MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 13

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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

BEFORE THE BOARD OF OPTOMETRISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to board meetings, applications for examination, examinations, reciprocity, general practice requirements, fees and applicants for licensure	NOTICE OF PROPOSED AMENDMENT OF RULES PERTAINING TO THE PRACTICE OF OPTOMETRY

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 14, 1993, the Board of Optometrists proposes to amend rules pertaining to the practice of optometry.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.36.401 BOARD MEETINGS (1) The board may convene at any time or place for purposes of transacting ~~any~~ business ~~other than giving examinations~~. The president shall call such meeting and name the time and place, and give notice to each member of the board as much in advance of the meeting as possible.

(2) will remain the same."

Auth: Sec. 37-10-201, MCA; IMP, Sec. 37-10-201, MCA

REASON: This amendment is required to delete reference to an annual meeting in July. The 1993 Legislature deleted the previous requirement that the Board meet on the fourth Monday in July.

"8.36.403 APPLICATION FOR EXAMINATION (1) All candidates for examination shall file the appropriate application with the national board of examiners in optometry along with the proper fees as required by the national board of examiners in optometry ~~in accordance with the clinical skills examination requirements~~."

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-10-302, MCA

REASON: This rule delegates responsibility for examination to the national board of examiners. The clinical skills examination is no longer labeled as such and therefore is deleted.

"8.36.404 EXAMINATIONS (1) The examination for admission to practice optometry in the state of Montana shall consist of ~~the following:~~

~~(a) All applicants must~~ passing all parts of the examinations administered by the national board of examiners in optometry.

~~(b) All applicants must pass all parts of the clinical skills/VRICS examination administered by the national board of examiners in optometry.~~"

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-10-201, 37-10-302, MCA

REASON: This amendment notes that the 1993 Legislature allowed examinations to be conducted by the national board. Furthermore, the rule requires the examinee to pass all portions of that examination.

"8.36.405 RECIPROCITY (1) will remain the same.

(2) Applicants meeting reciprocity requirements must appear before the board ~~at its annual or special meeting~~."

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-10-303, MCA

REASON: This amendment reflects the fact that the requirement for an annual meeting in July was deleted by the 1993 Legislature.

"8.36.406 GENERAL PRACTICE REQUIREMENTS (1) through (1)(d) will remain the same.

(e) all professional signs and advertising, etc., must include the names of all optometrist~~'s name~~ associated with the practice, and the title "Optometrists", "Doctor of Optometry", or initials "O.D." in connection therewith;

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

(3) Each registered optometrist, prior to examining a first-time patient, must identify himself or herself. In addition, the optometrist must assure that his or her identity is fully disclosed to the patient or the patient's guardian or agent upon demand.

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

Auth: Sec. 37-1-131, 37-10-202, MCA; IMP, Sec. 37-10-301, 37-10-311, MCA

REASON: This amendment is proposed to deal with a problem consumers in Montana are facing. Many individuals who go to a multi-practitioner office learn that they do not know the name of the optometrist who examined them when they decide to complain against a licensee and are not acknowledged when they seek that information. This amendment requires the optometrist to identify himself or herself to first-time patients and to strive to identify himself or herself upon subsequent inquiry. The Board feels this amendment will reduce the amount and number of misrepresentations and misleading statements.

"8.36.409 FEE SCHEDULE (1) through (3) will remain the same.

~~(4) Application for examination $50.00~~

(5) through (8) will remain the same but will be renumbered (4) through (7)."

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-1-134, 37-10-302, 37-10-303, 37-10-307, MCA

REASON: This amendment is proposed in order to delete the fee for examination application. Such a fee is obsolete as the examination will be conducted by the national board of examiners in optometry.

"8.36.802 APPLICANTS FOR LICENSURE (1) Effective October 1, 1987, all applicants for licensure (new graduates and reciprocity) must prove that they have met or exceeded the requirements of section 37-10-304(2), MCA, before they will ~~be permitted to take the licensing examination or~~ be granted a ~~reciprocity~~ license~~, as the case may be~~."

Auth: Sec. 37-10-202, MCA; IMP, Sec. 37-10-304, MCA

REASON: The Board will no longer give the licensing examination. The national board of examiners in optometry tests on the subject and the board will accept passage of that examination for new graduates or will allow licensure of reciprocity candidates who have taken a course offered by an accredited school and passed an examination on the material.

3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Optometrists, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 14, 1993.

4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Optometrists, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 14, 1993.

5. If the Board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a 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 24 based on the 239 licensees in Montana.

BOARD OF OPTOMETRISTS
LARRY J. BONDERUD, O.D.,
CHAIRMAN

Anne M. Bartos
ANNIE M. BARTOS
RULE REVIEWER

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

Certified to the Secretary of State, July 2, 1993.

BEFORE THE BOARD OF PRIVATE SECURITY
PATROL OFFICERS AND INVESTIGATORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to experience requirements, insurance requirements and fees)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF 8.50.428 EXPERIENCE REQUIREMENTS, 8.50.431 INSURANCE REQUIREMENTS AND 8.50.437 FEE SCHEDULE

TO: All Interested Persons:

1. On August 5, 1993, at 9:00 a.m., a public hearing will be held in the conference room of the Professional and Occupational Licensing Bureau, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.50.428 EXPERIENCE REQUIREMENTS (1) shall remain the same.

(a) two years full time lawful experience;

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

Auth: Sec. 37-50-202, MCA; IMP, Sec. 37-50-303, MCA

REASON: To clarify that the applicant's experience must be gained lawfully, and not in violation of the law. This rule change also brings the requirement that experience be gained lawfully in line with the experience required for other licensure categories under section 37-60-303, MCA.

"8.50.431 INSURANCE REQUIREMENTS ~~(1) All licensees regulated by Title 37, chapter 60, MCA, except private investigators and security alarm installers who do not employ response runners, shall file with the board, a certificate of insurance evidencing a comprehensive general liability coverage for both licensees and employees for bodily injury, and property damage on a form of comprehensive general liability endorsement which covers: personal injury and property damage including assault and battery and personal injury, including false arrest, false imprisonment, malicious prosecution, invasion of privacy, wrongful eviction or wrongful entry, mental anguish, defamation and discrimination. Security alarm installers shall only be required to have a comprehensive general liability insurance, but if the alarm installer employs alarm response runners, the alarm installer must then have the same insurance coverage as a contract security company is required to have.~~

~~(2) Persons licensed as private investigators must carry coverage for omissions and errors, destruction, damage or loss of property entrusted to their custody, care and control, as well as coverage for defamation, malicious prosecution and invasion of privacy.~~

~~(3) All licensees must be insured by a carrier licensed in the state in which the insurance has been purchased or in this state.~~

~~(4) Each licensee shall sign a release allowing its insurance carrier to inform the board in the event coverage is cancelled or allowed to lapse.~~

~~(5) In lieu of an insurance policy, proof of financial responsibility acceptable to the board requires a minimum showing by the licensee of a property bond, a fiduciary bond, trust fund, escrow account or a combination of these, in the amount of at least $25,000, and established for the purpose of satisfying this rule.~~

(1) Persons regulated by Title 37, chapter 60, MCA, and licensed as a private investigator, a security alarm installer, a contract security company or a proprietary security organization shall file with the board, a yearly certificate of insurance.

(a) Persons licensed as private investigators shall carry a minimum of $25,000 occurrence form of commercial general liability which includes personal injury.

(i) Persons licensed with armed status shall carry liability for firearms coverage.

(b) Persons licensed as security alarm installers shall carry a minimum of $100,000 occurrence form of commercial general liability which includes personal injury and errors and omissions coverage.

(c) Persons licensed as contract and proprietary security companies shall carry a minimum of $100,000 occurrence form of commercial general liability which includes personal injury.

(i) Persons licensed with armed status shall carry liability for firearms coverage.

(2) Except as provided in subsection (4), all licensees must be insured by a carrier:

(a) that is licensed in the state in which the insurance has been purchased and which is covered by that state's insolvency fund; or

(b) that is licensed in the state of Montana.

(3) Each licensee shall sign a release allowing its insurance carrier to inform the board in the event that the coverage is cancelled or allowed to lapse.

(4) Proof of financial responsibility may be accepted in lieu of an insurance policy. Such proof shall consist of a property bond, a fiduciary bond, trust fund, escrow account or a combination therefor, as follows:

(a) Persons licensed as private investigators shall carry a minimum of $25,000.

(b) Persons licensed as security alarm installers shall carry a minimum of $100,000.

(c) Persons licensed as contract and proprietary security companies shall carry a minimum of $100,000."

Auth: Sec. 37-1-131, 37-60-202, MCA; IMP, Sec. 37-60-202, MCA

REASON: The requirements of the existing rule cannot be met by licensees because no insurance company has been found that

will insure the categories currently required by the existing rule. The Board also wants to require the licensees to file a certificate of insurance with the Board. Under the existing rule, private investigators and security alarm installers are not required to file a certificate.

"8.50.437 FEE SCHEDULE (1) through (7) will remain the same.

~~(a) Handbook~~	~~5.00~~	
~~(b)~~(a) Examination	~~60.00~~	15.00

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

Auth: Sec. 37-1-134, 37-60-202, MCA; IMP, Sec. 25-1-1104, 37-1-134, 37-60-304, 37-60-312, MCA

REASON: This amendment is being proposed to make the fee commensurate with program area costs.

3. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may be submitted to the Board of Private Security Patrol Officers and Investigators, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana, to be received no later than 5:00 p.m., August 12, 1993.

4. Lance L. Melton, attorney, has been designated to preside over and conduct the hearing.

BOARD OF PRIVATE SECURITY PATROL OFFICERS AND INVESTIGATORS
GARY GRAY, PRESIDENT

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, July 2, 1993.

