use have obtained general recreational use license pursuant to Rule IV.

(2) To obtain a special recreational use license, a person must be at least 18 years of age and apply to the area or unit office on a form prescribed by the department. The applicant shall provide a description of or a map showing the area intended for use.

(3) To obtain a special recreational use license, a person must pay to the department the amount that the department determines to be the full market value of that use. A license granted pursuant to this rule may be subject to competitive bidding.

(4) A license granted pursuant to this rule may be exclusive, except the department shall reserve the right to grant other licenses for different uses on the same land. Issuance of an exclusive license does not prohibit general recreational use of state lands that have not been closed pursuant to Rules VI, VII, or VIII.

(5) A license issued pursuant to this rule shall include provisions regulating motor vehicle use and may include other restrictions on the activity.

(6) The holder of a special recreational use license shall comply with all provisions of that license.

(7) Pursuant to 77-1-804(8), MCA, the department may assess a civil penalty of up to $1,000 for each day of violation of this rule. The department may waive the civil penalty for minor or technical violations. The penalty assessment standards and procedures contained in Rule X are applicable to civil penalty proceedings under this rule.
(AUTH: 77-1-209, 77-1-804, MCA; IMP, 77-1-804, MCA.)

ARM 26.3.156, as proposed to be amended, would read as follows:

26.3.156 WEEDS, PESTS AND FIRE PROTECTION (1) A lessee or licensee of state land shall keep the land free of noxious weeds and pests and assume responsibility for fire prevention and suppression necessary to protect the forage, trees and improvements. The lessee or licensee shall perform these duties at his own cost and in the same manner as if he or she owned the land. The lessee or licensee is not responsible for the suppression of or damages resulting from a fire caused by a general recreational user, except that he or she shall make reasonable efforts to suppress the fire or report it to the proper firefighting authority or both, as circumstances dictate.
(AUTH: 77-1-209, MCA; IMP, 77-1-805, MCA)

4. The Board is requesting comments on two provisions that the Department considered but did not place in the proposed rules:

(a) The first would be a change to Rule V(1)(a). As currently written, the rule would allow general recreationists to use department roads "designated by the department as open for motor vehicle use." The Board requests comments on an amendment to this rule that would provide that, "west of the Continental Divide, Department roads are open to recreationists unless posted as closed." The purpose of this change, if made, would be to make the Department consistent in policy with other major landowners, such as the U.S. Forest Service, west of the Divide.

(b) The second change would be in Rule VIII and perhaps Rule VII, both of which deal with site-specific closures. The Board is considering inserting a provision that "the department may close a leased state tract if the lessee agrees in writing to open to general recreational use private land of equal or greater recreational value." The Board requests comments as to whether this language should be included and, if it were included, what restrictions and procedures should apply. Language that would implement the concept is: "The department may close a leased tract of state land if the lessee agrees in writing to open for general recreational use private land of similar recreational value."

5. Chapter 609, Laws of 1991, Legislature opened state lands administered by the Department of State Lands to general recreational access for hunting and fishing and directed the Board of Land Commissioners to adopt rules to authorize and govern recreational use and closure of state lands. These rules comply with this directive and are necessary to provide restrictions on recreational use, clarify recreational use rights, and provide procedures to implement and enforce this recreational use program.

6. Interested persons may present their data, views, or arguments either orally or in writing at the hearings. Written data, views, or arguments may also be submitted to Dennis D. Casey, Commissioner, Department of State Lands, Capitol Station, Helena, Montana 59620 no later than December 16, 1991. To guarantee consideration, written data, views, or arguments must be postmarked by December 16, 1991.

7. The following Department of State Lands personnel have been designated to preside over and conduct the hearings:

- Dennis D. Casey, Commissioner
- Randy Mosley, Administrator, Field Operations Division
- M. Jeff Hagener, Administrator, Lands Division
- Jeff Jahnke, Chief, Forest Management Bureau
- John F. North, Chief Legal Counsel

Assignments to specific hearing locations have not yet been made.

Reviewed by:

John F. North
Chief Legal Counsel

Dennis D. Casey
Commissioner

Certified to the Secretary of State October 21, 1991.

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

In the Matter of Proposed Adoption of Optional Rules Governing Rate Filings for Electric, Gas, Water and Sewer Rates.	)))))	NOTICE OF PROPOSED ADOPTION OF NEW RULES GOVERNING RATE FILINGS FOR ELECTRIC, GAS, WATER AND SEWER RATES NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On December 2, 1991 the Department of Public Service Regulation proposes to adopt optional new rules governing rate filings for electric, gas, water and sewer rates.

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

RULE I. PURPOSE (1) The purpose of this sub-chapter is to establish an optional ratemaking process for regulated gas, electric, water and sewer utilities. This process is designed to match the rates authorized by the commission for utility services to the costs actually incurred by the utilities in providing such service; and to increase the commission's scrutiny of the rates of return achieved by the utilities. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE II. SCOPE (1) In the event of any conflict between the rules of this sub-chapter and any other rule of the commission, the rules in this sub-chapter shall control, but only for those utilities making the election to proceed under this sub-chapter. Nothing in this sub-chapter applies to gas cost tracking adjustments filed pursuant to a commission authorized tariff. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE III. EFFECTIVENESS MEASUREMENTS (1) To measure the effectiveness of this optional ratemaking process the commission will evaluate a utility's rate of return actually earned without relying upon the ratemaking process set forth in these optional rules. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE IV. ELECTION (1) A utility filing for a general rate increase may elect to make its filing under this sub-chapter, provided such election is made within 24 months of the publication of the notice of adoption of the rules of this sub-chapter. Such election shall be binding and irrevocable for a period of 71 months after the date of such filing, subject to the provisions of (Rule V). The utility's election to proceed under this sub-chapter shall be contained in its initial filing and shall provide, without qualification, that:

(a) The utility elects to process its filing under this sub-chapter, and that it consents to having the rates under

consideration determined in accordance with this sub-chapter for a period of 71 months from the date of the filing in which it made its election, subject to the provisions of (Rule V).

(b) The utility will file with the commission, at intervals of 24 and 48 months after the date of the filing in which it made its election, a complete cost of service filing prepared in accordance with the commission's rules, including the rules of this sub-chapter.

(c) The utility will file with the commission 72 months after the date of the filing in which it made its election, a complete cost of service filing prepared in accordance with the commission's rules, excluding the rules of this sub-chapter. Nothing in this rule shall be construed as prohibiting the utility from simultaneously applying to the commission for authority to establish rates in the same manner as set forth in this sub-chapter, or any other manner.

(d) The filing requirements specified in [Rule IV(b)] are intended only to establish a minimum frequency of filings. Nothing in these rules shall be deemed to prohibit a utility, or any other party, from making application to the commission for additional rate changes. Except in the case of a filing pursuant to [Rule IV(c)], additional filings will be prepared in accordance with the commission's rules, including the rules of this sub-chapter. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE V. FINAL ORDERS -- APPEALS (1) Nothing in the rules of this sub-chapter shall be construed as limiting in any way the right of a utility, or any other party, from challenging the reasonableness of a final order pursuant to the applicable provisions of Title 69 of the Montana Code Annotated, and the Montana Administrative Procedure Act. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE VI. RATEMAKING PROCEDURE -- GENERAL RATE CASES (1) A utility which elects to proceed under the rules of this sub-chapter shall be permitted by the commission to include in its rates a cost of service which includes the following special components:

(a) All test year measures of cost shall be adjusted to reflect changes known with certainty and measurable with reasonable accuracy prior to the commission's hearing on the utility's application for increased rates, provided no such changes shall be reflected in the rates finally authorized by the commission if they occurred more than 13 months from the close of the test period used to determine the cost of service.

(b) Any costs incurred during the test year that were not adjusted pursuant to [Rule VI(a)], shall be adjusted pursuant to the following formula:

Costs x .45 x Consumer Price Index

(c) The rate base shall be computed on an end of test year basis.

(d) For matching purposes, test year revenues shall be restated to reflect end of year customer counts and the

annualization of known changes in revenues occurring during the test year. In addition, revenues shall be restated to reflect changes known with certainty and measurable with reasonable accuracy prior to the commission's hearing on the utility's application for increased rates, provided no such changes shall be reflected if they occurred more than 13 months from the close of the test period used to determine the cost of service in the utility's filing. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE VII. RATEMAKING PROCEDURES -- LIMITED ISSUE FILINGS (1) A utility which elects to proceed under this subchapter shall be permitted by the commission to make limited issue filings that do not meet the requirements of ARM 38.5.101, et seq. Such limited issue filings may only be made when the utility experiences an increase in costs which exceeds three percent (3%) of the utility's allowed overall return, in dollars, as determined by the last order in the last general rate case establishing rates for those services that are the subject of the filing or the cost of service filing required in [Rule IV(b)], whichever is most recent. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE VIII. COST OF EQUITY (1) The commission will permit no adjustments to the electing utility's cost of equity capital under a theory that the election has reduced the cost of capital to the electing utility. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE IX. COST OF SERVICE FILING (1) The electing utility will make the filings required in [Rule IV(b)] as follows:

(a) It will prepare its cost of service filing in compliance with the minimum filing standards, as modified by the rules of this sub-chapter. In addition:

(i) The utility will reflect in its filing as its cost of equity capital the last return on equity authorized by the commission, unless the utility proceeds in accordance with [Rule IX(b)].

(ii) If the utility's initial filing does not seek a change in rates, its initial filing need not comply with the provisions of ARM 38.5.103, 38.5.104, 38.5.105, 38.5.112, 38.5.176, 38.5.177 and 38.5.178.

(b) A utility which files an application to change its rates simultaneously with the submission of its initial cost of service filing may include in its initial cost of service filing a rate of return on equity other than that last authorized by the commission.

(c) If the cost of service filing sets forth a cost of service less than that last authorized by the commission, and the utility does not request a decrease in rates to reflect such a change, the utility expressly assumes the burden of proving why its rates should not be decreased to the extent reflected in its cost of service filing.

(d) Any party, including the utility, may make application to the commission for a change in rates based upon the filing and such other facts the parties by competent evidence may establish. All applications for a change in rates will be heard in accordance with Title 69, MCA, and the Montana Administrative Procedure Act. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE X. APPLICATION FOR SUMMARY CLOSURE (1) The commission will docket the utility's cost of service filings made pursuant to (Rule IV) as a contested case proceeding regardless of whether the utility applies for a change in rates, and:

(a) If the utility does not file an application to change its rates, it shall file an application for summary closure of the docket.

(b) The commission will notice the application for summary closure in accordance with the provisions of the Montana Administrative Procedure Act and permit intervention as in any other contested case proceeding.

(c) Upon considering the application for summary closure, the commission will either grant or deny the application. If its decision is to deny the application it shall by order establish a procedure for hearing the claims of those parties opposing the application. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE XI. SUNSET/REPEALER (1) The rules in this subchapter are of an experimental nature and are intended to be of limited duration. The rules in this sub-chapter are repealed 96 months after publication of their notice of adoption. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

3. Rationale: These rules are proposed pursuant to the petition of Montana Power Company and Montana-Dakota Utilities Company (petitioners). Petitioners, public utilities subject to regulation by the Montana Public Service Commission (commission), seek adoption of optional rules governing rate filings for electric, gas, water, and sewer rates.

Section 69-3-201, MCA, provides that the charges made by a public utility for utility service shall be reasonable and just. When determining what constitutes a reasonable and just charge the commission has relied on a number of factors including an analysis of a utility's cost of service. Since this analysis is based on historic data and utility charges are authorized on a prospective basis only, petitioners allege that charges may not accurately reflect a utility's actual cost of service. Therefore, Petitioners seek optional rules which reflect a utility's cost of service during the period when the authorized charges are in force. These rules are designed to adjust costs and revenues to reflect such actual costs and revenues.

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

Sweeney, Public Service Commission, 2701 Prospect Avenue, Helena, Montana 59620-2601 no later than November 29, 1991.

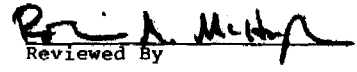
5. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a public hearing and submit this request along with any written comments he has to Tim Sweeney, Public Service Commission, 2701 Prospect Avenue, Helena, Montana 59620-2601, no later than November 29, 1991.

6. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of those 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. Ten percent of those persons directly affected has been determined to be three based upon the number of public utilities affected by the proposed rules.

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, Chairman

CERTIFIED TO THE SECRETARY OF STATE October 21, 1991.



Reviewed By

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.14.107 and 42.14.108 relating to accommodations tax	NOTICE OF PROPOSED AMENDMENT of ARM 42.14.107 and 42.14.108 relating to accommodations tax

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On December 13, 1991, the Department of Revenue proposes to amend ARM 42.14.107 and 42.14.108 relating to accommodations tax.

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

42.14.107 QUARTERLY REPORTS AND PAYMENTS - DUE DATES (1) remains the same.

(2) The owner/operator shall remit the amount of said tax with the quarterly report. The report will cover quarterly periods ending March 31, June 30, September 30 and December 31 and must be postmarked no later than the ~~30th~~ last day of the month following the close of the quarter. Reports must be made on forms supplied by the department.

(3) thru (6) remain the same.

AUTH: Sec. 15-65-102 MCA; IMP: Sec. 15-65-112 MCA

42.14.108 PENALTIES AND INTEREST (1) Failure to file the return and/or pay the tax collected, will result in a penalty of ~~2%~~ 10% of the tax that was collected or that should have been collected.

(2) and (3) remain the same.

AUTH: Sec. 15-65-102 MCA; IMP: Sec. 15-65-115 MCA;

3. ARM 42.14.107 and 42.14.108 are proposed to be amended because of statutory changes.

4. 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 November 29, 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 November 29, 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.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.19.1202, 42.19.1211, 42.19.1212, 42.19.1213, 42.19.1221, 42.19.1222, 42.19.1223 and TRANSFER AND AMENDMENT of 42.19.1220 relating to New Industry	NOTICE OF PROPOSED AMENDMENT of ARM 42.19.1202, 42.19.1211 42.19.1212, 42.19.1213, 42.I9.1221, 42.19.1222, 42.19.1223 and TRANSFER AND AMENDMENT of 42.19.1220 relating to New Industry

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On December 13, 1991, the Department of Revenue proposes to amend ARM 42.19.1202, 42.19.1211, 42.19.1212, 42.19.1213, 42.19.1221, 42.19.1222, 42.19.1223 and transfer and amendment of 42.19.1220 relating to new industry.

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

42.19.1202 TREATMENT OF PROPERTY NOT USED AS PART OF THE ~~INDUSTRIAL PLANT~~ NEW INDUSTRY (1) In order to qualify as new industrial property, the property in question must be used ~~as part of the industrial plant~~ by the new firm in a qualifying activity at all times during the 3-year exemption period. Land held for future use or for nonindustrial use is excluded from classification as new industrial property. Only property used directly in ~~manufacturing, fabricating, milling, processing, etc.~~ the qualifying activity may qualify. Property used in a supplementary fashion, such as a housing development in conjunction with an industrial plant, does not qualify.

(2) remains the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135, 15-6-152, 15-24-1401 and 15-24-1402 MCA

42.19.1211 PERIOD OF CLASSIFICATION AS NEW INDUSTRIAL PROPERTY (1) The classification ~~as~~ of property made by a new ~~industrial property~~ industry becomes operative as to all qualifying property on the first assessment date falling on or after the date of commencement of operations and continues for each taxable year thereafter for which the assessment date falls within the 3-year period beginning on the date of commencement of such operations.

(2) Once the 3-year period begins to run, starting on the date operations commence, the period runs to its expiration unaffected by additions of property to the ~~industrial~~ industry use, expansion of operations, changes in operations (other than changes that would disqualify the unit from classifications as

new ~~industrial~~ industry property), or cessation or curtailment of operations.

(3) Prior to and after the 3-year period of classification as new ~~industrial~~ industry property, the property in question is taxable as other similar property.

(4) remains the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and 15-6-152 MCA

42.19.1212 COMMENCEMENT OF OPERATIONS (1) The date of commencement of operations is the date when the new ~~industrial plant~~ industry first begins to function as an organized unit and for its primary purpose, even if the operation is only for limited production or upon a limited scale.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and 15-6-152 MCA

42.19.1213 CHANGES IN OPERATIONS (1) As a new industry adds to its plant and properties during the 3-year period provided for in 15-6-135, MCA, the additional property, if it otherwise qualifies, is also classified as new ~~industrial~~ industry property for the remainder of the period.

(2) Classification as new ~~industrial~~ industry property ceases upon sale; transfer; change of possession; or other change in ownership, possession, or control of such property, unless prior to such action, application is made by the transferee for continuation as new ~~industrial~~ industry property and the application is granted by the department. The loss of classification as new ~~industrial~~ industry property does not apply to transactions such as the mortgaging of the property or otherwise using the property as security when there is no change in ownership or possession.

(3) If a qualified new industry ceases to operate as a new industry under the provisions of 15-6-135, MCA, the classification as new ~~industrial~~ industry property terminates.

(4) remains the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and 15-6-152 MCA

42.19.1221 OPINION LETTERS (1) Upon written request and prior to formal application under ARM 42.19.1222, the department considers the status of a proposed operation with respect to treatment as new ~~industrial~~ industry property. The department after review of the potential applicants written submission issues an opinion letter as to classification of the property in question.

(2) remains the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and 15-6-152 MCA

42.19.1222 APPLICATION FOR SPECIAL CLASSIFICATION (1) A person desiring to have property classified as new ~~industrial~~ industry property ~~should~~ shall make written application for such classification to the department of revenue on or before May 1 of the year for which the classification is sought. The application is to contain a clear and concise statement of the

facts that entitle the applicant's property to receive classification as new industrial property.

(2) The application ~~should~~ shall contain as a minimum the following information:

(a) through (d) remain the same.

(e) the name of each county in which the new ~~industrial plant~~ industry is located or to be located;

(f) through (h) remain the same.

(i) the name and address of each person, firm, or corporation from which the applicant has or intends to acquire property for use in its ~~industrial~~ qualifying operation and for which application is made or for which the application if granted will afford classification;

(j) an exact description of the nature of the business, economic, or ~~industrial~~ industry operations or activities not conducted by the applicant, related persons or business units, or any controlling officers, directors, incorporators, partners, shareholders, investors, or any predecessor thereof;

(k) the date upon which it is contemplated that the operations of the new ~~industrial~~ industry undertaking of the applicant, for which application is made, will commence.

(l) applicants qualifying for new industry classification pursuant to 15-6-135(4)(b)(iv) or (v), MCA, shall include as part of the application:

(i) copies of existing financial statements, income statements and sales information showing where sales occur and where receipts are earned by state if completed for any fiscal period which covers any portion of the assessment year for which the new industry classification is sought;

(ii) a certification by the chief financial officer for the applicant that it is anticipated the applicant will meet the requirements of 15-6-135(4)(b)(iv) or (v), MCA, during the assessment year for which classification as new industry is sought;

(iii) a certification by the chief financial officer that the applicant will provide copies of financial statements, income statements and sales information showing where sales occur and where income and receipts are earned by state as soon as they are completed at the close of the applicant's fiscal year for any fiscal year which covers any portion of the assessment year for which classification as new industry is sought;

(iv) a certification by the chief financial officer that if the applicant does not meet the requirements of 15-6-135(4)(b)(iv) or (v), MCA, the applicant will pay the taxes which would have been due without the new industry classification (plus interest).

(3) and (4)(a) remain the same.

(b) an undertaking that the applicant will immediately furnish to the department of revenue and each affected county assessor a detailed written report of any change of a material nature in either its operations or the extent or nature of its

properties at any time during the 3-year special classification period, should such classification be granted, or any other information or matter the department ~~should~~ shall, in writing, request.

(5) remains the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135, 15-6-152, 15-24-1401 and 15-24-1402 MCA.

42.19.1223 PROCESSING OF APPLICATION (1) Upon receipt of an application for classification as new ~~industrial~~ industry property, the department reviews the application. If from this review the department determines that the proposed operation will employ 100 or more individuals, either during construction or operation, then the department notifies all affected local governments and conducts public hearings on the question of adverse impact. The hearings are held in the affected locale. The department may schedule other hearings on the application if considered necessary.

(2) and (3) remain the same.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and ~~15-6-152~~ MCA.

42.19.1224 ADVERSE IMPACTS (1) A new ~~industrial~~ industry facility is considered to have an adverse impact if it is located in an area that does not have a government infrastructure of sufficient magnitude to readily absorb the new facility without significant expansion.

AUTH: 15-1-201 MCA; IMP: 15-6-135 and 15-6-152 MCA.

3. ARM 42.19.1202 through 42.19.1224 are proposed to be amended in order to clarify the implementation of HB 970.

4. The Department proposes to transfer and amend ARM 42.19.1220 to the end of chapter 19. The amendments are as follows:

42.19.1220 (42.19.1235) TAX INCENTIVE FOR NEW AND EXPANDING INDUSTRY (1) and (2) remain the same.

(3) The plant owner must notify the property assessment division by sending a copy of the approved application described in subsection ~~1~~ (1) within 30 days after receiving approval from the affected taxing jurisdiction.

(4) The preceding year and current year's additions and investments ~~will all~~ may be considered and included for purposes of determining whether the threshold investment levels specified in 15-24-1401(1) and (3) have been met.

(5) through (8) remain the same.

(9) An applicant seeking to qualify pursuant to 15-24-1401(2)(d) or (e), MCA, shall include the same information and certifications as required by ARM 42.19.1222(2)(1).

AUTH: 15-1-201 MCA; IMP: 15-6-135, 15-24-1401, and 15-24-1402 MCA

5. The transfer of ARM 42.19.1220 is necessary because the current placement of the rule is confusing and better flow of the sequence of events will be shown if this rule is transferred to the end of the chapter.

6. 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 November 29, 1991.

7. 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 November 29, 1991.

8. 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.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE ADOPTION of Rules I and II relating to grain elevator equipment from Class 8 to Class 4	NOTICE OF PUBLIC HEARING on the PROPOSED ADOPTION of Rules I and II relating to grain elevator equipment from Class 8 to Class 4

TO: All Interested Persons:

1. On November 22, 1991, at 10:00 a.m., a public hearing will be held in the Fourth Floor Conference Room of the Mitchell Building, at Helena, Montana, to consider the adoption of rules I and II, relating to grain elevator equipment from Class 8 to Class 4.

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

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

RULE I ASSESSMENT OF GRAIN, SEED, AND FERTILIZER STORAGE FACILITIES (1) Grain storage facilities, seed treating plants, and fertilizer storage plants are improvements to real property for which the use is bulk storage of unprocessed grain, seed cleaning and treating, and bulk storage of fertilizers awaiting sale or processing. Blending, cleaning, treating, packaging, conditioning, dust removal, and pollution control are not considered a manufacturing process.

(2) Storage tanks, working houses, drive houses, and large platform truck and railroad scales are considered long lived assets. Elevator legs, metering scales, augers, conveyors, cleaning and treating equipment and all other permanently affixed equipment is product handling property and are examples of short-lived assets.

(3) All product handling property (short-lived assets) used in grain storage facilities, seed cleaning facilities, and bulk fertilizer facilities considered part and parcel to the facility are assessed under 15-6-134, MCA. This property shall be considered part and parcel if permanently affixed to the improvements and cannot be removed without destroying the value of the facility. Property under this rule shall not be considered manufacturing equipment.

(4) Bulk fertilizer facilities are defined as an improvement to land for storing, blending, and distributing dry fertilizers. Blending, cleaning, treating, packaging, conditioning, dust removal, and pollution control are not considered a manufacturing process.

(5) Seed cleaning facilities are defined as an improvement to land if used either solely or in conjunction with a grain elevator for the cleaning and treating of seed grain. Blending, cleaning, treating, packaging, conditioning, dust removal, and

pollution control are not considered a manufacturing process.

(6) All property described in paragraphs (1) and (2) shall be valued according to the reappraisal cycle established for other class 4 property in 15-7-103, MCA. The department will determine market value considering the cost approach, sales comparison approach, and income approach. When using the cost approach, a separate age/life schedule will be applied to the product handling portion of the facility to reflect physical depreciation and functional obsolescence. Any extraordinary obsolescence, including economic or external obsolescence, inherent to the facility will be addressed on a case by case basis. Cost data used in developing the cost approach for property included in this rule is found in the Marshall Valuation Service Manual.

(7) Mobile Equipment used in conjunction with the facilities described in this rule shall be valued in accordance with ARM 42.21.131.

(8) Other equipment not meeting the requirements of paragraph 2 shall be valued and assessed in accordance with ARM 42.22.1306. AUTH: Sec. 15-1-201, MCA; IMP: Secs. 15-6-134; 15-7-103; and 15-8-111, MCA.

RULE II REQUEST FOR REVIEW (1) An owner of property described in rule I may submit a property adjustment form (AB 26) to the department. If sales information is relied upon for a proposed adjustment the property owner must provide the department with one of the following to substantiate a sales price:

(a) an invoice signed by the seller stating the sales date, buyer, and the full price including all compensation and trade-in value received by the seller;

(b) a notarized affidavit signed by the seller stating the complete terms of the sale including the sales date, buyer and all compensation and trade-in value received by the seller;

(c) copy of the owner's most recent federal or state income tax return with the attached depreciation schedules or asset ledger/listing which specifically lists the property; or

(d) other reliable evidence which substantiates the sales information.

AUTH: Secs. 15-1-201 MCA; IMP: 15-8-111 MCA.

4. The department is proposing rule I to comply with Montana Supreme Court decision No. 90-441, United Grain Corporation v. The Department of Revenue of the State of Montana, which ruled that all grain handling equipment shall be valued and assessed as class 4 property. The decision does not address how the Department of Revenue is to implement the valuation of the property.

In previous years the machinery and equipment were assessed as class 8 property. There are currently no rules which apply to machinery and equipment being valued in class 4. The new rules proposed specify how the machinery and equipment are to be

valued.

The department is proposing rule II to enable taxpayers to present evidence to the department indicative of market value. Pursuant to 15-8-111, MCA, the department is obligated to reach market value on all property. This rule affords the taxpayer the opportunity to provide evidence towards that end.

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:

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

no later than November 29, 1991.

6. Cleo Anderson, Department of Revenue, Office of Legal Affairs, has been designated to preside over and conduct the hearing.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of the Amendment of ARM 44.5.101 through 44.5.110 amending corporation filing fees, license fee and forms.	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT TO RULES 44.5.101 through 44.5.110 AND ADOPTION OF RULES I AND II CORPORATION FILING FEES, LICENSE FEES, AND FORMS
TO: All Interested Persons:	

1. On November 20, 1991 at 10:00 a.m. a public hearing will be held in the conference room of the Secretary of State's Office, Room 225 Capitol Building, Helena, MT to consider the adoption of the above stated rules.

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

44.5.101 FEES FOR FILING DOCUMENTS ~~AND ISSUING CERTIFICATES~~ - BUSINESS CORPORATIONS The secretary of state shall charge and collect for:

(1) filing articles of incorporation ~~and issuing a certificate of incorporation~~, $20.00;

(2) filing articles of correction of an original document $15.00;

~~(2)~~ (3) filing articles of amendment ~~and issuing a certificate of amendment~~, $15.00;

~~(3)~~ (4) filing restated articles of incorporation ~~and issuing a restated certificate of incorporation~~, $15.00;

~~(4)~~ (5) filing articles of merger, consolidation, or exchange ~~and issuing a certificate of merger, consolidation or exchange~~, $20.00;

~~(5)~~ (6) filing an application to reserve a corporate name, $10.00;

~~(6)~~ (7) filing a notice of transfer of a reserved corporate name, $5.00;

~~(7)~~ (8) filing a statement of change of address of registered office or change of registered agent, or both, $5.00;

~~(8) filing a statement of the establishment of a series of shares $20.00;~~

~~(9) filing a statement of cancellation of shares $20.00;~~

~~(10) filing a statement of reduction of stated capital, $20.00;~~

~~(11) filing a statement of intent to dissolve, $15.00;~~

~~(12) filing a statement of revocation of voluntary dissolution proceedings, $20.00;~~

~~(13)~~ (9) filing articles of dissolution ~~and issuing a certificate of dissolution~~, $15.00;

(10) filing articles of revocation of voluntary dissolution, $15.00;

~~(14)~~ (11) filing an application of a foreign corporation for a certificate of authority to transact business in this state and issuing a certificate of authority, $20.00;

~~(15)~~ (12) filing an application of a foreign corporation for an amended certificate of authority to transact business in this state and issuing an amended certificate of authority, $15.00;

~~(16) filing a copy of an amendment to the articles of incorporation of a foreign corporation holding a certificate of authority to transact business in this state, $15.00;~~

~~(17) filing a copy of articles of merger of a foreign corporation holding a certificate of authority to transact business in this state, $20.00;~~

~~(18)~~ (13) filing an application for withdrawal of a foreign corporation and issuing a certificate of withdrawal, $15.00;

~~(19)~~ (14) filing an application for registration of corporate name of a foreign corporation, $10.00 per year, unless there are nine months or less remaining in year of application, then $1.00 per month;

~~(20)~~ (15) filing an application for renewal of registration of corporate name of a foreign corporation, $10.00 per year;

~~(21)~~ (16) filing an annual report within allotted time, $10.00;

~~(22)~~ (17) filing an annual report after the April 15 statutory deadline, ~~$15.00~~ $20.00;

(18) filing an annual report after September 1, $30.00;

~~(23)~~ (19) filing any other statement or report except an annual report, of a domestic or foreign corporation, $15.00;

~~(24)~~ (20) filing a statement of change, changing only the business address of the registered agent, $5.00 each for 1-25 corporations, $4.50 each for 25-50 corporations, and $4.00 each for over 50 corporations;

~~(25)~~ (21) issuing a certificate of ~~good standing~~ existence for domestic corporations or certificate of authorization for foreign corporations, $5.00;

~~(26)~~ (22) issuing a certificate of fact, $15.00.

~~(27) for furnishing a computerized printout of business corporation information, $1.00.~~

(Auth: Sec. 35-1-1307, MCA; IMP, Sec. 35-1-1206, MCA.)

44.5.103 FEES FOR FILING DOCUMENTS ~~AND ISSUING CERTIFICATES~~ - NONPROFIT CORPORATIONS The secretary of state shall charge and collect for:

(1) filing articles of incorporation ~~and issuing a certificate of incorporation~~, $20.00;

(2) filing articles of correction of original documents $15.00;

~~(2)~~ (3) filing articles of amendment ~~and issuing a certificate of amendment~~, $15.00;

(4) filing articles of amendment terminating, redeeming or canceling all memberships or any class of memberships, $15.00;

~~(3)~~ (5) filing restated articles of incorporation ~~and issuing a restated certificate of incorporation~~, $15.00;

~~(4)~~ (6) filing articles of merger, consolidation, or exchange ~~and issuing a certificate of merger, consolidation or exchange~~, $20.00;

~~(5)~~ (7) filing an application to reserve a corporate name, $10.00;

~~(6)~~ (8) filing a notice of transfer of a reserved corporate name, $5.00;

~~(7)~~ (9) filing a statement of change of address of registered office or change of registered agent, or both, $5.00;

~~(8)~~ (10) filing articles of dissolution ~~and issuing a certificate of dissolution~~, $15.00;

(11) filing articles of revocation of voluntary dissolution, $15.00;

~~(9)~~ (12) filing an application of a foreign corporation for a certificate of authority to transact business in this state and issuing a certificate of authority, $20.00;

~~(10)~~ (13) filing an application of a foreign corporation for an amended certificate of authority and issuing an amended certificate of authority, $15.00;

~~(11) filing a copy of an amendment to the articles of incorporation of a foreign corporation holding a certificate of authority to transact business in this state, $15.00;~~

~~(12) filing a copy of articles of merger of a foreign corporation holding a certificate of authority to transact business in this state, $20.00;~~

~~(13)~~ (14) filing an application for withdrawal of a foreign corporation and issuing a certificate of withdrawal, $15.00;

~~(14)~~ (15) filing an application for registration of corporate name of a foreign corporation, $10.00 per year, unless there are nine months or less remaining in year of application, then $1.00 per month;

~~(15)~~ (16) filing an application for renewal of registration of corporate name of a foreign corporation, $10.00 per year;

~~(16)~~ (17) filing an annual report within allotted time, $10.00;

~~(17)~~ (18) filing an annual report after the April 15 statutory deadline, ~~$15.00~~ $20.00;

(19) filing an annual report after September 1, $30.00;

~~(18)~~ (20) filing any other statement or report except an annual report, of a domestic or foreign corporation, $15.00;

~~(19)~~ (21) filing a statement of change, changing only the business address of the registered agent, $5.00 each for 1-25 corporations, $4.50 each for 25-50 corporations, and $4.00 each for over 50 corporations;

~~(20)~~ (22) issuing a certificate of ~~good standing~~ existence for domestic corporations or certificate of authorization for foreign corporations, $5.00;

~~(21)~~ (23) issuing a certificate of fact, $15.00;

(Auth: Sec. 35-2-1107, MCA; IMP, Sec. 35-1-1103, MCA.)

44.5.104 MISCELLANEOUS CHARGES - PROFIT AND NONPROFIT CORPORATIONS The secretary of state shall charge and collect:

(1) for furnishing a certified copy of any document, instrument or paper relating to a profit or nonprofit corporation, 50 cents per page and $2.00 for the ~~certificate~~ certification;

(2) and (3) remain the same;

(4) filing a document transmitted by facsimile machine, $10.00;

(5) priority handling for filing foreign or domestic profit or nonprofit corporations, $10.00;

(6) priority handling for all other documents, $5.00.

(Auth: Sec. 35-1-1307, 35-2-1107, MCA; IMP Sec. 35-1-1206, 35-2-1003, MCA.)