BEFORE THE BOARD OF PUBLIC ACCOUNTANTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of a rule pertaining to qualifications for a license as a licensed public accountant)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF 8.54.407 QUALIFICATIONS FOR A LICENSE AS A LICENSED PUBLIC ACCOUNTANT

TO: All Interested Persons:

1. On August 9, 1993, at 1:30 p.m., a public hearing will be held in the Professional and Occupational Licensing Bureau conference room, Lower Level, Arcade Building, 111 N. Jackson, Helena, Montana to consider the proposed amendment of the above-stated rule.

2. The proposed amendment will read as follows: (new matter underlined, deleted matter interlined)

"8.54.407 QUALIFICATIONS FOR A LICENSE AS LICENSED PUBLIC ACCOUNTANT (1) through (1)(b) will remain the same.

(2) Effective January 1, 1994, a person seeking licensure as a licensed public accountant by examination shall have sat for the examination provided for in ARM 8.54.402 and shall have passed the following subjects of the examination:

(a) auditing (AUDIT),

(b) financial accounting and reporting - business enterprises (FARE), and

(c) if the person is not the holder of a valid United States Treasury card at the time of sitting for the examination, he/she must pass:

(i) accounting and reporting - taxation, managerial, and governmental and not-for-profit organizations (ARE), or

(ii) business law and professional responsibilities (LPR).

(3) For purposes of considering successful completion of portions of the examination in transition of the old examination to the new structure and format of the examination:

(a) A person who has passed accounting practice prior to January 1, 1994, shall be considered to have passed accounting and reporting - taxation, managerial, and governmental and not-for-profit organizations (ARE) after that date.

(b) A person who has passed auditing (AUDIT) prior to January 1, 1994, shall be considered to have passed that same subject after that date.

(c) A person who has passed business law prior to January 1, 1994, shall be considered to have passed business law and professional responsibilities (LPR) after that date.

(d) A person who has passed accounting theory prior to January 1, 1994, shall be considered to have passed financial accounting and reporting - business enterprises (FARE) after that date."

Auth: Sec. 37-50-203, 37-50-304, MCA; IMP, Sec. 37-50-303, 37-50-304, 37-50-308, MCA

REASON: Section 37-50-304, MCA, was amended by the 1993 Legislature. The changes revised the examination requirements for licensed public accountants and authorized the Department of Commerce to adopt rules implementing the changes to be in place on January 1, 1994. The Statement of Intent in Chapter 218, Session Laws of 1993, provided a guideline on the portions of the examination to be passed and these changes reflect that intent.

3. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Board of Public Accountants, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 12, 1993.

4. Robert P. Verdon, Helena, Montana, has been designated to preside over and conduct the hearing.

BOARD OF PUBLIC ACCOUNTANTS
SHIRLEY J. WAREHIME, CPA
CHAIRMAN

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, July 2, 1993.

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

In the matter of the proposed amendment of rules pertaining to examinations, renewals, fees, permits and permit fees	)))	NOTICE OF PROPOSED AMENDMENT OF RULES PERTAINING TO THE PRACTICE OF RADIOLOGIC TECHNOLOGY

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 14, 1993, the Board of Radiologic Technologists proposes to amend rules pertaining to the practice of radiologic technology.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.56.407 RENEWALS (1) and (2) will remain the same.

(3) All applications for renewal of license by a radiologic technologist shall be made on printed forms provided by the board office. The information requirements which appear on the application form include:

(a) employer's name,

(b) employer's address,

(c) employer's telephone,

(d) social security number, and

(e) answer to question as to whether licensee has had disciplinary actions instituted against licensee.

(4) All applications for renewal of license by a radiologic technologist must include, in addition to the information required under subsection (3) of this rule, an application fee and a copy of the licensee's current A.R.R.T. wallet card."

Auth: Sec. 37-1-101, 37-14-202, 37-14-310, MCA; IMP, Sec. 37-14-310, MCA

REASON: The board is proposing this amendment to establish a method in which radiologic technologists renew their annual licenses. As proposed, this rule amendment will ensure that only qualified persons that continue to meet the requirements of the board are performing x-ray procedures in Montana.

"8.56.409 FEES SCHEDULE (1) through (1)(e) will remain the same.

(f) Duplicate or lost licenses or certificates ~~15.00~~ 5.00"

Auth: Sec. 37-1-101, 37-1-134, 37-14-202, 37-14-310, MCA; IMP, Sec. 37-1-134, 37-14-303, 37-14-310, MCA

REASON: The board is proposing to lower the fee for a duplicate license from $15.00 to $5.00 to make the fee commensurate with program area costs.

"8.56.602A PERMITS (1) and (1)(a) will remain the same.
(b) must have completed the minimum formal training in a board approved course as outlined in ARM 8.56.602B, or have successfully completed 12 months of a 24-month board approved x-ray course.
(2) will remain the same.
(a) Chest - AP or PA, ~~L~~lateral, and apical lordotic routine chest exposures, but in no case involving mammography procedures;
(b) through (d) will remain the same.
(e) Abdomen - routine supine and upright AP abdomen projection, and IVP scout and follow-up films as specified by the supervising radiologist;
(f) will remain the same."
Auth: Sec. 37-14-306, MCA; IMP, Sec. 37-14-306, MCA

REASON: These amendments are being proposed to offer second year students enrolled in a 24-month course the opportunity to obtain a limited permit until that person is eligible to become licensed as a radiologic technologist; to clarify the fact that permit holders cannot perform mammograms due to risks involved in such procedures and the difficulty in diagnosing correctly; and to clarify appropriate x-ray procedures involving the abdomen.

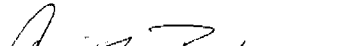
"8.56.607 PERMIT FEES (1) through (5) will remain the same.
(6) Duplicate or lost license fee ~~25.00~~ 5.00
(7) will remain the same."
Auth: Sec. 37-1-134, 37-14-202, 37-14-306, 37-14-310, MCA; IMP, Sec. 37-1-134, 37-14-305, 37-14-306, 37-14-309, 37-14-310, MCA

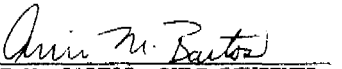
REASON: The board is proposing to lower the fee for a duplicate license from $15.00 to $5.00 to make the fee commensurate with program area costs.

3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Radiologic Technologists, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 12, 1993.
4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Radiologic Technologists, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 12, 1993.
5. If the board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25

members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

BOARD OF RADIOLOGIC
TECHNOLOGISTS
JIM WINTER, CHAIRMAN

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


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, July 2, 1993.

BEFORE THE BOARD OF RESPIRATORY CARE PRACTITIONERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to applications, temporary permits, renewals and continuing education	))))))	NOTICE OF PROPOSED AMENDMENT OF 8.59.501 APPLICATION FOR LICENSURE, 8.59.503 TEMPORARY PERMIT, 8.59.505 PROCEDURES FOR RENEWAL, AND 8.59.601 CONTINUING EDUCATION REQUIREMENTS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 14, 1993, the Board of Respiratory Care Practitioners proposes to amend the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.59.501 APPLICATION FOR LICENSURE (1) through (7) will remain the same.

(8) An applicant who has not worked in the profession of respiratory care for a period of three or more years must provide documentation of having acquired 20 continuing education units, as defined by rule, within 24 calendar months preceding application, or will re-test under an entry-level certification examination or registry examination promulgated by the national board of respiratory care with the passing score set by the national board of respiratory care."

Auth: Sec. 37-28-104, MCA; IMP, Sec. 37-28-201, 37-28-202, MCA

REASON: This amendment is necessary to insure that those applicants who have not been practicing are competent to perform licensed activities.

"8.59.503 TEMPORARY PERMIT (1) through (3)(b)(ii) will remain the same.

(iii) student respiratory care practitioner who either expects to graduate within 30 calendar days ~~of application date for temporary permit~~ or has graduated within the six months immediately prior to the date of application for a temporary permit.

(4) through (6) will remain the same."

Auth: Sec. 37-28-104, MCA; IMP, Sec. 37-28-206, MCA

REASON: This amendment is being proposed to make the rule consistent with statutory amendment. The effect of legislative and regulatory amendment is to expand the time in which one may apply for a temporary permit from the month before graduation to six months thereafter.

"8.59.505 PROCEDURES FOR RENEWAL (1) ~~Renewal date is one year after date of issuance of license and annually thereafter.~~ Renewals shall be due annually on May 1.

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

Auth: Sec. Sec. 37-28-104, MCA; IMP, Sec. 37-28-203, MCA

REASON: This amendment is being proposed to make the rule consistent with statutory language.

"8.59.601 CONTINUING EDUCATION REQUIREMENTS (1) through (3) will remain the same.

(4) For licensees who have received their initial license during the immediately preceding licensing year, continuing education will be required on the date of initial renewal on a pro-rated basis. This pro-rated basis will require that the licensee who has received his or her initial license must attain one credit of continuing education for each month, or greater portion thereof, of licensure."

Auth: Sec. 37-28-104, MCA; IMP, Sec. 37-28-104, 37-28-203, MCA

REASON: This amendment is being proposed to provide for licensees who receive their license during or in the middle of the license year. The required continuing education is pro-rated so as to avoid requiring a full year's worth of continuing education in a lesser amount of time.

3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Respiratory Care Practitioners, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 12, 1993.

4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Respiratory Care Practitioners, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., August 12, 1993.

5. If the Board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a 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 35 based on the 355 licensees in Montana.

BOARD OF RESPIRATORY CARE
PRACTITIONERS
RICH LUNDY, CHAIRMAN

ANNIE M. BARTOS
RULE REVIEWER

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

BEFORE THE STATE LIBRARY COMMISSION
OF THE STATE OF MONTANA

In the matter of the amendment of 10.101.101 pertaining to the organization of the State Library Agency	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT of ARM 10.101.101 RELATING TO THE ORGANIZATION OF THE STATE LIBRARY AGENCY

TO: All Interested Persons

1. On August 14, 1993, at 1:00 p.m., a public hearing will be held at the Outlaw Inn, 1701 Hwy 93 South, Kalispell, Montana 59901, to consider the proposed amendment of ARM 10.101.101 pertaining to the organization of the State Library.

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

10.101.101 AGENCY ORGANIZATION (1) remains the same.
(2) remains the same.
(3) remains the same.
(3)(a) remains the same.
(3)(b) The composition of the council shall be ~~sixteen~~ no more than fourteen members. ~~Fourteen~~ Twelve shall serve for two years and may be reappointed for a second term and may represent: users of public library services in each federation area, disadvantaged persons, local public libraries, school libraries, academic libraries, special libraries, library service to the institutionalized, library service to the disabled, ~~state employees,~~ state agency libraries, Montana participation in WHCLIS~~T~~ (White House Conference on Librar~~ies~~y and Information Services), and the Montana legislature. The president of the Montana library association ~~shall~~ may serve a one-year term on the council during the presidency of the association, and one library federation coordinator chosen each year by the coordinators shall serve a one-year term.
(3)(c) remains the same.
(3)(d) The number of yearly meetings shall be determined by the executive committee of the advisory council. The number shall remain flexible to include no less than two (2) and no more than four (4) meetings.
(4) remains the same.
(5) remains the same.

AUTH: 2-4-201 MCA IMP: 2-4-201 MCA

3. The proposed amendment will allow the leadership of the Advisory Council to determine the need for each meeting and to

schedule or cancel meetings as necessary. This amendment continues to allow for adequate representation from various segments of the public and the library community. This amendment may result in financial savings.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Richard Miller, State Librarian, Montana State Library, 1515 East Sixth Avenue, P.O. Box 201800, Helena, Montana 59620, no later than August 20, 1993.

5. Lloyd Wallin, Chair of the State Library Commission, will preside over and conduct the hearing.

Richard T. Miller, Jr.
State Librarian
Rule Reviewer

Certified to the Secretary of State July 2, 1993.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Teacher Certification	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF ARM 10.57.211 TEST FOR CERTIFICATION

To: All Interested Persons

1. On September 16, 1993 at 11:00 a.m., or as soon thereafter as it may be heard, a public hearing will be held at the Board of Public Education offices, 2500 Broadway, Helena, in the matter of the amendment of ARM 10.57.211 Test for Certification.

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

10.57.211 TEST FOR CERTIFICATION (1) Effective July 1, 1986, all new applicants for initial class 1, 2 or 3 certification must provide evidence of having completed the national teacher examination core battery with a minimum score established by the board. Exceptions:

(a) applicants holding a valid Montana Class 1, 2 or 3 certificate~~.~~; and

(b) applicants who show evidence of successful completion (grade C or above) in specific college level coursework within a state approved teacher education program in the area(s) of weakness identified by the national teacher examination student report;

(i) the area(s) of weakness identified by the testing service must be provided to the office of public instruction by the applicant, at which time the director of teacher education and certification will confirm or recommend in writing the specific courses which would qualify for the equivalent of successful completion of the exam;

(ii) evidence of successful course completion must be presented to the office of public instruction, certification division, within two (2) years of the last recorded unsuccessful attempt, or within two (2) years of the effective date of this rule;

(iii) after the effective date of this rule change, those issued class 5 provisional certification with plans of professional intent which include successful completion of the test, must successfully complete the testing or approved coursework within the three (3) year term of that certificate;

(iv) upon application, holders of class 5 certification at time of this rule change may apply this criteria as justification for renewal under ARM 10.57.405(a).

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

AUTH: Sec. 20-2-121, 20-4-102 IMP: Sec. 20-4-102

3. The board has proposed this amendment to the rule because the present system of requiring prospective teachers and specialists to achieve a passing score on the National Teachers Examination (NTE) prior to obtaining a Montana teaching certificate has been problematic. The failure rate for this examination has been particularly high for Native Americans. This has reduced the number of Native American teachers coming into the profession which further compounds the difficulty of educating Indian students. In addition, some successfully practicing teachers from other states have had difficulty with this requirement because of the time elapsed since their college preparation. This rule change would give individuals who have been unsuccessful in passing the NTE another avenue to certification.

4. Interested parties may submit their data, views or arguments either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to John Kinna, Chairman, Board of Public Education, 2500 Broadway, Helena, MT 59620, no later than September 3, 1993.

5. John Kinna of the Board of Public Education, 2500 Broadway, Helena, MT 59620, has been designated to preside over and conduct the hearing.

Wayne F. Buchanan

WAYNE BUCHANAN, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 7/2/93.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the proposed adoption of a rule prescribing the affidavit form for an indigence financial statement.	)))))	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On August 27, 1993, the Department of Justice proposes to adopt the following rule establishing the affidavit form for a financial statement for poor persons to submit to the court or administrative tribunal prior to approval of indigence status.

2. The proposed rule provides as follows:

RULE I AFFIDAVIT OF INDIGENCE (1) Persons applying to a court or administration tribunal for waiver of costs and approval of indigence status must complete the following affidavit. (A person represented by an entity that provides free legal services to indigent persons is excused from filing the affidavit).

AFFIDAVIT OF INDIGENCE

ANSWER ALL QUESTIONS. USE N/A IF NOT APPLICABLE

STATE OF MONTANA)
: ss.
County of _____)

I, _____, being first duly sworn, depose and say: That I have a good cause of action or defense but am unable to pay the costs or get security to secure the cause of action or defense and request the court or administrative tribunal to waive the costs and approve indigence status. I declare the following:

1. Name_____DOB_____

2. Address_____

3. Telephone____ Single__ Married__ Separated__ Divorced__

4. Employed: Yes__ No__ Self-Employed Yes__ No__

   a. Employer's name & address_____
   _____

   b. Your employment income? Monthly $_____

5. If unemployed, when last employed _____ Job_____
_____

6. Dependents? Spouse__ Number of children____
Others (Specify) _____

7. If married, is spouse employed? Yes____ No____

a. Employer's Name & Address_____
_____

b. Spouse's employment income? Monthly $ _____
Does spouse have any other income? Monthly $_____
(Example: support payments, alimony, interest, rent income, workers' compensation, unemployment, social security)

8. Do you have any other income from other sources? Yes___No___ Monthly $_____ Sources_____
_____. (Example: workers' compensation, unemployment, social security, support, alimony, interest, rent income)

9. Do you have a car? Yes___ No___ Is it paid for?_____

a. If not, how much do you owe? $_____

b. Year, Make and Model_____

10. Do you own any land or other real estate, or are you buying any? Yes ___ No ___

a. What is its approximate value? $_____

b. How much did you pay for it? $_____ When? _____

c. Is it paid for? Yes___ No ___

d. If not, how much do you owe? $ _____

11. Do you have any: a. Cash or savings? Yes___ No___
Amount? $_____ Bank _____

b. Checking accounts? Yes___ No___ Amount? $_____

c. Stocks or bonds? Yes___ No___ Value? $_____

d. Other property? Yes___ No___ Value? $_____

(Trailer, boat, camper, cycle, guns, tools, collections, etc.) Describe: _____
_____

I further declare that I am the person named above, that I have read the foregoing questions and information and know the same to be true of my own knowledge, and that if any part of the above is made falsely I am subject to prosecution for perjury.

_____
Signature of Requestor

SUBSCRIBED AND SWORN TO before me this ____ day of _____, 19___.

_____
Notary Public for the State of Montana.
Residing at _____, Montana.
My Commission expires _____.

(S E A L)

AUTH: MCA § 25-10-404
IMP: MCA § 25-10-404

3. The new rule prescribing a form for use in determining indigence is being proposed for adoption because the 1993 Legislature, in HB 409, required that the department adopt such a rule.

4. Interested parties may submit their data, views or arguments concerning the proposed rule in writing to Beverly M. Rhodes, Attorney General's Office, 215 North Sanders, Helena, MT 59620, to be received no later than August 13, 1993.

5. If a person who is directly affected by the proposed adoption wishes to express any data, views and arguments orally or in writing at a public hearing, he/she must make a written request for a hearing and submit that request along with any written comments to Beverly M. Rhodes, Attorney General's Office, 215 North Sanders, Helena, MT 59620. The request and comments must be received no later than August 13, 1993.

6. If the agency receives requests for a public hearing on the proposed adoption from 25 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 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.

By: Joseph P. Mazurek
Joseph P. Mazurek
Attorney General

Rule Reviewer

Certified to the Secretary of State July 2, 1993.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of rule 23.5.101 pertaining to the state adoption of federal hazardous materials regulations	)))))	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE 23.5.101 PERTAINING TO THE STATE ADOPTION OF FEDERAL HAZARDOUS MATERIALS REGULATIONS

TO: All Interested Persons.

1. On August 18, 1993, at 10 a.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 North Roberts, Helena, Montana to consider the amendment of rule 23.5.101.

2. The proposed amendment will read as follows:

23.5.101 TRANSPORTATION OF HAZARDOUS MATERIALS

(1) ~~Transportation of hazardous materials in regard to all motor carriers, railroads, pipelines or utilities under the jurisdiction of this department and hereby adopted by the various federal departments and agencies including department of transportation, interstate commerce commission, federal power commission, and the federal communication commission.~~ All commercial motor vehicles as defined in section 61-1-134, MCA, and subject to regulation by the department under section 44-1-1005, MCA, shall comply with and the department does hereby adopt, by reference, the following federal regulations of the department of transportation which concern the transportation of hazardous materials. The regulations adopted by reference are 49 C.F.R. Part 107, 49 C.F.R. Part 171, 49 C.F.R. Part 172, 49 C.F.R. Part 173, 49 C.F.R. Part 177, 49 C.F.R. Part 178, and 49 C.F.R. Part 180. ~~These rules~~ The regulations adopted may be found in the Code of Federal Regulations, Title 49, chapter 1~~,~~ subchapters B and C (1992), updated through the effective date of this rule; they may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

AUTH: 44-1-1005(1), MCA IMP: 44-1-1005(1), MCA

3. Amendment of this rule is necessary because the current version of the rule was originally written under the authority of the Public Service Commission. The current rule adopts all federal rules and regulations concerning hazardous materials that apply to motor carriers, railroads, pipelines and utilities. In 1985, motor carrier safety regulation was transferred from the Public Service Commission to the Department of Justice. This rule has never been amended to reflect the jurisdiction of the Department of Justice, which concerns only

motor carriers, other commercial motor vehicles and motor vehicles which transport hazardous materials. In addition, the federal rules relating to hazardous materials and motor vehicles have been substantially changed since 1985. The new federal rules must be formally adopted under the provisions of MCA § 2-4-307(3).