44.5.105 FEES FOR FILING DOCUMENTS AND ISSUING CERTIFICATES - LIMITED PARTNERSHIPS The secretary of state shall charge and collect for:

(1) through (3) remain the same;

(4) filing an application for renewal of certification of a limited partnership and issuing a certificate, $15.00;

~~(4)~~ (5) filing an application to reserve a limited partnership name, $10.00;

~~(5)~~ (6) filing a notice of transfer of a reserved limited partnership name, $5.00;

~~(6)~~ (7) filing a statement of change of address of specified office or change of specified agent, or both, $5.00;

~~(7)~~ (8) filing an application for registration of a foreign limited partnership and issuing a certificate, $20.00;

~~(8)~~ (9) filing a certificate of cancellation or correction of a foreign limited partnership and issuing a certificate, $15.00;

~~(9)~~ (10) filing any other statement or report of a domestic or foreign limited partnership, $15.00;

~~(10)~~ (11) issuing a certificate of fact of limited partnership, $15.00.

(Auth: Sec. 35-12-521, MCA; IMP, Sec. 35-12-521, MCA.)

44.5.108 MISCELLANEOUS CHARGES - ASSUMED BUSINESS NAMES The secretary of state shall charge and collect:

(1) for furnishing a certified copy of any document, instrument or paper relating to an assumed business name, 50 cents per page and $2.00 for the ~~certificate~~ certification;

(2) and (3) remain the same.

(Auth: Sec. 30-13-217, MCA; IMP, Sec. 30-13-217, MCA.)

44.5.110 MISCELLANEOUS CHARGES - TRADEMARKS The secretary of state shall charge and collect:

(1) for furnishing a certified copy of any document, instrument or paper relating to a trademark name, 50 cents per page and $2.00 for the ~~certificate~~ certification;

(2) and (3) remain the same.

(Auth: Sec. 30-13-311, 313, 315, MCA; IMP, Sec. 30-13-311, 313, 315 and Sec. 30-13-320, MCA.)

I. LICENSE FEE FOR DOMESTIC OR FOREIGN PROFIT CORPORATIONS BASED ON AUTHORIZED SHARES The secretary of state shall collect the following license fees in addition to the filing fee listed under ARM 45.5.101:

(1) For domestic corporations the license fee is as follows as required by 35-1-1207, MCA:

(a)	0 to 50,000 shares	$ 50
(b)	50,001 to 100,000 shares	100
(c)	100,001 to 250,000 shares	250
(d)	250,001 to 500,000 shares	400
(e)	500,001 to 1,000,000 shares	600
(f)	over 1,000,001 shares	1,000

(2) For foreign corporation the license fee as required by 35-1-1207 is $100.00.

(Auth: Sec. 35-1-1307, MCA; IMP, Sec. 35-1-1207, MCA.)

II. FORMS The following shall be the official mandatory forms as prescribed by the secretary of state. The forms are available at the Secretary of State's Office, State Capitol, Room 225, Helena, Montana 59620:

(1) Application for certificate of authority form number FC-4, shall contain the following information:

(a) The name of the corporation and the known in Montana name if it is different than the name of the corporation.

(b) If the name is not acceptable the corporation must adopt the name listed.

(c) The state which the corporation was incorporated.

(d) The date of incorporation and the period of duration.

(e) The address of the principal office in the state of jurisdiction.

(f) The address of the registered agent in Montana and the name of the registered agent.

(g) The names and addresses of the directors and officers of the corporation.

(h) The purpose for which the corporation is transacting business in the state of Montana.

(i) If the corporation is a nonprofit corporation, does it have any members.

(j) If the corporation is a nonprofit corporation which type of corporation it elects to be:

(i) public benefit,

(ii) mutual benefit, or

(iii) religious corporation.

(2) Application for amended certificate of authority of foreign corporation form number FCM-6, shall contain the following information:

(a) The date of the issuance of the certificate of authority and the name of the corporation the certificate of authority was issued to.

(b) The name of the corporation if the name has been changed.

(c) The period of the corporations duration.

(d) The state or country of its incorporation.

(e) If the corporation was involved in a merger or consolidation it must list the surviving corporation and its state of jurisdiction.

(3) Application for withdrawal of a foreign corporation form number FC-10, shall contain the following information:

(a) The name of the corporation.

(b) The state of jurisdiction.

(c) The corporation is not transacting business and surrenders its certificate of authority.

(d) The corporation revokes the authority of its registered agent in Montana to accept service of process and consents that service of process in any action, suit or proceeding based upon any cause of action arising in Montana may thereafter be made on it by service thereof on the secretary of state of the state of Montana.

(e) The mailing address to which the secretary of state may mail a copy of any process against the corporation.

(f) An assurance the corporation will notify the secretary of state of any change of its mailing address.

(g) If the corporation was involved in a merger it must list the surviving corporation and its state of jurisdiction and mailing address.

(h) If a profit corporation, it has paid all taxes imposed upon it by Title 15, Montana Code Annotated, and must attach a certificate by the department of revenue to the effect that the department of revenue is satisfied from the available evidence that all taxes imposed by Title 15 Montana Code Annotated, have been paid.

(4) Montana annual corporate report form, shall contain the following information:

(a) The state of incorporation.

(b) Address of principal office in state of incorporation.

(c) Brief description of business in which corporation is actually engaged.

(d) Name of corporation.

(e) Registered agent.

(f) Registered office address.

(g) Officers and their addresses.

(h) Directors and their addresses.

(i) Shares.

(j) Shareholders names, addresses and number of shares for professional service corporations only.

(k) Property statement for foreign corporations only.

(l) Election of a nonprofit corporation to be a public benefit, mutual benefit or religious corporation.

(Auth: Sec. 35-1-1307, MCA; IMP, Sec. 35-1-1308.)

3. The proposed rules are necessary to implement Chapters 368, 411 and 533 of the Laws of Montana 1991. The acts require the Secretary of State to establish fees commensurate with costs. The proposed service fees are identified in these rules. In addition to the fees, it is necessary to make certain changes

in the terminology of services provided by the Office of the Secretary of State. The above identified legislation also requires the adoption of form requirements for certain filings. These forms are identified in these rules.

4. These rules become effective January 1, 1992 except rules 44.5.104, 44.5.105, 44.5.108 and 44.5.110 will become effective the day after notice of adoption is published.

5. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to:

Garth Jacobson
Office of the Secretary of State
Room 225, Capitol Building
Helena, MT 59620

no later than November 29th, 1991.

6. Garth Jacobson has been designated to preside over and conduct the hearing.

GARTH JACOBSON
Rule Reviewer

MIKE COONEY
Secretary of State

Dated this 21st day of October.

BEFORE THE BOARD OF DENTISTRY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to dental hygienist examination and adoption of a new rule pertaining to dental hygienist licensure by credentials	)))))	NOTICE OF AMENDMENT OF 8.16.605 DENTAL HYGIENIST EXAMINATION AND ADOPTION OF NEW RULE I (8.16.605A) DENTAL HYGIENIST LICENSURE BY CREDENTIALS

TO: All Interested Persons:

1. On September 12, 1991, the Board of Dentistry published a notice of proposed amendment and adoption of the above-stated rules at page 1615, 1991 Montana Administrative Register, issue number 17.

2. The Board has amended and adopted the rules exactly as proposed.

3. The Board has thoroughly considered all comments received. Those comments and the Board's responses thereto are as follows:

COMMENT: One comment was received from the staff of the Administrative Code Committee. This comment stated that the language "board approved" proposed for deletion from 8.16.605 be left in the rule. The rationale given for this comment was that the rule would be in conflict with the statute if the language "board approved" were deleted.

REASON: Section 37-4-302, MCA, states that the Board shall recognize those dental hygiene schools accredited by the Commission on Dental Accreditation (CODA) or its duly-appointed successor. As such, the Board's discretion in determining what dental hygiene programs are sufficient to be accredited is shared with CODA. The Board is willing to accede to the accreditation determinations made by CODA, and accept the Commission's recognition of those dental hygiene programs. The Board therefore feels it is no longer necessary for it to approve each individual dental hygiene program.

4. No other comments or testimony were received.

BOARD OF DENTISTRY
WAYNE L. HANSEN, D.D.S.,
PRESIDENT

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, October 21, 1991.

BEFORE THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to EMT's	)	NOTICE OF AMENDMENT OF 8.28.908 EQUIVALENCY AND 8.28.1112 EMT - ADVANCED: CERTIFICATION

TO: All Interested Persons:

1. On May 30, 1991, the Board of Medical Examiners published a notice of proposed amendment of the above-stated rules at page 764, 1991 Montana Administrative Register, issue number 10.

2. The Board has adopted the rules exactly as proposed.

3. The Board has thoroughly considered all comments received. Those comments and the Board's responses thereto are as follows:

COMMENT: One comment was received from the staff of the Administrative Code Committee stating that section 50-6-202, MCA, does not authorize rulemaking respecting the subject matter of 8.28.908 or 8.28.1112. Section 50-6-203 does authorize rulemaking on these two subjects, however, and can properly be cited as authority.

RESPONSE: The Board agrees that section 50-6-202 does not authorize rulemaking on such subjects and deletes the references to section 50-6-202 from the authority section. The Board retains the citation to section 50-6-203 as authority for the amendments to 8.28.908 and 8.28.1112.

COMMENT: The staff of the Administrative Code Committee also stated that the language "as approved by the board" or its equivalent in these proposed amendments is objectionable in that (1) it fails to give maximum notice to persons of what is required of them by the regulatory body, and may therefore be subject to constitutional challenge on due process or equal protection grounds, and (2) puts the burden on the regulated party to determine what is expected of him or her, and may cause him or her inconvenience.

RESPONSE: In establishing "educational equivalency" as an alternative to the standard educational requirements for EMT certification which already appear in statute and rule, the Board is opening the field to individuals who may qualify on a case by case basis for the privilege of EMT certification. Since these individuals, by definition, have not qualified under the standard criteria, the Board will have to look at the particular qualifications and educational background of each applicant to determine whether he or she has the necessary skills and knowledge to perform EMT tasks. By definition, each of these applicants is a "special case" and must perforce be treated as one. It would not be possible to standardize criteria for this category of applicant.

The Board, in establishing fees, is bound by law to set fees commensurate with costs. Section 37-1-134. At this point in the development of this new "equivalency" program, the Board has insufficient information to determine what it will cost to evaluate the qualifications of each of these "equivalency" applicants. For the present, the Board will require the same fee as that imposed on regular applicants, and will promulgate rules changing that fee for the "equivalency" applicants when more data is available on which to base a fee actually commensurate with costs.

Similarly, since the Board will be dealing with non-standard qualifications for certification, the Board will need the flexibility to inquire of any particular applicant all information relevant to his or her particular credentials. This will of necessity vary, applicant by applicant. An "application" which fully discloses the qualifications of one "equivalency" applicant may not disclose the qualifications of another. Thus, the Board must have authority to approve the sufficiency of the application on a case-by-case basis.

Where there is good cause, reasonably based on a legitimate public interest, and there is no suspect classification involved in the different treatment of different groups, a governmental entity may constitutionally treat different groups differently. The Board believes that the public health, welfare and safety is a legitimate public interest, and that allowing qualified persons with non-standard educational backgrounds the opportunity to serve the public as EMT's is a good cause. There is no suspect classification operative here. Therefore, the Board believes the flexibility allowed under the "approved by the board" language is constitutional herein.

COMMENT: One comment was received stating that individual EMT applicants must receive a recommendation from only a licensed advanced life support service, as opposed to a service which has merely applied for license.

RESPONSE: An advanced life support service cannot be licensed by the Department of Health and Environmental Sciences until they have personnel trained to the appropriate advanced life support level. On the other hand, personnel cannot be certified by the Board of Medical Examiners until they are recommended by a medical director of a licensed emergency medical service. This can present a "Catch-22" situation, which is resolved by allowing services which have applied for a license to recommend the EMT applicant.

When the foregoing was brought to the attention of the commentor, the commentor concurred with the amendment as originally proposed.

4. No other comments or testimony were received.

BOARD OF MEDICAL EXAMINERS
PETER L. BURLEIGH, M.D.
PRESIDENT

BY: Annie M. Bartos
ANNIE BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE BARTOS, RULE REVIEWER

Certified to the Secretary of State, October 21, 1991.

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

In the matter of the amendment of rules pertaining to fees and continuing education and the adoption of new rules pertaining to definitions, applications for certification, examinations, continuing education, use of specific drugs - supervision, record keeping and unprofessional conduct with respect to embryo transfer	NOTICE OF AMENDMENT OF 8.64.402 FEE SCHEDULE AND 8.64.505 CONTINUING EDUCATION AND THE ADOPTION OF NEW RULES PERTAINING TO THE PRACTICE OF EMBRYO TRANSFER IN VETERINARY MEDICINE

TO: All Interested Persons:

1. On September 12, 1991, the Board of Veterinary Medicine published a notice of proposed amendment and adoption of the above-stated rules at page 1625, 1991 Montana Administrative Register, issue number 17.

2. The Board has amended ARM 8.64.402 and 8.64.505 exactly as proposed and has adopted new rules I (8.64.801), III (8.64.803), IV (8.64.804), V (8.64.805), VI (8.64.806) and VII (8.64.807) exactly as proposed. New rule II (8.64.802) has been adopted as proposed but with the following change:

"8.64.802 APPLICATIONS FOR CERTIFICATION - QUALIFICATION

(1) and (2) will remain the same as proposed.

(3) Applicants must be at least 18 years of age and have successfully completed at least six semester hours of 300 level reproductive physiology and endocrinology courses from accredited colleges or universities, OR, THROUGH JUNE 30, 1992, EQUIVALENT EDUCATION OR EXPERIENCE AS DETERMINED BY THE BOARD."

Auth: Sec. 37-18-202, MCA; IMP, Sec. 37-18-104, MCA

3. The Board has thoroughly considered the comments received. Those comments and the Board's responses thereto are as follows:

COMMENT: One comment was received asking the Board to reduce the examination fee by requiring the applicants to provide their own equipment and supplies for the practical examination.

RESPONSE: The fees set are commensurate with program area costs as required by section 37-1-134, MCA. The fees are reasonably necessary to meet application, examination, development and administration, supplies and equipment and other costs. The board must provide equipment and supplies in order to assure fairness to all applicants by taking the examination under the same conditions.

COMMENT: One comment stated that the supervising veterinarian of embryo transfer technician should be Montana licensed but

not necessarily a Montana resident.

RESPONSE: A Montana veterinarian is required to assure actual supervision of embryo transfer technicians.

COMMENT: A comment was received stating that the rules should provide for "substantially equivalent education" as an alternative to the stated education requirement.

RESPONSE: ARM 8.64.802(3) sets forth minimum education requirements. However, to allow a transition period for persons with equivalent education or experience, the rule will be amended effective through June 30, 1992.

COMMENT: One comment was received asking that the rules provide for "substantially equivalent experience" as an alternative to the stated education requirement.

RESPONSE: ARM 8.64.802(3) sets forth minimum education requirements. However, to allow a transition period for persons with equivalent education or experience, the rule will be amended effective through June 30, 1992.

4. No other comments or testimony were received.

BOARD OF VETERINARY MEDICINE

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, October 21, 1991.

BEFORE THE DEPARTMENT OF FISH, WILDLIFE & PARKS
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT OF ARM 12.5.301 PERTAINING TO FRESHWATER MUSSELS AS NONGAME SPECIES IN NEED OF MANAGEMENT	))))	NOTICE OF AMENDMENT OF ARM 12.5.301

TO: All interested persons

1. On August 29, 1991, the Department of Fish, Wildlife and Parks published notice at page 1541 of the Montana Administrative Register, issue number 16, of the proposed amendment of ARM 12.5.301 pertaining to freshwater mussels as nongame species in need of management.
2. The Department has amended ARM 12.5.301 as proposed.
3. No comments or testimony were received.

Patrick Graham, Deputy Director
Montana Department of Fish,
Wildlife and Parks

Robert N. Lane, Rule Reviewer

Certified to the Secretary of State October 21, 1991

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

In the matter of the adoption of new rules I through VII relating to 401 Certification	)))	NOTICE OF ADOPTION OF NEW RULES I THROUGH VII

(Water Quality Bureau)

To: All Interested Persons

1. On August 15, 1991, the Board published notice at page 1397 of the Montana Administrative Register, Issue No. 15, of the proposed adoption of the above-captioned rules which describe a process for department review and issuance, denial or waiver of certification under section 401 of the federal Clean Water Act of any activity that requires a federal license or permit and which may result in discharge in state waters.

2. After consideration of the comments received on the proposed rules, the board has adopted the rules as proposed with the following changes (new material is underlined, deleted material is interlined):

RULE I (16.20.1701) PURPOSE AND POLICY Remains the same.

RULE II (16.20.1702) DEFINITIONS Remain the same.

RULE III (16.20.1703) APPLICATION FOR CERTIFICATION (1) A person may not conduct or commence construction for any activity requiring state water quality certification under 33 U.S.C. section 1341, as amended, unless the department has issued certification~~, conditionally issued certification~~ issued with conditions, or waived certification under this subchapter.

(2)-(6) Remains the same.

RULE IV (16.20.1705) DEPARTMENT CERTIFICATION OPTIONS Remains the same.

RULE V (16.20.1706) TENTATIVE DETERMINATION BY THE DEPARTMENT (1) The department shall, within 30 days of receipt of a completed application, notify the applicant, the federal permitting or licensing agency, and the regional administrator of its tentative determination to either issue, issue ~~conditionally~~ with conditions, or deny certification. If the department does not notify the applicant of a tentative determination within 30 days after the application is determined to be complete, the department is deemed to have waived certification.

(2)-(7) Remain the same.

RULE VI (16.20.1708) PUBLIC NOTICE AND FINAL DETERMINATION BY THE DEPARTMENT (1)(a)-(b) Remain the same.

(c) any other notice that the department considers ~~necessary~~ reasonable to encourage public participation in the decision.

(2)-(6) Remains the same.

RULE VII (16.20.1709) APPEAL TO THE BOARD (1) Remains the same.

~~(2) The board's review is limited to the issue of whether the department has properly interpreted and applied the effluent limits and water quality standards stated in or developed pursuant to ARM Title 16, chapter 20, to the discharge from the facility or activity for which the department's certification decision is under appeal.~~

(3)-(4) Remain the same but are renumbered (2)-(3).

3. The board has thoroughly considered the comments received on the proposed rules. The following is a summary of comments received, along with department responses to ~~these~~ comments.

COMMENT:

G. Steven Brown urged the board to remove subsection (2) of proposed Rule VII because it restricts the scope of the board's review in a manner that is inconsistent with the board's jurisdiction under the Water Quality Act. Others also testified in support of this recommendation.

RESPONSE:

The Department agreed with this proposed amendment, and the amendment is made accordingly.

COMMENT:

Jim Jensen, Montana Environmental Information Center, requested technical changes in wording.

RESPONSE:

The technical amendments made to these rules reflect Mr. Jensen's recommendations.

DAVID W. SIMPSON, Chairman
BOARD OF HEALTH AND
ENVIRONMENTAL SCIENCES

by William J. Pitz
for DENNIS IVERSON, Director

Certified to the Secretary of State October 21, 1991 .

Reviewed by:

Eleanor J. Parker
Eleanor Parker, DHES Attorney

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

In the matter of the amendment of rules 16.44.103, 16.44.105-106, 16.44.109, 16.44.114-116, 16.44.118, 16.44.123-124, 16.44.202, 16.44.610, 16.44.901-902, 16.44.911, and new Rule I dealing with permits for owners and operators of hazardous waste	NOTICE OF ADOPTION OF AMENDMENT OF RULES AND THE ADOPTION OF NEW RULE I (Solid & Hazardous Waste)

To: All Interested Persons

1. On September 12, 1991, the department published notice at page 1641 of the Montana Administrative Register, Issue No. 17, to consider the amendment of the above-captioned rules which are part of the ongoing process of seeking re-authorization from the Environmental Protection Agency under RCRA to the State of Montana to continue to operate an independent hazardous waste program. Owners and operators of hazardous waste management units must have hazardous waste management permits during the active life, including the closure period, for the unit. These amendments reflect those changes required by EPA's revisions of existing permit requirements. The EPA revisions, mirrored by the amendments to the current rules, more fully explain and outline the permitting process. One new rule describes the Department of Health and Environmental Sciences's authority to deny a permit.

2. The department has adopted the amendments and Rule I (16.44.127) as proposed with no changes.

3. No comments were received.

DENNIS IVERSON, Director

Certified to the Secretary of State October 21, 1991.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE PETROLEUM TANK RELEASE COMPENSATION BOARD
OF THE STATE OF MONTANA

In the matter of the amendment of rules 16.47.101, 16.47.311-312, 16.47.314, 16.47.316, 16.47.321, 16.47.323-324, 16.47.333-334, 16.47.342 and 16.47.351, and new rules I and II relating to leaking petroleum storage tank compensation program	NOTICE OF AMENDMENT OF RULES AND THE ADOPTION OF NEW RULES I & II (Petroleum Tank Release Compensation Program)

To: All Interested Persons

1. On August 15, 1991, the Petroleum Tank Release Compensation Board published notice at page 1390 of the Montana Administrative Register, Issue No. 15, to consider the amendment of the above-captioned rules. The two new rules and the amendments to 16.47.101, 16.47.312, 16.47.314, and 16.47.351, implement House Bill 973, enacted as chapter 763 of the Laws of 1991. The amendments to 16.47.311, 16.47.321, 16.47.333, and 16.47.336 implement House Bill 485, enacted as chapter 389 of the Laws of 1991. The amendments to 16.47.316, 16.47.323, 16.47.324, 16.47.334, and 16.47.342 are based upon the board's biennial review of its existing rules.

2. The board has amended and adopted the rules, as proposed, with the following changes (new material is underlined; material to be deleted is interlined):

16.47.311 DEFINITIONS (1)(a)-(e) Remain the same.

(g) "Site" means a complex of tanks under the same ownership on a contiguous piece of property.

(h) Remains the same.

(2) Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-302 through 75-11-318, MCA

16.47.314 RELEASE DISCOVERED ON OR AFTER APRIL 13, 1989 CONSTRUED (1) A tank owner or operator may be eligible under the 603 program for reimbursement for eligible costs resulting from an accidental release from a petroleum storage tank if the release was discovered on or after April 13, 1989, even though the tank, in place, was out of service on the date of discovery or is presently out of service.

(2) A tank owner or operator may be eligible under the 973 program for reimbursement of eligible expenditures ~~made~~ incurred after May 9, 1991 if the release was discovered on or after April 13, 1989, even though the tank, in place, was out of service on the date of discovery or is presently out of service.

AUTH: 75-11-318, MCA; IMP: 75-11-308, MCA

16.47.316 CRITERIA FOR DECISION -- COSTS ACTUALLY, NECESSARILY, AND REASONABLY INCURRED (1) Remains the same.

(2) "Actually incurred" means, in the case of corrective action expenditures, that one entity--the owner, the operator, the insurer of either, or a contractor hired by any of them--has made a payment or that a contractor has expended time and materials and that only that entity is receiving reimbursement from the board. Time and labor contributed by the owner or operator or by an unpaid volunteer is not normally an expenditure actually incurred, but the labor of a subordinate employee or a contractor reflected by checks and treated by the recipient as income is actually incurred. An owner or operator may, with prior approval of the department in the corrective action plan, provide his own labor and be reimbursed for it when the cost of hiring out the work would have been greater. The board will also require proof of payment from an owner or operator or an insurer, or proof of work completed from a contractor.

EXAMPLES: Remains the same.

(b) Remains the same.

(3)-(4) Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

16.47.336 REVIEW AND DETERMINATION (1) The board's staff shall receive all applications for reimbursement. The staff will determine if the application is complete, then forward it to the department for its review. ~~Following the department review, the~~ The staff will promptly advise the applicant of any incompleteness or deficiency which appears on the application. Further review will be suspended pending the submission of additional information as the applicant, acknowledging an incomplete or deficient application, agrees to furnish. An applicant who believes any request for additional information by the staff is not authorized by the Act or these rules may request the board to process and consider his application, and the board shall proceed. Following this initial staff review the application will be forwarded to the department for its review.

(2)-(6) Remain the same.

AUTH: 75-11-318, MCA; IMP: 75-11-309(2) and (3), MCA

RULE I (16.47.317) ~~MAJOR 603~~ TANK PROGRAM AND ~~MINOR 973~~ TANK PROGRAM

(1) The board has two reimbursement programs: ~~one for major tanks, which are all covered tanks not clearly eligible under the 973 program, and the other for certain minor tanks.~~ the 973 program, which covers heating oil tanks (as defined in the Act) without reference to a maximum size and farm, ranch, and residential petroleum storage tanks (as defined in the Act) holding up to 1,100 gallons, and the 603 program for all covered tanks not clearly eligible under the 973 program. The 603 program covers liability up to $1,000,000 with a potential co-payment amount of $17,500 (half the first $35,000). ~~The 973 program covers farm, ranch, and residential tanks not exceeding 1,100 gallons, used to store petroleum products for noncommercial purposes, and tanks used to store heating oil for consump-~~

~~tive use on the premises. This~~ The 973 program covers liability up to $500,000 with a potential co-payment amount of $5,000 (half the first $10,000).

(2) Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-307, MCA

RULE II (16.47.318) HEATING OIL STORED FOR CONSUMPTIVE USE ON THE PREMISES Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-307, MCA

3. The department has thoroughly considered the comments received on the proposed rules. The following is a summary of the comments received and the department's responses:

Comment No. 1: Change 16.47.101 to describe program cleanup activity as in response to releases from tanks or piping.

Response: This change is unnecessary as the statutory definition of a petroleum storage tank includes piping.

Comment No. 2: Add definitions of corrective action plan and heating oil to the terms defined in 16.47.311.

Response: The board understands that heating oil is construed by the department to include diesel fuel or waste oil from engine maintenance operations, when stored in a tank and then burned as heating oil. The change would therefore be unnecessary. The board will follow the department's definition of corrective action plan in 16.45.1101(4) and thus it is unnecessary to repeat that definition in its own rules.

Comment No. 3: The proposed definition of "site" is too broad and could be construed to mean two separate service stations in different locations. A better term would be "facility" and it should be defined as a contiguous parcel of property under one ownership containing one or more tank systems.

Response: The board agrees with the point and has decided to retain the term "site" but to amend its definition to refer to a contiguous parcel of property.

Comment No. 4: Existing language in 16.47.314 regarding out of service tanks should clarify that the tanks had to have been in the ground on April 13, 1989.

Response: The board agrees with this comment in substance, and has amended the rule accordingly.

Comment No. 5: Owners or operators of small farm or residential tanks should be able to be reimbursed for their own labor in taking corrective action if prior approval has been obtained from the department.

Response: The board agrees with this comment and has amended 16.47.316(2) accordingly.

Comment No. 6: The new example in 16.47.316(3) is poor

because if a tank is leaking it must be removed.

Response: The comment misconstrues the example. A release could be the consequence of a spill or overfill or of a failure of piping outside the tank vessel itself. In this example only the term "tank" refers just to the vessel and not to the piping, in order to illustrate when a tightness test is or is not an eligible expenditure.

Comment No. 7: In the same new example, the board should consider whether expenditures to investigate a suspected release would be eligible for reimbursement regardless of whether a release is subsequently confirmed at the site.

Response: The example makes it clear that the expenditure for a tightness test is eligible only if a release is confirmed.

Comment No. 8: The second new example in 16.47.316(3) is misleading because if the suspect release was identified through inventory checks a loose fitting would not be a likely cause.

Response: Staff investigations for the board have found such fact patterns.

Comment No. 9: The board should revise the example of a reasonably incurred expenditure in 16.47.316(4) so that an owner or operator is not required to find the lowest qualified bidder when selecting an environmental consultant.

Response: The board rejects the proposed change at this time without prejudice to return to this issue if and when it gives notice of proposed rulemaking in this part of the rule.

Comment No. 10: Subsection (1) in 16.47.321 should be revised to be cast in terms of a tank system.

Response: The definition of a tank takes in the system; see response no. 1.

Comment No. 11: Several department rules should be specifically mentioned in 16.47.321(1)(d).

Response: This part of the rule was not mentioned in the notice of proposed rulemaking and the board declines to take the recommended action on it at this time.

Comment No. 12: The board should revise 16.47.334(1)(a) to recognize that a corrective action plan can be approved verbally, and when that is done the application should so state.

Response: Same as response no. 11.

Comment No. 13: The board should amend 16.47.334(3) to set a one-year limit on the submission of claims after corrective action has been completed.

Response: Same as response no. 11.

Comment No. 14: The board should amend 16.47.336(1) to

state that the board's staff will advise an applicant of any incompleteness or deficiency and suspend further review before the application is forwarded to the department for its review.

Response: The board agrees with the point that the rule as set out in the notice is unclear and is revising it, although not exactly as requested. An applicant has the right to have the board consider its application even if the staff considers it incomplete.

Comment No. 15: The board should amend 16.47.336(3) to extend the 7-day period before board consideration of applications and staff reports on them, to give the parties more time to resolve or clarify questions about the application.

Response: Same as response no. 11.

Comment No. 16: The board should amend the last sentence of 16.47.342(3) to state that if the board modifies a corrective action plan the department must concur in the modification.

Response: Same as response no. 11.

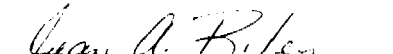
Comment No. 17: The board should clarify the wording of subsection (1) in new rule I to use the 603 or 973 program titles and to clarify that no size limit applies to heating oil tanks.

Response: The board agrees with these comments and has revised new rule I(1) accordingly.

Comment No. 18: The board should revise the second sentence in new rule I(2) to read as follows: "A person who seeks reimbursement under the 973 program must prove that no leaking tank at the site is eligible under the 603 program, unless separate releases can be isolated or occurred at different periods of time."

Response: The board declines to make this change. It would appear to create many more problems than it would solve.

PETROLEUM TANK RELEASE
COMPENSATION BOARD
Howard Wheatley, Chairman

By: 
Jean Riley, Executive Director

Certified to the Secretary of State October 21, 1991.

Reviewed by:


Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.19.401 relating to low income property tax reduction	NOTICE OF THE AMENDMENT of ARM 42.19.401 relating to low income property tax reduction

TO: All Interested Persons:

1. On September 12, 1991 the Department published notice of the proposed amendment of ARM 42.19.401 relating to low income property tax reduction at page 1682 of the 1991 Montana Administrative Register, issue no. 17.

2. A Public Hearing was held on October 9, 1991, to consider the proposed amendment. No one appeared to testify and no written comments were received except from department staff who offered additional amendments to the rule as follows:

42.19.401 LOW INCOME PROPERTY TAX REDUCTION (1) remains as proposed.

(2) The department or its agent will review the application and any supporting documents. The department may review income tax records to determine accuracy of information. The department or its agent will approve or deny the application. The applicant will be advised in writing of the decision. An annual statement of eligibility is required unless a review of income tax records or other records related to the applicant's income demonstrates that an individual ~~who met the provisions of (1)(a)~~ had no significant change in income level AND SUCCESSFULLY QUALIFIED DURING THE PRECEDING 12 MONTHS PRIOR TO JANUARY 1 OF THE CURRENT TAX YEAR. In that situation the annual statement of eligibility required may be waived by the department or its agent.

(3) and (4) remain as proposed.

(5) Business income is that income reported AS NET PROFIT OR LOSS on schedule C ~~line 5~~, or schedule F, ~~line 12~~, of the federal income tax return~~, or the income reported on state income tax return form CBT line 11, or the income reported on federal corporation tax return form 1120 line 11, whichever is greater~~.

(6) remains as proposed.

3. The department has adopted the rule with these additional amendments.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.20.102 and 42.20.147 relating to applications for property tax exemptions and criteria for agricultural land valuation	NOTICE OF AMENDMENT of ARM 42.20.102 and 42.20.147 relating to applications for property tax exemptions and criteria for agricultural land valuation

TO: All Interested Persons:

1. On September 12, 1991, the Department published notice of the proposed amendment of ARM 42.20.102 and 42.20.147 relating to applications for property tax exemption and criteria for agricultural land valuation at page 1672 of the 1991 Montana Administrative Register, issue no. 17.

2. No hearing was held and no public comments were received regarding these rules.

3. The Department has amended the rules as proposed.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.21.106, 42.21.107, 42.21.113, 42.21.123, 42.21.131, 42.21.137, 42.21.138, 42.21.139, 42.21.140, 42.21.151, 42.21.155, and 42.21.305 and the ADOPTION of RULE I (42.21.163) and RULE II (42.21.164) relating to personal property	NOTICE OF THE AMENDMENT of ARM 42.21.106, 42.21.107, 42.21.113, 42.21.123, 42.21.131, 42.21.137, 42.21.138, 42.21.139, 42.21.140, 42.21.151, 42.21.155, and 42.21.305 and the ADOPTION of RULE I (42.21.163) and RULE II (42.21.164) relating to personal property

TO: All Interested Persons:

1. On September 12, 1991, the Department published notice of the proposed amendment and adoption of rules relating to personal property at page 1694 of the 1991 Montana Administrative Register, issue no. 17.

2. A Public Hearing was held on October 9, 1991, to consider the proposed amendments and adoption. Written and oral testimony was received during and subsequent to the hearing.

3. Oral and written comments received during and subsequent to the hearing are summarized as follows along with the response of the Department:

GENERAL STATEMENTS REGARDING COMMENTS: Supporting comments came from Kiewit Western Co. on new Rule I (42.21.163) and from the Montana Taxpayers' Association on new Rule II (42.21.164).

Opposing written and oral comments received from Phillips County, Rosebud County and Bighorn County were only directed towards ARM 42.21.131. Also, written testimony in opposition to ARM 42.21.131 was received and signed by 25 County Assessors.

RESPONSES TO OPPOSING COMMENTS:

Comment: The Department's failure again this year to state and adequately justify its proposed change to ARM 42.21.131, as occurred in 1991, may subject this proposed 1992 rule to judicial invalidation.

Response: The Department believes it did adequately justify its 1991 rule change. The department responded to questions on the 1991 changes to ARM 42.21.131 during at least 2 public meetings and provided written responses to concerns raised during the rule hearing.

The proposed rule change to ARM 42.21.131 for 1992 is limited to updating the trended depreciation schedule. The methodology for valuing heavy equipment isn't a subject of these rule changes.

Justification for the change is quite simple. Schedules must be updated annually to reflect changing property values and provide for valuing new equipment that wasn't listed on the schedule for the previous year.

Comment: If the Department's position that Green Guides don't yield market value is accepted as correct, then it has adopted a standard of value for heavy equipment which is inconsistent with the statute which is being implemented through the administrative rule.

Response: The proper methodology for valuing heavy equipment is not the subject of these rules. The rule change for heavy equipment is limited to updating the trended depreciation schedule.

The Department believes the acquired cost method of valuing heavy equipment it adopted for 1991 best reflects the market price of this type of equipment. Green Guide values may be used, but only if information needed for using acquired cost is unavailable or unacceptable. However, if the Guides are used and result in an incorrect value the Department is adopting new Rule II allowing the property owner to present evidence of true market value.

Comment: If the Department has concluded that the use of the data in the Green Guides is not a reliable indicator of value of heavy equipment, it is difficult to fathom how the data in the same Green Guides could be accepted by the Department as a reliable basis for calculating the depreciation for heavy equipment.

Response: The proper methodology for valuing heavy equipment is not the subject of these rules. The rule change for heavy equipment is limited to updating the trended depreciation schedule.

The Department has concluded that the acquired cost method most accurately identifies the market value of heavy equipment. The use of this method requires a determination of the rate at which heavy equipment depreciates. Aggregate information from the Green Guide is used to determine this rate. However, individual property "quick sale" (wholesale) values from the guide aren't used for the acquired cost method.

The Green Guide is still used as an alternative to "acquired cost minus depreciation." The Department has never said that the Green Guide was not a method for determining market value - its just that the acquired cost minus depreciation is a better method for determining market value of heavy equipment.

Comment: The Department should abandon all efforts to amend the heavy equipment rule until it has appointed an advisory committee to examine the issue of whether the use of

the Green Guides yields the market value of heavy equipment.

Response: The proper methodology for valuing heavy equipment is not the subject of these rules. The rule change for heavy equipment is limited to updating the trended depreciation schedule. The Department must proceed with the adoption of the changes to ARM 42.21.131 to ensure that a current schedule is available for valuing heavy equipment in 1992.

The Department properly adopted a rule on the methodology for valuing heavy equipment for 1991. Since that methodology isn't being changed for 1992, an advisory committee is unnecessary.

Comment: The validity of this rule is presently under litigation and shouldn't be heard until the court renders a decision.

Response: The Department must proceed with the adoption of the changes to ARM 42.21.131 to ensure that a current schedule is available for valuing heavy equipment in 1992. When the court renders a decision on the methodology used for valuing heavy equipment in 1991, the Department will carefully examine its impact on the methodology for valuing heavy equipment for 1992. The case at issue is Rosebud County v. Montana Department of Revenue, Sixteenth Judicial District Court, No. DV-91-77, and has been pending with the court for several months.

Comment: Several comments were received specific to the methodology used to value heavy equipment.

Response: The Department isn't proposing to change the methodology with these rules. The methodology for valuing heavy equipment is currently under review by the courts. The Department will comply with judicial direction on methodology.

3. The Department has adopted the rules as proposed.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) of ARM 42.22.104 relating to) Centrally Assessed Property)	NOTICE OF THE AMENDMENT of ARM 42.22.104 relating to Centrally Assessed Property

TO: All Interested Persons:

1. On September 12, 1991, the Department published notice of the proposed amendment of ARM 42.22.104 relating to centrally assessed property at page 1680 of the 1991 Montana Administrative Register, issue no. 17.

2. A public hearing was held on October 9, 1991, to consider the proposed amendment. Department staff were the only persons to appear at the hearing. No written comments were received. Department staff offered additional amendments to the rule which are as follows:

42.22.104 TREATMENT OF MOTOR VEHICLES AND MOBILE EQUIPMENT (1) Automobiles, trucks, equipment attached to the vehicle and special mobile equipment excluded from the definition of situs property are to be ~~reported to the department by each county. The county assessor shall transmit to the department a statement showing the total market and taxable value for all automobiles, trucks, and special mobile equipment assessed in the county for~~ locally assessed and reported to the department of revenue by each centrally assessed company.

(2) Each centrally assessed company having such equipment shall provide the department with a statement showing A DESCRIPTION AND the total market ~~and taxable~~ value for ~~this type of~~ each piece of equipment ~~for each county~~. The market value shall be the value shown on the automobile, truck, equipment ~~on the back~~ ATTACHED TO THE VEHICLE or special mobile equipment Montana vehicle registration ~~and~~ OR OTHER TAX payment receipt. Companies with prorated vehicles shall provide the department with the total number of miles traveled in and out of the state of Montana, A DESCRIPTION and the market value for each vehicle. Companies that license fleet vehicles with the Montana Gross Vehicle Weight (GVW) Division will use the value for each piece of equipment ~~reported to~~ DETERMINED BY GVW as the market value to report to the department. This statement is to be filed at the same time the report required by ARM 42.22.105 is filed.

(3) The department of revenue may, at any time, ask for verification of the reported equipment's market value from the county, other agencies, other states or the company. This verification may be, but is not limited to, supplying the department with copies of each vehicle's Montana registration form. Omission of any requested information may result in loss of or a partial deduction for the equipment.

~~(3)~~ (4) The total market value for these assessed automobiles, trucks, equipment attached to the vehicle and special mobile equipment is deducted from the Montana unit value, as defined in ARM 42.22.121, to determine the amount of the Montana unit value to be allocated under the provisions of ARM 42.22.122. This methodology shall be effective for all reporting years beginning after December 31, 1991. AUTH: Sec. 15-23-108, MCA; IMP, 15-23-101, MCA.

4. Therefore, the Department adopts the rule with the amendments listed above.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State on October 21, 1991

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.22.1311 relating to industrial machinery and equipment trend factors	) NOTICE OF PROPOSED AMENDMENT) of ARM 42.22.1311 relating to) industrial machinery and) equipment trend factors)

TO: All Interested Persons:

1. On September 12, 1991, the Department published notice of the proposed amendment of ARM 42.22.1311 relating to industrial machinery and equipment trend factors at page 1675 of the 1991 Montana Administrative Register, issue no. 17.

2. No hearing was held and no public comments were received regarding these rules.

3. The Department has adopted the rule as proposed.

CLEO ANDERSON
Rule Reviewer

DENIS ADAMS
Director of Revenue

Certified to Secretary of State October 21, 1991

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

In the matter of the amendment of Rules 46.12.102, 46.12.583 and 46.12.584 pertaining to organ transplantation	))))	NOTICE OF THE AMENDMENT OF RULES 46.12.102, 46.12.583 AND 46.12.584 PERTAINING TO ORGAN TRANSPLANTATION

TO: All Interested Persons

1. On September 12, 1991, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.12.102, 46.12.583 and 46.12.584 pertaining to organ transplantation at page 1719 of the 1991 Montana Administrative Register, issue number 17.

2. The Department has amended Rules 46.12.102, 46.12.583 and 46.12.584 as proposed.

3. No written comments or testimony were received.

4. The amendment expanding coverage to include liver transplantation for adults in certain cases will be effective retroactive to October 17, 1991. The rule is being made retroactive because the U.S. Department of Health and Human Services has recently approved coverage of liver transplants for adults as well as children. In doing so they have concluded that liver transplants for adults are not to be considered experimental. On October 17th the Department of Social and Rehabilitation Services has likewise agreed with this decision and believes it to be necessary to start coverage immediately in order to save the lives of individuals currently awaiting approval.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State October 21, 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 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

TO: All Interested Persons

1. On July 25, 1991, the Department of Social and Rehabilitation Services published notice of 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 at page 1212 of the 1991 Montana Administrative Register, issue number 14.

2. The Department has adopted [RULE V] 46.12.1228, RATE EFFECTIVE DATES; [RULE X] 46.12.1237, CALCULATED PROPERTY COST COMPONENT; [RULE XVIII] 46.12.1254, BED HOLD PAYMENTS; [RULE XIX] 46.12.1255, MEDICARE HOSPICE BENEFIT - REIMBURSEMENT; [RULE XX] 46.12.1258, ALLOWABLE COSTS; [RULE XXI] 46.12.1260, COST REPORTING, DESK REVIEW AND AUDIT; [RULE XXIII] 46.12.1264, THIRD PARTY PAYMENTS AND PAYMENT IN FULL; and [RULE XXIV] 46.12.1265, UTILIZATION REVIEW AND QUALITY OF CARE as proposed.

3. The Department has adopted the following Rules as proposed with the following changes:

[RULE I] 46.12.1221 SCOPE, APPLICABILITY AND PURPOSE

Subsections (1) through (3) remain as proposed.

(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, INCLUDING THE COSTS OF SERVICES REQUIRED TO ATTAIN OR MAINTAIN THE HIGHEST PRACTICABLE PHYSICAL, MENTAL AND PSYCHOSOCIAL WELL-BEING OF EACH MEDICAID RECIPIENT, 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] 46.12.1222 DEFINITIONS ~~(1)~~ Unless the context requires otherwise, in sub-chapter 12 the following definitions apply:

Original subsections (1)(a) through (1)(t) remain as proposed but will be renumbered as subsections (1) through (20).

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

[RULE III] 46.12.1223 PROVIDER PARTICIPATION REQUIREMENTS Subsections (1) through (1)(b) remain as proposed.

(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 FOR THE CATEGORY OF NURSING FACILITY CARE BEING PROVIDED;

Subsections (1)(d) and (1)(e) remain as proposed.

(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~~ IN AMOUNTS UP TO $50 must be maintained ~~in a non-interest bearing account or petty cash fund~~ IN SUCH A MANNER THAT THE RESIDENT HAS CONVENIENT ACCESS TO SUCH FUNDS WITHIN A REASONABLE TIME UPON REQUEST. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

Subsections (1)(g) and (1)(h) remain as proposed.

(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) (1991 SUPP.), WHICH CONTAINS FEDERAL LAWS RELATING TO NURSING HOME REFORM. 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.

Subsection (2) remains as proposed.

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] 46.12.1226 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 BE SUBJECT TO THE MINIMUM AND MAXIMUM LEVELS ~~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:

Subsections (1)(a) through (1)(c) remain as proposed.

(d) a calculated property cost component, individually determined for each provider in accordance with [Rule X] ARM 46.12.1237, or a grandfathered property component determined in accordance with [Rule XI] ARM 46.12.1240, if the provider is entitled to a grandfathered property rate under the provisions of [Rule XI] ARM 46.12.1240.

Subsection (2) remains as proposed.

(3) A provider's per diem rate for rate year 1992 shall ~~not~~ NEITHER exceed the provider's average per diem rate, including the OBRA increment, in effect for rate year 1991 plus ~~$9.50~~ $8.00 per diem, NOR BE LESS THAN THE PROVIDER'S AVERAGE PER DIEM RATE, INCLUDING THE OBRA INCREMENT, IN EFFECT FOR RATE YEAR 1991 PLUS 5.5% OF SUCH 1991 RATE.

Subsections (4) through (11) remain as proposed.

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

[RULE VI] 46.12.1229 OPERATING COST COMPONENT Subsections (1) through (2)(a) remain as proposed.

(i) Except as otherwise specified in [Rule XIII] ARM 46.12.1243, for rate years ~~beginning on or after July 1, 1991~~ 1992, 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.

(ii) EXCEPT AS OTHERWISE SPECIFIED IN [RULE XIII] ARM 46.12.1243, FOR RATE YEAR 1993, THE BASE PERIOD IS THE PROVIDER'S COST REPORT PERIOD OF AT LEAST SIX MONTHS WITH A FISCAL YEAR ENDING BETWEEN JANUARY 1, 1991 AND DECEMBER 31, 1991 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, 1992.

Subsections (2)(b) through (2)(d)(i) remain as proposed.

(ii) FOR PURPOSES OF SETTING STATE FISCAL YEAR 1993 RATES, IF A PROVIDER HAS NOT FILLED A COST REPORT FOR A PERIOD OF AT LEAST SIX MONTHS WITH A FISCAL YEAR ENDING BETWEEN JANUARY 1, 1991 AND DECEMBER 31, 1991 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, SUBJECT TO THE PROVISIONS OF [RULE XX] ARM 46.12.1258, not included in the direct nursing personnel cost component or the property cost component.

Subsections (2)(f) and (3) remain as proposed.

(4) The operating cost limit is ~~115%~~ 110% of median operating costs.

Subsection (5) remains as proposed.

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

[RULE VII] 46.12.1231 DIRECT NURSING PERSONNEL COST COMPONENT Subsections (1) through (2)(a) remain as proposed.

(i) Except as otherwise specified in [Rule XIII] ARM 46.12.1243, for rate years ~~beginning on or after July 1, 1991~~ 1992, 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.

(ii) EXCEPT AS OTHERWISE SPECIFIED IN [RULE XIII] ARM 46.12.1243, FOR RATE YEAR 1993, THE BASE PERIOD IS THE PROVIDER'S COST REPORT PERIOD OF AT LEAST SIX MONTHS WITH A FISCAL YEAR ENDING BETWEEN JANUARY 1, 1991 AND DECEMBER 31, 1991 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, 1992.

Subsection (2)(b) remains as proposed.

(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 AND SUBJECT TO THE PROVISIONS OF [RULE XX] ARM 46.12.1258.

Subsections (2)(d) through (2)(f)(i) remain as proposed.

(ii) FOR PURPOSES OF SETTING STATE FISCAL YEAR 1993 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, 1991 AND DECEMBER 31, 1991 INCLUSIVE, SUCH PROVIDER SHALL NOT BE INCLUDED IN THE ARRAY FOR PURPOSES OF CALCULATING THE MEDIAN.

Subsection (3) remains as proposed.

(a) FOR PURPOSES OF SUBSECTION (3), THE PROVIDER'S INFLATED BASE PERIOD COMPOSITE NURSING WAGE RATE SHALL NOT BE

LESS THAN 85% OF THE STATEWIDE MEDIAN AVERAGE WAGE, AS DETERMINED FROM INFLATED BASE YEAR COST REPORT INFORMATION FOR ALL PROVIDERS.

(4) The direct nursing personnel cost limit is ~~140%~~ 125% of the statewide median average wage, multiplied by the provider's most recent average patient assessment score, determined in accordance with [Rule VIII] ARM 46.12.1232.

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

[RULE VIII] 46.12.1232 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, WHICH CONTAINS REQUIREMENTS AND INSTRUCTIONS FOR COMPLETION OF PATIENT ABSTRACTS. The patient assessment manual dated ~~July 15,~~ SEPTEMBER 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.

Subsections (2) and (3) remain as proposed.

(4) Based upon the monthly patient (resident) assessment form submitted BY 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:

Subsections (4)(a) through (5)(c) remain as proposed.

(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~~ AS SUBMITTED TO THE DEPARTMENT BY THE PROVIDER FOR THE MONTH, are significantly different, as defined in subsection (6)(a), than the abstracts as ~~submitted to the department by the provider for the same month~~ SUPPORTED AND VERIFIED BY THE PROVIDER'S MEDICAL RECORDS, the provider's average patient assessment score, for purposes of determining the direct nursing personnel cost limit under [Rule VII] ARM 46.12.1231, 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~~ THAT THE MINUTES REPORTED IN THE ABSTRACTS AS SUBMITTED BY THE PROVIDER TO THE DEPARTMENT ARE TEN OR MORE PERCENT GREATER OR LESS THAN THE MINUTES AS DETERMINED BY THE MONITOR TEAM.

Subsections (6)(b) through (6)(d)(i)(B) remain as proposed.

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

Subsections (6)(e)(i) through (6)(e)(iii) remain as proposed.

(7) A provider whose direct nursing personnel cost component, effective July 1, has been determined using a THE 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.

Subsections (7)(a) and (7)(a)(i) remain as proposed.

(b) IF 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~~ AVERAGE patient assessment score ~~for the month~~, determined in accordance with this section.

Subsections (8)(a) through (8)(b)(ii) remain as proposed.

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

[RULE IX] 46.12.1235 OBRA COST COMPONENT Subsection (1) remains as proposed.

(2) For all providers, the OBRA increment will be ~~$1.90~~ $2.00 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 101-508, 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.

Subsections (2)(b) through (3)(c)(i) remain as proposed.

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

[RULE XI] 46.12.1240 GRANDFATHERED PROPERTY COST COMPONENT Subsections (1) through (5)(e) remain as proposed.

~~(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] 46.12.1241 CHANGE IN PROVIDER DEFINED
Subsections (1) through (1)(d) remain as proposed.
(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~~ ARE not applicable.

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

[RULE XIII] 46.12.1243 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS Subsection (1) remains as proposed.
(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] ARM 46.12.1241, the interim per diem rate shall be the bed-weighted median per diem rate for all nursing facility providers. IF THE NEW PROVIDER RESULTS FROM A CHANGE IN PROVIDER AS DEFINED IN [RULE XII] ARM 46.12.1241, THE NEW PROVIDER'S INTERIM RATE IS SUBJECT TO THE PROVISIONS OF [RULE IV(3)] ARM 46.12.1226(3), AS APPLIED TO THE FACILITY'S AVERAGE PER DIEM RATE IN EFFECT FOR THE ENTIRE PREVIOUS RATE YEAR, AS IF NO CHANGE IN PROVIDER HAD OCCURRED. 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.
Subsections (2)(a) through (3)(b)(iii) remain as proposed.

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

[RULE XIV] 46.12.1245 SEPARATELY BILLABLE ITEMS
(1) In addition to the amount payable under the provisions of [Rule VI(1) or (4)] ARM 46.12.1229(1) or (4), the department will reimburse nursing facilities located in the state of Montana for THE FOLLOWING separately billable items ~~listed in the following subsections (a) through (nnnnn)~~:
Subsections (1)(a) through (1)(aa) remain as proposed.
Original subsections (1)(bb) through (1)(fffff)(iii) remain as proposed but will be renumbered as subsections (1)(ab) through (1)(df)(iii).

Original subsection (1)(ggggg) remains as proposed but will be renumbered as subsection (2).

(~~i~~a) If the items listed in subsections (1)(a) through ~~(fffff)~~ (1)(df) 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)~~ (2). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

Original subsection (1)(ggggg)(ii) remains the same in text but will be renumbered as subsection (2)(b).

Original subsections (1)(hhhhh) through (1)(jjjjj) remain as proposed but will be renumbered as subsections (3) through (5).

(~~kkkkk~~6) Non-emergency transportation for activities other than those described in [Rule II~~(1)(m)~~(13)] ARM 46.12.1222(13), 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.

Original subsection (1)(lllll) remains as proposed but will be renumbered as subsection (7).

(~~mmmmm~~8) The provisions of subsections ~~(hhhhh)~~ (3) through ~~(lllll)~~ (7) apply to all nursing facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana.

Original subsection (1)(nnnnn) remains as proposed but will be renumbered as subsection (9).

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

[RULE XV] 46.12.1246 ITEMS BILLABLE TO RESIDENTS Subsections (1) through (1)(m) remain as proposed.

(n) ~~for~~ items usually reimbursed under the per diem rate ~~or~~ BUT FOR 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 THE routine stock items, such as acetaminophen, aspirin, milk of magnesia, mineral oil, suppositories for evacuation, maalox and mylanta, WHICH ARE REIMBURSED AS PART OF THE PER DIEM RATE.

Subsections (2) through (2)(b) remain as proposed.

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

[RULE XVI] 46.12.1249 REIMBURSEMENT FOR INTERMEDIATE CARE FOR THE MENTALLY RETARDED Subsections (1) through (4) remain as proposed.

(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~~ XXII] ARM 46.12.1261.

Subsection (6) remains as proposed.

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

[RULE XVII] 46.12.1251 REIMBURSEMENT TO OUT OF STATE FACILITIES Subsections (1) through (4)(c) remain as proposed.

(d) a properly completed level I screening form for the resident, as required by ARM 46.12.1302~~1~~, et seq.;

(i) TO THE EXTENT REQUIRED BY ARM 46.12.1301, ET SEQ., A ~~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.

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

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

[RULE XXII] 46.12.1261 COST SETTLEMENT PROCEDURES Subsections (1) through (6) remain as proposed.

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

[RULE XXV] 46.12.1268 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 WHICH THE PROVIDER WISHES THE DEPARTMENT TO CONSIDER IN THE ADMINISTRATIVE REVIEW.

Subsections (1)(a) and (1)(b) remain as proposed.

(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~~,~~ AND detailed objections~~, and~~ IF A PROVIDER REQUESTS A CONFERENCE AS PART OF THE ADMINISTRATIVE REVIEW, ANY substantiating information and documentation THE PROVIDER WISHES THE DEPARTMENT TO CONSIDER AS PART OF THE REVIEW MAY BE SUBMITTED NO LATER THAN THE TIME OF THE CONFERENCE. The conference shall be based upon the department's RECORDS AND determination and the provider's written request,

detailed objections and substantiating information and documentation, IF ANY.

Subsection (1)(d) remains as proposed.

(2) ~~Fair hearing.~~ In the event the provider does not agree with the department's ~~determination following~~ administrative review ~~by the department~~ DETERMINATION, 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).

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

(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~~ CONTAIN A SHORT AND PLAIN STATEMENT OF EACH REASON THE PROVIDER CONTENDS THE DEPARTMENT'S ADMINISTRATIVE REVIEW DETERMINATION FAILS TO COMPLY WITH APPLICABLE LAW, REGULATIONS, RULES OR POLICIES.

(e) The provider must ~~provide~~ SERVE a copy of the hearing request ~~and substantiating materials to~~ UPON the department's medicaid services division WITHIN 3 WORKING DAYS OF FILING THE REQUEST.

Subsections (2)(f) and (2)(g) remain as proposed.

(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~~ 30 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 WITHIN 3 WORKING DAYS OF FILING THE NOTICE OF APPEAL.

(b) The notice of appeal must state the specific grounds for appeal. If no notice of appeal is filed within ~~15~~ 30 days, the hearings officer's proposed decision shall become the final agency decision.

Subsections (3)(c) and (3)(d) remain as proposed.

(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.

Subsection (4) remains as proposed.

(5) THE PROVISIONS OF THIS SECTION APPLY IN ADDITION TO THE APPLICABLE PROVISIONS OF ARM 46.2.201, ET SEQ., EXCEPT THAT THE PROVISIONS OF THIS SECTION SHALL CONTROL IN THE EVENT OF A CONFLICT WITH THE PROVISIONS OF ARM 46.2.201, ET SEQ.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-111 and 53-6-113 MCA

4. The Department has amended Rule 46.12.1209, OVERPAYMENT AND UNDERPAYMENT as proposed.

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

46.12.1208 COST REPORTING The procedures and forms for maintaining cost information and reporting are as follows:

(1) ~~Accounting Principles.~~ Generally accepted accounting principles shall be used by each provider to record and report costs. As part of the cost report these costs will be adjusted in accordance with these rules to determine includable costs.

(2) ~~Method of Accounting.~~ The accrual method of accounting shall be employed, 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.~~ 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 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) ~~Uniform Financial and Statistical Report.~~ Provider costs are to be reported based upon the provider's fiscal year using the financial and statistical report form provided by the department. The use of the department's financial and statistical report form is mandatory for participating facilities. These reports shall be complete and accurate; incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) ~~Filing period.~~ -- Cost reports must be filed within 90 days after the end of the provider's fiscal year.

(b) ~~Late filing.~~ -- In the event a provider does not file within 90 days of the closing date of its fiscal year, or files an incomplete cost report, an amount equal to 10 percent of the provider's total reimbursement for the following month shall be withheld by the department. If the report is overdue or incomplete a second month, 20 percent shall be withheld. For each succeeding month the report is overdue or incomplete, the provider's total reimbursement shall be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report. Unavoidable delays may be reported with a full explanation and a request

made for an extension of time limits prior to the filing deadline. However, there is a maximum limitation of one 30-day extension.

Subsection (4)(c) remains as proposed.

(5) ~~Maintenance of Records.~~ Records of financial and statistical information supporting cost reports shall be maintained by the provider and the department for three years after the date a cost report is filed, or the date the cost report is due, whichever is later.

Subsections (5)(a) through (6) remain as proposed.

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 Review.~~ 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 ANY substantiating documents and information WHICH THE PROVIDER WISHES THE DEPARTMENT TO CONSIDER IN THE ADMINISTRATIVE REVIEW. 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~~ REQUEST FOR A CONFERENCE. IF A PROVIDER REQUESTS A CONFERENCE AS PART OF THE ADMINISTRATIVE REVIEW, ANY substantiating materials THE PROVIDER WISHES THE DEPARTMENT TO CONSIDER AS PART OF THE REVIEW MAY BE SUBMITTED NO LATER THAN THE TIME OF THE ~~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 RECORDS AND determination and the provider's written objections and ~~justifications~~ SUBSTANTIATING MATERIALS, IF ANY.

(b) No later than 60 days following receipt of the written objections and SUBSTANTIATING MATERIALS, IF ANY ~~justifications~~, or the conference, whichever is later, the department must mail a written determination concerning the provider's objections and SUBSTANTIATING MATERIALS ~~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 ADMINISTRATIVE REVIEW 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).

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

(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~~ CONTAIN A SHORT AND PLAIN STATEMENT OF EACH REASON THE PROVIDER CONTENDS THE DEPARTMENT'S ADMINISTRATIVE REVIEW DETERMINATION FAILS TO COMPLY WITH APPLICABLE LAW, REGULATIONS, RULES OR POLICIES.

(e) The ~~hearings officer will~~ provider must ~~provide copies~~ SERVE A COPY of THE hearing requests~~, notices and written decisions~~ and ~~substantiating information to~~ UPON the department's ~~director,~~ medicaid ~~bureau and office of legal affairs~~ services division WITHIN 3 WORKING DAYS OF FILING THE REQUEST.

Subsections 2(f) and (g) remain as proposed.

(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)~~ THIRTY (30) 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 WITHIN 3 WORKING DAYS OF FILING THE NOTICE OF APPEAL.

(b) The notice of appeal must set forth the specific grounds for appeal. If no notice of appeal is filed within ~~15~~

30 days, the hearings officer's proposed decision shall become the final agency decision.

Subsections (3)(c) through (5) remain as proposed.

(6) THE PROVISIONS OF THIS SECTION APPLY IN ADDITION TO THE APPLICABLE PROVISIONS OF ARM 46.2.201, ET SEQ., EXCEPT THAT THE PROVISIONS OF THIS SECTION SHALL CONTROL IN THE EVENT OF A CONFLICT WITH THE PROVISIONS OF ARM 46.2.201, ET SEQ.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-111 and 53-6-113 MCA

6. The department has repealed 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.

7. The Department has thoroughly considered all commentary received:

1. Adequacy of nursing Facility Funding

COMMENT: Adequate reimbursement is not being achieved. The system continues to be underfunded and this proposal exacerbates that problem by inequitably distributing the available funding.

COMMENT: Some contend that the appropriation for nursing facility services is inadequate to pay for the costs of all economically and efficiently operated facilities. Certainly, it is inadequate to meet everyone's expectations. The department therefore must allocate scarce dollars in an equitable fashion. All must share in the burden of an underfunded system.

COMMENT: The department should continue to work on the formula until it meets all expectations.

RESPONSE: The department contracted for a nursing facility reimbursement study in 1989/1990. The results of the study were used to establish the budget request to the legislature for funding the nursing facility program for fiscal years 1992/1993. The funding requested was derived from an analysis of fiscal year 1987 cost report information adjusted by inflation, utilizing the DRI index. This analysis suggested that the system of reimbursement for nursing facilities should be updated to more current cost information. The department feels that the funding level is adequate to reimburse the economical and efficient costs of nursing facilities if it is distributed appropriately.

The department was concerned that the current system of reimbursement would not meet the department's goals for the program and would not set rates fairly. The department believes the proposed system as finally adopted meets the

department's goals of compliance with federal medicaid reimbursement law, promotion of quality of care, provision of incentives to control costs, and fair and equitable rates.

The department agrees that any reimbursement formula must be evaluated on an ongoing basis to insure that the formula is achieving the desired results and to improve it. The department will continue to work with interested parties to improve the system.

COMMENT: The department should defer final changes to the rate methodology because the source of funding for the 92-93 biennium is uncertain. Much of the increased funding comes from the nursing facility utilization fee enacted by the 1991 legislature. This source of funding for the state's share of medicaid funding is controversial and HCFA is opposed to it. OBRA 1990 provides that this type of funding is permissible but that federal funding would not be available to compensate facilities directly for such fees. Also, OBRA 1990 extended through December 31, 1991 an existing moratorium on issuance of any final regulations by HCFA on the subject. Congressional action has not entirely resolved this controversy and these funding devices have drastically escalated the federal share of medicaid spending. Given the uncertainty the department should wait to make any changes until there is greater certainty about the long term use of such funding sources.

RESPONSE: The department agrees that there is controversy surrounding, and that HCFA opposes, the use of certain provider specific fees and taxes. However, the department believes that under OBRA 1990, Congress specifically authorized provider-specific taxes, so long as the state does not use federal funds to reimburse facilities for the costs attributable to such taxes. See 42 U.S.C.A. § 1396a(t) and 1396b(i)(10). The department believes that the regulations recently published by HCFA on the subject exceed the authority granted by Congress and directly contradict the congressional decision to allow use of such fund raising measures, despite the opposition of HCFA. Because the department believes that the utilization fee is within the scope of congressional approval, the department will not forego this source of funding in setting reimbursement rates for nursing facilities.

COMMENT: It appears the nursing facility utilization fee is put on those people least able to pay. Then it goes into the general fund. It will take a legislative act to get it out.

RESPONSE: The legislature provided that the fee may not be assessed against those people who are least able to pay. The fee cannot be assessed for days of care paid for by private individuals. Persons whose nursing home care is funded by medicaid or medicare, over two-thirds of the people in nursing homes, cannot legally be made to pay the fee personally. While the funds generated by the fee are deposited in the

general fund, the legislature appropriated the funds for various purposes.

COMMENT: Most of the newly appropriated money is being distributed in the first year of the biennium. Next year with updated cost information, fewer facilities will have costs met.

RESPONSE: In total there is available $6.62 per bed day in fiscal year 1992 and $10.36 per bed day in fiscal year 1993 in new funding for medicaid nursing facility services. It is true that the biggest increase will occur during fiscal year 1992. The appropriated funding was projected using DRI inflation indicators. The department believes that unless cost trends in the Montana industry are substantially higher than cost trends nationwide, funding in the second year of the biennium will be adequate to provide reimbursement which meets federal reimbursement requirements.

2. Why Adopt A New Methodology Now?

COMMENT: Commentors stated they support the proposed major changes to the current reimbursement system because the current system does not reflect the true cost of operating a facility today. The current system does not relate closely to individual facility costs but rather is based upon averaging. Each facility is unique, and has different problems and different justifiable costs. By contrast the proposed system is more sensitive to patient acuity, direct nursing costs and general operating costs. The proposed system will improve quality of care and help facilities meet OBRA requirements, while keeping unnecessary spending to a minimum. We support the philosophy of the proposed system which is more facility-specific and sensitive to direct patient care issues. The current system has received substantial criticism from the industry in recent years. The department worked hard in the past legislative session to obtain adequate funding for nursing facilities. But substantial increases in funding alone do not assure rates which comply with law. The state could be vulnerable to suits and to disapproval of its state plan if it continues to use the current system.

RESPONSE: The commentor has described many of the reasons that the department has elected to revise the reimbursement system. The department agrees that a change is needed and believes that the new methodology addresses these issues.

COMMENT: Commentors stated that they support the proposed system with the understanding that its problems will be cured during the next twelve months.

RESPONSE: The department believes the new reimbursement methodology provides a legally sound and a fair basis for ratesetting. However, as with any new system, refinements and

adjustments likely will be necessary. The department intends to continue working to improve the new system through working committees that will be appointed to do further study.

COMMENT: Nearly everyone would agree that the current system is in need of repair and revision. It was put into effect in 1982 as a 3-year system. The system is now entering its tenth year of operation without a thorough review of its effectiveness. There are inequities which need to be addressed. But it is an error to simply throw together a third-rate replacement. The danger of adopting a poorly planned methodology are greater than the risks of retaining the present system for one or two more years.

COMMENT: The existing methodology is not inherently flawed, but has been inadequately funded, leading to four major problems: (1) use of a budget based inflation index which bore no relation to actual industry experience in Montana; (2) failure to timely rebase rates; (3) insufficient adjustments to account for patient acuity due to the averaging process; and (4) some inequities with the geographic wage factor. At the same time the existing system featured appropriate and legitimate incentives to contain costs and to profit by operating efficiently and economically while furnishing quality care. The department's proposal would eliminate not only some of the problems with the old system, but also many of its redeeming qualities.

COMMENT: What's the rush? The department should delay implementation, study the new system further and then use 1991 cost data as base period information. The old system has worked well. There has been virtually no time to study and digest the effects of the new system.

RESPONSE: The department has thoroughly studied the existing system and believes that it has serious flaws that prevent achievement of the department's goals. The new system has been developed through careful and thorough analysis and will better serve the needs and goals of the medicaid nursing facility program. Whether or not the current system is "inherently flawed" depends upon one's perspective and goals. Certainly, for a for-profit facility making a large profit, the current system is doing exactly what it should. However, the department is charged with a broader mission than insuring profits. We believe the new system will facilitate the department's objectives much more closely than the current system, especially in the key area of quality of patient care. It will encourage all facilities to continue to find ways to economize and increase efficiency.