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to Larry Barton, Montana Highway Patrol, Scott Hart Building, 303 North Roberts, Helena, Montana 59620-1422, and must be received no later than August 18, 1993.

5. Larry Barton, Montana Highway Patrol, Scott Hart Building, 303 North Roberts, Helena, Montana 59602-1422 has been designated to preside over and conduct the hearing.

By: _____
for JOSEPH P. MAZUREK, Attorney General

_____
Rule Reviewer

Certified to the Secretary of State, July 2, 1993

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

In the matter of the amendment of A.R.M. 26.3.180, 26.3.182 and 26.3.186, pertaining to recreational use of state lands and A.R.M. 26.3.157, pertaining to posting of state lands to prevent trespass.	))))))	NOTICE OF PUBLIC HEARING

TO: All Interested Persons

1. On August 9 and August 11, 1993, the Department of State Lands and Board of Land Commissioners will hold hearings to consider amendment of ARM 26.3.180 and 26.3.182, pertaining to the definition of recreational use of state lands; ARM 26.3.186, pertaining to application of block management restrictions to state lands; and ARM 26.3.157, regarding posting of state lands. The hearings will be held at the following locations on the following dates and at the following times:

- Polson at the Lake County Courthouse, 105 4th Ave. E. on August 9, 1993, at 7:00 p.m.

- Bozeman at the Community Room, Gallatin County Courthouse, 311 W. Main on August 9, 1993, at 7:00 p.m.

- Circle at the Circle High School Auditorium, 100 Meridian on August 11, 1993, at 7:00 p.m.

- Great Falls at the Great Falls High School Auditorium, 1900 2nd Ave. South on August 11, 1993, at 7:00 p.m.

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

26.3.180 OVERVIEW OF RECREATIONAL USE RULES (1) ARM 26.3.183 through ARM 26.3.198 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 three categories as follows:

(a) General recreational use - This use is generally defined as licensed hunting, ~~hunting-related activities, and~~ fishing, hiking, horseback riding, and bird-watching. This is more specifically defined in ARM 26.3.182(11). It requires purchase of a recreational use license. Detailed procedures and restrictions are contained in ARM 26.3.183 through ARM 26.3.197.

(b) Special recreational use - This use is defined in ARM 26.3.182(21) 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 ARM 26.3.198.

(c) Other recreational use - Types of recreational use not within the definitions of general recreational use or special recreational use, such as ~~hiking~~ non-commercial berry

picking, do not require a recreational use or special recreational use license from the department. On leased state land, however, permission must be secured in accordance with ARM 26.3.157.
AUTH: 77-1-209 and 77-1-804, MCA.
IMP: 77-1-101, MCA.

26.3.182 DEFINITIONS Wherever used in ARM 26.3.180 through ARM 26.3.198, unless a different meaning clearly appears from the context:

(1) through (10) remain the same.

(11) "General recreational use" means fishing, ~~and~~ hunting for game for which a hunting license is required by the department of fish, wildlife and parks, hiking, horseback riding, and bird-watching. It also includes accompanying a person who is hunting or fishing for the purpose of assisting that person. Day horseback use in conjunction with hunting and fishing is included as general recreation use. ~~General recreational use includes scouting for big game on leased land if conducted during the weekend and the day before the beginning of any hunting season during which the recreationist intends to hunt.~~

(12) through (21) remain the same.
AUTH: 77-1-209, MCA.
77-1-804, MCA.
IMP: 77-1-101, MCA.

26.3.186 GENERAL RECREATIONAL USE OF STATE LANDS: RESTRICTIONS (1) The following restrictions apply to persons engaging in general recreational use of state lands:

(a) through (e) remain the same.

(f) For state lands included within a wildlife 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) For state lands that are within the exterior boundaries of a block management area administered by the department of fish, wildlife, and parks as part of its block management program, recreational use is subject to the restrictions of a block management area for state land that:

(i) is completely surrounded by private land that is part of the block management area; and

(ii) is not accessible by dedicated public road, right of way or easement; by public waters; or by adjacent federal, state, county, or municipal land that is open to public use.

~~(g)~~ (h) Littering on state lands is prohibited. Recreationists shall pack out their litter.

(2) remains the same.
AUTH: 77-1-804, MCA.
IMP: 77-1-804, MCA.

26.3.157 RESERVATIONS (1) and (2) remain the same.

(3) The state reserves the right to sell or otherwise dispose of any interest other than that for which the lessee or licensee has leased or licensed the premises, including hunting or fishing access privileges on state land; however, the lessee may post state land with signs provided by the department to prevent trespass and unauthorized persons. The lessee may not use any other method, including orange paint, to post state land.
AUTH: 7-1-209, MCA.
IMP: 7-1-202, MCA.

3. Pursuant to 77-1-203, MCA, the Board of Land Commissioners is required, consistent with its trust responsibilities, to manage state lands under the multiple use concept. In addition, the statement of intent that accompanied Chapter 609, Laws of 1991, which opened state lands to general recreational use, stated that "it is intended that public recreational use of state lands be accomplished to the fullest extent possible." Section 77-1-101(6) defines "general recreational use" as "non-commercial and non-concentrated hunting, fishing, and other activities determined by the board of land commissioners to be compatible with the use of state land." The amendments to ARM 26.3.180 and 26.3.182 are proposed because hiking, bird watching and horseback riding are generally compatible with grazing and agricultural use of state lands (lands are closed to general recreational use while crops are growing) and because expansion of definition meets the intent of the Legislature by expanding permissible recreation. Under section 77-1-804, MCA, the Board may exempt state lands within block management areas from block management restrictions. The amendment to ARM 26.3.186 as proposed advances the intent of full recreational use by removing restrictions on general recreational use. The amendment to ARM 26.3.157(3) is proposed to eliminate public confusion that is caused when state lessees post state lands with orange paint, which is normally associated with private land. This raises questions of whether the land is state land and whether it is open to general recreational use. The proposed amendment would provide a uniform system of posting state lands.

4. 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 Bud Clinch, Commissioner, Department of State Lands, P.O. Box 201601, Capitol Station, Helena, Montana 59620 no later than August 16, 1993. To guarantee consideration, written data, views, or arguments must be postmarked by August 16, 1993.

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

- Bud Clinch, Commissioner, for the Polson and Great Falls hearings;

- M. Jeff Hagener, Administrator, Lands Division, for the Bozeman and Circle hearings.

Reviewed by:

John F. North
Chief Legal Counsel

Arthur R. Clinch
Commissioner

Certified to the Secretary of State July 2, 1993.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.11.301 and ADOPTION of NEW RULE I relating to Opening a New Liquor Store	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT of ARM 42.11.301 and ADOPTION of NEW RULE I relating to Opening a New Liquor Store

TO: All Interested Persons:

1. On August 10, 1993, at 1:30 p.m., a public hearing will be held in the Fourth Floor Conference Room of the Mitchell Building, at Helena, Montana, to consider the Amendment of ARM 42.11.301 and the Adoption of New Rule I relating to Opening a New Liquor Store.

2. The proposed rule I, does not replace or modify any section currently found in the Administrative Rules of Montana.

3. The proposed amendment is as follows:

42.11.301 DEFINITIONS (1) As used in this subchapter, the following definitions apply:

(a) "Agency store" means a state liquor store operated by an agent.

(b) "Agent" means a person, partnership, or corporation that markets liquor on a commission basis under an agency agreement with the department and provides all the resources, including personnel and store premises, needed to market liquor under the agreement except the liquor product, which is owned by the department until purchased by a customer.

(c) "Liquor" includes table wine when the alcoholic beverage code permits the department to distribute table wine to a state liquor store.

(d) "State liquor store" includes agency stores and liquor stores operated by state employees.

(e) "New state liquor store" means, a state liquor store that begins operation in a community that has not had a state liquor store in operation for one or more years.

(f) "Community boundary" means:

(i) in the case of an incorporated city or town, the city or town limits;

(ii) in other communities, the generally recognized and commonly accepted outer edge of the community.

(2) Other words and phrases used in these rules shall have the meaning ascribed to them in the Montana Alcoholic Beverage Code, as amended, and if not defined therein have their usual and customary meaning. (AUTH: Sec. 16-1-303 MCA, IMP, Sec. 16-2-101 MCA.

4. New Rule I as proposed to be adopted provides as follows:

NEW RULE I OPENING A NEW STATE LIQUOR STORE (1) The number of state liquor stores that may be located in a community will vary with the liters of liquor sold in a community annually. If there is no history of liquor sales for a community, the department will estimate the liter sales based on experience with communities that have similar population sizes. The number of stores that may be located in a community per liter volume is as follows:

(a) 5 stores for 930,000 liters or more annually;

(b) 4 stores for 680,000 to 929,999 liters annually;

(c) 3 stores for 430,000 to 679,999 liters annually;

(d) 2 stores for 180,000 to 429,999 liters annually; and

(e) 1 store for less than 180,000 liters annually.

(2) A new state liquor store will be operated by an agent unless operation by state employees would be less expensive to the department.

(3) The department will conduct a public hearing to open a new agency store in a community when all of the following conditions are met:

(a) The department receives a petition signed by 20 registered voters who reside in the community to open an agency store in the community. The petition must clearly state that its purpose is to have the department open a state liquor store in the community which will be operated by an agent under contract with the department. The petition must show the printed name, mailing address and signature of each person signing the petition.