The department disagrees that this process has been rushed or that there has not been ample notice given by the department that a change was going to be made in the future for reimbursement to nursing facilities. The department established a

nursing home task force over two years ago which discussed at length the problems with the current system of reimbursement, what could be done to incorporate changes within the scope of the current methodology and what changes would have to be made under a modified methodology or studied further. Based upon the discussions of the nursing home task force, the department believed it needed an independent evaluation of how the system of reimbursement was currently working in Montana. The department contracted for a study to analyze the current system of reimbursement and recommend changes to make the system more responsive to the needs of the industry and the department. The resulting reimbursement study was the basis for establishing funding levels granted by the legislature for fiscal years 1992 and 1993.

In addition, the department hired a national consulting firm to advise the department regarding improvements in reimbursement methodology. This process included evaluation of cost information submitted by providers, Montana specific industry data, information available nationally regarding distribution methodologies, and the results of such methodologies in other states. This was not a rushed process, but a planned process that has spanned more than two years.

The department believes that the current system no longer serves the needs of the medicaid program, medicaid residents or medicaid providers as a whole. Otherwise it would not have pursued studies or performed the amount of analysis that has been done to find a better way to determine rates. The department believes there are inequities in the current methodology and has chosen to address those inequities now to the extent possible. The department believes that to do otherwise would be to stick its head in the sand in the hope that the inequities would take care of themselves.

The complaints listed above about the current methodology have been addressed in the new system. The use of a defined inflation index has been remedied by selection of the DRI index. The failure to timely rebase rates has been addressed in the proposed system by rebasing to recent cost data and indicating that rebasing will occur again for 1993 rates. The system has been improved by using facility specific cost information to establish upper limits rather than averages of industry cost information. The use of averaging in the patient acuity factor has been eliminated and individual facility patient assessment information is used in setting each facility's direct nursing component. The geographic wage factor has been eliminated, and the direct nursing cost component is based instead upon actual wages being paid.

Some supporters of the current methodology say that the current system was very good at containing costs and allowing facilities to achieve a profit while providing quality care. However, the department believes the current system depended

too much on profit motivation, took too little account of legitimate facility differences, and failed to adequately emphasize quality of care. The department believes there were enough inequities under the current system of reimbursement to warrant a shift in emphasis from profits to quality of care and a system that is more responsive to individual facility circumstances.

3. Boren Amendment Requirements

COMMENT: Neither the original proposal or the modified proposal meet either the procedural or substantive requirements of federal law, i.e., the Boren Amendment. Under federal law, the state must make appropriate findings to support its assurances that its rates are reasonable and adequate to cover the costs that must be incurred by efficiently and economically operated facilities in order to comply with federal and state licensure and certification standards. The procedural requirements are that the state must at a minimum make findings which identify and determine: (1) efficiently and economically operated facilities; (2) the costs that must be incurred by such facilities; and (3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated facilities. These requirements mean that the state agency must engage in reasoned ratemaking, i.e., it must weigh all significant factors in a principled manner in order to determine the adequacy of the rate and it must articulate its reasoning process with clarity.

It is evident that the department has not complied with these procedural requirements. When initial public comment revealed problems, the department hurriedly revised its proposal to deal with those problems. Even so, the revised proposal still has major problems. It is not clear how the department would define economically and efficiently operated facilities or identify costs that must be incurred by such facilities. The proposal includes certain limiters that implicitly define economy and efficiency. Yet, the system then goes on to cap those amounts. Thus, economic and efficient facilities receive less than their costs, in patent violation of the Boren Amendment.

The department has made no attempt to reconcile its proposals with earlier assurances made to the federal government. The state has suggested to HCFA that it does not and should not reimburse facilities for excess staffing. The department evidently has reversed itself on this point but has offered no explanation why it has done so.

Further, despite a significant funding increase, there are serious questions whether the manner in which the department's proposals would allocate the funds would result in rates that are substantively adequate under the Boren Amendment. Less

than 30% of facilities would have their full allowable costs covered by the medicaid rates generated under the department's proposals. Rate methodologies producing rates within the 0-40th percentile range have generally been found to be substantively and/or procedurally invalid by the courts.

By the department's own estimates, 52% of facilities will not receive rates equal to or exceeding their full allowable cost. This figure is based upon the department's comparison of facilities' proposed rates to inflated allowable costs. This comparison is invalid because the department's "estimate" of inflated allowable cost is flawed. The department's use of 1989 cost reports for purposes of determining inflated allowable costs is unreasonable because 1989 cost reports do not reflect substantial cost increases experienced by facilities between 1989 and 1990. They include no cost of OBRA compliance, no adjustment for patient acuity or increased mandatory staffing requirements, and no adjustment for the $1.00 per day utilization fee. These are all costs which must be incurred. When these costs are considered, 68 out of 95 facilities (over 70%) will not have costs met by the proposed rates.

Further, the arbitrary cap on rate increases has been adopted to stay within budget limits, as indicated by the department's August 14 memorandum stating that the operating cap and increase cap were lowered to redistribute funding. This is a blatant example of rates being set based upon budgetary constraints, contrary to the Boren Amendment. The proposed system implicitly defines an "economically and efficiently operated facility" as one which is able to keep operating costs at or below 115% of median operating cost and its direct nursing personnel costs at or below 140% of the statewide median average wage adjusted for the facility's patient assessment score. The system "agrees" that costs up to these levels are allowable and should be paid, yet some facilities are not paid for these costs simply because such payments would exceed an arbitrary limit. The facilities which are affected by this limit are facilities whose rates fall short of meeting reasonable and allowable costs identified by the department.

COMMENT: The proposed system fails to meet Boren Amendment requirements because it was designed to distribute a predetermined number of dollars. No studies have been performed to determine the effects on providers or residents or how rates will be adequate under federal law. The number of providers who recoup actual costs is meaningless without documentation that the system ensures that all provider requirements are met. Unless the state can show that the parameters of the system are based on quality of care or access, the state will lose a Boren suit. Budgets rather than Boren controlled the final parameters of the system.

RESPONSE: The department strongly disagrees with the assertion that the department's new reimbursement methodology, as finally adopted in these rules, fails to comply with the requirements of the Boren Amendment. The department will not attempt here to fully state its case under the Boren Amendment. However, the department has engaged in an extensive findings process which has resulted in reasoned choices regarding the features of the new system.

The commentors misunderstand the findings process followed by the department. The department does not rely upon the percentages or other similar parameters in the methodology to "implicitly define" an economically and efficiently operated facility. Rather, the department has explicitly and carefully identified the cost that must be incurred by an efficiently and economically operated provider. A comparison of these costs to the rates generated by the system indicates that the department's rates meet Boren Amendment standards. For reasons which are described in other responses in great detail, the department believes its cost projections used in this process are valid and reasonable. The department has also made appropriate findings regarding quality of care and access to services.

There is no legal requirement that a particular percentage of facilities receive rates which cover all of their actual costs. The department has reviewed the numbers of facilities which are reimbursed all costs and certain percentages of their costs. The department believes that the system meets the substantive requirements of the Boren Amendment.

The department does not agree that it has elected to reimburse "excess" staffing. The department recognizes that in light of OBRA requirements and apparent understaffing by many facilities, patient care should be a higher priority than it is under the current system. The department is not limited in this process by the assumptions or shortcomings of the current system, which encouraged facilities to staff at the lowest possible level. Throughout the first rule notice and this document, and on numerous other occasions, the department has provided extensive explanation of its goal of improved quality of patient care.

The other issues raised in these comments are addressed in other comments and responses.

COMMENT: The required OBRA assurances will not be met by the proposed system.

RESPONSE: The law requires the state to assure the federal government that its state plan provides for payment of nursing facility services through the use of rates that take into account the costs of complying with the nursing home reform requirements of OBRA 1987, including the costs of services

required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each medicaid resident.

The department has assessed the impact of implementing the OBRA requirements. The department reimburses each facility an amount in addition to the per diem rate to meet the cost of training for nurse aides, ongoing education, 24-hour staffing, physician involvement, patient trust funds, quality assurance committee, and other costs of OBRA implementation. The department also reimburses facilities up to 20 cents per hour plus benefits for increased nurse aide wages due to obtaining certification. For fiscal year 1992 the department will inflate the OBRA per diem add on component using the DRI index. The requirement of maintaining the highest practicable physical, mental, and psychosocial well-being of each medicaid resident is met under the OBRA requirements and there will be no new costs associated with this OBRA 90 language change. The department has added language to Rule I(4) to clarify that the reimbursement methodology was designed to take meet such costs.

Moreover, many of the OBRA requirements relate to direct patient care and the new methodology recognizes the costs of direct patient care to a greater extent than the current methodology. The department believes that the new methodology provides further assurances that the costs of meeting OBRA requirements will be met.

The department believes that its reimbursement rates, determined using the new methodology and add-on components, meet the OBRA requirements and take into account facilities' costs including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each medicaid resident.

COMMENT: Considering the OBRA, minimum wage and bed tax increases, it is unrealistic to expect a provider to accept a rate decrease for fiscal year 1992. Since the department has assured the federal government that prior rates were adequate but not excessive, it would be difficult to give assurances that lower rates are adequate in light of increased costs and inflation.

RESPONSE: The department believes that a facility's rate should relate to its projected cost, subject to reasonable limits, rather than to a previous rate. The department has assured the federal government that its rates met federal reimbursement standards for prior rate years. This does not establish that any particular facility was economically and efficiently operated or that rates were barely adequate, such that any reduction would automatically violate federal law. The courts have rejected the argument that state agency assurances to the federal government constitute recognition of a

particular facility as economic and efficient or designation of rates as the minimum legal level of reimbursement. See Wisconsin Hospital Association v. Reivitz, 733 F.2d 1226, 1232-33 (7th Cir. 1984). The issue is not how a rate compares to a previous rate, but rather whether the actual rate paid meets federal standards.

The department believes, based upon reasoned and principled analysis and taking into consideration the noted cost increases, that rates under the new system will meet or exceed federal requirements. The department will not increase rates to cover the bed fee. However, a 5.5% minimum rate increase over the fiscal year 1991 level of reimbursement has been implemented in the final rule as a transitional measure. This provision is discussed in greater detail in other responses in this document.

COMMENT: Do Myers & Stauffer believe the distribution under their proposal meets Boren Amendment Standards? If the current system were rebased and yielded rates that paid the full costs of the same number of facilities as their proposal, would such a system meet Boren Amendment requirements? In addition to counting up how many facilities receive full costs, what other major factors do they consider in determining whether a system will withstand a Boren Amendment challenge? Is it possible to work those factors into the current system? If not, why not?

RESPONSE: The department and Myers and Stauffer believe that the rates generated under the new system will meet or exceed Boren Amendment standards. The Boren Amendment does not require that any particular number or percentage of facilities receive a rate equal to or exceeding actual costs. The Boren Amendment requires compliance with both procedural and substantive requirements. The department has summarized in response to other comments above the analysis, findings and determinations involved in determining Boren Amendment compliance. While it may be possible to revise the current system to comply with Boren Amendment requirements, the department believes that the new methodology better suits the requirements of the Boren Amendment and meets the department's other goals for a medicaid nursing facility reimbursement system.

4. Quality of Care and Access to Services

COMMENT: One of the major problems with the way rates are set is the lack of consumer input. Historically, reimbursement rule hearings have been attended only by industry representatives. That's a problem because so much of the industry has become profit-driven and no longer appears to be motivated by a desire to provide the best quality of care to nursing home residents.

Our skepticism about industry performance comes from experience which has taught us that, along with the increased corporatization of the industry, comes an increase in the need for outside monitoring of industry's commitment to the task at hand. In the 1989 legislative session, MHCA asked workers to lobby for the so-called $.20 per hour raise in conjunction with new training and certification requirements for nurse aides. When workers did lobby and the bill was passed, the industry then tried to convince the state that facilities could only pass on a 7 or 8 cent raise to workers because of overhead costs. Recently, a nursing home administrator informed staff that there would be no wage increases for the upcoming year because medicaid increases only amounted to $2,000 for the year. Yet, department staff stated that the same provider would receive an $11,000 increase for the year.

Most certified nurse aides work for wages and benefits that keep them at or below the poverty level and that include no health insurance. While large corporations make record profits, the same companies pay $4.25 per hour only because the law says they must. Minimum wage workers with low benefits who are not treated with dignity or respect cannot be expected to provide the high quality of care that nursing home residents should be able to expect from their facility.

Our research shows that for-profit nursing facilities in Montana are making plenty of money and most of it is going out of state to the parent corporation. One corporation earned a net profit of one and a half million dollars on 3 facilities in Montana. The state should take this into consideration as it decides what the formula will be.

Several national studies show the direct correlation between increases in staffing levels and staff compensation and increases in quality of care. Direct experience working in nursing facilities show that many injustices occur when you try to run a nursing facility without enough staff. Lack of adequate staffing levels can cause residents to lie in their own urine and feces, baths to be forfeited, feeding to be rushed at the expense of resident health, and many other horrible injustices.

Advocates for residents believe the newly appropriated funds should be used for increased staffing ratios and better compensation for direct care staff. Lack of adequate staffing is the number one issue with nursing facility residents. The state should take a greater role in monitoring to make sure medicaid reimbursement coincides with quality care. The formula should specifically address increases in the number of staff in each facility based on patient acuity. The formula should include built in measures of how facilities respond to incentives for increased staffing, such as a periodic state review or a mid-biennium hearing.

Advocates for residents and workers will be watching to see how the increased funding has been used. Nursing facilities should be held accountable to show that the funds have been used to provide quality of care.

COMMENT: The single largest area of complaints received in the state long term care ombudsman's office is lack of adequate staffing in nursing homes. If a facility is operating without adequate staff, residents' basic needs are not met on a daily basis and in a timely manner. Understaffing can also have far reaching health, safety and psychosocial implications for residents. When residents and family members have discussed understaffing with facilities, lack of money invariably is mentioned as the reason more staff cannot be hired. Consumers have been led to believe that either medicaid reimbursement is too low or that facilities cannot receive reimbursement for any increases above staffing levels set by the state. The proposed rule addresses both of these issues through increased funding and development of a direct care cost center with substantial incentives for increased staffing. By using an incentives approach rather than a directive approach, the department allows facilities flexibility in allocating funds to meet their individual situations.

Changes in federal nursing facility requirements are intended to increase the quality of life and care provided in nursing homes. They are positive changes but many of them require additional funding if they are to be implemented. Given the size of increases in funding granted by the legislature, consumers rightfully expect increased quality in services. If nursing facilities have been doing an adequate job meeting federal requirements with past funding levels, it is logical that a significant increase in funding should have a very positive impact on future services. I urge the department to develop a strong monitoring system to see how increases are being spent and whether the new incentives are having the desired impact. It appears that as in no time in the past, facilities as a whole have the ability to address the issue of understaffing. Facilities should be accountable to spend increases in a manner that is most responsive to resident needs.

COMMENT: Advocates for the elderly desire that the quality, quantity and training of staff be addressed. The department has taken a positive step toward improving quality of care in nursing homes by the proposed changes in the formula. These changes will provide the opportunity to increase investment in direct care staff. These changes will be accomplished without harming either the availability of services or the profitability of this industry. The proposed rules are responsive to the concerns and desires of nursing home residents and their families.

COMMENT: The new money should go to pay more to low paid workers in nursing facilities who do the actual patient care. The administrative staff doesn't help take care of patients.

RESPONSE: The department welcomes comment from individuals and groups representing nursing facility residents and nursing care workers. Their comment is necessary to a balanced perspective on medicaid nursing facility services and reimbursement.

The department agrees that the emphasis under a publicly funded program such as medicaid should be high quality care rather than facility profits. We believe the new system will encourage and reward high quality of care rather than rewarding profit without regard for the quality of patient care.

It is only logical to conclude that inadequate staffing levels and underpayment of staff negatively affect quality of patient care. The new system incorporates incentives for facilities to direct available resources toward direct, hands on patient care rather than toward spending for items which only indirectly or remotely affect patient care, if at all. The department agrees generally that increases in staffing levels and reimbursement will positively affect the quality of patient care. While it is true that the reimbursement study by Myers and Stauffer found no direct correlation between total facility spending and performance on certain selected indicators, the department believes that allocation of more resources toward direct patient care will improve the quality of care. Moreover, most of the recently enacted federal nursing home reforms concentrate on improving the quality of care of facility residents. Improvements in these areas will require increased spending in many cases.

The new system will recognize and reimburse the legitimate costs of providing quality care and will give priority to recognition of cost incurred for direct nursing care. The department has historically required facilities to staff at a minimum of 100% of the facility's patient assessment score (which measures patient acuity), although not all facilities have done so. The department has revised the rule to clarify this requirement.

The system will also respond more directly to facility differences in patient acuity, because the facility's individual average patient assessment score is factored directly into its rate. Under the current system, a facility's rate was affected by its patient acuity level only to the extent it exceeded or fell below the statewide average.

The department agrees that there is a need for monitoring how increased medicaid funding is spent and whether the desired goals are achieved. Facilities are required to report annually to the department the costs incurred in providing

services. Facility cost reports will allow the department to monitor how facilities spend in the area of direct patient care and other areas. Information gathered through inspections of care and licensure and certification surveys will allow the department to monitor the quality of patient care.

The department believes that improved quality of care can be achieved while allowing facilities a degree of flexibility in setting staffing levels and allowing the opportunity for a reasonable profit. We believe the new system will further these objectives.

COMMENT: The proposed system fails to meet the department's goal of encouraging quality of care and access because there is no direct correlation between higher costs and higher quality or improved access. Costs will increase with no increase in either quality or access.

COMMENT: The spread in rates between high and low cost facilities is unreasonably high. This is no way to encourage quality care. Some of the lowest cost facilities have some of the best state surveys. Our facility has a high occupancy rate and our residents stay a long time, which means that residents prefer our facility. Low cost facilities can give better care than high cost facilities.

COMMENT: There is a clear mandate to increase quality of care. Why not encourage the least costly facilities to spend more on quality of care rather than encouraging the most costly and perhaps least efficient to spend more?

COMMENT: Facilities will not be able to maintain quality under the proposed system unless they can find someone to lend them money for increased staffing and unless they are willing to assume that the department will rebase in 2 years and recognize those costs.

RESPONSE: The department believes generally that increases in staffing levels and reimbursement will positively affect the quality of patient care. Most of the recently enacted federal nursing home reforms concentrate on improving the quality of care of facility residents. Improvements in these areas will require increased spending in many cases.

The department agrees that the fact that a facility spends more money in total does not assure that it will provide quality care or access to services. However, we believe that allocation of more facility resources to the area of direct patient care will improve quality of care. At present, 100% of nursing facilities in the state of Montana participate in the medicaid program. We believe that this broad program participation and the resulting access to medicaid nursing facility services will continue or improve, given the large increases in medicaid funding.

The department does not agree that the differences in rates between high and low cost facilities are unreasonable, or that low cost facilities necessarily provide better care. We believe that all facilities should be encouraged to make improved quality of care a priority, not only low cost facilities. The department believes that rates under the new system will provide adequate funding to provide quality care and sufficient incentives to encourage providers to make quality of care a priority. The increased funding and new system will make a reasonable amount of funds available to improve patient care. It is true that these incentives will not be provided entirely in advance of the desired facility behavior; however, we believe the rates provided will allow facilities to respond reasonably to these incentives.

It is quite interesting that the same commentors who argue that spending will spiral upward out of control under the new system also argue that there will no funds available for spending to maintain quality of care. A number of commentors argue that the new system penalizes low cost facilities because rather than receiving a higher rate based on average costs of all facilities, they receive a lower rate closer to their actual cost. However, it can also be said that it would be unfair and unwise to reward those who have allocated only minimal resources to direct patient care before such facilities have demonstrated a willingness to make direct patient care a higher priority.

5. Reduction of Cost Shifting

COMMENT: The proposed system will reduce cost shifting to private pay residents because increased medicaid reimbursement and more facility specific reimbursement will leave less need to shift costs. If a facility is paid below cost, it has little alternative to cost shifting. The proposed system eliminates or reduces the need and incentive for facilities to cost shift.

COMMENT: The proposed system encourages cost shifting because low cost facilities will not receive enough medicaid reimbursement to avoid cost shifting. Under the proposed system our facility will have to raise private pay rates. Legislators supported funding increases because they did not want private pay patients paying for the medicaid program. They'll be unhappy.

COMMENT: The proposed formula does not consider the effects of cost shifting.

COMMENT: The hospital portion of our facilities are subsidizing the nursing facilities because medicaid is not paying its share. It is not proper for private pay residents to absorb the state's shortages.

RESPONSE: The department believes the new system will reduce cost shifting to private pay residents. The department believes the new system generates rates which are reasonable and adequate to meet the costs of providing services to medicaid residents. With increased funding levels, increased emphasis on facility-specific cost and patient acuity information, and use of a nationally-recognized inflation index, the department believes FY92 rates will be a great improvement over previous rates. Because medicaid rates will be increased and will be directed toward individual facilities in a more equitable manner, cost shifting should be reduced or eliminated under the new reimbursement system. However, even with the substantial increase in medicaid funding the department cannot guarantee that nursing facilities will not increase rates to private pay recipients. If the real reason that private pay rates are increasing is that medicaid has not been paying it share of costs, the new system should greatly reduce cost shifting.

6. General Comments on Proposed Reimbursement Methodology

COMMENT: Some commentors simply stated that they support the proposed system, while others simply stated that they oppose the proposed system.

RESPONSE: The department is fully aware that there are widely divergent viewpoints on the merits of the proposed system. Many viewpoints seem to depend solely upon the rate a facility would receive under a particular proposal, rather than upon specific reasons related to the logic of a given proposal. The department has considered carefully the reasons advanced by proponents and opponents, and has made its own analysis, findings and determinations prior to making a decision on which proposal to adopt.

7. Cost Issues

a. 1989 v. 1990 Cost Data

COMMENT: The department should use 1989 cost report information because it is the most complete audited information. Were OBRA costs not an issue, the more recent reports would be preferable. The department should allow providers some time to identify and correct wage and property cost issues which affect their rates. Some facilities have already taken these steps.

COMMENT: The department's use of 1989 cost reports for purposes of determining base period costs is unreasonable because 1989 cost reports do not reflect substantial cost increases experienced by facilities between 1989 and 1990. They include no cost of OBRA compliance, no adjustment for patient acuity or increased mandatory staffing requirements, and no adjustment for the utilization fee. The use of

unrepresentative 1989 cost information together with use of an inflation factor that is too low is unreasonable. There is no question that the department should use the most recent available cost information. Since 1990 cost reports are available, they should be used.

COMMENT: There is no reasonable explanation for using 1989 cost reports as base period cost information when more recent cost data is available. 1991 cost reports would reflect the costs of increased minimum wage, OBRA and the bed fee.

RESPONSE: The department will use fiscal year 1989 cost data for several reasons. The 1989 data is the most recent, available data which is complete and consistent. Use of the 1990 cost data is problematic because OBRA costs are not consistently or completely reflected in the data for all providers. Due to timing differences in fiscal year ends, some facilities have reported six months of OBRA costs while some may have reported none. Further, OBRA costs are difficult to isolate in 1990 costs as reported. Because the department will separately reimburse OBRA costs, some providers would receive double payment if fiscal year 1990 cost data was used. The department prefers to use the most current information available. However, the department believes that problems with the 1990 data clearly outweigh any advantages of using the 1990 data. The department has encouraged providers to review their 1989 cost report information. The department has been very cooperative in making appropriate cost adjustments.

Concerns have been raised that use of 1989 costs fails to account for the increase in federal minimum wage in the last two years. The department has adopted a floor on the direct nursing cost component so that no facility receives less than 85% of the average hourly wage median in the computation of its direct nursing personnel component. This means that a provider will receive a direct nursing personnel cost component that is no less than the current federal minimum wage plus an accommodation for benefits, times the provider's patient assessment score.

Moreover, while it is true that the most complete information would be derived from fiscal year 1991 cost reports, these reports cannot be used to set fiscal year 1992 rates because all of the reports are not available until March of 1992. The 1991 cost reports should reflect the costs of increased minimum wages, OBRA and any other cost increases. The department will use 1991 cost data for setting fiscal year 1993 rates. Additional rule language has been added to so provide.

COMMENT: The department should use 1991 cost report information for purposes of setting rate year 1993 rates and should so provide in the rule.

RESPONSE: The department has revised the rule to so provide.

COMMENT: Changes in occupancy between the base period and the rate year cause rate distortions. Increases in occupancy will allow spending in excess of inflation, while decreases in occupancy will cause the provider to be paid far less than actual cost.

RESPONSE: This comment is difficult to understand, but the commentor appears to suggest that the proposed system is invalid because it fails to properly take into account changes in occupancy levels between the base year and the rate year. The department disagrees with this suggestion. The department uses a twelve month base period, which should provide a representative indication of occupancy levels. Further, sound management generally should result in lower total costs during periods of low occupancy. The department does not believe that occupancy changes have resulted in significant rate distortions.

b. Validity of Cost Report Data

COMMENT: Since 1982, filing of cost reports has been a mere formality. Cost reports have not been used in ratesetting since 1982 and extensive auditing has not been done since 1987. The proposed system puts more emphasis on cost reports than ever before. For the system to be equitable among providers, the cost data used to determine rates must be comparable. It is not. In fact, similar costs are reported differently by different facilities. For example, director of nursing (DON) salaries and benefits are not reported consistently. Some social services and activities are reported as direct nursing costs. Some direct nursing costs are reported in the wrong categories. The cost of contract nurses are direct nursing costs not reported as salaries. Some facilities file their medicare cost reports in lieu of a medicaid cost report. Medicare considers property taxes and property insurance as capital costs, whereas medicaid considers these costs as operating costs.

Thus, reporting is inconsistent. Cost reports need to be adjusted for these differences in reporting. If the department were to provide clear guidelines about where specific types of costs are to be reported under the proposed system, this problem would be resolved. However, because cost reports have been filed without the benefit of clear guidelines and because cost reporting is not consistent, the cost reports should not be used for the proposed facility-specific type of system.

COMMENT: No existing cost report data is comparable, and no cost report data should be used until the department establishes cost reporting definitions which would provide comparable data and accurate calculations. Wage data is not

comparably reported. Neither cost reports from 1989 or 1990 reflect costs associated with OBRA, minimum data set preparation, nurse aide training, workers' compensation increases, OSHA mandated changes, Hepta Vax shots, eye wash equipment, minimum wage increases and ripple effects.

RESPONSE: The department strongly disagrees with the claims that it is inappropriate or improper to use cost report information to set reimbursement rates.

The department has never considered cost reporting a mere formality and the department's serious attitude toward cost reporting is reflected in its rules. Current ARM 46.12.1208 requires that providers must use generally accepted accounting principles to record and report cost information, that filed cost reports must be complete and accurate, that the appropriate facility authority must sign the cost report under penalty of false swearing, certifying that he has examined the cost report and to the best of his knowledge and belief, it is true, accurate and complete and prepared in accordance with governing laws and regulations.

The current system, which is preferred by the commentors, also uses cost report information to set rates, although in a less direct way. Payment of rates under the current system is based upon providers' representations, subject to audit, that they are in fact incurring reported costs to provide care. If complete and accurate cost reports are not filed, reimbursement may be withheld.

The department also strongly disagrees with the claims that it has not provided clear guidelines for cost reporting. Current ARM 46.12.1207 defines the costs that may be reported and in what categories they must be reported. This rule incorporates the Health Insurance Manual (HIM)-15, which sets forth in great detail how costs are to be reported. The department has added language to the definitions of "operating costs" in Rule VI(2)(e) and "direct nursing personnel cost" in Rule VII(2)(c) to clarify that the allowability of specific items included in these definitions are subject to the more specific allowable costs provisions in Rule XX. The department believes that although cost reports are not perfect, they provide a generally consistent, comparable and reliable source of information about facility costs. They also are the only source of such data.

The department has made it clearly and widely known throughout the development of the proposed system that it will consider requests from individual facilities to adjust base year cost report information being used to set rates. Indeed, the cost reports of many facilities have already been adjusted voluntarily by the department. The department will continue to consider such changes through the rate setting process.

The department will continue to use cost report information to perform analysis, make decisions regarding funding and rate levels, and to set rates for individual facilities. The rates to be determined under the new system will take into consideration the costs of the required items and services listed in the comment. Over recent years, providers have complained that rates did not take into consideration specific facility costs. The department believes that the use of facility-specific costs in setting rates under the current system will address many of the inequities and anomalies which have resulted under the current system. Further, the department believes the costs used in setting rates, together with the inflation index and all add-on components will account for the costs which must be incurred by an efficiently and economically operating provider.

COMMENT: Use of cost report information to base the formula is unfair to freestanding facilities. Cost allocation methods available to combined facilities gives them a tremendous benefit without increasing patient care. If the proposed system is adopted, our nursing facility will actively seek ways to increase cost from services provided at the hospital or will merge with the hospital to obtain the benefits of combined facility allocation methods.

RESPONSE: The department disagrees that use of cost report information in the proposed system is unfair to any particular group of facilities or to facilities as a whole. The department recognizes that some contend that the medicare cost allocation rules used to allocate costs to the nursing facility result in high nursing facility costs.

However, the fact that these costs may be included in the cost report and are "allowable" does not mean that the department will reimburse these costs under the new system. Combined facilities are subject to the same rate limitations as freestanding facilities and do not receive reimbursement for costs exceeding the limits. Moreover, viewing the combined facility as a whole, it appears these costs are being incurred. The combined structure may result in overall economies and efficiencies which benefit the medicaid program through other service areas. In light of these considerations, the department does not believe it is unreasonable to set rates within a zone of reasonableness, rather than based upon an average which virtually ignores actual facility costs.

The commentor is of course free to report costs in accordance with applicable law and regulations, and even to alter its facility organizational structure within the limits of law. The department believes that such decisions will be made within the total context in which the facility operates, not simply because of cost reporting rules. If the cost allocation rules for combined facilities were such an advantage, it is fair to assume that there would be far fewer remaining

freestanding facilities, and far fewer combined facilities would complain of the large losses they will continue to incur under the new system.

c. Adequacy of DRI Inflation Factor

COMMENT: The proposed system uses a nationally recognized inflation index in the computation of reimbursement rates. This index reflects the costs being incurred nationally to operate a skilled nursing facility.

RESPONSE: A national DRI inflation index is being used to project costs forward from the base year. Analysis indicates that Montana nursing facility cost increases from 1988 to 1990 were lower than the DRI inflation index for this period. Costs increased in Montana by 11.29% while the DRI-HC Index for the comparable period was 12.83%. The department believes the DRI index is an appropriate and adequate measure of inflation.

COMMENT: Evaluation of 1989 and 1990 cost report information shows that the average total cost per day in 1989 was $57.58 and in 1990 was $64.45. This is an overall increase of 11.9%. Average total operating cost was $52.20 in 1989 and $59.01 in 1990. This is an increase of 13.1%. Clearly, costs increased in excess of the inflation used in the department's formula. There are obvious reasons for these increases, given federal nursing home reform requirements, minimum wage requirements, workers' compensation premium increases and a variety of other increases not accounted for in the inflation index used by the department. Use of a percentage inflator is unfair and inequitable because high cost facilities will automatically receive a higher percentage increase. The differences can be very substantial.

COMMENT: Analysis of 1991 costs shows the inflation factor and formula do not reflect actual costs incurred. Increases are two to three times greater than the inflation factor. Minimum wage, payroll tax and benefit increases are not accounted for in the proposed methodology. The inflation factor does not reflect the costs of hiring and retaining nurses in Missoula. Hospital collective bargaining agreements call for a 9.5% increase in RN wages and benefits during 1990-92. Nursing facilities will have to meet these increases to compete for staff.

COMMENT: Has the department calculated the actual cost increases incurred by Montana facilities from 1989 to 1990? If so, please provide us with information on the amount of increase in total costs, operating costs and property costs.

How does this methodology take into account the 13.1% increase in cost experienced by facilities from 1989 to 1990 as indicated by cost information provided to us by the depart-

ment? How does it take into account changes in the minimum wage and the ripple effect of those changes? How does it take into account the cost of complying with OBRA 1987 and 1990, particularly the "costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident?" What evidence has the department used to determine that the DRI-HC index is appropriate for determining rates for Montana providers? How has this index compared to actual cost changes as reported by Montana providers on cost reports received and reviewed by the department during the past five years?

COMMENT: In the department's spreadsheet in the cost vs. rate comparison, did the department use 1989 costs indexed forward by 5.5%? If the department used 1989 cost reports which did not include OBRA costs, how did it adjust indexed costs to account for OBRA? Was anything added for OBRA? Should OBRA be added to the cost estimates?

RESPONSE: The actual cost increase incurred by nursing facilities is 11.29% for the two-year period 1988-1990. This increase includes cost increases for operating and property costs. The DRI-HC index for a comparable period is 12.83%, which does not include property increases. Preliminary information which may have shown a higher percentage increase has been adjusted based on facility corrections to costs and reverifications of data reported. The 11.29% figure is more accurate. The commentors' assumption that actual inflation exceeds the department's inflation index is incorrect and the department accordingly disagrees with the comments.

The final reimbursement methodology includes a minimum wage floor in the direct nursing personnel component so that no facility will receive less than 85% of the average hourly wage median in the computation of their direct nursing personnel component. Facilities will not receive rates in the direct nursing personnel area less than the current federal minimum wage plus an accommodation for benefits.