(b) The department receives a letter from a person willing to submit a proposal or bid to operate an agency store in the community. This person must control or expect to control a building in the community that could be used as the agency store location.

(c) The number of state liquor stores currently operating in the community does not exceed the limit in (1).

(d) The nearest community with an operating state liquor store is more than 35 miles as measured from the nearest community boundaries along the shortest route on a paved road between the two communities unless the new store is to be located in a community eligible for more than one store pursuant to (1).

(e) The department has not solicited for an agent in the community within the previous three years.

(f) The petition identified in (a) and the letter from a potential agent in (b) must be received within six months of each other.

(4) When all of the conditions in subsection (3) are met, the department will hold a public hearing in the community to receive comments from interested parties concerning the department's intention to advertise for proposals or bids for a liquor store agent. The procedures concerning the public hearing are:

(a) The notice will contain the following:

(i) the date, time and place in the community where the public hearing will be conducted; and

(ii) provide the name and address of the hearing officer appointed by the liquor division administrator to conduct the hearing.

(b) Notice of the public hearing will be advertised twice during a two-week period in the legal section of:

(i) the nearest daily newspaper in general circulation for the affected area; and

(ii) in the local community newspaper, if there is one.

(c) The hearing will be conducted approximately one week following the last publication of the notice in the newspapers.

(d) The hearing officer will preside over the hearing and collect the information presented by all persons. The hearing will be directed to the following:

(i) whether the department should proceed with its intention to advertise for proposals or bids for a liquor store agent for the community; and

(ii) whether any limitations or restrictions on the location and operation of the agency should be considered.

(e) Within one week following the public hearing, the hearing officer will submit a report to the liquor division administrator. This report will provide the following:

(i) identify all of the issues raised at the hearing;

(ii) recommend whether proceeding with the advertisement for proposals or bids for a liquor store agent is in the best interest of the state, and the community; and

(iii) recommend whether any limitations or restrictions on the location and operation of the agency should be considered.

(f) One week following receipt of the hearing officer's report, the liquor division administrator will decide what action will be taken in response to the hearing officer's recommendations.

(5) Notice of the liquor division administrator's decision will be mailed to all parties who signed the petition and gave a mailing address or who attended the public hearing and gave a mailing address.

(6) If the decision is to proceed with the advertisement for request for proposals or invitation for bids for a liquor store agent, the process to select an agent will be conducted in accordance with ARM 42.11.103.

(7) If no proposals or bids are received in response to a request for proposals or invitation for bids, or none of the proposals or bids received meet the minimum requirements specified in the request for proposals or the invitation for bids, the department will make no further solicitation for an agent in the community for three years. If the conditions in subsection (3) and (4) are met after the three year period, the department will begin the process again.

AUTH: Sec. 16-1-303, MCA; IMP: Sec. 16-2-101, MCA.

5. The Department is proposing the amendment to ARM

42.11.301 to clarify the definition of a new state liquor store. The Department is proposing the adoption of New Rule I to establish conditions under which a new store would be considered. Also to prevent frivolous requests for store openings and prevent the establishment of new stores in locations that will unreasonably draw sales away from existing stores. The proposed rule also provides for a public hearing in the locale of the proposed new store. This opportunity will provide both the public and the division with the necessary information about the issues concerning a new store and those most affected by having a new liquor store in the area.

6. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to:

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

no later than August 20, 1993.

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

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State July 2, 1993.

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

In the matter of the amendment of rules 46.10.318 and 46.10.319 pertaining to emergency assistance to needy families with dependent children	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.10.318 AND 46.10.319 PERTAINING TO EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH DEPENDENT CHILDREN

TO: All Interested Persons

1. On August 4, 1993, at 10:30 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.10.318 and 46.10.319 pertaining to emergency assistance to needy families with dependent children.

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

46.10.318 EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH DEPENDENT CHILDREN (1) For purposes of this chapter, "emergency assistance" means aid, care and services authorized to meet the emergency needs of a child under 21 or the household in which he is living in the following circumstances:

(a) where ~~such~~ the emergency arises from an unforeseen event which was beyond the household's control ~~a disaster such as a fire, flood, earthquake, violent storm or drought, civil disorder, illness, accident or death, eviction, utility cut-off, travel emergency, or from the breakdown of necessary food storage or food preparation appliances~~, and which has caused or threatens to cause the destitution of the child ~~and/or the household~~; or

(b) where the emergency arises out of a situation identified by the department of family services (DFS) involving abuse, neglect or delinquency of the child.

(2) For purposes of this rule, household means the child whose needs are to be met by the emergency assistance and all other persons who live with the child and are related to the child by blood or marriage.

(3) Emergency assistance will be provided only if:

(~~b~~a) ~~where such~~ the emergency needs did not arise because ~~such~~ the child or the child's caretaker relative refused without good cause to accept or maintain employment or training for employment;

(i) in determining whether good cause exists for failure to accept or maintain employment or training for employment, a consideration of all facts and circumstances will be made including those submitted by the Montana ~~employment security~~

~~division~~ job service at the time of the alleged failure. Participation in a labor strike does not constitute an emergency situation nor qualify as good cause.

(A) "Good cause" ~~includes~~ requires circumstances beyond the person's control, and includes but ~~are~~ is not limited to:

(I) illness of the ~~person~~ child or caretaker relative;

(II) illness of another household member sufficiently serious to require the presence of the ~~person~~ child or caretaker relative;

(III) unavailability of transportation;~~or~~ and

(IV) ~~unanticipated emergency~~ employment demands or conditions which render employment unreasonable, such as working without being paid as agreed or discrimination by an employer based on age, race, sex, color, handicap, religious beliefs, national origin or political beliefs.

(~~eb~~) ~~where such~~ the emergency situation could not have been foreseen by the applicant and was not under ~~his~~ the applicant's control; and

(~~dc~~) ~~where other resources, including public assistance benefits or services and all liquid resources, have been exhausted.~~ the applicant has exhausted all other means available to meet the emergency need, including but not limited to all liquid resources of the household and any benefits or services for which the household is eligible.

(~~24~~) Emergency assistance ~~is limited to~~ will be authorized for one period not to exceed 30 consecutive days in any 12 consecutive months.

~~(3) Payment for shelter and utilities will be limited to the two (2) most recent months of rent or utilities service due. An eviction notice or final utility cut-off notice will be required before emergency assistance will be granted.~~

~~(4) Emergency assistance is not available to pay any taxes that an applicant or recipient has failed to pay. If the failure to pay property taxes is due to unforeseeable reasons not under the control of the applicant and results in actual eviction, emergency assistance will be available in the form of vendor payments to provide the first two months of rent in a rental unit. An eviction notice will be required before emergency assistance will be granted.~~

(5) Emergency assistance shall be provided as follows:

(a) ~~Medical assistance shall be limited to the amount, scope and duration of services provided under the medicaid program. The services shall be provided through vendor payments.~~ Assistance is issued by food and clothing distributions whenever possible or otherwise by vendor or cash payments. Cash payments shall be made directly to the recipient unless there is a protective payee.

(b) ~~Food and clothing distributions will be made in lieu of money or county disbursing orders whenever possible. Vendor payments or cash payments will be used when necessary.~~ Medical assistance shall be limited to services authorized under the Montana medicaid program and shall not exceed the current medicaid rate for that service. Medical assistance will be provided only if the family assistance division

central office grants approval prior to the date of delivery of the service.

~~(c) Shelter and utilities payments will be made by vendor payment.~~

~~(d) Other emergency needs, such as replacement of necessary appliances, furniture, bedding and other necessary household equipment may be supplied through vendor payments or cash payments.~~

~~(e) If available, social services will be provided on an as-needed basis upon the request of the recipient for information, referral to other agencies, counseling, securing family shelter, child care, legal services, homemaker service, and other service needs that arise from the emergency or crisis situation.~~

~~(f) Cash payments shall be paid directly to the recipient unless there is a protective payee.~~

(6) Emergency assistance shall not be provided to pay for the following:

(a) penalties, fines, and taxes, including but not limited to personal and real property taxes;

(b) insurance - home, auto, or life;

(c) burials;

(d) mortgages - however, if a foreclosure notice has been received, emergency assistance may be provided for temporary shelter payment at a motel or other rental unit not to exceed two months' expenses;

(e) reimbursements for expenses already paid or money loaned to the household to pay expenses;

(f) rental and/or utility deposits;

(g) medical bills for services already received;

(h) bills more than 30 days past due, excepting the two most recent months of past due rent or utility bills if an eviction notice or utility cut-off notice has been given to the household;

(i) legal fees, including but not limited to court costs and attorney fees;

(j) the purchase of a vehicle; or

(k) any travel that would be payable by medicaid, AFDC transition-to-work allowance, or JOBS supportive services.

(7) Emergency assistance may be provided to pay for social worker services in the home if:

(a) DFS has identified a need for social worker services to prevent the child's removal, expedite the return of the child to the home, or prevent the need for protective services for the child; and

(b) the child is not eligible for social worker services under Title IV-E (foster care) or Title XIX (medicaid).

(8) Information will be provided and referrals will be made to meet the needs of the household for counseling, shelter, child care, legal services, homemaker services, or other services.

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

46.10.319 EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH DEPENDENT CHILDREN, PROCEDURES FOLLOWED IN DETERMINING ELIGIBILITY (1) A person or the department of family services (DFS) acting on behalf of the child seeking emergency assistance shall make ~~application~~ a request for emergency assistance at the county office administering public assistance programs or the DFS office in the county where ~~he~~ the applicant lives.

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

(a) that a child under the age of 21 is living with, or within six (6) months prior to the date of the request for emergency assistance ~~application~~ did live with, a relative specified in ARM 46.10.302(1) in a place of residence maintained by the relative as the child's own home; and

(b) that ~~the circumstances listed~~ all requirements set forth in ARM 46.10.318~~(1)~~ have been met.

(4) Emergency assistance may be ~~used~~ provided in addition to but not as a substitute for ~~categorical~~ AFDC assistance. ~~Emergency assistance may be extended to those families with dependent children on a supplementary basis who have specified needs arising from an emergency situation.~~

(5) The completed ~~application is~~ request for emergency assistance shall be submitted to the county or DFS office. The applicant ~~which~~ shall ~~notify the person~~ be notified by the county office of the approval or reasons for disapproval of ~~his application~~ the request for emergency assistance.

(6) There are no residency requirements for emergency assistance. Non-residents. ~~M~~migrants and transients who otherwise meet the requirements of this part are eligible for emergency assistance.

(7) County offices shall give priority to ~~applications~~ requests for emergency assistance.

(8) An expedited administrative review of a denial of ~~an application~~ a request for emergency assistance will be available to applicants who request in writing such an expedited review within five (5) working days of the date of the denial. Such a review will be held within five (5) working days of the date the request is received by the county. Requests not made in accordance with these provisions will be processed according to the department's standard fair hearing procedures.

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

3. Emergency assistance to needy families with children is a federally funded program to meet the emergency needs of such families. Federal regulations governing the emergency assistance program at 45 CFR 233.120 give the state agencies administering the program wide latitude to determine what needs will be met by the program.

ARM 46.10.318 specifies in what circumstances emergency assistance will be provided. As currently written, it sets very few limitations on the kinds of needs which can be met by

emergency assistance. The Department has recently reviewed the emergency assistance program and has determined that in order to allocate its limited funds in a prudent manner, some limits must be added to the rule.

Subsection (1)(a) of ARM 46.10.318 is being amended by deleting the list of types of emergencies for which assistance will be given and stating instead that the emergency must arise from an unforeseen event beyond the household's control. The department believes that assistance should be given to families who are unable to provide for the needs of their children due to circumstances they could not have anticipated or controlled. It is the fact that the event could not have been predicted or prevented which the Department considers to be important, rather than the specific cause of the emergency, such as a natural disaster or illness.

A provision is also being added to specify that assistance can be given where an emergency has arisen from child abuse, neglect, or delinquency as identified by the Department of Family Services, because the department considers that assistance should be given in such cases regardless of whether the emergency arose from an unforeseen event, in order to protect children who may be at risk of harm.

The rule currently states that emergency assistance will not be given to pay taxes. This policy is unchanged in the amended rule but subsection (6) of the rule now lists additional purposes for which emergency assistance will not be provided, such as the purchase of a vehicle or mortgage payments. The department determined that its limited funds should not be spent to provide emergency assistance for the excluded purposes.

ARM 46.10.318 currently provides that assistance will not be given for an emergency which arose due to failure of the child or caretaker relative to accept employment or training for employment, unless there was good cause for the failure. ARM 46.10.318 is being amended to add failure to maintain employment or training for employment as a basis for denying emergency assistance. The Department considers that failure to maintain a job without good cause is as serious as failure to accept a job and should disqualify a household from receiving emergency assistance.

The rule is being amended to specify that participation in a labor strike does not constitute good cause for failing to accept employment or training. Since participation in a strike is something over which a person has control, and good cause consists of circumstances beyond the applicant's control, the department believes that participation in a strike should not constitute good cause. Unreasonable working conditions and discrimination by an employer are now specifically listed as circumstances which constitute good cause. In

addition, ARM 46.10.318 has been re-organized and re-written to make it clearer and more readable.

ARM 46.10.319 sets forth the procedures used to determine eligibility for emergency assistance. Minor changes have been made to ARM 46.10.319 for reasons of style and clarity. The only substantive change to ARM 46.10.319 is in subsection (1). It now provides that DFS may file a request for emergency assistance on behalf of a child and that a request for assistance can be made at a DFS office as well as at the county office which administers public assistance programs.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than August 12, 1993.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 2, 1993.

BEFORE THE BOARD OF THE
STATE COMPENSATION MUTUAL INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the adoption of amendments to rules pertaining to method for assignment of classifications of employments and the construction industry premium credit program.	NOTICE OF AMENDMENT OF RULES 2.55.320 AND 2.55.327

TO: All Interested Persons:

1. On May 27, 1993, the board published notice of public hearing on the proposed amendments of rules 2.55.320 and 2.55.327 pertaining to the State Compensation Mutual Insurance Fund. The notice can be found on pages 970 through 971 of the 1993 Montana Administrative Register, Issue No. 10.

2. No comments or testimony concerning the rules were received.

3. The Board has adopted the rules as proposed and corrected.

4. The authority of the State Compensation Mutual Insurance Fund to adopt the proposed rules is based on sections 2-4-201, 2-3-103, and 39-71-2316, MCA and the rules implement sections 2-4-201, 2-3-103, 39-71-2311, 39-71-2316, MCA.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Rick Hill
Chairman of the Board

Nancy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State July 2, 1993.

BEFORE THE DEPARTMENT OF AGRICULTURE
STATE OF MONTANA

In the matter of the adoption of new rules on civil penalties relating to the distribution of seed in Montana; amending ARM 4.12.3007 on seed license fees; amending references to seed processing plants in Title 4, Chapter 12, Sub-chapter 30; deleting sub-sections (3) and (4) of ARM 4.12.3002 on Seed Buyers and Seed Public Warehouses; and repealing of ARM 4.12.3006 on bonding of Seed Buyers and Seed Public Warehouses	)NOTICE OF ADOPTION OF)NEW RULES ON CIVIL)PENALTIES RELATING TO THE)DISTRIBUTION OF SEED IN)MONTANA; AMENDING ARM)4.12.3007 ON SEED LICENSE)FEES; AMENDING REFERENCES)TO SEED PROCESSING PLANTS)IN TITLE 4, CHAPTER 12,)SUB-CHAPTER 30; DELETING)SUBSECTIONS (3) AND (4) OF)ARM 4.12.3002 ON SEED BUYERS)AND SEED PUBLIC WAREHOUSES;)AND REPEALING OF ARM 4.12.3006)ON BONDING OF SEED BUYERS AND)SEED PUBLIC WAREHOUSES

TO: All Interested Persons:

1. On May 27, 1993, the Department of Agriculture published a notice of proposed adoption of new rules on civil penalties relating to the distribution of seed in Montana; amending ARM 4.12.3007 increasing seed license fees; amending all references in Title 4, Chapter 12, sub-chapter 30 to Seed Processing Plant(s) by deleting the word "processing" and inserting the word "conditioning"; deleting subsections (3) and (4) of ARM 4.12.3002 on Seed Buyers and Seed Public Warehouses; and repeal of ARM 4.12.3006 on bonding of Seed Buyers and Seed Public Warehouses at page 972 of the Montana Administrative Register, issue number 10.

2. The department has adopted new rules, Rule I (4.12.3012), Rule II (4.12.3013), amended ARM 4.12.3007 4.12.3002, 4.12.3003 and 4.12.3004 as proposed.

3. The department has amended ARM 4.12.3001 as proposed with the following change:

4.12.3001 EQUIPMENT STANDARDS (1) Seed Conditioning Plants Licensed as ~~(1)~~ First Class Seed Conditioning Plants shall have: (a) thru (9) remain the same.

4. The department has repealed ARM 4.12.3006 as proposed.

5. No comments or testimony were received.

Leo A. Giacometto, Director
Department of Agriculture

Timothy J. Meloy, Attorney
Rule Reviewer

Certified to the Secretary of State Office July 2, 1993.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
STATE OF MONTANA

In the matter of the general revision of rules pertaining to medicare supplement insurance	)))))	NOTICE OF AMENDMENT AND REPEAL OF EXISTING RULES AND ADOPTION OF NEW RULES PERTAINING TO MEDICARE SUPPLEMENT INSURANCE

TO: All interested persons

1. On May 27, 1993, the state auditor and commissioner of insurance of the state of Montana, Montana Insurance Department, published notice of proposed amendment and repeal of existing rules and adoption of new rules pertaining to medicare supplement insurance at page 979 of the Montana Administrative Register, issue No. 10.

2. Oral comment was taken at a public hearing on June 18, 1993, at 10:00 a.m., MDT, at the east conference room on the ground floor of the Mitchell Building, 126 North Sanders, Helena, Montana. Written comments were received through June 28, 1993. Comments to the proposed rules are summarized below.

3. The agency has repealed 6.6.502, 6.6.512 through 6.6.514, 6.6.516, and 6.6.518 as proposed.

4. The agency has adopted new Rule II (ARM 6.6.507B) as proposed.

5. The agency has adopted new Rules I (ARM 6.6.507A) and III (ARM 6.6.508A) with the following changes (new matter underlined, stricken material interlined).

6. The agency has amended ARM 6.6.503, 6.6.505, 6.6.506, 6.6.515, 6.6.517, 6.6.519, 6.6.520, and 6.6.522 as proposed.

7. The agency has revised amendments to ARM 6.6.507, 6.6.508, 6.6.509, 6.6.510, 6.6.511, and 6.6.521. Revisions are shown in the following manner:

New material at ARM 6.6.507(1)(a)(i) and 6.6.507(1)(b)(v) is capitalized. Outline reference corrections to ARM 6.6.507 are shown with stricken references interlined and substituted references double underlined.

Three forms omitted from the Notice of Intent have been inserted. They are a report form for individual policies, a report form for group policies, and a form for reporting medicare supplement policies. These are standard forms proposed by the national association of insurance commissioners (NAIC) and accepted by the health care financing administration (HCFA).

All forms related to ARM 6.6.508 have been transferred to the end of the subchapter of the rules as adopted.

With respect to ARM 6.6.509, the annexed form entitled "Outline of Medicare Supplement Coverage - Cover Page" has been revised in the 5th box down from the top under column "G" by interlining "(100%)" and substituting "(80%)" underlined.