The department's cost to rate analyses compare 1989 costs indexed forward by the DRI index from the quarter falling in the midpoint of the cost report period to the midpoint of the reimbursement period, to rates generated by the system. The percentages or limits for each of the components are set at the following levels: the operating component at 110% of the median, the direct nursing component at 125% of the median, a transitional upper limit cap on the increase in a provider's per diem rate from fiscal year 1991 to 1992 at $8.00 and a minimum per diem rate increase of 5.5% over the fiscal year 1991 level, to assure that each facility receives a rate increase during the transition from the previous reimbursement methodology to the proposed reimbursement methodology. In addition to the components outlined above there is a continua-

tion of the OBRA increment at $2.00, which has been adjusted to account for inflation.

The rate to cost that must be incurred comparison includes 1989 costs indexed by DRI, indexed OBRA costs and the utilization fee. The DRI component accounts for increases in minimum wage and workers' compensation increases, which are being experienced nationwide. The department's comparison of rates to costs that must be incurred shows that rates are reasonable and adequate to reimburse costs that must be incurred in these areas. The department believes that the DRI is adequate as a measure of inflation, and that the department has fairly considered the impacts of the utilization fee, OBRA, minimum wage and other cost increases that will be experienced by the nursing home industry.

COMMENT: How does this proposed system take into account substantial increases in workers' compensation premiums since 1989?

COMMENT: The formula should include a variable to adjust for different workers' compensation rates paid by combined and freestanding facilities. There is a 270% differential. A freestanding 85-bed facility pays $90,000 more per year than a combined 85-bed facility.

RESPONSE: Workers' compensation rates reflect a group's loss experience. Lower rates in workers' compensation result if facilities reduce their losses. There are also various methods by which facilities may obtain workers' compensation coverage. County homes participate in the MACO pool, some facilities are privately or self-insured, and some participate in the state fund. All facilities pay a different rate based on the experience of their group and the experience rating of their individual facility. The department does not believe the state should pay more for a facility that has a high workers' compensation rate due to their high loss experience or due to the coverage that they have chosen to acquire.

The department believes that workers' compensation cost is included in the cost base that is being used for reimbursement, that the DRI index recognizes workers' compensation increases, and that the department's rates will reasonably and adequately cover workers' compensation rates.

COMMENT: The DRI index measures only changes in cost or price, and cannot measure changes in intensity or volume. Inadequate indexing is actionable under the Boren Amendment.

RESPONSE: The DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket is published by DRI/McGraw Hill on a quarterly basis. The index is intended to measure changes in the input prices of certain defined nursing homes. The department will use the most recent data

available to adjust allowable base period costs. The department believes that other features of the methodology account for changes in "intensity and volume." For example, increases in patient acuity are accounted for by the patient assessment factor. The department believes rates as a whole meet the requirements of the Boren Amendment.

COMMENT: Use of different inflators for different facilities results in higher inflation allowance for governmental and non-profit facilities, because they do not budget increases or increase expenditures until July announcement of the medicaid rate.

RESPONSE: The department will apply the DRI index necessary to index costs from the quarter falling in the midpoint of the cost report period to the midpoint of the reimbursement period. The older the facility cost report information, the higher the index necessary to inflate the cost forward to the midpoint of the reimbursement period. The closer the cost reporting period is to the midpoint of the reimbursement period, the lower the index necessary to trend costs forward to the midpoint of the reimbursement period. Calendar year-end providers require less indexing to get to the midpoint of the reimbursement period than June year end providers. Governmental and non-profit facilities do not gain any unfair advantage in this process.

d. Cost Control Incentives

COMMENT: The proposed system does a fair job of reimbursing cost, and provides incentives for facilities to contain costs while providing quality care. The proposed system uses aggregate cost information to establish parameters that limit reimbursement levels and provide incentives for achieving economy and efficiency.

RESPONSE: The department agrees.

COMMENT: We concur with the department's stated objectives in developing the proposed system - i.e, complying with federal legal standards, promoting quality of care, designing a framework for legitimate cost containment and accounting in a equitable manner for reasonable differences among nursing facilities. However, the proposed system would not achieve these objectives either now or in the long run. Rather by denigrating current and appropriate cost containment incentives while emphasizing cost-based reimbursement, the proposal would ensure that medicaid rates will begin to spiral uncontrollably. The proposed system would encourage providers to increase spending and decrease efficiency. Reimbursement dollars will be transferred from low to high cost facilities. In some cases rate increases would be warranted because of past underpayment. In other cases, the increases would merely reflect and pay for historical inefficiencies. Once costs

rise, they never go back down. Some facilities would receive rate decreases or only modest increases only because they have been economically operated in the past. By using a system that is largely cost, rather than incentive based, the department is committing itself to a system it will be unwilling or unable to fund. This will cause the system to be jettisoned abruptly by SRS and the legislature, undoubtedly in a manner that will stress budgetary constraints at the expense of reasoned ratemaking. If this happens, the legislature may turn its back upon the medicaid program and the result could be underfunding in perpetuity.

COMMENT: Under the proposed system, unchecked spending will result in rates for inefficient providers up to $100 per day. This approach bankrupted medicare in the 1970's and 1980's, and will do the same for medicaid in the 1990's.

RESPONSE: The department disagrees with the claims that the proposed system will not encourage cost containment. The system incorporates numerous cost containment measures and incentives. Further, business and market realities can reasonably be expected to strongly discourage the orgy of spending predicted by critics.

The new system is, like the current system, a prospective rate system. This means that the provider will receive the rate set under the system and, if the provider is able to provide services for an amount lower than the rate, will be allowed to keep any savings. If the provider spends more than the rate, no additional payment will be made. This provides a strong incentive to contain costs in order to either make a profit or minimize the amount of loss.

Both the operating and direct nursing personnel cost components are subject to upper limits, which will prevent reimbursement of excessive costs and thereby encourage providers to contain spending. The operating cost component also includes an incentive payment of up to $1.47 per diem over projected cost for facilities with operating costs below the operating cost limit.

In addition, other business and market realities will discourage foolish and unnecessary spending like that predicted in the comments. Providers must consider the overall revenue and expenses of the facility. Providers generally serve not only medicaid residents, but other patients as well. Excessive spending would lower the net income to the facility for all operations. Further, the department does not believe providers generally have available the amount of uncommitted funds which commentors suggest will be frivolously spent. Lending institutions will not be inclined to loan funds without a demonstration by the facility of solid planning, good reasons and clear ability to repay.

The department will continue to refine and adjust the system to respond to facility costs and spending patterns. If the department finds that facilities are spending excessively and without restraint, there is no requirement that the department reimburse for such spending. Providers are or should be well aware that the department will not uncritically reimburse whatever costs providers incur. This awareness should serve to sober those providers whose urge to go on a spending spree has not already been checked by the factors mentioned above.

The comparison of the department's system to the medicare system in the 1980's and 1990's is inappropriate. Medicare uses a retrospective cost-based system which reimburses all allowable costs. The department's new prospective payment system bears no resemblance to the medicare system.

The department does not agree that the new system merely rewards historical inefficiency and penalizes low cost providers. The current system rewards low cost providers (without regard to whether they are low cost because of economy and efficiency or because they are cutting corners on critical items such as patient care) for the higher costs of other facilities (without regard to whether those higher costs are nonetheless economical and efficient for that provider). The new system responds more closely to the cost experience of individual providers, subject to reasonable limitations. We believe this is a far more appropriate approach to reimbursement than the current system employs. Moreover, the issue is not whether the rate of some other provider is too high, but whether the provider's actual rate is appropriate and in accordance with legal standards.

The department expects costs to rise regardless of the details of the medicaid reimbursement system. The department recognizes there is some risk of additional spending. The new system does encourage providers to incur the necessary economic and efficient cost in the area of direct patient care to comply with new standards. However, the department believes the commentors have greatly overstated the risk of increased spending in an attempt to frighten the department out of making needed changes which will reduce the amount of their profits. The department does not agree that the new system will encourage the spending which critics claim.

COMMENT: There are no cost control incentives in the proposed formula because increasing costs artificially through hospital service charges will far outweigh efficiency incentives built into the formula.

COMMENT: Higher costs are not necessarily caused by inefficient operation or lack of appropriate cost containment efforts. Mandatory cost allocation methods and uniqueness of facilities contribute to cost differences.

RESPONSE: The department disagrees that hospital service charges "artificially" increase costs or that hospital service charges outweigh the cost control incentives in the new system. The department does not find reasonable either adopting a single average rate system, which recognizes no differences, or dividing facilities into peer groups, which ignores the fact that the services may be provided less expensively in certain settings. The department believes that the new system appropriately recognizes differences in provider organizational structures within a reasonable range.

COMMENT: The current system has been very efficient and also has been among the best in the nation in cost containment. Montana's increases have been in the area of 2 - 4%, much lower than the national rate of inflation. The department should not overlook the successes of the current system. What are the cost containment mechanisms of the proposed system and how are they to be implemented?

COMMENT: The department will not be able to make accurate budget predictions under the proposed system. One reason the department converted to the present system in 1982 was to make budgeting more certain. At present, budgeting is more certain. With the proposed system, budgeting will return to guesswork.

RESPONSE: Certainly, it is "easier" to make budget projections if the amount of increase is determined by a set percentage increase related to the amount of revenue the state has available rather than to the actual cost experience of providers. Critics of the current system, who now have converted into supporters of the current system, have said in the past that Montana's system has been too good at rate containment, at the expense of adequately reimbursing costs. The current budgeting approach has been one of the most repeated criticisms made by providers seeking higher funding for the current system.

It would now appear, as the department believes, that the opponents of the proposed system were in fact doing quite well under the current system. This is because they were able to make large profits under a system which set rates based upon averages and mostly ignored the lower actual costs such facilities incurred. Patient care may become a convenient sacrifice when a rate system ignores actual costs in favor of simple averaging and easier budgeting. Opponents of the proposed system now seek to sell the legally least defensible feature of the current system as a virtue, when all along it has been the achilles heel of the system and a weapon consistently used by providers against the department.

The proposed system is being designed specifically to comply with Boren Amendment and other legal requirements, which clearly require reimbursement to be related to costs which must be incurred rather than solely to budgetary consider-

ations. While this may require more work and less certainty in certain respects, the department believes it is worthwhile, if not simply required by law.

COMMENT: A system that uses an average operating cost encourages cost containment and allows the reasonable cost to be established and defended. Use of a modified retrospective system allows excessive operating costs to be passed on and does not provide adequate cost containment incentives. Retrospective systems have been rejected in favor of prospective systems, which have led to reductions in expenses. Use of a retrospective system will lead to rapid cost growth and will require huge budget increases to sustain. The same commentor complains that the proposed system limits reimbursement for operating cost to "allowable" cost, stating that under the current system extra reimbursement from the operating rate covers a shortfall in the property rate.

RESPONSE: The proposed system is not a retrospective reimbursement system. A retrospective system is one in which all allowable costs are reimbursed after filing and review or audit of a cost report which covers the rate year. Such a system has no cost containment features. A prospective system is one in which rates are set in advance based upon a prescribed formula and no adjustment is made after filing of a cost report to assure full reimbursement of allowable costs. The provider has a set rate and is encouraged to contain costs in order to spend less than recovered under the rate, because the provider may keep the savings. Providers who spend more than the rate do not receive additional payments to cover costs incurred in excess of the rate.

The proposed system is a prospective rate system. It does not reimburse all allowable cost, but rather sets a rate based upon provider-specific and aggregate data. The provider must live with this rate even if more or less is actually spent. However, since the provider-specific information is drawn from providers' cost reports, the department must have some assurance that providers will completely, accurately and properly report costs. Thus, if an audit or desk review of the base period cost report used to set the provider's rate results in adjustments, the prospective rate will be adjusted accordingly to assure that the provider is reimbursed according to the proper prospective rate. Absent such a check, providers would have no incentive to completely, accurately and properly report costs, and could receive excess reimbursement by misreporting costs.

This audit feature does not make the proposed system a retrospective system which lacks cost containment incentives or which requires the department to reimburse whatever providers spend, as was the case under the pre-1982 retrospective reimbursement system. It appears that the term "retrospective reimbursement system" is being used by opponents of the

proposed system as a scare tactic to raise fears of uncontrollable cost increases under the proposed system. Further, it is apparent from the comment that what is really desired is to be able to receive even more than the allowable costs reimbursed under retrospective systems, which is possible under the current system to a far greater extent than under the proposed system. There is no reasonable basis upon which to pay facilities at such levels above cost. The proposed system is clearly distinguishable from retrospective systems and contains adequate and appropriate cost containment incentives.

8. Direct Nursing Personnel Component

COMMENT: The current formula is not adequately sensitive to patient acuity because facilities are compared to a statewide average is rising. Facilities willing to take higher acuity patients are placed at greater risk. The proposed system addresses individual facility patient acuity in a more direct manner and should reduce some of that risk. The proposed system also addresses salary costs in a more fair and equitable manner than the current system, which is based upon averaging and results in inadequate reimbursement to facilities with higher but justifiable salary costs.

RESPONSE: The department agrees that the proposed methodology is more sensitive to patient acuity because each facility's patient assessment average is used in the rate computation and is not subject to a comparison with the statewide average. The new system addresses the direct nursing personnel costs through a separate component, which 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, or a limit set at 125% of the statewide median average wage multiplied by the provider's most recent patient assessment score. Each provider's composite nursing wage rate will be based upon base period costs, patient assessment score and patient days. In addition, the component is subject to a floor set at 85% of the average hourly wage median. This will assure that rates in the direct nursing personnel area will be no less than the current federal minimum wage plus accommodation for benefits. The direct nursing personnel component is intended to encourage a provider to direct resources toward direct nursing care to residents, thereby improving the quality of care provided. Patient assessment scores will be determined as under the current system. However, the direct nursing personnel component, including the limit, will 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.

COMMENT: The Rebase Study by Myers & Stauffer found that neither the level of medicaid rate or the level of provider

cost seemed to explain a nursing facility's experience in meeting selected performance indicators published by HCFA. Yet, the department is spending more on nursing care on the assumption that it will result in better care. There is no clear evidence that higher cost facilities take better care of residents.

RESPONSE: It is only logical to conclude that inadequate staffing levels and underpayment of staff negatively affect quality of patient care. The comments of the state long term care ombudsman and others, as well as complaints from providers that they receive inadequate reimbursement to respond to patient care requirements, support this conclusion. The new system incorporates incentives for facilities to direct available resources toward direct, hands on patient care rather than toward spending for items which only indirectly or remotely affect patient care, if at all. The department believes that increases in staffing levels and staff wages and benefits will positively affect the quality of patient care.

While it is true that the reimbursement study by Myers & Stauffer found no direct correlation between total facility spending and performance on certain selected indicators, the department believes that allocation of more resources toward direct patient care will improve the quality of care. The finding by Myers & Stauffer compared total facility spending, rather than spending on patient care, to performance on selected indicators. Moreover, most of the recently enacted federal nursing home reforms concentrate on improving the quality of care of facility residents. Improvements in these areas will require increased spending in many cases.

COMMENT: The proposal does not take into account unusual circumstances that have forced dramatic increases for rural homes. The nursing shortage in the state causes rural homes to hire from nursing pools at costs approximately 4 times the typical LPN wage. Additional costs are incurred for room and board for these nurses. Under the proposed system, these costs would not be considered wages and would not be recognized in the nursing component.

RESPONSE: The department believes the new system reasonably and adequately meets the costs which must be incurred by economically and efficiently operating facilities. While this proposal does not provide for individual reimbursement modifications to take into account special or unusual circumstances, it does a much better job of recognizing the costs that are being incurred at each individual facility.

The department does not believe the use of nursing pools is common in Montana. The costs of nursing services may be allowable to the extent the requirements of the HIM-15 are met. The costs of such services are allowable as contracted services to the extent they are directly related to patient

care. Room and board for such nurses is not directly related to patient care and is not an allowable cost. "Benefits" for such nurses are allowable only to the extent such nurses are employees of the provider and the "benefits" are provided across the board to all employees of the provider. Other limitations contained in the HIM-15 may apply. Providers with specific questions regarding the allowability or classification of such costs should ask the department for clarification.

a. Level of Direct Nursing Personnel Cost Limitation

COMMENT: The proposed median of 140% serves a valid purpose and is logical in any reimbursement system. By establishing a higher percentage around the median, this component will provide greater reimbursement for direct nursing costs. The additional funds may be used to hire more staff or provide better wages and benefits to existing staff in an attempt to recruit and retain qualified staff and provide higher quality patient care. Yet, facilities with very high direct nursing costs will be capped at an appropriate level.

COMMENT: The direct nursing cap is too high and encourages inefficiency. The caps in all areas, i.e., nursing, operating and operating incentive, should be the same.

COMMENT: How did the department determine the 140% limit contained in the direct nursing personnel cost component? Were other limits analyzed? Specifically, how did it determine that setting the limit at 140% of the average median wage would pay all the costs that must be incurred by economically and efficiently operated facilities? If the department has performed an analysis, we request a copy of such or of other supporting documentation for the decision to include a 140% limit. If no such analysis has been done, we recommend that it be done before implementing this proposal.

RESPONSE: The department analyzed a range of parameters for each of the components. The percentages were adjusted through sensitivity analysis in order to better achieve the department's goals. The percentages were also modified based upon analysis of cost and projected rates, provider and other input, and studies and other published materials regarding medicaid limitation percentages.

A primary goal of the system is to improve quality of care, which is the main focus of the OBRA requirements. One way to achieve this goal is to set a higher percentage around the median of the direct nursing personnel component so that more of the costs related to direct patient care (more staff, better wages and benefits) are recognized for reimbursement purposes. An upper limit percentage is necessary to cap the

direct nursing component at an appropriate level so as to not reimburse excessive costs.

The final rule sets the direct nursing personnel limit percentage at 125% of the median times the facility's patient assessment score. 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.

The design of the new methodology is consistent with features recommended by experts in the field of nursing home reimbursement. The methodology divides costs into direct patient care, other operating expense, and capital, with application of a relatively liberal allowable-cost ceiling in the direct patient care area. The system employs weaker incentives to contain costs in the direct nursing area, and applies a more stringent ceiling on other operating costs and provides strong incentives to contain or reduce such costs. The use of ceilings set at particular percentages of the median does not represent judgements about the level of efficient, economic or necessary costs, but rather reflects an accommodation to providers in an attempt to recognize as much of the full costs of providers as possible. The department has provided the commentor with the requested documentation.

b. Wage Floor - Use of Cost Report v. Wage Survey

COMMENT: In many instances, the new system will not cover actual costs. Some facilities will be forced to close or to violate state and federal laws. The direct nursing personnel component in the original proposal is too low to pay nursing help at the required minimum wage plus benefits and payroll taxes. The minimum wage increases affect low cost facilities to a greater extent than high cost facilities, while other purchased supplies and services equally affect both.

COMMENT: The original proposal contained serious flaws in this component, which is perhaps the most important part of the proposed formula. The revised proposal is an improvement but does not satisfactorily address whether the "fictitious" hourly wage developed under the formula accurately reflects the cost of an hour of nursing care in a given facility. In many instances, the actual cost of an hour of nursing care, as reported in the March 1991 wage survey, far exceeds the hourly wage floor proposed by the department in its revised proposal.

There are substantial discrepancies between the hourly wage determined under the original proposal and the actual hourly wage under the March 1991 wage survey. Under the original proposal, about 60% of facilities would receive a wage component substantially less than the wage reported on the March 1991 wage survey. These differences range from $1.56 to $2.48 per hour. Under the revised proposal, about 57% of facilities

still receive an hourly wage below the amount reflected in the survey. Further, in many instances, the "fictitious" wage developed under the formula is far greater than actual reported hourly wage costs. This again suggests that the 1989 cost report data is inconsistent with current cost experience and calls into question the validity of the proposed system.

Because this hourly wage is multiplied by the facility's patient assessment score to arrive at a rate, rate discrepancies can amount to a rate difference of from $3 to $16. Use of the "fictitious" hourly wage based on 1989 cost reports and staffing is unreasonable when 1991 wage survey data is available.

We ask the department to explain why the March 1991 wage surveys are not used to determine a facility specific hourly wage, why the formula does not yield hourly rates which accurately reflect actual costs, and why discrepancies for some facilities are so large. If the department has done a facility by facility analysis of the hourly wage reported on the March 1991 wage survey as compared to the hourly wage calculated under the proposed formula, we are requesting a copy of that analysis. If not, we recommend that such an analysis be performed.

COMMENT: The March 1991 wage survey should not be used to set rates. The survey reflects only one month of data and is less reliable than cost report information. However, the department should allow providers with significant reporting errors to correct the 1989 data.

RESPONSE: The department agrees that the March 1991 wage survey should not be used to set rates. The survey is a one month snap shot of data and, based on department audit of some survey forms, the department believes it contains unreliable information regarding nursing costs being incurred. In many instances, the actual hourly wage under the March 1991 wage survey form is significantly overstated in dollars as well as in the hours of direct nursing care being provided. Substantial adjustments would be necessary to reflect accurately the wage costs being incurred. Moreover, comparison of the wage survey form and the cost report data, after adjustment for the minimum wage floor and corrections to the data, indicates that there is a variance of only 4 cents in aggregate between the wage survey data and the cost report information used to establish rates.

The department has other concerns regarding use of the wage survey information. The salary survey was not part of the cost reporting process. The survey collected data regarding average wages for a one-month period, which may not be reflective of a facility's general experience. The impact of holidays reported in the survey month, the use of pooled nursing, and vacations taken during the survey month undermine

the validity of the data. A twelve-month cost report does not have these shortcomings. The use of non-cost report information from the survey form provides an opportunity for "gaming" the system. There is no link between the salary survey and the facilities' patient assessment scores. The proposed rate system, which uses cost report data, provides a benefit to those providers staffing above their patient assessment score and penalizes those providers staffing below their patient assessment score. Using the salary survey in the rate setting process would eliminate the benefits and penalties associated with over or under staffing. Cost report information is more representative of facility salary experience and is a more appropriate basis for rate determinations.

COMMENT: The minimum direct nursing personnel component amount of $7.19 is logical, as it addresses the need of providers since 1989 to comply with minimum wage laws and increased wages paid to obtain nursing help.

RESPONSE: The department agrees.

COMMENT: The PAS information used in the rate calculation is from the October 1990 through March 1991 period. The wage information should be from a comparable period.

RESPONSE: The wage information used is indexed by the DRI to trend it forward to the midpoint of the reimbursement period. The inflated wage cost information matches closely the October-March 1991 reporting and averaging period for establishment of the six month patient assessment average used for reimbursement purposes. The most accurate reliable wage information is the cost report information being used for reimbursement purposes. The wage survey for March 1991 is available, but the department considers this data to be unreliable for this purpose. The department believes the wage and PAS data used are appropriate and adequately account for wage cost and patient acuity.

COMMENT: The department cannot afford the wage floor in light of losses that will be incurred by facilities and because the wage floor simply insulates facilities from financial risk. Further, the facilities that benefit from the wage floor already receive adequate overall rates without the floor. Nine of the 13 facilities affected will receive rates more than $9.00 over cost. The wage floor is unnecessary.

COMMENT: Commentors stated that they support the rule as originally proposed, rather than with the wage floor and lower cap on increases proposed by the department.

RESPONSE: After the filing of the first rule notice, the department continued to evaluate data and information that was received from the industry and from consultants. The department believed that the concerns regarding increases in the

federal minimum wage, and that the federal wage increases were not being reported in the base period cost information, had merit. The wage floor will insure that facilities do not have direct nursing personnel components that do not reflect the most recent federal minimum wage requirements. This floor only guarantees that facilities receive 85% of the direct wage median ($8.46 X 85% = $7.19) in the computation of this component. While this may be more than the cost reported in the base period, it recognizes little, if any, more than the minimum wage, plus an accommodation for some benefits. The department does not agree that this floor creates a profit or insulates facilities from financial risk.

Further analysis and study of the proposed system, additional data analysis, analysis of comments received at the public hearing, and analysis of the goals of the reimbursement system continued long after the filing of the first notice and all the way through the rulemaking process. While some commentors supported the rule as proposed, many of the components have been modified based on comments and ongoing analysis of the reimbursement methodology.

c. Patient Assessment Score

COMMENT: We support the proposal to reduce the information required for patient assessment.

RESPONSE: The department believes the reduction will help to reduce the paperwork burden on providers.

COMMENT: The patient assessment system is arbitrary and depends upon the auditor's ability to recognize different forms of documentation and the ability of provider staff to learn the documentation process and communicate documentation to the auditor. Our facility currently pays consultants and assigns three employees to the process to insure that documentation is in accordance with guidelines. There has to be a simpler, more cost effective means of providing adequate documentation.

RESPONSE: The department recognizes that anytime different individuals perform a task there is the possibility of variation. However, the department does not believe there is a significant difference in patient assessment scores as a result of different individuals performing monitors. The department trains monitor staff based upon uniform information and provides uniform guidelines for use by monitor staff. Monitor results are reviewed for consistency, among other things, by a single person in the department's Helena office. If a provider does not believe the monitor findings are correct, it may request an administrative review and a fair hearing to dispute the department's determination. The department believes these procedures more than compensate for any individual differences in monitor personnel.

The patient assessment system does require an effort by providers to learn and apply the requirements of the system. The department believes this effort is justified in order to obtain information about patient acuity which is sufficiently specific to be meaningful. The department does provide regular training for facility staff and will gladly set up special training sessions if desired by providers. The department does not believe that the patient assessment system is too difficult or burdensome for a provider that takes advantage of training opportunities and, if faced with specific questions, takes the time and opportunity to call the department for additional guidance when necessary.

COMMENT: The rule should allow facilities with deficient monitors to request a second monitor as soon as they are ready. It makes little sense to require a facility to wait for a second monitor if deficiencies are corrected. The facility would be rewarded for prompt compliance and the rate could be adjusted sooner than January 1 of the rate year. The department should consider a maximum reimbursement penalty of three months.

RESPONSE: It certainly would be easier from a facility standpoint to correct deficiencies and request an immediate monitor. This would allow the facility to implement a short term "fix" to maximize reimbursement, but would not meet the ongoing need to document patient care provided in the facility or to rectify failures to follow the patient assessment documentation requirements.

The facility deficiency is a penalty for not following patient assessment criteria for claiming management minutes and for having a significant variance between abstracts submitted to the department and documentation in the medical record. Minor variances do not result in a facility deficiency. It is the facility's responsibility to know the rules regarding documentation and assessment of management minutes. The department regularly provides training on patient assessment and is available to provide training on the manual to those facilities with problems or questions.

Allowing facilities to request their own monitor period would limit the department's ability to select a representative sample month and could allow facilities to manipulate reimbursement based on the months chosen. A six month average is a representative average of the patient assessment activity in a facility; a shorter period would not be. The department pays for the cost of the second monitor when it is requested. More frequent monitoring would be more costly from a monitor standpoint and an administrative standpoint. More frequent monitoring would be costly as it would not be done in conjunction with other activities the monitor agency is performing and would increase travel costs. The department will not allow facilities to determine the timing of monitors by

requesting a second monitor when they believe the time is right.

Facilities have been subject to the same patient assessment requirements for many years. Effort and commitment to learn and understand the patient assessment system on an ongoing basis, rather than as a quick fix to maximize reimbursement, is the best approach to assure that facility records are always ready for a monitor. A facility that pursues such an effort will not find itself in a deficiency situation due to lack of information, training or documentation.

COMMENT: We oppose the rule that limits providers' ability to appeal adverse monitor findings. Because of the restriction proposed by the department, facilities will now request that the monitor team review all documentation present in the facility solely to cover the risk of receiving a deficient score. This will be necessary because facilities will not know what the outcome of the monitor will be.

The proposed rule also restricts providers' right to question the sampling technique used by the monitor team. What sampling technique is used by the monitor team? Is it statistically valid in all cases?

RESPONSE: When monitor teams review patient care abstracts to compare actual documented nursing care time to the time reported by the facility, they use a sampling technique to obtain a sample of abstracts for monitoring rather than reviewing all abstracts. The results of the monitor are then extrapolated to the entire group of abstracts. This is a commonly accepted statistical method which allows a substantial time savings to all parties. The department's manual on statistical sampling is available on request. The department believes its methods are statistically valid.

The proposed rule provides that if a provider objects to the sampling technique, the only available appeal is to request that 100% of the abstracts be reviewed rather than merely a sample.

The department believes this approach is reasonable and prevents the parties from becoming bogged down in complicated arguments about what sampling technique is most appropriate. The 100% monitor assures that any problems resulting from the sampling technique are eliminated. If the 100% monitor shows that the provider correctly believed the sampling technique was flawed, the expense of the 100% monitor will be borne by the department. Providers may appeal any other monitor or patient assessment determination once the 100% monitor is completed. The department does not believe changes to this aspect of the rule are warranted.

The department will require providers to make all supporting documentation available at the time of the monitor. This requirement prevents after-the-fact creation of documentation which is required to be kept contemporaneously. Obviously, the provider is the only one that can locate particular portions of its own records and it makes no sense to merely tell the monitor to look at all of the facility's records. Providers will be told during the monitor process the results of the monitor and what documentation is lacking, and will be given an opportunity to provide missing documentation to the monitor. A record will be kept of the additional documentation that was requested but not provided. This process will eliminate the need for providers to request that monitors review all facility documentation.

COMMENT: May any provider request a 100% monitor instead of using the sampling method?

RESPONSE: The 100% sampling technique is available only as an appeal method for those who object to the sampling techniques employed. Language has been added to the rule to clarify this point.

COMMENT: The definition of significant difference is unclear. Is the 10% amount 10% of the monitor score or 10% of the provider's reported minutes?

RESPONSE: It is 10% of the monitor score. The rule has been revised to clarify any confusion.

COMMENT: It appears the word "if" was omitted from the beginning of Rule VIII(7)(b). In the second line of Rule VIII(7), the word "a" should be "the." In Rule VIII(4), the word "by" appears to have been omitted.

RESPONSE: The department agrees and has corrected the omissions and changed the referenced word.

(i) 100% Staffing Requirement

COMMENT: The proposed rule will require providers to staff at 100% of the patient assessment score (PAS). In 1989, providers were only required to staff at 90% of the PAS. Since providers only staffed at 90% of the PAS in 1989, direct nursing costs during that period were lower than now required. Because rates under the proposed system will be set using 1989 as the base cost period, those rates will not take into account the costs of staffing at 100% of the PAS in FY 1992. The direct nursing personnel cost component does not take into consideration the increased staffing required by this rule change. If this change is kept in the final rule, the direct nursing personnel cost component should be adjusted to take these substantial additional costs into consideration.

Has the department analyzed 1989 staffing patterns by facility to determine how many and which facilities were staffing at less than 100% of PAS in 1989? Has the department adjusted the average hourly wage for these facilities to account for the new staffing requirements? If not, why not?

RESPONSE: The proposed rule does not change the minimum staffing requirement, but simply clarifies what has always been the rule. See, e.g., current ARM 46.12.1201(h)(2) and 46.12.1206(2). The belief that the department previously required staffing at only 90% of the PAS is erroneous. This belief apparently arises because the department allows, for purposes of rate penalties, for a 10% variance between the patient care time reported by a facility and the time actually supported by facility records as found by the department's monitor team. This remains true under the proposed rule. Providers are well aware that the department has previously required staffing at 100% of PAS that is used in the establishment of the facility reimbursement rate.

The patient assessment process is designed to measure actual care requirements, not 110% of actual care requirements. The department's current rules require providers to completely and accurately report care requirements for each medicaid recipient. If a facility has deliberately staffed at only 90% of the PAS, either its PAS should have continually decreased over time or the provider has deliberately overstated the care requirements of its residents.

Because in 1989 the department required providers to staff at 100% of their PAS, the department does not agree that the proposed patient assessment rule imposes additional staffing costs which are not reflected in the 1989 base year costs.

COMMENT: The rule should be changed to clearly state that to avoid sanction facilities must staff at 90% of the PAS used to set the facility's rate. It is true that facilities generally should have staff equal to the reported patient acuity.

RESPONSE: The department does not agree that additional clarification is necessary or appropriate. The rule clearly states the rate penalties that will result if the monitor indicates a 10% deficiency. This allows providers some room for error or flexibility in the event of difficult circumstances. However, the department does not consider the 100% requirement to be a meaningless standard. In an appropriate case of abuse, the department would be authorized to sanction a provider under the provisions of ARM 46.12.401, et seq., for failure to staff at 100% of the PAS. Such a sanction would be in addition to any rate penalty that might be applied in the case of a finding of a significant difference.

COMMENT: The department should recognize that many patients are not included in the patient acuity measurement.

Facilities which exceed minimum staffing levels may not be inefficient; they may be reflecting higher acuity in the non-medicaid population.

RESPONSE: It is certainly true that the patient assessment system only provides information on the medicaid population in the nursing facility. Since medicaid utilization statewide is 62%, and is much higher in some facilities, we believe that the patient assessment average is reflective of the acuity trends of the facility population as a whole, even though facilities may have higher or lower care need residents in the facility than the averages used in establishing reimbursement represent. The department has used the staffing reflected by the PAS to set payment rates and as a measure of the minimum staffing requirement. Certainly the department expects that a facility will staff to the care needs of the residents in the facility or would not admit residents for whom it cannot provide appropriate and adequate care.

(ii) Use of Monthly PAS

COMMENT: The proposed rule requires staffing at 100% of the provider's hourly patient assessment score for the month. Since the PAS for a given month is not calculated and provided to a facility until after the month has passed, this requirement is unreasonable. This should be changed to relate the staffing requirement to the average PAS.

RESPONSE: The department agrees that the staffing requirement should relate to the average PAS rather than the provider's hourly patient assessment score for the month. The reference to the monthly score in this context was an error in the rule notice. The department intends the staffing requirement to relate to the average PAS. The final rule has been changed to correct this error.

9. Operating Cost Component

a. Percentage of the Median

COMMENT: The proposed median of 112% serves a valid purpose and is logical in any reimbursement system.