ARM 6.6.510 has been revised by inserting question (2) and revising question (4), shown in capital letters, and adding outline letter references for other follow-up questions.

ARM 6.6.511 has been revised by showing a corrected reference under the "Cover Page" provision at the end of the next to last paragraph in the text. Deleted material is interlined. Inserted material is double underlined.

ARM 6.6.521(1) is revised by inserting in capital letters a reference to an Appendix B and including that form at the end of the rules.

The revisions are shown as follows:

6.6.507 MINIMUM BENEFIT STANDARDS (1) through (1)(a) Same as proposed.

(i) A medicare supplement policy or certificate must not indemnify against losses resulting from SICKNESS ON A DIFFERENT BASIS THAN LOSSES RESULTING FROM accidents.

(ii) through (iv)(B) Same as proposed.

(v) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(ea)(vii) hereof, the issuer must offer certificateholders an individual medicare supplement policy which (at the option of the certificateholder):

(A) Same as proposed.

(B) Pprovides for such benefits as otherwise meets the requirements of this subsection.

(vi) Same as proposed.

(A) offer the certificateholder the conversion opportunity described in section (1)(ea)(~~v~~iv),

(B) through (b)(iv) Same as proposed.

(v) COVERAGE FOR THE COINSURANCE AMOUNT OF MEDICARE ELIGIBLE EXPENSES UNDER PART B REGARDLESS OF HOSPITAL CONFINEMENT, SUBJECT TO THE MEDICARE PART B DEDUCTIBLE.

(c) Same as proposed.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-905, MCA

NEW RULE I (6.6.507A) STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS (1) through (3) Same as proposed.

(4) An issuer may use, in addition to the benefit plan designations required in (~~5~~3), other designations to the extent permitted by law.

(5)(a) through (i) Same as proposed.

(j) Standardized medicare supplement benefit plan "J" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, the skilled nursing facility care, medicare Part B deductible, 100% of the medicare Part B excess charges, extended prescription

drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as established in ARM 6.6.507(1)(c)(i), (ii), (iii), (v), (~~vi~~vii), (viii), (ix), and (x).

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-905, MCA

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM The text of this rule remains the same. New forms have been added. All forms related to this rule have been transferred to the end of the subchapter.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-906, MCA

NEW RULE III (6.6.508A) FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) through (2) Same as proposed.

(3) Except as provided in (~~2~~a), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

(a) through (b) Same as proposed.

(4) Except as provided in (~~1~~a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(a) through (c) Same as proposed.

(d) A change in the rating structure or methodology shall be considered a discontinuance under (~~1~~4) unless the issuer complies with the following requirements:

(i) through (ii) Same as proposed.

(5) Except as provided in (~~2~~a) below, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in ARM 6.6.508.

(a) Same as proposed.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-906, MCA

6.6.509 REQUIRED DISCLOSURE PROVISIONS Text remains the same. Revisions to form are shown.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s) _____(insert letter(s) of plan(s) being offered)

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%) (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

AUTH: 33-1-313, MCA IMP: 33-22-907, MCA

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) through "(STATEMENTS)" Same as proposed.

(QUESTIONS)

To the best of your knowledge:

(a1) Do you have another medicare supplement ~~insurance~~ policy or certificate in force (including health care service contract, health maintenance contract)?

~~(b) Did you have another medicare supplement policy or certificate in force during the last 12 months?~~

~~(i) If so, with which company?~~

~~(ii) If that policy lapsed, when did it lapse?~~

(2) IF THE ANSWER TO (1) IS YES, WITH WHICH COMPANY?

(3) Do you have any other health insurance policies that provide benefits which this medicare supplement policy would duplicate?

(4) If soTHE ANSWER TO (3) IS YES, with which company?

(5) What kind of policy?

(6) If the answer to questions (1) or (~~2~~3) is yes, do you intend to replace these medical or health policies with this policy (certificate)?

~~(c)~~(7) Are you covered by medicaid?

~~(d) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate).~~

(2) through (5) Same as proposed.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-907, MCA

6.6.511 ~~SAMPLE FORMS~~SAMPLE FORMS OUTLINING COVERAGE (1) through (a) under title "NOTICE" Same as proposed.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the

charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to ~~section 9B~~New Rule I(4), of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Forms Plan A through Plan J, Parts A and B, same as proposed.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA; and 33-22-907, MCA

6.6.521 REPORTING OF MULTIPLE POLICIES (1) On or before March 1 of each year, every ~~insurer or other entity providing~~issuer ~~medicare supplement insurance coverage in this state~~ shall report the following information, CONTAINED IN APPENDIX B, for every individual resident of this state for which the ~~insurer or entity~~issuer has in force more than one medicare supplement insurance policy or certificate:

(a) policy and certificate number; and

(b) date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

AUTH: 33-1-313, MCA IMP: 33-22-904, MCA

Appendix A

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p)_____
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

Appendix A

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p)_____
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception:(l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged.
(y) Excludes Active Life Reserves.
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

Line		(a) Earned Premium (x)	(b) Incurred Claims(y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a - 1b)	---------	---------
2	Past Years' Experience (All Policy Years)	---------	---------
3	Total Experience (Net Current Year + Past Years' Experience)	---------	---------
4	Refunds last year (Excluding Interest)		
5	Previous Since Inception (Excluding Interest)		
6	Refunds Since Inception (Excluding Interest)		
7	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8	Experienced Ratio Since Inception		

Total Actual Incurred Claims (line 3, col b) = Ratio 2

Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)

9 Life Years Exposed Since Inception _____

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SHSBP (w)_____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

11 Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =

[Tot. Earned Premiums(line 3, col a)-Refunds Since Inception(line 6)] X Ratio 3(line 11)

13 Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) -

$$\frac{\text{Adjusted Incurred Claims (line 12)}}{\text{Benchmark Ratio (Ratio 1)}}$$

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

At the hearing on the proposed rules, a representative of an insurer, a representative of an insurer organization, and a representative of a senior citizens organization appeared and participated. Subsequent to the hearing, four entities submitted written comments. These included HCFA, the Health Insurance Association of America, and two insurers.

The agency has fully considered all written and oral submissions respecting the proposed rules and responds as follows:

COMMENT:
There were several suggested errata, outline reference, and grammatical corrections, as well as calling to the agency's attention the inadvertent omission of some forms included in the NAIC model rules, which have been approved by HCFA. These suggested corrections do not change the substantive intent of the rules. The forms make the rules easier to understand.

RESPONSE:
The agency accepts the suggested corrections and incorporates them and the previously omitted forms in the rules as adopted.

COMMENT:
One participant noted that the proposed rules did not include a definition of "preexisting conditions."

RESPONSE:
The parameters of "preexisting conditions" as they relate to medicare supplement insurance regulation in Montana are spelled out in Section 33-22-904(4), MCA, as amended. To attempt to define further would be either to unnecessarily repeat statutory language or to run the risk of an unlawful extension of authority.

COMMENT:
One participant noted that there was no proposed provision for filing advertising with the insurance commissioner.

RESPONSE:
Section 33-22-910, MCA, as amended, treats the subject of filing advertising with the insurance commissioner for approval. It was because of the statute that ARM 6.6.518 was repealed.

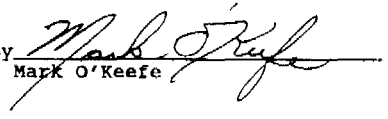
COMMENT:
Comment was made both at the hearing and in written submissions that the loss ratio standard should be independent of the method of distribution. Proposed loss ratios are 75% in the case of group policies and 65% in the case of individual under ARM 6.6.508(1). ARM 6.6.508(3) proposes a loss ratio of 75% for policies issued as a result of solicitations through the mails or by mass media. Specifically, it was contended that individual (as opposed to group) policies solicited through mass media or mail should be subject to the loss ratio standard

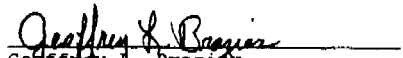
applicable to producer-solicited individual policies (65%). Those who commented argued that this is contrary to the NAIC model rules. One person commented, "A lower premium proves more beneficial to the consumer than a higher loss ratio requirement."

RESPONSE:

The rule is adopted as proposed. With mass media or mail solicitation, the producer commission is eliminated. While there are some additional costs created with mass media or mail solicitation, there are also additional off-setting expense economies. Another concern is differentiating between individual and group policies. If, for example, an insurer solicits policies through the american association of retired persons (AARP), such policies should rightly be considered subject to the group loss ratio standard. However, if the insurer issues individual policies to the AARP members, the lower loss ratio standard would allow the insurer to charge a higher premium for the coverage. The rule, as proposed, mandates a lower premium and is thus more beneficial to Montana consumers, which is consistent with NAIC and federal guidelines. Those who commented on this subject agreed that there is little or no difference between expenses incurred in producer-solicited policies and those of mass media or mail-solicited business. Only minimal, non-convincing statistical evidence was provided in support of that contention. If and when convincing industry data are provided to demonstrate consistency in the expense needs for producer-solicited business versus mass media or mail-solicited business (individual versus group), any appropriate rule amendments can be made at that time.

State Auditor and
Commissioner of Insurance

By 
Mark O'Keefe


Geoffrey L. Brazier
Rules Reviewer

Certified to the secretary of state this 2nd day of July, 1993.

BEFORE THE WEIGHTS AND MEASURES BUREAU
PUBLIC SAFETY DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees for testing and certification of weighing and measuring devices; and adoption of a new rule concerning license fees for weighing and measuring devices	) NOTICE OF AMENDMENT OF 8.77.102 FEES FOR TESTING AND CERTIFICATION; AND ADOPTION OF NEW RULE I (8.77.107) LICENSE FEE SCHEDULE FOR WEIGHING AND MEASURING DEVICES

TO: All Interested Persons:

1. On May 27, 1993, the Bureau of Weights and Measures published a notice of public hearing at page 1077, 1993 Montana Administrative Register, issue number 10, on the proposed amendment and adoption of the above-stated rules. The public hearing was held on June 16, 1993, in Helena, Montana.