RESPONSE: The proposed median was analyzed in conjunction with a range of other percentages. The percentage set by the final rule will be 110% of the median operating cost. Limitation parameters have been subjected to modifications based on analysis of cost and projected rates, and with the benefit of provider and other interested party comment, and to best meet the goals of the reimbursement system.

COMMENT: The operating component sets a limit at 115% of median without consideration of appropriateness of costs included in the category. Some costs such as taxes are not

subject to cost containment. Facilities without taxes can overspend in other categories and effectively receive a higher cap than those facilities which pay taxes.

RESPONSE: The proposed reimbursement system considers allowable costs being incurred at each facility. All providers will receive their indexed base period per diem operating cost, subject to the operating cost limit of 110% of median operating costs. Overspending does not affect the upper limit, as the same upper limit is applied to all facilities. Facilities which keep operating costs below the operating cost limit will qualify for an incentive as a motivation to control costs rather than to overspend. The department believes the 100% of median operating cost limit takes into account "fixed" amounts such as taxes, while encouraging containment of the non "fixed" costs.

COMMENT: Did the department undertake any analysis to determine the 115% limit? How did the department determine this limit? Did the department analyze other limits? Specifically, how did it determine that setting the limit at 115% of the median operating costs would pay all the costs that must be incurred by economically and efficiently operated facilities? If the department has performed an analysis, we request a copy of such or of other supporting documentation for the decision to include a 115% limit. If no such analysis has been done, we recommend that it be done before implementing this proposal.

RESPONSE: The department analyzed a range of limits in establishing the final limits that will be applied. The department has adjusted the operating limit from 115% to 110% based on further analysis performed. The department determined the limits based upon a sensitivity analysis, input from the industry, and consideration of other state's limits. The sensitivity analysis included evaluation of how the various components of reimbursement reacted to changes in the parameters and limits. Because of the department's desire to maximize recognition of direct nursing personnel costs component, the percentage of the median that is being applied to the operating component limitation is lower than the percentage being applied to the direct nursing personnel component upper limit. The ranges of limits analyzed are comparable to other states' limitation percentages.

The rate setting component ceilings are not intended as definitions of the levels of efficient or economic costs or the costs which must be incurred. Percentages have been adjusted above the median in an attempt to accommodate providers by recognizing the greatest amount of costs of as many providers as possible.

b. Operating Incentive Payment

COMMENT: How did the department arrive at the $1.46 maximum incentive?

RESPONSE: The incentive is allowed where a provider's inflated base period per diem operating costs is less than the operating cost limit (110% of median operating costs). The incentive is the lesser of 5% of median operating costs or 40% of the difference between the provider's inflated base year per diem operating costs and the operating cost limit. The upper limit is 5% x median operating cost ($29.41) = $1.47.

COMMENT: The cap on the incentive should be set at 15% rather than 5%, in order to correct cost differences and overcome problems with the operating per diem.

COMMENT: The profit incentive is too low. The plan in effect prior to 1982 allowed for a $1.50 profit. Adjusted for inflation, that would now be $2.30. The current plan allows only $1.46. The current plan does not allow for a sufficient margin to cover costs required for the operation of a facility and which benefit medicaid residents but are not allowable costs, such as indirect costs of separately billable items, chaplain fees, memberships in civic organizations to encourage community participation. The failure to provide sufficient profit incentive will unfairly force private pay residents to bear these costs.

RESPONSE: The department believes the incentives proposed are reasonable and adequate to accommodate their purpose. The medicaid program is not required to reimburse facilities for more than the costs incurred to provide nursing facility care. The department is providing a degree of profit motivation for facilities which can control costs in the operating area. If facilities cannot control costs in the operating area, they will be limited to the upper limit of 110% of the median operating costs and will not receive the incentive allowance. The $1.50 profit referred to is an incentive computation based on the conversion from a cost based reimbursement system to a prospective system in 1982. The $1.50 was the maximum incentive that a facility could receive in dollars per medicaid day in effect on 6/30/82. Not all facilities had an incentive component. The $1.50 profit component is not a comparable provision to current operating incentive and attempts to compare the relative amounts are not meaningful.

Medicaid does not reimburse for costs such as chaplain and civic organizations, which is why these costs are non-allowable costs. To disallow these costs yet provide payment of these costs in the per diem rate or the incentive component makes no sense. As non-reimbursable costs there should be no provision for medicaid payment for these costs.

10. OBRA Cost Component

COMMENT: The department should index the OBRA increment and the nurse aide wage increment to account for inflation.

RESPONSE: The department agrees that there is merit in indexing the OBRA component to account for the changes in inflation. The OBRA component will be $2.00 for fiscal year 1992. The nurse aide wage increment is current information through April 1991. The impacts of inflation on this increment would be minimal due to the current nature of the data. It is not necessary to inflate these costs.

COMMENT: The OBRA increment should be further adjusted to cover the costs associated with providing the "services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each medicaid recipient." The $1.90 OBRA increment did not take these costs into account. The $1.90 OBRA increment was specifically calculated to cover costs associated with the items listed in the department's August 7, 1990 letter to HCFA. That list does not include the costs associated with expanded residents' rights and choices, reduction or elimination of the use of restraints, or other requirements associated with the new OBRA 1990 standard. Has the department undertaken any research, study or analysis to determine the costs associated with this requirement? If so we request a copy of such.

RESPONSE: The department has reimbursed for costs of implementing OBRA requirements since July 1, 1989. The department has met the requirements for providing for the "services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each medicaid recipient" by establishing a OBRA component and reimbursing for OBRA costs as a separate component of the reimbursement rate. The implementation of the OBRA 1987 requirements regarding quality of care, testing and training, meets the attainment or maintenance of the highest practicable, physical, mental and psychosocial well-being standard. The OBRA 90 requirement does not add new requirements or costs, but is a continuation of the 1987 requirements that have been addressed previously. The department will index the OBRA component for fiscal year 1992 to $2.00 to account for inflation. The department has added language to clarify that the rates take these costs into consideration.

11. Property Cost Component

COMMENT: The property formula continues to be ignored. Using an operating formula based on cost while maintaining a non-cost based property formula implies complete incompetence or malicious disregard for an equitable reimbursement system.

COMMENT: We understand that the property rates will be addressed next year. How will the anticipated increase in costs for property rates be funded? What will the process be for evaluating these rates? The department may have to adjust the operating rate to afford revision to the property rate system.

RESPONSE: The department is committed to forming a committee to evaluate property reimbursement and make recommendations regarding property reimbursement for fiscal year 1993. The analysis that has been performed by the department indicates that, in the aggregate, property rates exceed property costs by over 110%. This indicates that the property system is not underfunded. Based on comments, there may be problems in how the current system distributes funding for the property component. At this time it is premature to state precisely how these issues will be addressed.

COMMENT: Some classes of providers, i.e., state and governmental, do not pay property costs because their property costs are paid for by the taxpayers. Thus, the property rate for those providers subsidizes inefficiencies in per diem and nursing costs. Private facilities which do not receive adequate property reimbursement subsidize property costs out of operating reimbursement. The net result is no extra money to cover real property costs or to spend to get spending up to median operating or nursing cost levels.

RESPONSE: The current reimbursement system for property is based on the rate in effect since 1985 which has been indexed forward to account for inflation. The previous reimbursement system that established the pre-1985 reimbursement rate for property was based on the age of the facility and the type of construction. The correlation between costs and reimbursement has not been a part of the system of property reimbursement for many years.

All facilities report some amount of property costs, such as depreciation, interest, rental or lease, on their cost reports. Property costs such as depreciation decrease so that there is less correlation between cost and reimbursement over time. This is why there is such differential between reimbursement and cost in many cases.

The department disagrees with the suggestion that governmental facilities do not have property costs. Many facilities have the option of subsidizing their operating rate from their property reimbursement. However, these facilities are typically older facilities that will need to undertake renovation or remodeling in order to meet changing code requirements, and as such, should be investing the reserve so that they can undertake remodeling and maintenance to meet the fire, life, and safety codes and maintain certification. This is true of all facility types whether state, governmental or freestand-

ing. This area will be examined by the working committee that will be established to work on property reimbursement.

COMMENT: The deletion of further grandfathering protection breaks a promise made by the department in June 1985. The grandfathered rate should remain a floor below which the provider's property rate should not go.

RESPONSE: The department has removed this provision from the rule. Grandfathering issues will be addressed in the working committee on property reimbursement.

COMMENT: The definition of change in provider at Rule XII(1)(c) does not allow for the transfer of interests between family members due to death, retirement or other valid business reasons. It does not allow for a 50% shareholder partner to buy out the other shareholder or partner's interest. The loss of a grandfathered rate is not appropriate in these instances. Department responses from prior rule hearings should be adopted into formal rule to protect family and closely held businesses.

RESPONSE: Grandfathering issues will be addressed through the working committee on property reimbursement.

a. Remodeling and New Construction

COMMENT: The current capital payment formula needs to be revamped. Many homes are required to upgrade their physical plants to meet new fire, life and safety standards. Medicaid must contribute its fair share to those costs. However, at this time increased property reimbursement would mean decreased operating rates, which further shift the burden of loss inherent in the system. For this reason, the department's plan to address property issue in next year's rule is acceptable.

COMMENT: Negotiated rates should be allowed for homes required to incur new property costs to meet fire, life and safety standards.

COMMENT: Commentors expressed concern about the capital payment formula proposed for remodeled facilities. The property cost component fails to acknowledge the true costs associated with new construction, remodeling and additions. Despite the 3% indexing of property rates, the $8.90 rate paid to a newly constructed facility fails to compensate reasonable property costs. Because the cost assigned to new construction is the basis for setting all other property rates, the entire property component is suspect. Making major changes to the operating side of the reimbursement formula without correcting the serious problems in the property formula exacerbates the problems of newly constructed facilities and those with newer additions or renovations. The department should not make

major changes in the operating formula without making the needed changes in the property formula. The department should recognize that it is the legal integrity of the entire rate that is at issue and should grapple with revisions to the entire methodology at the same time.

COMMENT: For several years, it has been recommended that a new property system be developed based upon appraisals of facilities, so that the property rate would relate to the value of the use of the facility. Yet, no changes are proposed.

What is the basis for the $8.90 maximum reimbursement rate for newly constructed facilities? What are the down payment, interest and other assumptions on which the rate is built? Does the department believe that $8.90 per patient day compensates a newly constructed facility for its reasonable property costs? What basis does the department have for this assumption? What are the per diem costs for the most recently constructed facilities in Montana?

COMMENT: In testing substantive compliance with the Boren Amendment, the issue is the overall adequacy of the rates and not the adequacy of individual components of the rates. The department's efforts to resolve major problems with the rates may be doomed if it does not consider factors and circumstances relating to the entire rate. Legitimate and desirable options that may be available if all components are considered together may be foreclosed if final changes are made now to the operating rate methodology. All components of the rate methodology should be considered at the same time.

RESPONSE: The proposed rule retains the current property rate structure, indexed at 3% to account for inflation. The property cost component allows for an adjustment for extensive remodeling, if the total depreciable cost of the remodeling project exceeds in a twelve-month period, $2,400 times the total number of licensed nursing facility beds in the facility. This includes remodeling to meet the fire, life and safety standards. The department believes that the property cost component calculated under the proposed rule adequately addresses property costs. The proposed rule reimburses 110% of aggregate reported property costs. However, the department will further review the property reimbursement methodology through the working committee during the next year to determine whether adjustments are necessary and appropriate.

While the $8.90 new construction rate may be below the cost of new construction during the first year or two after construction, within approximately a 3-year period property costs per day are lower than the $8.90 new construction rate. The property rate is indexed forward each year, while actual property costs decrease over time due to assets becoming fully

depreciated, loans amortized, and interest payments decreasing.

Unaudited per diem property costs from the fiscal year 1990 cost report of the most recently constructed facility in Montana are $22.39 for Discovery Care Center in Hamilton, built in 1990. The department believes these costs will decrease within approximately 3 years to less than the department's property rate and that, overtime, all costs will be reimbursed.

Compliance with the Boren Amendment standard depends upon the overall adequacy of the rates and not the adequacy of individual components. There is no requirement that the state provide reasonable and adequate reimbursement for each individual cost item.

The department will not reimburse property costs through negotiated rates. While the department believes property reimbursement is adequate, we will continue to review this area through ongoing study of the reimbursement system and as part of the working committee studying property reimbursement.

COMMENT: One relatively new facility has property costs ($11.48 per patient day) higher than its capped property rate component ($8.90 per patient day). The department concedes this is too low, but is doing nothing to change it. This provider is supposed to deal with decreased operating reimbursement and yet no relief is offered as to a property rate that is admittedly inadequate.

COMMENT: Our facility is undertaking a remodeling and construction project. A contract has been awarded and financing has been obtained. We will lose $190,666 under the current property system.

RESPONSE: The department has not "conceded" that the referenced rate is too low. The department questions whether the suggested losses will in fact occur. However, the area of new construction and remodeling will be addressed by the working committee appointed to study property reimbursement.

COMMENT: Use of excess acute care beds must remain a viable option in areas where nursing beds are needed. The payment formula is discouraging to those facilities attempting to meet resident needs and keep acute care services available in rural areas.

RESPONSE: Evaluation of need for nursing beds is performed by the Department of Health and Environmental Sciences through the certificate of need process. If need exists in the community for long term care beds, the acute care facility should consider having excess acute care beds certified as nursing facility beds. An alternative may be swing bed certification

for circumstances when there are no long term care beds available within 25 miles of the discharging hospital and the need for long term care services exists. Both of these uses of excess acute care beds would meet resident needs and serve to keep acute care services available in rural areas.

12. Other System Features

a. Rate Increase Cap

COMMENT: The proposed $8.00 cap on rate increases severely limits the extent to which the proposed system meets the desired objectives of meeting Boren Amendment requirements and more equitably and fairly reimbursing individual nursing facilities. This is an arbitrary cap which has been adopted to stay within budget limits, as indicated by the department's August 14 memorandum stating that the operating cap and increase cap were lowered to redistribute funding. This is a blatant example of rates being set based upon budgetary constraints, contrary to the Boren Amendment. This cap is unreasonable and discriminatory among providers. The system recognizes costs up to the operating and direct nursing personnel limits and pays these costs for some facilities; yet for others it arbitrarily pays less than these amounts.

COMMENT: The state has told us we are entitled to $97.73 per day. This was arrived at by capping nursing costs at 140% of the median and administrative costs at 110% of the median. We were then told the state could not sustain these costs and another cap of $8.00 was imposed. This is a cap on a capped rate. Given the amount of money we are losing, a Boren challenge may be a viable alternative in the future.

RESPONSE: The department originally proposed a $9.50 cap on the amount a facility's rate could increase from FY 1991 to FY 1992. The department, in response to provider comments received prior to the rule hearing, proposed revisions in the direct nursing methodology and proposed reduction of the cap to $8.00. The proposed system will implement a large increase in aggregate funding. The department believes that sudden increases beyond this level would encourage poor spending decisions by providers which suddenly received such large increases. The cap, along with a 5.5% minimum increase provision, is included as a transitional measure designed to avoid wide swings in reimbursement from FY 91 to 92.

The department does not believe that the compliance of a reimbursement system with the Boren Amendment can be measured on the basis of any single feature of the system. Rather, the overall process used to determine rates and the overall rates must be measured against the requirements of the law. Further, although rates may not be determined based solely upon budgetary considerations, states may consider budgetary factors in setting rates. The department believes that when

viewed together with all other parameters and features of the proposed rate system, the cap is reasonable and results in rates which comply with the Boren Amendment.

The commentors' conclusions that the cap violates the Boren Amendment are based upon the erroneous assumption that the rates generated without the cap are linked to the department's determinations regarding the facilities' economy and efficiency. This assumption is incorrect. The rate component ceilings (125% of the median direct nursing personnel cost and 110% of the median operating cost) that are applied before application of the cap are not intended as proxies for the levels of efficient or economic cost or "cost that must be incurred." These standards were defined and applied through a different analysis, which compares rates after application of the cap to the level of costs that must be incurred for each facility. Thus, use of the cap is not an abandonment of the department's standards of economy and efficiency for purposes of staying within the budget. Further, the earlier use of higher percentages in various analyses and proposals did not represent judgments about the level of cost that must be incurred, but rather reflected an attempt by the department to recognize the full cost of as many providers as possible.

Moreover, the level of available appropriations corresponds to department estimates of the funding levels necessary to meet Boren Amendment standards. Thus, even if the $8.00 cap were related to the department's budget, the department's use of the $8.00 cap was not driven by budgetary factors established without regard to Boren Amendment requirements.

COMMENT: How were the $9.50 cap in the original proposal and the $8.00 cap in the revised proposal determined?

RESPONSE: The cap represents the department's effort beyond mere compliance with legal minimums, to make overall rates more equitable. The original $9.50 cap was determined based upon a sensitivity analysis with a goal of minimizing the number of facilities which would experience a rate decrease under the proposed system. This analysis was performed with respect to all facilities and was not targeted at any particular group of facilities. After adjustments to other rate components, such as addition of the wage floor and changes in operating and direct nursing percentages, the department performed a similar analysis to arrive at the $8.00 cap. The department believes these adjustments were made within a discretionary zone of reimbursement which exceeds the minimum level of reimbursement required by law.

COMMENT: Has the department done study or analysis to show why facilities which need large rate increases to be paid at the level set by the proposed reimbursement system are less economic and efficient than other facilities? If so, we ask that the department provide us with the analysis.

RESPONSE: The department has performed an analysis to determine the costs that must be incurred by each facility. That analysis demonstrates that the department's rates after application of the $8.00 cap and 5.5% minimum increase are reasonable and adequate to meet the costs which must be incurred by economically and efficiently operated facilities. This analysis implicitly establishes that facilities with costs above the capped rates are incurring uneconomic and inefficient costs. A copy of the analysis is available upon request from the department.

COMMENT: The department should not reduce the cap to $8.00 to fund the wage floor because the department cannot afford the wage floor in light of losses that will be incurred by facilities and because the wage floor simply insulates facilities from financial risk. Further, the facilities that benefit from the wage floor already receive adequate overall rates without the floor. Nine of the 13 facilities affected will receive rates more than $9.00 over cost. The wage floor is unnecessary. Any changes in the rate should be paid for through lower incentive payments and profit margins. The rule should provide that the cap will apply only for FY 1992 rates.

RESPONSE: The department has adopted the wage floor for several reasons. The department believes the component should take into account the minimum wage levels which providers are legally required to pay. The department also believes that to pay a nursing component which is less than adequate to meet legally required minimum wage levels would undermine the department's otherwise extensive efforts to encourage improvement in quality of care. The department believes the wage floor is justified for these reasons. The department believes the combination of cap levels, percentage of median limitations and other parameters adopted in the final rule best achieve all of the department's objectives, including overall fairness and equity. It has not yet been determined whether a cap will be employed for rate years after 1992.

COMMENT: The department should consider placing a cap on medicaid profits (probably 2% or less) until the rate increase cap is ended. Providers should not expect to make unreasonable profits from a governmental welfare program, while there are insufficient funds to properly pay for all medicaid services or cover costs of all facilities. Any reduction in the $9.50 cap should be matched by an upper limit on profits. Any excess payments should go to property reimbursement.

RESPONSE: The department believes the new system in fact does limit profits in the operating and direct nursing areas. A provider cannot receive more than projected operating costs plus the incentive payment in the operating cost area. A provider cannot receive more than projected costs times the patient assessment score in the direct nursing cost area. The department does not believe the proposed system allows payment

of excessive profits and the department will not place a further cap on profits or otherwise make adjustments premised upon an assumption of excess profits at this time. This issue may be further addressed through the committee appointed to further study the reimbursement system.

b. Minimum Rate Increases

COMMENT: The department's proposals generate rate decreases for some facilities and very small increases (under 5.5%) for others. In light of the utilization fee, which amounts to nearly a 2% increase in costs, and in light of substantial increases in facility costs since 1989, the base year used in the proposals, no facility should receive less than a 5.5% increase in its rate. This is the percentage increase for inflation used by the department in its original proposal.

COMMENT: The minimum rate increase for any facility should be the DRI inflation factor (5.5%) plus $1.00 to account for the bed fee. This proposal is fair to the industry as a whole, would not require any facility to pay any more in bed taxes than it receives in return, and would give the department another year to study and implement a new methodology. This would also insure that no facility is seriously disadvantaged because of the department's need to do further study.

RESPONSE: The department does not agree that a minimum percentage increase should be given to account for payment of the nursing facility utilization fee. However, the department does believe that all providers would receive at least a modest increase for rate year 1992. For this reason and as a transitional measure, the department has adopted a minimum 5.5% increase, equal to the DRI inflation index, in the final rule.

COMMENT: Because of the variability of costs, flat fee increases would be inappropriate. It would simply add profit dollars for providers already being paid over cost and would continue underfunding for those paid below cost.

COMMENT: The department must not guarantee the financial performance of a few providers. Grandfathering, hold harmless and other transition strategies simply attempt to protect the status quo. There is no justification for providing minimum rate increases to some facilities while other facilities are faced with limits on their rates.

RESPONSE: The department agrees that transition strategies should be employed with caution. If overused, such mechanisms may undermine the validity of rates by not allowing the established methodology to work. The department has adopted a minimum rate increase provision and a maximum rate increase provision. The department believes these modest measures enhance rather than detract from the overall fairness of 1992

rates, and these measures are taken into consideration in the department's findings that the actual rates meet or exceed the levels required by federal law.

13. Fair and Equitable Rates To Individual Facilities

COMMENT: The proposed system provides a more fair and equitable methodology than currently exists. The proposed system is fair and needs very few changes.

RESPONSE: While the department agrees that the proposed system is more fair, equitable and reasonable, we must continually evaluate the system for improvements. The department will be forming a working committee to continue to evaluate the methodology for reimbursement as well as to specifically evaluate the system of property reimbursement.

COMMENT: Because costs vary for numerous and legitimate reasons from facility to facility, a universal payment rate is neither fair nor equitable. Such a system would merely perpetuate or worsen the inequities of the current system. There is no such thing as a perfect payment methodology. To determine fairness, one must look at the methodology in its aggregate and not at each component separately. The key to fair and equitable reimbursement is to reimburse costs. The proposed system does a fair job of reimbursing cost, and provides incentives for facilities to contain costs while providing quality care.

COMMENT: We have heard the argument that the state should not pay our costs because as a higher cost facility we are inefficient. We would like the state to tell us where we are inefficient so we may address those areas and receive full reimbursement. The commentor lists various reasons why its facility is efficient despite the fact that some costs are higher than average. Differences in facilities are not explained by inefficiencies alone.

COMMENT: The department should be sensitive to the fact that combined facilities have taken years of losses under the system while waiting for changes in the rate formula. The proposed rule does not give combined facilities everything they want. Hospital facilities must meet unrealistically low spending levels to receive only modest incentive payments. Perhaps other facilities should now share in the burden of medicaid rates rather than having the system continue to be tilted to their advantage. Providers should not expect excessive profits from a tax supported program. Combined facilities will not accept the status quo any longer. A new direction is warranted and necessary. It appears the department has done a very good job in distributing the available funds.

COMMENT: Under the proposed system, some facilities will fully recover cost and perhaps earn a profit. Such facilities are receiving an appropriate payment from a publicly funded welfare program, regardless of rates paid to other facilities. We cannot support the status quo, where facilities are paid a prospective rate without any regard to actual cost being incurred for delivery of care. Most combined facilities will continue to lose money because the department still refuses to recognize the unique cost structure of combined facilities. Efficiency of these facilities must be measured by looking at the entire facility, not just the nursing facility portion. By combining services in one plant, these facilities provide efficient and economical health services to their communities.

COMMENT: Under the proposal, 25 facilities will lose more than $10 per patient day while 5 facilities will profit more than $10 per patient day. It would not be equitable or fair to increase the deficit of underfunded facilities in an adjustment effort which in turn provides a greater profit to other facilities.

RESPONSE: Differences in costs occur at all facilities for many reasons, such as management philosophy, type of ownership, occupancy, services provided, as well as the facilities' overall goals and objectives. A reimbursement system cannot fully allow all costs arising from the differences that occur. The department must consider the total picture and must evaluate the impacts of reimbursement decisions on the industry as a whole in order to reimburse facilities in the most equitable and fairest manner.

The department believes the proposed system in its aggregate is fair and equitable. It considers the actual costs being incurred in each facility, provides incentives to maximize quality of care, incentives to control cost and uses the patient acuity level at each facility in a more direct manner than the previous system. The new system uses a national inflationary index. The department's rule recognizes facility differences within a zone of reasonableness, while still limiting costs to reasonable levels.

The original proposal has been modified to implement a floor in the direct nursing component to recognize the impact of the minimum wage increases, to establish a 5.5% minimum rate increase from 1991 levels, to adjust the percentages to 110% for operating and 125% for the direct nursing component. We feel the resulting rates are equitable and address many of the concerns that have been raised by the industry.

The department will continue to evaluate the methodology over the next year through the use of a working committee to further fine tune the system of reimbursement. As part of the working committee there will be ongoing discussions regarding

the combined versus freestanding arguments surrounding costs and economy and efficiency.

COMMENT: Peer grouping would provide a more accurate comparison of providers' efficiency and would more closely reimburse facilities' cost. It would recognize inherent cost features of each type of facility. This might lead to more equitable motivation by the department to improve efficiencies.

RESPONSE: Peer grouping is used in many states to establish a rate for a class of facilities. However, peer groups are typically based upon particular type of resident served or the number of beds rather than upon the type of facility. The department analyzed peer grouping in its simplest form (combined, freestanding, and state) and the analysis indicated that there would be very significant differences in rates if providers were peer grouped. The differential between combined and freestanding facilities would be magnified with a peer grouping system. One of the complaints regarding the proposed system was that the variance in reimbursement between freestanding and combined was too great. The use of peer grouping may be discussed by the working committee on reimbursement.

COMMENT: Under the department's original proposal, facilities rate increases would not cover actual cost increases for some facilities, while others would receive whopping rate increases. The rates and rate increases cannot be correlated to existing cost efficiencies, patient acuity or any objective measure of quality of care or to any meaningful standard of efficiency, patient acuity or quality of care. The revised proposal is somewhat but only marginally better. Increases are still inadequate to cover inflation. This means that the facilities receiving inadequate increases will be unable under either proposal to compete effectively in the labor market or to offer comparable wage and benefit packages to facilities receiving large rate increases. Also, rate increases will be insufficient to cover increased costs incurred to pay additional benefits to employees gaining sufficient seniority to qualify for them. This will result in low employee morale, increased staff turnover, and an inevitable reduction in quality of care because of staff turnover.

RESPONSE: This comment assumes that (1) facilities' FY 1991 rates were set at the minimum amount necessary to reimburse actual costs; and (2) that the amount of rate increase must equal or exceed the amount by which costs have increased. These assumptions are incorrect. The current system essentially generated rates based upon averaging, with certain adjustments depending upon how the facility compared to statewide averages. In many cases, FY 1991 rates exceeded actual costs incurred by the facilities, indicating that the facilities were profiting from medicaid rates. On the other hand, some facilities were receiving rates far below actual cost.

The measure of medicaid rates is not whether the amount of rate increase covers inflation, but rather, whether the total rate is reasonable and adequate to reimburse the costs that must be incurred by efficiently and economically operated facilities. The comparisons made by the commentor provide no meaningful measure of rates generated under the proposed methodology.

The department believes that the rates do in fact correlate to reasonable standards of cost efficiency, patient acuity and quality of care. The department believes that use of the DRI index adequately accounts for inflation and that the direct nursing personnel cost component adequately accounts for wage and benefit costs. Contrary to the commentor's assertion, the department believes the proposed system will enhance rather than lower quality of care.

COMMENT: The department's proposal is controversial. Higher cost combined and governmental facilities (representing one third or less of the industry) tend to support the proposal because they would receive large rate increases, while most private and freestanding facilities (representing two thirds or more of the industry) object because the new methodology would be driven more by costs (including high costs) than by cost containment incentives and because they believe the allocation of rate increases is unfair. It is important that the rate methodology be fair and responsive to all types of facilities.

Data shows that under the department's proposals: (1) traditionally high cost facilities get the largest rate increases; (2) low cost facilities suffer because of their efficiencies; and (3) locally owned and tax paying facilities, which should be encouraged by any rational public policy, fare worse than other entities. By applying the DRI index to each facility's historical cost, high cost facilities receive larger increases to account for inflation, thereby widening the rate gap between high and low cost facilities. The department has not fully considered all of the factors that result in differences among facilities, such as higher workmen's compensation rates for freestanding facilities. The proposals need substantive revision if balance and equity are to be achieved.

COMMENT: The department should reduce the increase cap to $8.00, change operating median to $29.06, change direct nursing cap to 120% of indexed wages and benefits, index inflation to an average of $1.60 for all facilities, and add $1.00 to incentive for all facilities to account for utilization fee. This greatly reduces the difference between highest and lowest facilities. This meets the criteria of reasonable and adequate and meets the cost of efficiently and economically operated.

COMMENT: Combined facilities are not the standard of efficiency and economy. The department has stated in a letter to HCFA that combined facilities pay higher nursing wages and staff in excess of staffing requirements. Yet the proposed rule does nothing to correct this pattern of excessive spending. Government facilities also incur greater costs, yet the proposed rule does nothing to correct this excessive spending. By contrast, locally-owned private facilities historically have the lowest cost yet receive the lowest rates under the proposed system. This system will bankrupt locally-owned facilities. Certainly no facility should receive a rate reduction. Under the proposed rule, 8 of 9 facilities with a rate decrease are locally or regionally owned facilities.

COMMENT: The proposed rule inequitably distributes funding. Combined facilities receive and average increase of $2.13 more than freestanding facilities. Why the difference? At the same time freestanding facility PAS has increased 2.07% while combined facility PAS has increased 1.85%. Therefore, freestanding facilities should get higher increases than combined facilities.

COMMENT: The real test of fairness is whether the system meets Boren Amendment requirements. The best value is the most efficient facilities. Because less money would go to locally-owned facilities than state-owned facilities (a difference of $6.468), the proposed system does not meet the test of efficiency.

COMMENT: There is appropriated funding available to increase rates an average of $6.75 per patient day. Without the efforts of MHCA, there would only be $2.83 per patient day available. The MHCA represents big numbers and diverse types of providers. It must always look at the good of the whole, not just one small faction. Under the department's proposal, non-MHCA members receive higher average increase than MHCA members. Combined facilities receive greater average increases than freestanding. Freestanding facilities had a greater increase in PAS than combined facilities. Under the 5% band proposal, MHCA member facilities receive nearer to the amounts non-members receive and freestanding facilities receive more than combined facilities. The 5% band proposal is more equitable. The department's proposal is seriously flawed, so providers won't really get the rates suggested by the department, even without MHCA input. If members just fight for their own interests and don't support the MHCA 5% band proposal, members could receive worse rates. Providers should support the 5% band proposal.

COMMENT: The proposed system does not provide for equitable distribution of funding among facilities. Lower cost facilities receiving lower increases will not be able to compete for labor or market share with higher cost facilities getting larger increases. The rate our facility would receive

under the proposed system will not allow needed improvements or staff raises. We cannot raise private pay rates enough to make up the difference because we have very high medicaid utilization. We worry about the survival of our facility.

COMMENT: Myers & Stauffer in their report stated that if a number of facilities are producing substantially similar services, its seems only logical for an agency concerned about economy and efficiency to establish payment levels at the lower end of the cost spectrum. How do they explain giving greater increases to higher cost facilities and lower increases to the lowest cost facilities?

RESPONSE: A significant distinction must be made between rate and cost. The valid comparison is between reimbursement rates and the projected cost which must be incurred. With the system being rebased to more current costs, the attempt to correlate rates to prior rates is not a meaningful comparison. It is true that the proposed system of reimbursement is more responsive to actual costs, but it is also true that there are limits on reimbursement in each of the components so that excessively high costs are not reimbursed. Low cost facilities do not suffer because of their efficiencies. Their lower costs are used to establish the reimbursement levels and they may qualify for an incentive payment due to their cost containment. Further, low cost facilities are being helped by the wage floor in the direct nursing component, and in the implementation of the minimum floor of 5.5% over the fiscal year 1991 level of reimbursement as a transitional reimbursement measure.

An analysis of locally owned freestanding facilities shows that they are receiving a higher percentage of rates in excess of costs than the combined facilities. The analysis of average reimbursement increases for 1992 indicates that there is little differential in the reimbursement between facility types. This indicates that there is not an inequity in the distribution of the funding.

Average total dollar rate increase combined	$ 7.36
Average total dollar rate increase freestanding	$ 6.51
Variance	.85

Historically, combined facilities as a group have received reimbursement at 8 or 9 percent above freestanding facilities as a group, even using the current system of reimbursement. The new system does not make a great change in that differential.

Application of the DRI treats all facilities costs in the same manner and does not index high cost facilities at a greater rate. If high costs are excessive (over the limits), they are not fully reimbursed, and there will be no encouragement to incur such costs.

The analysis of the current system of reimbursement with a 5% band was requested by several commentors. This analysis was not intended as a representation of what actual reimbursement rates would be utilizing the current system with a 5% band. The department did not propose this analysis as a reimbursement option, and it does not include any of the modifications the department would consider if continuing to use the current system of reimbursement. The MHCA analysis of MHCA member rates and MHCA non-member rates under either system of reimbursement has no validity or merit in the establishment of a reimbursement methodology. A system cannot be designed to reimburse one organization's membership differently than another's no matter how strongly they lobby or would like to believe that they are more deserving of higher rates.

COMMENT: Higher nursing facility costs are due partly to the hospital DRG system. There is no incentive to incur costs in the hospital portion of a combined facility because the DRG system is not cost based, so costs are shifted to the nursing facility portion. The commentor stated that if the proposed system is implemented, his primary goal will be to increase and shift costs to the nursing facility associated with his hospital facility. Allocated costs are too high compared to the actual costs incurred by nursing facility portions of combined facilities.

RESPONSE: Facilities must keep in mind that costs must be directly related to patient care and verifiable through audit. Allocation statistics will also be verified through an audit and will be adjusted to comply with the HIM-15 guidelines for cost reporting and cost allocation. While in theory this may sound like an advantage, providers must keep in mind that reimbursement will be subject to the limits in the operating and the direct nursing personnel components. By shifting costs to the nursing facility, a provider may jeopardize its ability to receive an incentive payment and may lose rather than gain money. By shifting costs from the hospital, they may even jeopardize the computation of costs used to establish hospital reimbursement under medicare and medicaid. This is a big gamble because future rebasing may shift the medians and the percentages that will be applied to the reimbursement limits for each of the components. The department does not agree that nursing facility costs in combined facilities are unfairly recognized to the disadvantage of freestanding facilities.

COMMENT: Under the original department proposal, of 98 facilities participating in medicaid, only 9 would have a rate decrease and 7 of those 9 would still receive a rate that exceeds projected cost and the other two would receive a rate that approximates cost. In FY 1991 only 19 providers received a rate that equalled their reported cost, whereas under the proposed system 45 would receive a rate that equals their

reported cost. The proposed system is fair and meets the requirements of the Boren Amendment.

COMMENT: Nine out of nine facilities receiving a rate decrease had 1990 costs increasing more than the 5.5% inflation factor in the proposed rule.

RESPONSE: Under the system as finally adopted, all facilities will receive an increase of at least 5.5%. For reasons summarized above in responses to other comments, the department believes the system meets the requirements of the Boren Amendment.

COMMENT: Under the department's proposal, our facility would receive a rate of $6.87 less per patient day than our cost and we would have to raise private pay rates to make up the difference. This is not a just reward for being the third-lowest cost facility in the state and does nothing to encourage future cost containment. Under the department's proposal, the five lowest cost facilities would receive rate decreases. We will have to increase spending, raise private pay rates, pay less than minimum wage, transfer medicaid patients to other facilities, or close our facility. It would cost the state a lot more to provide care in a higher cost facility. Residents and their families would be unhappy if they had to move to a less desirable facility, especially at increased rates.

COMMENT: We have a 29-bed facility. My wife and I perform many of the duties in running the home, but because of OBRA can no longer keep up. Based on past costs, I cannot get a reimbursement to afford all the positions I have been doing myself. We cannot get nurses to work in the community. One RN will work for only one week per month and only on contract for $15 per hour plus $200 per month housing allowance and utilities. I pay more for help than the tax-supported non-profit facility across town, yet they get $20 per day more than my facility. Help me to continue providing care at a rate that will pay the bills.

COMMENT: Numerous facilities described specifically the rate they would receive, the amount of loss they believe they would incur under various proposals.

RESPONSE: If the provider's rate under the new system is in fact inadequate to meet reported costs, either the costs are not necessary, efficient and economic costs or there may be a cost reporting problem. The department has made it clear that it is willing to review cost report information used to set rates. The department believes that the new system provides providers with reasonable and adequate rates to meet the costs which must be incurred.

COMMENT: Smaller nursing homes have higher fixed costs per resident. The formula needs to include a variable to consider bed size or utilization.

RESPONSE: Because the department is using inflated actual per diem costs to calculate per diem rates, utilization is taken into account. However, the department also recognizes that certain economies of scale are available to other facilities. Actual costs are recognized up to a certain level, however, above the operating and direct nursing component limits these actual costs will not be reimbursed. The department does not believe it is appropriate to reimburse the inefficient costs which may be inherent in small facilities.

COMMENT: Under the department's proposal, there are unexplainable rate discrepancies in the same community (as high as $16 to $20).

RESPONSE: The department does not agree that these rate differences are unexplainable. The differences arise because of considerable differences between the specific facilities. The proposed system recognizes, within a reasonable range, the differences between different facility types and also recognizes differences in patient acuity and other factors, which may be quite substantial. The department's review and evaluation of the rates generated under the final rule does not support the commentor's assertion.

COMMENT: The proposed formula does not consider the impact of a tax base or large corporate structure in subsidizing losses. The availability of such subsidies encourages inefficiency, while independent facilities are forced to be efficient.

RESPONSE: The department disagrees with the premise of this comment, that tax supported and corporate-owned facilities have available unlimited funds to waste. Accordingly, the department disagrees with the comment.

a. "Current System" With 5% Band

COMMENT: Did Myers & Stauffer analyze the current system before they proposed the new system? If so, what year was used for the rebase? We understand the department used 1987 for the rebase and indexed 1982 data to set the bands. Did use of old data affect results? What are the major problems in using the current system with rebasing and a band? Why isn't it more equitable to use the current system rebased to 1989 or 1990? What features of the proposed system are superior to the current system rebased?

RESPONSE: Numerous scenarios involving the current system were prepared and analyzed by the department and its consultants throughout the process of developing the proposed reimbursement system. Undoubtedly, the use of "old" data affected the

results. The department also analyzed the current system with newer data. The commentor's remaining questions are answered in other responses in this document.

COMMENT: The department should fully rebase the current system using 1989 or 1990 cost reports, eliminating the geographic wage factor, and increasing the existing "band" from 1.25% to 5%. The rebase should include updating the fixed cost and average patient day parameters, statewide average patient assessment score, statewide average nursing care hourly wage, and OBRA increments. The department's spreadsheet on this scenario dated July 26, 1991 is based on this proposal and encompasses what we are recommending, although some changes are necessary to individual facility rates as shown on that spread sheet.

The department should also establish work groups including provider association and facility representatives to study, analyze and make necessary improvements to the department's proposals so that they can be considered for adoption in July 1992.

Several commentors stated that they support this proposal and consider it to be the most equitable at this point, even though they would receive a lower increase than under the department's proposal. They urge the department to work with the proponents of this system to adopt it for FY 1992.

The board of the Montana Health Care Association, which represents 75% of the beds in Montana, voted unanimously to retain the existing system with a 5% band.

COMMENT: A number of facilities commented that they are members of MHCA, yet were never asked their opinion on the 5% band proposal supported by MHCA and that they do not support that proposal. MHCA does not have the degree of support it represents on the 5% band proposal. Some facilities also commented that they are MHA members and do not support the position taken by MHA.

COMMENT: We do not believe the statement made by some proposal opponents that 70% of nursing home beds in the state support keeping the old system. We have found only one facility that does not support the new system and they had not yet had time to review the proposal.

COMMENT: The department should use the current system modified as follows: adjust 1987 or newer data for deflated value of OBRA and any other adjustments; use adjusted cost data to establish fixed and variable cost parameters through the use of regression analysis; establish appropriate bands as in prior years; index each provider's 1987 or newer costs forward to the midpoint of the 1992 rate year; add on OBRA and/or other adjustments; compare the indexed costs to bands,

and, if below low band, set rate at low band, if above high band, set rate at high band, or if between, set at cost figure; adjust for patient assessment as in prior years; incorporate a hold harmless or minimum increase where necessary, particularly in light of the bed tax issue (this will insure that providers whose rates have substantially exceeded costs in recent years will be limited to receiving only increases directly related to OBRA or other specific adjustments and over time the system will be self-correcting); and make no change to the property component.

While this is basically a continuation of the current system, the use of 1987 or newer cost information would bring the system back into touch with reality and use of actual cost data would remove the outrageous discrepancies between costs and rates which have developed over the years. The state would avoid large audit costs and legal battles inevitable under the proposed system. Increases in medicaid costs would more closely match true inflation in future years, rather than expanding at 50-75% over inflation as in the pre-1982 system. To insure that medicaid costs will not increase in excess of inflation, the department could index rates rather than costs after this one-time adjustment to cost. This would insure the state of absolutely predictable levels of expenditures, subject only to fluctuations in resident days. This simple scheme would give all parties a chance to develop an appropriate system. Adopting a poorly planned component methodology without research or planning just to "do something" is inappropriate. It will increase costs, cause confusion and fail to achieve the goals intended.

COMMENT: Our calculations show that the 5% band proposal would distribute the average $6.75 increase with an average $6.62 increase to combined facilities and $6.79 to free-standing. Wouldn't this be a more equitable distribution of the available dollars?

RESPONSE: The authors or supporters of these comments apparently would receive more favorable individual rates under the suggested scenarios, but such scenarios do not present a balanced approach to reimbursement across the spectrum of facilities. The commentors do not address how the suggested plans would meet legal requirements or even how they would better address the criticisms the same commentors have leveled against the proposed system. The suggested plans would merely continue the inequities of the current system. Such plans would continue to funnel profits to the commentors' facilities and would allow facilities to load cost reports while the department "studies" further. That is what makes delay such a sweet prospect for those who suggest it. Prior to and throughout the course of this rule proceeding, the department has thoroughly analyzed the basic system suggested. The department believes that the proposed system, as finally adopted, better achieves the department's goals and more

equitably takes into consideration the needs of all providers and provider types.

COMMENT: The department should give out the appropriated money through a flat across-the-board increase to all providers.

RESPONSE: The department disagrees because such a method ignores the requirements of federal law and merely perpetuates existing inequities.

COMMENT: We do not support keeping the old formula because we were never able to obtain a rate that was even reasonably close to fair.

COMMENT: Our facility is losing $12 per day under the current system and would take an additional rate reduction under the 5% band proposal. The original proposal would reduce the amount of loss we take to $6.08 per day.

RESPONSE: The department agrees that the proposed system is more equitable.

b. Provider Input Bias

COMMENT: The department should be cautious in its consideration of provider input because each provider offers an inherently biased perspective. The department must separate bias from fact and, because the department is the only neutral party, it ultimately must rely upon its own judgment in making a decision about the system.

COMMENT: Some freestanding facilities oppose the rule because they will not be able to make enough profit. Other facilities take a loss on medicaid patients. The proposed system is fairer because it helps facilities which have taken a big loss for a long time catch up or get closer to the break even point.

COMMENT: Some have tried to portray combined facility support of the proposal as selfish, contending they are not advocating in the best interest of all homes. This is not true. Our support reflects a belief that a welfare program should allow all providers, regardless of type, an opportunity to recover the cost of serving medicaid residents and earn a modest profit as well. The proposed rule does not fully accomplish that goal, but is a start in the right direction.

RESPONSE: The department agrees that comments must be evaluated in light of the commentor's interest in the outcome of the rule proceeding. The department has taken such matters into consideration and has independently evaluated the issues in reaching decisions about the reimbursement system. The department has attempted to take into account all viewpoints

and to find balanced solutions to the various issues and conflicts that have arisen in the course of designing the new system.

14. Miscellaneous Comments

a. Resident Funds

COMMENT: Federal law, as interpreted by HCFA, does not prohibit placement of resident funds of less than $50 in interest bearing accounts, so long as residents have convenient access to up to $50 when desired. The department should either remove from the rule references to separate interest and non-interest bearing accounts or change the proposal to coincide with the federal interpretation.

RESPONSE: Federal regulations at 42 CFR 483.10(c)(3)(ii) currently require that facilities must maintain resident funds of less than $50 in a non-interest bearing account or petty cash fund. Regional Identical Letter No. 91-34, issued by HCFA on May 15, 1991, states that this regulation was designed to permit facility flexibility in managing resident funds under $50 and to insure that residents have convenient access to $50 in cash within a reasonable period of time when requested. Therefore, HCFA states that a facility may place a resident's total funds, including those funds under $50, in an interest bearing account. However, facilities must maintain such amounts of cash on hand to allow such convenient access to resident funds up to $50 per resident. The final rule has been modified consistent with this HCFA interpretation.

b. Separately Billable Items

COMMENT: The department should allow billing of indirect costs of separately billable items. The cost finding rules adopted by the department require the allocation of costs to these ancillary cost centers. Failure to reimburse these costs lowers the profit incentive allowed by the department and may cause facilities to lose money.

RESPONSE: The department does reimburse indirect costs of such items through the per diem rate. These costs are reimbursed through the operating cost component. The department will not double reimburse these items by including an additional indirect cost component as part of the separate payment for these items.

c. Allowable Costs

COMMENT: Subsection (2)(a) of proposed Rule XX defines the term "allowable costs" as those costs which are reportable and which are "considered in determining the costs of providing medicaid nursing facility services." Would all costs "that must be incurred by efficiently and economically operated

providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards" be considered "allowable costs?" Does the department consider the utilization fee enacted by the 1991 legislature effective July 1, 1991 to be an "allowable cost?"

RESPONSE: All costs "that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards" are considered "allowable costs." The department's analysis shows that the rates generated under the new system will comply with this standard, even if one considers the utilization fee to be such a cost. The department considers the utilization fee enacted by the 1991 legislature effective July 1, 1991 to be an "allowable cost" in the sense that it is reportable. However, federal law prohibits the department from reimbursing such cost or including it in the cost base used to set prospective rates. Accordingly, the department cannot and will not do so.

COMMENT: Many salaried employees, such as supervisors, office staff, maintenance staff and administrators, do not and have not kept contemporaneous time records. Often these people have no ownership interest. Prior audits have never required contemporaneous time records. This adds needless paperwork and does not contribute to patient care. If not deleted, the department should provide specific guidance as to acceptable documentation.

RESPONSE: By "contemporaneous time records" the department means some documentation generated in the usual course of the provider's business at or near the time of the hours worked and which records the services performed or the time worked. For example, employees may prepare a weekly or monthly time sheet showing the hours worked, which is in turn used by payroll to prepare withholding and paychecks. Such documentation would be considered "contemporaneous." Other similar forms of documentation may be sufficient. The department believes that generally accepted accounting principles require keeping such records. The department would be surprised to find that facilities are willing to pay employees without some type of contemporaneous documentation to support the expense. The department will not accept documentation generated outside the usual course of provider's business which is essentially generated after the fact to support a claimed cost item. Claimed cost items should be based upon contemporaneous documentation, rather than generating "documentation" to support claimed costs.

d. Interim Rates

COMMENT: An interim rate under Rule XIII should be subject to the same cap and minimum rate as other rates.

RESPONSE: The department agrees and has added language to so provide.

e. Audits and Appeals

COMMENT: The proposed system is cumbersome because annual audits or desk reviews must be made and it will encourage an onslaught of appeals. If the department cannot handle the current appeal load, how does it propose to handle the increase?

RESPONSE: The department does not anticipate that the proposed system will require or generate an increase in the number of desk reviews or audits. The department does agree that providers will have more incentive to challenge adverse audit determinations. However, this is a necessary feature of a system that is more responsive than the current system to the cost experience of particular providers. The department believes that this feature is justified and that, in fact, the department does and will continue to handle its appeal load.

COMMENT: The proposed system will result in numerous and protracted disagreements and litigation as allowable costs and allocations once again become the subject of debate. Audit results will once again become immensely important because retrospective settlements will be required once audits are complete. This system will reverse the trend away from retrospective cost settlement and will resurrect problems solved ten years ago. This will increase costs for both providers and the program, while producing nothing of value for anyone except the firm that designed the system and other accountants and attorneys. The firm that suggested the proposed system suggested this system because it stands to benefit financially from audits and appeals. There will be conflict of interest problems because that firm both designed the system and will perform audits for the department.

RESPONSE: The department disagrees with the assertion that the use of costs report and audit information under the proposed system is of no value to anyone and will only resurrect old problems. Providers have continually complained that the current system fails to take into account facility-specific cost differences. The proposed system addresses that complaint by placing more weight on facility-specific cost information. The department believes this change will benefit providers. However, no reasonable system would rely totally upon unaudited cost information or fail to employ some controls to assure that providers accurately report costs. Without such checks, providers would be encouraged to inflate reported costs. Under the proposed system, audits and the resulting rate adjustments will provide necessary checks upon provider cost reporting. While providers will have more incentive to challenge audit determinations, the audit and rate adjustment features will provide incentives to accurately

report costs so as to avoid audit adjustments and rate reductions. Moreover, rate reductions will occur only if base period costs are adjusted, and not where actual per diem costs simply differ from projected costs.

These features were not adopted merely upon the suggestion of the department's accounting consultants, but rather were insisted upon by the department as means of assuring the integrity of the system. Moreover, the department disagrees with the contention that the role of the present audit contractor in designing the system creates any conflict of interest. Their experience in assisting with design of the system will certainly help them to more capably perform their audit function. But the auditors will perform audits only according to department instructions and subject to department review.

COMMENT: Did Myers and Stauffer study and provide the department with estimates of the audit costs, appeal costs, legal costs, associated with the retroactive adjustments? What do they estimate these costs to be? How high is it in other states where they have developed this type of system?

RESPONSE: The department did not ask Myers and Stauffer to perform such a study or to provide the department with such information. The department does not believe such an inquiry is warranted. Obviously, these features of the system will require some expenditures. However, the department believes such costs will be relatively minimal and will be justified by the benefits of the audit and rate adjustment features.

COMMENT: The department should be required to complete a desk review of each cost report within 9 months (another comment by the same individual says 6 months) of the date the completed cost report is submitted and any overpayments or underpayments should be completed within 60 days. The department deleted time requirements on desk reviews because the cost reports did not directly affect reimbursement. Since cost reports now will directly affect reimbursement, the prompt review of reports is critical. If the department cannot promptly review cost reports and revise per diem rates, it should not change to a retrospective system.

RESPONSE: The department will not place a time limit upon completion of desk reviews or audits. While the department agrees that such prompt completion of these functions is desirable, it is not always realistic given the limitations upon department staff and funding. Such a time limit would merely be a means by which providers would seek to escape repayment of amounts to which they were not entitled under the rules. The department does not agree that the desk review time limit was deleted because cost reports did not directly affect rates. Rather, it was done because the time limit might jeopardize federal financial participation if the dead-

line were not met. As stated elsewhere in this document, the proposed system is not a retrospective system and will not require audit and settlement of every cost report.

COMMENT: Providers are required to repay overpayments within 60 days. The department is required to reimburse providers "promptly" for underpayments. What is the definition of "promptly"? The department should have to meet the same 60 day requirement as providers.

RESPONSE: The department normally reimburses underpayments in a much shorter time than providers are required to repay the department. The department generally makes payment in the next payment cycle of its fiscal agent following a determination of the amount due. This is usually less than 15 days. The department believes this is a "prompt" reimbursement within the meaning of the rule.

e. Administrative Review and Fair Hearing Procedures

COMMENT: The penalty on providers for untimely appeal is loss of appeal rights. It is unclear what is the penalty if the department fails to respond timely. Would such a failure result in a finding favorable to provider?

RESPONSE: The result of the department's failure to timely respond would ultimately be decided by the hearings officer based upon the facts of a particular case. However, the rule is not intended to create a penalty upon the department for failure to timely respond. While the department will make every effort to respond timely, we do not believe that lack of a timely response warrants allowing a provider to keep public funds to which it is not legally entitled.

COMMENT: The proposed procedures for contested cases are burdensome and unworkable in the administrative forum. The pleading requirements, notice procedures and time frames are more rigid and formal than in either state or federal district court. The proposed rules are inconsistent and conflict with the Montana Administrative Procedure Act (MAPA), are not reasonably necessary to effectuate the purposes of MAPA, are contrary to the Attorney General's model rules, and are inconsistent with other department rules. Section 2-4-201(2), MCA requires each agency to adopt rules of practice, not inconsistent with statutory provisions, setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the agency. MAPA authorizes the Attorney General to adopt model rules of practice and procedure to be used by state agencies as a guide in fulfilling the requirements of section 2-4-201, MCA. Agency rules of practice must be consistent with MAPA contested case provisions, must be reasonably necessary to effectuate the purpose of such provisions, and

must be within the scope of authority conferred by section 2-4-201(2).

RESPONSE: The department disagrees. The proposed rules are not inconsistent with or in violation of MAPA, but are reasonably necessary to effectuate the purposes of both MAPA and the statutes implementing the medicaid program. To the extent the rules conflict with the Attorney General's model rules, if at all, the department points out that those rules are not legally binding except to the extent they have been adopted by the department. However, the department has, as outlined below, made some revisions to the rules as proposed in response to these comments. These points are discussed in greater detail in the following comments and responses.

COMMENT: Proposed 46.12.1210 requires submission of two separate requests before a provider can obtain a fair hearing. The first request is for an informal administrative review. If the provider is unsatisfied with the result, the provider must make a second written request for a hearing. This is beyond the scope of authority conferred by MAPA, contrary to the Attorney General's Model Rules, unreasonable and burdensome. Nothing in MAPA, AG model rules, or general department procedural rules requires two requests. The administrative review process is automatic for claimants and providers under the general departmental rules. The department should consider eliminating the requirement that two requests be made for a hearing.

The mandatory administrative review procedure is beyond the scope of authority conferred by MAPA. MAPA makes informal administrative proceedings optional alternatives to contested case proceedings when the parties jointly waive formal proceedings. Further, in informal proceedings under MAPA, written decisions must be provided in 7 rather than 60 days.

RESPONSE: The rules do not require two separate requests for a hearing. Rather, the rules require that a provider request an administrative review if it disagrees with the department's determination. Then, if the provider wishes to request a hearing, only one request is required. While this procedure differs for medicaid recipients, the department does not believe that the same procedures are necessarily appropriate for both providers and recipients.

The department believes it is authorized to require the separate administrative review procedure. Section 53-6-113 (1), MCA requires the department to adopt appropriate rules necessary for administration of the medicaid program. Given the large number of providers and potential disputes arising out of determinations of provider reimbursement, audits, patient assessment scoring, medical necessity and many other issues, the department believes it is necessary to establish a method by which to avoid unnecessary litigation. Otherwise,

the amount of litigation would bury the medicaid program. The department believes that administrative review is a benefit to both providers and the department, to the extent the parties truly desire to resolve a conflict short of litigation. It assures that the department has considered all pertinent information and authorities. It provides an informal opportunity for the parties to review and discuss the issues prior to formal and more costly litigation. This is not unreasonable or burdensome to a party who desires to resolve rather than protract a dispute. Moreover, if a party does not wish to be burdened, it may simply file a statement of its objections to the department's determination and, without further effort, allow the department to complete the review.

MAPA does not prohibit such a requirement. MAPA authorizes and requires agencies to adopt rules setting forth the nature and requirements of all formal and informal procedures available. The authorization is not limited to rules relating to contested case proceedings and extends to the informal administrative review which the department finds necessary to assist in managing disputes which arise in administration of the medicaid program. Moreover, the MAPA provisions relating to informal administrative proceedings do not apply to the administrative review. The MAPA provisions apply only where the parties voluntarily agree to waive formal contested case procedures in favor of an informal proceeding. Accordingly, the 7 day limit is inapplicable.

The department intends to undertake in the near future a review and revision of all of its procedural rules. Although the department believes it is authorized to require administrative review, we will consider, as part of this overall review, changes in this longstanding practice of requiring administrative review. At this time, the department is not favorably disposed to eliminate the requirement.

COMMENT: The time frame for requesting an administrative review and fair hearing should be 90 rather than 30 days. Claimants have 90 days to request a hearing. Providers dealing with complex issues of medical necessity, cost reporting and reimbursement should be allowed the same reasonable time frame of 90 days. If not, the department should amend the rules to allow an extension of time beyond the 30-day time period to request a hearing. The rule as written does not allow such extensions.

RESPONSE: The department believes that 30 days is an adequate period of time for a provider to evaluate a determination and, if appropriate, present a request for administrative review or fair hearing. By the time a provider receives a department determination, it is usually quite familiar with the issues as a result of previous discussions, correspondence or proceedings with the department regarding the matter. Providers are generally more sophisticated than medicaid recipients and have

access to legal or other advice necessary to review the matter. The department believes 30 days is adequate to specifically identify any legitimate issues arising from the determination.

COMMENT: Why is the department changing the rule to require filing of an administrative review request within 30 days of mailing of the department's written determination? This change and the requirement of more documentation place an additional time burden on provider staff and discourages efficiency and effectiveness. In considering rule changes, the department should keep in mind how to simplify documentation and reporting procedures.

RESPONSE: The date of mailing is more easily ascertainable than the date of receipt, which is often impossible to determine with certainty. The documentation requirements for administrative review have been eased somewhat in the final rule. The point of the documentation requirement is not to burden the provider, but rather to give the provider an opportunity to submit additional documentation that may not have been considered previously by the department. The provider is not required to submit additional documentation for the administrative review. It may be to the provider's advantage to submit additional documentation to persuade the department that the provider's arguments have merit. If the provider wishes to forego this opportunity, that is the provider's choice.

COMMENT: Providers requesting fair hearings should not be required to identify the individual items and amounts in disagreement, give the reasons for the disagreement and furnish substantiating materials and information before being given an opportunity for a hearing. These requirements are overly burdensome, highly technical, inconsistent with MAPA and not reasonably necessary to effectuate the purposes of MAPA. A provider may be dependent on a patient's family to provide substantiating evidence to support an appeal. Delay in production of that evidence may result in a lapse of the appeal deadline. These requirements are more demanding than notice pleading requirements under state and federal rules of civil procedure. MAPA requires only a short and plain statement of the matters asserted. 2-4-601(2)(d). The rule should be amended to require only a short and plain statement of the matters asserted. The rule should require more specificity as to the reason for appeal, but should not create barriers to the appeal process. The requirements of the proposed rule overlook the fact that discovery is allowed in contested cases. Discovery would be unnecessary if the provider could meet these requirements in the hearing request.

RESPONSE: The proposed rule was not intended to require the degree of specificity suggested by the comment or to create a bar to submission of further evidence or raising of additional

issues. Rather, the purpose is to require a short and plain statement of the reasons the provider contends the department's determination fails to comply with applicable law, regulation, rule or policy. It is not sufficient to simply state that the provider disagrees or wishes to appeal. Specific reasons must be stated. The rule has been revised to clarify this requirement. The rule has also been revised to delete the requirement that substantiating information and documentation be provided with a fair hearing request.

COMMENT: The proposed rules do not provide for discovery. MAPA requires that discovery be available.

RESPONSE: As the commentor knows, the department's rules do provide for discovery as required by MAPA. See ARM 46.2.209 (5). A provision has been added to clarify that the provisions of Rule XXV and 46.12.1210 are in addition to the applicable provisions of ARM 46.2.201, et seq., and that the provisions of Rule XXV or 46.12.1210 control in the event of a conflict with ARM 46.2.201, et seq.

COMMENT: There is no authority under MAPA or the AG model rules for a hearing officer to summarily dismiss a hearing for the reasons allowed in the proposed rule. This is not reasonably necessary to effectuate the purpose of MAPA. The exercise of this right would also violate procedural due process by depriving the provider of the right to a hearing or to correct any technical pleading errors which serve as the basis for the dismissal. The dismissal authority should be removed from the rule. The dismissal authority should be amended to conform to 46.12.205, which already applies. If the department is unwilling to change this rule, it should clarify that dismissal is without prejudice to refile correctly.

RESPONSE: The department disagrees. The provider has the right to a hearing, subject to following the rules for requesting a hearing. There is not necessarily a due process or MAPA violation where a proceeding is dismissed because a provider has failed to follow such rules. In a particular case, a provider may argue that such would be the effect if dismissal were granted. A provider whose request has been dismissed may refile to the extent the deadline for filing has not expired.

COMMENT: 46.12.1210(2)(e) is unclear as to when and how many copies of the hearing request and substantiating information must be furnished by the provider. It is unreasonable to require providers to submit copies to both the hearings officer and the division under 46.12.1210 when providers under 46.12.202(2) need submit it only to the hearing officer. A consistent uniform procedure for all providers makes more sense.

RESPONSE: The rule has been revised to clarify that only one copy of the hearing request need be served by the provider upon the medicaid services division and that the copy must be served within 3 working days of filing the hearing request. The department will be reviewing its procedural rules in the near future and at that time will seek, to the extent possible, to create one uniform process for all providers. It is likely that the uniform rule will require all providers to serve a copy of the hearing request upon the medicaid services division.

COMMENT: The 15-day period for appeal to the board is unreasonably short. The provider may not receive the decision until four or five days have already expired. Weekends and holidays may add to the delay. The provider and their legal counsel must then analyze the decision and decide whether to appeal. There may not be enough time remaining to timely file. Thirty days would be a reasonable period. Some provision allowing an extension must be made.

RESPONSE: The department has revised the rule to allow a 30-day period for filing a notice of appeal. The department does not agree that an extension period is necessary. By the time the proceeding reaches the appeal stage, the parties are sufficiently familiar with the issue to make a decision regarding appeal and to file the notice within the required time.

COMMENT: Providers should not be required to submit a separate notice of appeal to the hearing officer and the division. Both offices are part of the same department. One should be enough. The department should decide where it wants the notice filed. Also, is there a difference between providing copies and serving notice in the different parts of the rule?

RESPONSE: The Office of Fair Hearings is attached to the department for administrative purposes only. It is not an integral part of, but rather maintains independence from, the medicaid services division. It is standard practice for parties filing complaints or appeal notices to serve a copy upon the opposing party. This requirement will not be deleted. The rule has been revised to consistently require service of a copy of the request or notice. "Service" is intended in the same fashion it is used under the Montana Rules of Civil Procedure.

COMMENT: A provider should not be required to set forth specific grounds for appeal. MAPA requires only the filing of exceptions to the proposed decision. Then a party may file briefs and present oral argument. Filing exceptions means merely identifying the decision appealed from. The specific grounds for appeal are more properly set forth in the briefs and arguments.

RESPONSE: The department disagrees with the commentor's interpretation of the MAPA reference to "exceptions." By the time the proceeding reaches the appeal stage, the parties are sufficiently familiar with the issues to specify the alleged errors. This assures that providers will consider in a principled fashion whether an appeal is warranted and will give notice to the department of the basis for the appeal.

COMMENT: The proposed procedural rules add yet another conflicting level to the various procedural rules applicable to medicaid providers. The reference at 46.12.202(3) should be updated to reflect the new rule for nursing facility providers. Providers are subject to the procedures at ARM 46.12.201, et seq., with respect to certain appeals and ARM 46.12.1210 for others. It is unclear under which procedural rules appeals are to be taken under ARM 46.12.307(3). Because a provider may appeal on behalf of a recipient under ARM 46.122.307(4), a provider should be entitled to the same procedural rules as recipients in such cases. Does the rule in ARM 46.12.307(4)(a), which prohibits providers from appealing medical necessity determinations, apply to the inpatient psychiatric program? The department routinely accepts such appeals. Which of the department's procedural rules apply to medicaid providers contesting department finding regarding medical necessity? The department should adopt one uniform hearing procedure applicable to all medicaid providers and covering all issues relating to such proceedings.

RESPONSE: The department has added language to Rule XXV and 46.12.1210 to clarify that the provisions of Rule XXV and 46.12.1210 are in addition to the applicable provisions of ARM 46.2.201, et seq., and that the provisions of Rule XXV or 46.12.1210 control in the event of a conflict with ARM 46.2.201, et seq. As the commentor knows, the department has not applied ARM 46.12.307(4)(a) to prohibit providers from appealing medical necessity determinations. The department intends to review and update in the near future all of its procedural rules. At that time it will consider the issues and questions raised and, to the extent possible, will adopt one uniform procedure for all providers.

COMMENT: If the rules at ARM 46.12.1208 through 1210 apply only to inpatient psychiatric providers, they should be relocated to the inpatient psychiatric rules at ARM 46.12.590, et seq.

RESPONSE: The department agrees. This change will be made at another time when all the affected rule provisions can be addressed in the first rule notice.

COMMENT: The commentor agrees that appeals from fair hearing decisions should be heard by the Board of Social and Rehabilitation Appeals rather than the department director. The board provides a more independent forum for appeals.

RESPONSE: The department agrees.

f. Other Miscellaneous

COMMENT: The language of Rule XV(1)(n) and (o) is unclear and confusing.

RESPONSE: The department agrees and has clarified the language.

COMMENT: Rule III((1)(c) should require that certification be in the same category as the care being provided.

RESPONSE: The department agrees and has added language to so provide.

COMMENT: The reference in Rule IX(2)(a) to the federal OBRA laws should include a reference to OBRA 1990, which is currently omitted.

RESPONSE: The reference has been included in the final rule.

COMMENT: Rule XII(2) is grammatically incorrect.

RESPONSE: The sentence has been revised.

COMMENT: Rule XVI(5) incorrectly refers to Rule XIX, when it should refer to Rule XXII.

RESPONSE: The error has been corrected.

COMMENT: Rule XVII(4)(d) incorrectly refers to ARM 46.12.1302, when it should refer to 1301.

RESPONSE: The error has been corrected.

COMMENT: Rule XVII(4)(d)(i) should be revised to clarify that the screening is necessary only as required by the screening rules.

RESPONSE: The department agrees and has added clarifying language.

COMMENT: Rule XXV(3)(e) incorrectly refers to the "board director" rather than the board.

RESPONSE: The error has been corrected.

15. Process Used to Develop Proposal

COMMENT: The department has performed a careful, thorough and deliberate review and analysis of the issues. The SRS staff has reflected on the strengths and weaknesses of the current system, they have obtained the assistance of knowledgeable

consultants and have sought the input of providers and their professional organizations. This approach is appropriate and has resulted in a quality product.

RESPONSE: The department agrees.

COMMENT: Development of an entirely new reimbursement system requires far more time, research, analysis and input than has been available during this rulemaking process. The proposals have been developed far too hastily and without sufficient analysis and backup data. The components of the proposed system contain major flaws which the department is trying to hastily correct with a "band-aid" approach in order to have a new methodology in effect for FY 1992. Arbitrary caps and limits are included for which there is no well-defined or well thought out basis. The shortcomings in the rule must be reviewed, addressed and corrected before any permanent change is made.

RESPONSE: The department strongly disagrees with this comment. As described above in other responses, the proposed rule resulted from a lengthy process involving considerable study, evaluation, discussion, debate and other factors.

COMMENT: Has the department done any projections or studies of the effects of the new rule? If no, why not? If so, what were the results and can we have them?

RESPONSE: The department has done numerous projections and studies, some of which are described in these responses. Any of the numerous documents prepared by the department are available upon request from the medicaid services division. We will be glad to provide copies, subject to department policies regarding payment of costs, if you will identify specifically what items you are requesting.

COMMENT: The department was strongly committed in advance to the proposed system. The department should not let its emotional attachment to the proposed system and the desire of its staff to have their own system in place lead it to make a costly mistake. The feeling is that the department is going to adopt the proposed system right or wrong, fair or unfair, and regardless of problems.

RESPONSE: The department began this process without any attachment to a particular reimbursement approach. By the time the proposal was first published, a considerable amount of work had been done to consider and evaluate various approaches. The department has already considered many of the issues and criticisms which were later raised. Accordingly, the department believed the proposed system met many of the department's objectives. However, the department remained committed to considering alternatives and criticisms. Indeed, the department has adopted numerous revisions to the proposed

system as a result of dialogue with interested parties. The department understands that many providers are opposed to the proposed system because they would like to receive a higher rate. The department has taken into consideration all comments and where valid criticisms and suggestions about the methodology have been made, the department has attempted to accommodate them. The department believes the process has been open, fair and constructive.

COMMENT: Providers have worked to build relationships between freestanding and combined facilities. The issues raised by the proposed formula pits classes of providers against each other. This is divisive and destructive to relationships.

RESPONSE: The department has not intentionally divided any such classes. The department is aware that disagreements exist among various provider groups as to the most desirable reimbursement methodology, and that any proposal regarding nursing facility reimbursement is unlikely to be agreeable to all providers. The department has attempted to take into consideration all viewpoints and interests and to find balanced and fair solutions to the issues. The department has attempted to bring all classes of providers into the process, as well as other interested groups such as residents. The department believes the final rule accommodates all interests in a fair and equitable manner.

a. Adequacy of Notice

COMMENT: By revising its proposal on the day before the hearing, August 14, and only eight days before the deadline for written comments, the department may have violated the Montana Administrative Procedure Act (MAPA). Section 2-4-302, MCA requires detailed written notice well in advance of the hearing or the date for submission of written comments.

RESPONSE: The department has met or exceeded all requirements of MAPA in this rulemaking proceeding. On July 25, 1991, the department published the required notice in the Montana Administrative Register (MAR Notice No. 46-2-671). Section 2-4-305 (1), MCA allows a rulemaking agency to adopt a final rule with substantial differences from the rule as originally proposed, so long as the differences are described or set forth in the adopted rule as printed in the Montana administrative register or in the statement of reasons for and against agency action.

The department developed the August 14 proposed revisions as one potential response to a considerable amount of comment that had been received to date. However, some persons affected by the rule would not have had an opportunity to comment upon those revisions and others would not have had an opportunity to see how the department might respond to those comments if the department had not given the additional information on August 14. The department was not legally required

to inform anyone of the proposed revisions unless the department finally decided to adopt them. The department could have adopted the proposal as amended by the August 14 revisions without giving notice of the revisions until publishing of the final notice. However, the department wished to do more than legally required, and accordingly gave interested persons an additional opportunity to comment on one specific manner in which the department believed it could address certain comments received as of that date.

The department has afforded far more opportunity for input and comment than the law requires. The department's various officials and staff members have met numerous times with providers, association representatives and other interested persons. The department believes that the notice and opportunity to comment provided before and during this rulemaking proceeding met all legal requirements and allowed more than a fair opportunity to be heard.

b. Authority and Implementing Citations

COMMENT: The proper authorizing section for ARM 46.12.1210 and Rule XXV is section 2-4-201, MCA, rather than the sections cited in the notice.

RESPONSE: The department has added section 2-4-201, MCA as an additional authorizing and implementing section with respect to Rule XXV and ARM 46.12.1210.

COMMENT: Section 53-2-606, MCA should be deleted as an implementing section with respect to Rule XXV and ARM 46.12.1210 because it relates to hearing requests by recipients rather than by providers.

RESPONSE: The department agrees and has removed the citation.

COMMENT: The citation to section 53-6-201, MCA as the authorizing section for Rule XXII is an error and should be section 53-2-201, MCA.

RESPONSE: The department agrees and has corrected the error.

COMMENT: Rule IV(1)(d) incorrectly refers to Rule X rather than Rule XI.

RESPONSE: The error has been corrected.

d. Adequacy of Statement of Reasonable Necessity

COMMENT: A Legislative Council reviewer commented that the a separate statement of reasonable necessity was not provided for each separate rule section proposed or proposed to be amended, but rather was provided in one statement for the entire proposal. The commentor stated that the reader cannot

tell what the rationale is, or whether reasonable necessity exists, as required by law, for each individual adoption, amendment and repeal. The commentor stated it is helpful to the reader to have individual rationales provided and that it is necessary from a legal standpoint to demonstrate that each rule, as opposed to the proposal as a whole, is reasonably necessary to effectuate the purposes of the statute. The commentor did not, however, indicate that he believed the statement of reasonable necessity was inadequate to satisfy the legal requirement.

RESPONSE: The department believes that the statement of reasonable necessity contained in the notice of public hearing satisfies the legal requirement. The law requires only that reasonable necessity to effectuate the purpose of the statute be demonstrated in the agency's notice of proposed rulemaking and in the written and oral data, views, comments, or testimony submitted by the public or the agency and considered by the agency. The department's statement, read together with the proposed rules, amendments and repeals, adequately demonstrates the reasonable necessity of each rule, amendment and repeal proposed. The department believes that the legal standard has been met.

d. Numbering of Rule Sections

COMMENT: The Secretary of State's office commented that: (1) in the lead in to Rule II, the (1) should be deleted and the following subsections renumbered accordingly; (2) certain specified incorporations by reference should include a date and general description of the incorporated material; (3) internal catchphrases should be deleted in certain specified rules; and (4) other specified subsections should be renumbered to follow numbering conventions followed by the secretary of state's office.

RESPONSE: The department has made the suggested changes.

Russell E. Catlee
Rule Reviewer

Julia E. Robinson
Director, Social and Rehabilitation Services

Certified to the Secretary of State October 21, 1991.

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 June 30, 1991. This table includes those rules adopted during the period July 1, 1991 through September 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 June 30, 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 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 September, 1991, are published. Vacancies scheduled to appear from November 1, 1991, through January 31, 1992 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 October 21, 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: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Alternative Health Care Board (Commerce)			
Dr. Michael Bergkamp Helena Qualifications (if required): none listed	Governor	new appointment	9/1/1991 9/1/1995
Ms. Dolly Browder Missoula Qualifications (if required): certified nurse midwife	Governor	new appointment	9/1/1991 9/1/1995
Ms. Ollie Hamilton-Guerrero Billings Qualifications (if required): direct entry midwife	Governor	Dusing	9/26/1991 9/1/1997
Dr. Daniel M. Molloy Billings Qualifications (if required): medical doctor	Governor	new appointment	9/1/1991 9/1/1995
Dr. Willow Moore Bozeman Qualifications (if required): naturopath	Governor	new appointment	9/1/1991 9/1/1997
Dr. Tom Rasmussen Helena Qualifications (if required): public member	Governor	new appointment	9/1/1991 9/1/1995
Board of Chiropractors (Commerce)			
Dr. Christopher Buzan Missoula Qualifications (if required): chiropractor	Governor	Sage	9/11/1991 1/1/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Investments (Commerce)			
Mr. Jerry Thomas	Governor	MacKay	9/11/1991
Billings			1/2/1993
Qualifications (if required): rep. Public Employees Retirement Board			
Board of Pardons (Institutions)			
Mr. John G. Thomas	Governor	Burgess	9/27/1991
Helena			1/1/1995
Qualifications (if required): public member			
Board of Pharmacy (Commerce)			
Mr. Ed J. Harrington	Governor	Bollinger	9/24/1991
Belgrade			7/1/1996
Qualifications (if required): pharmacist			
Board of Private Security Patrolmen and Investigators (Commerce)			
Mr. John C. Burkhartsmeyer	Governor	reappointed	9/24/1991
Helena			8/1/1994
Qualifications (if required): licensed private investigator			
Sheriff Bill Slaughter	Governor	Ash	9/24/1991
Bozeman			8/1/1994
Qualifications (if required): sheriff			
Mr. Randy Vogel	Governor	Samson	9/24/1991
Billings			8/1/1994
Qualifications (if required): city policeman			
Board of Psychologists (Commerce)			
Dr. Evan Lewis	Governor	McLaughlin	9/11/1991
Jefferson City			9/1/1994
Qualifications (if required): licensed psychologist			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Veterinarians (Commerce)			
Dr. John H. Leeds	Governor	McFarland	9/11/1991
Havre			7/31/1996
Qualifications (if required): licensed veterinarian			
Election Advisory Council (Secretary of State)			
Ms. Karen Amende	Governor	reappointed	9/4/1991
Broadus			9/30/1991
Qualifications (if required): none specified			
Ms. Wendy Cromwell	Governor	reappointed	9/4/1991
Missoula			9/30/1991
Qualifications (if required): none specified			
Ms. Coral Cummings	Governor	reappointed	9/4/1991
Libby			9/30/1991
Qualifications (if required): none specified			
Mr. Bill Driscoll	Governor	reappointed	9/4/1991
Butte			9/30/1991
Qualifications (if required): none specified			
Ms. Peggy J. Erickson	Governor	reappointed	9/4/1991
Billings			9/30/1991
Qualifications (if required): none specified			
Ms. Nancy J. Harte	Governor	reappointed	9/4/1991
Helena			9/30/1991
Qualifications (if required): none specified			
Ms. Betty T. Lund	Governor	reappointed	9/4/1991
Hamilton			9/30/1991
Qualifications (if required): none specified			

Appointee	Appointed by	Succeeds	Appointment/End Date
Election Advisory Council (Secretary of State) cont.			
Ms. Carol Malone Scobey Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
Ms. Debbie Pallett Lewistown Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
Mr. Charles W. Walk Helena Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
ICC Administered Economic Development Programs (Governor)			
Ms. Karen Barclay Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Chuck Brooke Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Dr. John Hutchinson Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Mike Micone Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Dennis Rehberg Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
ICC Administered Economic Development Programs (Governor) cont.			
Ms. Julia Robinson Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. John Rothwell Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Everett Snortland Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Library Services Advisory Council (Education)			
Ms. Jean R. Anderson Billings Qualifications (if required): rep. user of public library service in South Central Fed.	Chairperson	appointed	9/12/1991 5/31/1993
Mr. Dave Beatty Deer Lodge Qualifications (if required); rep. state agency employees and the institutionalized	Chairperson	reappointed	9/12/1991 5/31/1993
Ms. Evelyn Casterline Culbertson Qualifications (if required): rep. user of public library service in Golden Plains Fed.	Chairperson	appointed	9/12/1991 5/31/1993
Ms. Greta Chapman Libby Qualifications (if required): rep. public libraries	Chairperson	appointed	9/12/1991 5/31/1993
Mr. Bill Cochran Billings Qualifications (if required): rep. federation coordinators	Chairperson	appointed	9/12/1991 5/31/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Election Advisory Council (Secretary of State) cont.			
Ms. Carol Malone Scobey Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
Ms. Debbie Pallett Lewistown Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
Mr. Charles W. Walk Helena Qualifications (if required): none specified	Governor	reappointed	9/4/1991 9/30/1991
ICC Administered Economic Development Programs (Governor)			
Ms. Karen Barclay Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Chuck Brooke Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Dr. John Hutchinson Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Mike Micone Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992
Mr. Dennis Rehberg Helena Qualifications (if required): none specified	Governor	none listed	9/19/1991 12/31/1992

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
ICC Administered Economic Development Programs (Governor) cont.			
Ms. Julia Robinson	Governor	none listed	9/19/1991
Helena			12/31/1992
Qualifications (if required): none specified			
Mr. John Rothwell	Governor	none listed	9/19/1991
Helena			12/31/1992
Qualifications (if required): none specified			
Mr. Everett Snortland	Governor	none listed	9/19/1991
Helena			12/31/1992
Qualifications (if required): none specified			
Library Services Advisory Council (Education)			
Ms. Jean R. Anderson	Chairperson	appointed	9/12/1991
Billings			5/31/1993
Qualifications (if required): rep. user of public library service in South Central Fed.			
Mr. Dave Beatty	Chairperson	reappointed	9/12/1991
Deer Lodge			5/31/1993
Qualifications (if required); rep. state agency employees and the institutionalized			
Ms. Evelyn Casterline	Chairperson	appointed	9/12/1991
Culbertson			5/31/1993
Qualifications (if required): rep. user of public library service in Golden Plains Fed.			
Ms. Greta Chapman	Chairperson	appointed	9/12/1991
Libby			5/31/1993
Qualifications (if required): rep. public libraries			
Mr. Bill Cochran	Chairperson	appointed	9/12/1991
Billings			5/31/1993
Qualifications (if required): rep. federation coordinators			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Library Services Advisory Council (Education) cont.			
Ms. Connie Heckathorn Whitefish Qualifications (if required): rep. users of public library service in Tamarack Federation	Chairperson	reappointed	9/12/1991 5/31/1993
Ms. Beverly Knapp Bozeman Qualifications (if required): rep. user of public library service in Broad Valleys Fed.	Chairperson	appointed	9/12/1991 5/31/1993
Ms. Susan Long Kalispell Qualifications (if required): rep. special libraries	Chairperson	reappointed	9/12/1991 5/31/1993
Ms. Anita Nelson Missoula Qualifications (if required): rep. disabled	Chairperson	appointed	9/12/1991 5/31/1993
Mr. Al Randall Libby Qualifications (if required): rep. school libraries	Chairperson	appointed	9/12/1991 5/31/1993
Mr. Jim Reno Billings Qualifications (if required): rep. disadvantaged	Chairperson	appointed	9/12/1991 5/31/1993
Rep. Bill Strizich Great Falls Qualifications (if required): rep. legislature	Chairperson	reappointed	9/12/1991 5/31/1993
Ms. Elise Thomas Chinook Qualifications (if required): rep. user of public library service in Pathfinder Federation	Chairperson	reappointed	9/12/1991 5/31/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Library Services Advisory Council (Education) cont.			
Mr. John Thomas	Chairperson	reappointed	9/12/1991
Helena			5/31/1993
Qualifications (if required): rep. academic libraries			
Ms. Diane VanGorden	Chairperson	appointed	9/12/1991
Baker			5/31/1993
Qualifications (if required): rep. Montana Library Association			
Public Employees Retirement Board (Administration)			
Mr. James Lucas	Governor	MacKay	9/11/1991
Miles City			4/1/1994
Qualifications (if required): member of public employees' retirement system			
Public Vehicle Fueling Advisory Council (Governor)			
Ms. Ronna Alexander	Governor	none listed	9/1/1991
Bozeman			6/30/1993
Qualifications (if required): none specified			
Mr. Bob Anderson	Governor	none listed	9/1/1991
Helena			6/30/1993
Qualifications (if required): none specified			
Mr. Bill Ballard	Governor	none listed	9/1/1991
Butte			6/30/1993
Qualifications (if required): none specified			
Mr. Larry Blades	Governor	none listed	9/1/1991
Joliet			6/30/1993
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Public Vehicle Fueling Advisory Council (Governor) cont.			
Mr. Bob Blyth Butte Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Ms. Donna Campbell Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Russ Fillner Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. John Geach Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Ms. Beverly Gibson Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Ms. Gail Gray Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Ms. Donna Hall Great Falls Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Alec Hansen Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Public Vehicle Fueling Advisory Council (Governor) cont.			
Mr. Curt Hilyard Fort Benton Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Bob Marks Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Randy Mosely Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Ed Robinson Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Bill Rose Bozeman Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. George Swartz Helena Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993
Mr. Howard Wheatley Great Falls Qualifications (if required): none specified	Governor	none listed	9/1/1991 6/30/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Rehabilitative Services Advisory Council (Social and Rehabilitation Services)			
Mr. Mark Bowlds Helena Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Ms. Julie Anna Clay Missoula Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Rep. Paula A. Darko Libby Qualifications (if required): none specified	Director	Gould	9/18/1991 0/0/0
Mr. W.R. "Bob" Donaldson Kalispell Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Mr. Bob LeMieux Great Falls Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Ms. Peggy Macdonald Bozeman Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Mr. Ralph Martin Willow Creek Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0
Ms. Kelly Moorse Helena Qualifications (if required): none specified	Director	not listed	9/18/1991 0/0/0

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Rehabilitative Services Advisory Council (Social and Rehabilitation Services) cont.			
Ms. Gail Neal	Director	not listed	9/18/1991
Billings			0/0/0
Qualifications (if required): none specified			
State Employee Group Benefits (Administration)			
Ms. Cindy Anders	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Ms. Laurie Ekanger	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Ms. Nancy Ellery	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Mr. Dave Evenson	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Mr. Ken Givens	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Ms. Sheila Hogan	Director	reappointed	9/1/1991
Butte			9/1/1993
Qualifications (if required): none specified			
Mr. Tom McCarthy	Director	reappointed	9/1/1991
Warm Springs			9/1/1993
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
State Employee Group Benefits (Administration) cont.			
Mr. Curt Nichols	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Mr. William Salisbury	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Mr. Thomas Schneider	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Mr. Scott Seacat	Director	reappointed	9/1/1991
Helena			9/1/1993
Qualifications (if required): none specified			
Teachers' Retirement Board (Administration)			
Mr. E. Joseph Cross	Governor	Egli	9/11/1991
Billings			7/1/1995
Qualifications (if required): member of a retirement system			
Ms. Nancy B. Trackwell	Governor	Green	9/11/1991
Great Falls			7/1/1993
Qualifications (if required): public member			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Wheat and Barley Committee (Agriculture)			
Mr. Stephen P. McDonnell	Governor	Krueger	9/13/1991
Three Forks			8/20/1994
Qualifications (if required): rep. District VI and a Democrat			
Mr. Richard E. Sampsen	Governor	reappointed	9/13/1991
Dagmar			8/20/1994
Qualifications (if required): rep. District I and a Democrat			
Youth Service Advisory Council (Justice)			
Mr. Craig Anderson	Governor	appointed	9/10/1991
Glendive			9/10/1993
Qualifications (if required): none specified			
Ms. Gail Cleveland	Governor	appointed	9/10/1991
Great Falls			9/10/1993
Qualifications (if required): none specified			
Mr. Al Davis	Governor	appointed	9/10/1991
Helena			9/10/1993
Qualifications (if required): none specified			
Mr. Gordon Eldredge	Governor	appointed	9/10/1991
Billings			9/10/1993
Qualifications (if required): none specified			
Ms. Susan Good	Governor	appointed	9/10/1991
Great Falls			9/10/1993
Qualifications (if required): none specified			
Mr. Tony Harbaugh	Governor	appointed	9/10/1991
Miles City			9/10/1993
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Youth Service Advisory Council (Justice) cont.			
Ms. Randi Mae Hood **Helena** Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Rep. Royal Johnson Billings Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Mr. Ted O. Lympus Kalispell Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Ms. Joan-Nell Macfadden **Great Falls** Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Ms. Chris Negus Helena Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Mr. Steve P. Nelson Bozeman Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Judge Thomas A. Olson Bozeman Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Mr. Garry Rafter Hobson Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993

BOARD AND COUNCIL APPOINTEES: SEPTEMBER, 1991

Appointee	Appointed by	Succeeds	Appointment/End Date
Youth Service Advisory Council (Justice) cont.			
Ms. Sally Stansbury Missoula Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Ms. Margaret Stuart Helena Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Mr. Donald Wetzel Harlem Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993
Mr. John E. Witt Carter Qualifications (if required): none specified	Governor	appointed	9/10/1991 9/10/1993

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Air Pollution Control Advisory Council (Health and Environmental Sciences)		
Mr. Ronald E. Burnam, Billings	Governor	11/8/91
Qualifications (if required): practicing physician licensed in this state		
Mr. Ed Handl, Butte	Governor	11/8/91
Qualifications (if required): chemical engineer		
Mr. Rodney A. James, Butte	Governor	11/8/91
Qualifications (if required): practicing registered professional chemical or environmental engineer		
Mr. Jess Kilgore, Three Forks	Governor	11/8/91
Qualifications (if required): agriculture representative		
Mr. Terry Konkright, Superior	Governor	11/8/91
Qualifications (if required): rep. of manufacturing industry		
Mr. Stephen L'Heureux, Great Falls	Governor	11/8/91
Qualifications (if required): urban planning consultant		
Mr. Joe Nelson, Walkerville	Governor	11/8/91
Qualifications (if required): labor representative		
Mr. Martin W. Perga, Laurel	Governor	11/8/91
Qualifications (if required): rep. of fuel industry		
Dr. Earl Pruyn, Missoula	Governor	11/8/91
Qualifications (if required): practicing veterinarian licensed in Montana		
Mr. Paul Sawyer, Butte	Governor	11/8/91
Qualifications (if required): conservationist		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Alfalfa Seed Committee (Agriculture)		
Mr. Thomas W. Matchett, Chinook	Governor	12/21/91
Qualifications (if required): none specified		
Ms. Gayle Patrick, Wagner	Governor	12/21/91
Qualifications (if required): none specified		
Board of Chiropractors (Commerce)		
Dr. Arvin R. Wilson, Whitefish	Governor	1/2/92
Qualifications (if required): none specified		
Board of Dentistry (Commerce)		
Ms. Fern Flanagan, Helena	Governor	1/4/92
Qualifications (if required): public member		
Board of Horseracing (Commerce)		
Mr. Steve Christian, Whitefish	Governor	1/20/92
Qualifications (if required): rep. from 5th District		
Mr. Dale Hoffman, Billings	Governor	1/20/92
Qualifications (if required): rep. from 2nd District		
Board of Occupational Therapy Practice (Commerce)		
Ms. Debra J. Ammondson, Great Falls	Governor	12/31/91
Qualifications (if required): none specified		
Board of Speech Pathologists and Audiologists (Commerce)		
Ms. Lonna Tempel, Joplin	Governor	12/31/91
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Capitol Finance Advisory Council (Administration)		
Rep. Francis Bardanouve, Harlem	Governor	1/23/92
Qualifications (if required): legislator		
Sen. Delwyn "Del" Gage, Cut Bank	Governor	1/23/92
Qualifications (if required): legislator		
Mr. Dennis Iverson, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Health and Environmental Sciences		
Dr. Amos Little, Helena	Governor	1/23/92
Qualifications (if required): Chairman of Montana Health Facility Authority Board		
Mr. Bob Marks, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Administration		
Mr. Tom Mather, Great Falls	Governor	1/23/92
Qualifications (if required): Chairperson of MT Board of Housing		
Mr. William L. Mathers, Miles City	Governor	1/23/92
Qualifications (if required): Chairperson of Board of Regents		
Ms. Mary D. Munger, Helena	Governor	1/23/92
Qualifications (if required): Chairperson of MT Health Facilities Authority		
Mr. John Rothwell, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Highways		
Mr. Everett Snortland, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Agriculture		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Capitol Finance Advisory Council (Administration) cont.		
Mr. Rod Sundsted, Helena	Governor	1/23/92
Qualifications (if required): Director of Office of Budget & Program Planning		
Mr. Warren Vaughn, Billings	Governor	1/23/92
Qualifications (if required): Chairperson of Board of Investments		
Mr. Steve Yeakel, Helena	Governor	1/23/92
Qualifications (if required): Budget Director for Governor's Budget Office		
Childrens Trust Fund Board (Social and Rehabilitation Services)		
Ms. Darlene Dowen, Kalispell	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Arnie A. Hove, Circle	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Richard Kerstein, Billings	Governor	1/2/92
Qualifications (if required): 1 of 2 board members from state agency involved in education and social work relating to children		
Mr. Randy Koutnik, Great Falls	Governor	1/1/92
Qualifications (if required): none specified		
Ms. Dollean Lind, Hardin	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Mike Males, Bozeman	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Gaylord Walls, Havre	Governor	1/1/92
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Capitol Finance Advisory Council (Administration)		
Rep. Francis Bardanouve, Harlem	Governor	1/23/92
Qualifications (if required): legislator		
Sen. Delwyn "Del" Gage, Cut Bank	Governor	1/23/92
Qualifications (if required): legislator		
Mr. Dennis Iverson, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Health and Environmental Sciences		
Dr. Amos Little, Helena	Governor	1/23/92
Qualifications (if required): Chairman of Montana Health Facility Authority Board		
Mr. Bob Marks, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Administration		
Mr. Tom Mather, Great Falls	Governor	1/23/92
Qualifications (if required): Chairperson of MT Board of Housing		
Mr. William L. Mathers, Miles City	Governor	1/23/92
Qualifications (if required): Chairperson of Board of Regents		
Ms. Mary D. Munger, Helena	Governor	1/23/92
Qualifications (if required): Chairperson of MT Health Facilities Authority		
Mr. John Rothwell, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Highways		
Mr. Everett Snortland, Helena	Governor	1/23/92
Qualifications (if required): Director of Department of Agriculture		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Capitol Finance Advisory Council (Administration) cont.		
Mr. Rod Sundsted, Helena	Governor	1/23/92
Qualifications (if required): Director of Office of Budget & Program Planning		
Mr. Warren Vaughn, Billings	Governor	1/23/92
Qualifications (if required): Chairperson of Board of Investments		
Mr. Steve Yeakel, Helena	Governor	1/23/92
Qualifications (if required): Budget Director for Governor's Budget Office		
Childrens Trust Fund Board (Social and Rehabilitation Services)		
Ms. Darlene Dowen, Kalispell	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Arnie A. Hove, Circle	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Richard Kerstein, Billings	Governor	1/2/92
Qualifications (if required): 1 of 2 board members from state agency involved in education and social work relating to children		
Mr. Randy Koutnik, Great Falls	Governor	1/1/92
Qualifications (if required): none specified		
Ms. Dollean Lind, Hardin	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Mike Males, Bozeman	Governor	1/1/92
Qualifications (if required): none specified		
Mr. Gaylord Walls, Havre	Governor	1/1/92
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Developmental Disabilities Planning and Advisory Council (Social and Rehabilitation Services)		
Rep. Timothy J. Whalen, Billings	Governor	1/1/92
Qualifications (if required): member of House of Representatives		
Family Support Services Advisory Council (Social and Rehabilitation Services)		
Mr. Dan McCarthy, Helena	Governor	11/6/91
Qualifications (if required): represents Office of Public Instruction		
Fertilizer Advisory Council (Education)		
Mr. Bill Koenig, Kalispell	Director	1/1/92
Qualifications (if required): none specified		
Mr. Allan Peace, Fairfield	Director	1/1/92
Qualifications (if required): none specified		
Health Care Services Availability Advisory Council (Governor)		
Dr. Jimmie L. Ashcraft, Sidney	Governor	1/26/92
Qualifications (if required): medical profession		
Mr. John Bartos, Hamilton	Governor	1/26/92
Qualifications (if required): health care professionals		
Mr. Paul F. Boylan, Bozeman	Governor	1/26/92
Qualifications (if required): legislator		
Mr. Charles Butler Jr., Missoula	Governor	1/26/92
Qualifications (if required): insurance industry		
Rep. Paula A. Darko, Libby	Governor	1/26/92
Qualifications (if required): legislator		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Health Care Services Availability Advisory Council (Governor) cont.		
Dr. Donald Espelin, Helena Qualifications (if required): ex-officio member	Governor	1/26/92
Ms. Laura Grinde, Lewistown Qualifications (if required): health care professional	Governor	1/26/92
Ms. Peggy Guthrie, Choteau Qualifications (if required): health care professional	Governor	1/26/92
Dr. Jim Hoyne, Clancy Qualifications (if required): medical profession	Governor	1/26/92
Mr. Loren Jenkins, Big Sandy Qualifications (if required): legislator	Governor	1/26/92
Mr. Leonard A. Kaufman, Billings Qualifications (if required): insurance industry	Governor	1/26/92
Rep. John Mercer, Polson Qualifications (if required): legislator	Governor	1/26/92
Dr. Gordon K. Phillips, Great Falls Qualifications (if required): medical profession	Governor	1/26/92
Mr. Larry E. Riley, Missoula Qualifications (if required): legal profession	Governor	1/26/92
Ms. Julia Robinson, Helena Qualifications (if required): ex-officio member	Governor	1/26/92
Mr. Chadwick Smith, Helena Qualifications (if required): legal profession	Governor	1/26/92

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Health Facility Authority Board (Commerce)		
Mr. John H. Solheim, Glendive	Governor	1/1/92
Qualifications (if required): expert in hospital administration		
Judicial Nomination Commission (Governor)		
Mr. Ken Byerly, Lewistown	Governor	1/1/92
Qualifications (if required): none specified		
Mr. John R. Devier, Glendive	Governor	1/1/92
Qualifications (if required): none specified		
Ms. Donna Metcalf, Helena	Governor	1/1/92
Qualifications (if required): none specified		
Ms. Norma C. Wood, Loma	Governor	1/1/92
Qualifications (if required): none specified		
Management Development Advisory Council (Administration)		
Ms. Karen Barclay, Helena	Director	1/1/92
Qualifications (if required): state employee		
Mr. Peter Blouke, Helena	Director	1/1/92
Qualifications (if required): state employee		
Ms. Carolyn Doering, Helena	Director	1/1/92
Qualifications (if required): state employee		
Ms. Laurie Ekanger, Helena	Director	1/1/92
Qualifications (if required): none specified		
Ms. Maureen J. Fleming, Missoula	Director	1/1/92
Qualifications (if required): Montana University System Member		

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Management Development Advisory Council (Administration) cont.		
Mr. Michael A. Lavin, Helena Qualifications (if required): state employee	Director	1/1/92
Mr. Russell G. McDonald, Helena Qualifications (if required): state employee	Director	1/1/92
Mr. Mike Micone, Helena Qualifications (if required): state employee	Director	1/1/92
Dr. Kenneth L. Weaver, Bozeman Qualifications (if required): Montana University System Member	Director	1/1/92
Natural Gas Marketing Advisory Council (Governor)		
Mr. William W. Ballard, Billings Qualifications (if required): none specified	Governor	11/1/91
Mr. Chuck Brooke, Helena Qualifications (if required): none specified	Governor	11/1/91
Mr. Dennis Casey, Helena Qualifications (if required): none specified	Governor	11/1/91
Mr. Dennis L. Haider, Bismarck Qualifications (if required): none specified	Governor	11/1/91
Mr. Carl J. Iverson, Shelby Qualifications (if required): none specified	Governor	11/1/91
Mr. Pete Madison, Butte Qualifications (if required): none specified	Governor	11/1/91

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Natural Gas Marketing Advisory Council (Governor) cont.		
Mr. Kneelon Teague, Shelby Qualifications (if required): none specified	Governor	11/1/91
Mr. Bill Vaughey, Havre Qualifications (if required): none specified	Governor	11/1/91
Passenger Tramway Advisory Council (Commerce)		
Mr. J.R. Crabtree, Choteau Qualifications (if required): public member who skis	Governor	1/1/92
Mr. Tim Prather, Red Lodge Qualifications (if required): ski area operator	Governor	1/1/92
Peace Officers Standards and Training Advisory Council (Justice)		
Mayor Garry Adams, Malta Qualifications (if required): none specified	Governor	12/31/91
Captain Jeff Bryson, Helena Qualifications (if required): none specified	Governor	12/31/91
Mr. James Burnes, Great Falls Qualifications (if required): none specified	Governor	12/31/91
Colonel Robert Griffith, Helena Qualifications (if required): none specified	Governor	12/31/91
Mr. Robert A. Harvie, Bozeman Qualifications (if required): none specified	Governor	12/31/91
Mr. William Heinecke, Belgrade Qualifications (if required): none specified	Governor	12/31/91

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Peace Officers Standards and Training Advisory Council (Justice) cont.		
Mr. Donald R. Houghton, Bozeman Qualifications (if required): deputy sheriff	Governor	12/31/91
Chief Robert Jones, Great Falls Qualifications (if required): none specified	Governor	12/31/91
Mr. R.F. "Dick" Labbe, Deer Lodge Qualifications (if required): mayor	Governor	12/31/91
Mr. Rick Later, Dillon Qualifications (if required): none specified	Governor	12/31/91
Commissioner Mike Matthews, Billings Qualifications (if required): none specified	Governor	12/31/91
Mr. Dennis McCave, Billings Qualifications (if required): none specified	Governor	12/31/91
Mr. Christopher Miller, Deer Lodge Qualifications (if required): none specified	Governor	12/31/91
Mr. Greg Noose, Bozeman Qualifications (if required): none specified	Governor	12/31/91
Mr. Gary Olson, Glendive Qualifications (if required): none specified	Governor	12/31/91
Ms. Donna "Midge" Warrington, Great Falls Qualifications (if required): dispatcher	Governor	12/31/91
Sen. John H. Anderson, Jr. Alder Qualifications (if required): none specified	Director	11/30/91

VACANCIES ON BOARDS AND COUNCILS -- November 1, 1991 through January 31, 1992

Board/current position holder	Appointed by	Term end
Resource Conservation Advisory Council (Natural Resources and Conservation)		
Mr. Ellis Hagen, Westby	Governor	11/15/91
Qualifications (if required): conservation district supervisor		
Mr. Jack Hughes, Grass Range	Director	11/30/91
Qualifications (if required): rep. Grazing Districts		
Mr. Herb Karst, Sunburst	Director	11/30/91
Qualifications (if required): rep. North Central Montana		
Mr. Arville Lammers, Shawmut	Director	11/30/91
Qualifications (if required): general public		
Mr. Ken Minnie, Roundup	Director	11/30/91
Qualifications (if required): rep. South Central Montana		
Mr. Bob Schroeder, Missoula	Director	11/30/91
Qualifications (if required): rep. Conservation Districts		