2. The Bureau has amended ARM 8.77.102 and adopted new rule I (8.77.107) exactly as proposed.

3. The Bureau has thoroughly considered all comments and testimony received. Those comments and the Bureau's responses follow:

COMMENT NO. 1: Dallas Herron, of Valcon Distributing, Ltd., Inc. in Kalispell, Montana, submitted written comments. Mr. Herron commented that a 150% increase is not justifiable regardless of the circumstances. Mr. Herron suggested alternative possibilities the Bureau should consider before adopting the fee increases. The following options were suggested.

1. With todays more modern equipment, do they need to be tested as often?
2. Can you offer discounts to customers to group tests together to expedite your staff time?
3. Penalties to those customers that don't maintain their equipment and/or cause extra time to be spent testing.
4. Customers can test their own equipment and send in reports saving you time and money. Spot checking could monitor this with penalties for cheating.
5. Hire private people to do testing on a bid basis. Privatizing will save money.

RESPONSE: 1. The Bureau, over the last several years reduced its staffing from 12 to 10 persons. In addition, because of the workload, testing is now at about a two-year inspection cycle for measuring devices and 80% of the large weighing devices are inspected every year. Approximately 70% of the smaller weighing devices are inspected annually. Reducing the frequency of these inspections further will not adequately provide for the protection of consumers.

2. The only possible grouping of devices would be in the category of truck mounted measuring devices. It is doubtful that enough time would be saved to reduce the number of employees and thus result in cost savings. This method is already being used in some cases and more of the same will be encouraged.

3. There already exists retest fees for weighing and measuring devices to offset the additional costs.

4. There already exists a voluntary certified service agency program that allows private individuals to place new devices or repaired devices in service, until such time as the Bureau can test the device. The equipment needed to perform the tests is costly and not many persons are willing to pay for testing devices. A 100 gallon prover cost $2,500 last year. The benefits of this arrangement are already being realized and if more wish to get involved the program is available.

5. Privatization is another possibility that can be looked at in the future. However, the current budget does not take this into account and thus the fees have to be set commensurate with the approved budget for the program to operate. The Bureau's experience has been that services provided by private firms are much more costly than the State's license fees. As an example, recently a scale owner needed a scale inspected prior to the Bureau's ability to test it. The owner retained a private company to test the scale and paid $600 for a test that the Bureau covers with a proposed fee of $40 to $100.

COMMENT NO. 2: Ronna Alexander testified at the hearing opposing the increase because she claimed the fees for retailers and truck stops would double under the proposal and fees for bulk operators would increase by 2 1/2 times. Ms. Alexander proposed a fee increase of between 25 and 30 percent and stated that the industry had already experienced enough fee increases in the past and could not take more. Ms. Alexander, in general form, suggested that the Bureau consider privatization.

RESPONSE: The fees proposed for both the measuring and weighing devices have both more than doubled. Measuring device fees increased 220% and weighing devices have increased by 249%. The reason for these large increases is that, in the past, the Bureau's program was funded by tax moneys with the fees collected covering less than one-half of the actual costs of the program. To cover the approved legislative budget, the fees had to be raised to match the budget. If the fees were only raised 25% to 30%, the program costs would not be covered and the program would have to be closed down when the funds run out.

Privatization is an idea that could be addressed in the future but the current Legislative approved budget does not address this type of program.

COMMENT: Howard Wheatley, a wholesaler and retailer from Great Falls, testified at the hearing. Mr. Wheatley agreed that a fee increase is necessary but suggested that the fee increase proposed is exorbitant. Mr. Wheatley also questioned the accuracy of the Bureau's estimate of costs of the program. Mr. Wheatley requested that the Bureau double check its figures to insure that their estimate of costs was accurate. Mr. Wheatley also suggested setting testing devices up and asking licensees to come to a common area rather than sending the testing devices out to each of the licensees.

RESPONSE: The fee increase is in line with the approved budget and not excessive. The shortage of fees to cover the costs in the past were offset by general fund tax revenues. The general fund tax revenues are no longer available to the Bureau with the recent changes enacted by the Legislature in House Bills 17 and 70. Thus, the fees must cover all program costs.

Mr. Wheatley stated that the number of devices used to calculate the fee for gasoline nozzles were inaccurate. The Bureau computed its fee based upon the average number of devices in operation over the last five fiscal years, which amounted to 8,760 devices. This number also happened to be very close to the number of devices in use during fiscal year 1992. The Bureau believes that this is an accurate and fair way to determine the likely number of devices that will be in use for future fiscal years. Of course, if this number were to fluctuate, the fee structure would be changed accordingly.

Setting up a central testing location and asking owners to bring their devices to that location has been used to some extent and the Bureau will continue to encourage staff to use this method wherever possible. The Bureau does not feel that this approach will reduce the costs significantly enough to make much difference.

COMMENT: Don Allen, consultant to the Montana Wood Products Association, testified at the hearing. Mr. Allen commented that it is critical that agencies recognize that fee increases will not go unnoticed. Mr. Allen also stated that there was no reason to believe that the Bureau intends to go beyond the absolute necessities of the program expense, but he urged the Bureau to carefully consider the costs and stay conservative on fees.

RESPONSE: The Bureau does indeed intend to keep fees at an absolute minimum to support the Legislative approved budget.

BUREAU OF WEIGHTS AND MEASURES
W. JAMES KEMBEL, ADMINISTRATOR

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, July 2, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rule I, and the amendment of Rules 11.7.601, 11.7.602, 11.7.604, 11.7.608 and 11.7.609 pertaining to youth care facilities.	NOTICE OF ADOPTION OF RULE I, AND AMENDMENT OF RULES 11.7.601, 11.7.602, 11.7.604, 11.7.608 and 11.7.609 PERTAINING TO YOUTH CARE FACILITIES

TO: All Interested Persons.

1. On May 27, 1993, the Department of Family Services published notice of public hearing on the proposed adoption of Rule I [11.7.603], and the amendment of Rules 11.7.601, 11.7.602, 11.7.604, 11.7.608, and 11.7.609 pertaining to youth care facilities, at page 1086 of the 1993 Montana Administrative Register, issue number 10.

2. The department has adopted and amended the rules as proposed.

3. On June 18, 1993, a hearing was held in the second floor conference room of the Department of Family Service, 48 North Last Chance Gulch, Helena, Montana, to consider the proposed adoption and amendment of rules. No person appeared to offer testimony at the hearing, and only one written comment was received. The department has thoroughly considered the comment.

COMMENT: (Twila Costigan, Department of Family Services, Family Resource Specialist) Increases in allowances for foster parents help to alleviate the lack of adequate resources for placements. The amendments and the adoption of Rule I should go forward, and the department should pay the increases in a timely manner.

RESPONSE: The department agrees, and the increases will be implemented beginning with the new fiscal year.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, July 2, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 11.12.101, 11.12.413, 11.12.416 and 11.12.417 pertaining to youth care facilities.	))))))	NOTICE OF AMENDMENT OF RULES 11.12.101, 11.12.413, 11.12.416 AND 11.12.417 PERTAINING TO YOUTH CARE FACILITIES

TO: All Interested Persons.

1. On May 27, 1993, the Department of Family Services published notice of public hearing on the proposed amendment of Rules 11.12.101, 11.12.413, 11.12.416 and 11.12.417 pertaining to youth care facilities, at page 1079 of the 1993 Montana Administrative Register, issue number 10.

2. On June 16, 1993 a public hearing was held in the auditorium of the Department of Social and Rehabilitation Services, located at 111 Sanders, Helena, Montana. Written and verbal testimony was received at the hearing. Questioning of department staff at the hearing in regard to the proposal was allowed. Additional written comment has also been submitted.

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

11.12.101 YOUTH CARE FACILITY, DEFINITIONS Subsections (1)(a) through (2)(d) remain the same.

(3) The following definitions apply only to youth care facilities which are licensed as therapeutic youth group homes:

(a) "Therapeutic youth group home" is a youth care facility licensed by and under contract with the department as a therapeutic youth group home, in which staff who are trained to provide services to emotionally disturbed youth in a therapeutic environment, perform assessments, develop and implement planned treatment interventions designed to address a youth's therapeutic needs in accordance with an individualized written treatment plan, and provide group, individual and family therapy. Providers of moderate, ~~intermediate~~ campus based and intensive therapeutic youth group home services must directly employ or contract for services of clinicians, program managers, child care staff, relief staff, and administrative staff.

Subsections (3)(b) and (3)(c) remain the same.

(d) ~~"Intermediate level"~~ "Campus based" means the supervision and intensity of treatment required in a therapeutic youth group home to manage and treat children who present severe emotional and/or behavioral disorders as evidenced by meeting four or more of the medical necessity criteria set forth in ARM 11.12.417. Treatment, therapeutic interventions and supervision are tailored to the age and diagnosis of the children served. Therapeutic interventions are individualized and are provided

several times per day. ~~Intermediate~~ Campus based level care is provided on a campus ~~with an on-grounds school~~ where treatment is provided throughout the milieu. In addition to treatment, the children are provided with 24 hour awake staff supervision.

Subsection (3)(e) remains the same.

(f) "Lead clinical staff (LCS)" is an employee of, or under contract with, the moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home provider who is responsible for the supervision and overall provision of treatment services to children in the group home(s). The LCS must be a clinical psychologist, master level social worker (MSW), licensed professional counselor (LPC), or have a masters degree in a human services field with a minimum of one year of clinical experience.

(g) "Program manager" is an employee of the moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home provider who trains and supervises child care staff, and provides treatment under the clinical supervision of the LCS. Program managers must have a bachelor's degree in a human services field, or the experience or experience and education, equivalent to a bachelor's degree. Human services experience equivalent to a bachelor's degree for a non-degree program manager is six years. Each year of post-secondary education in human services for a non-degree program manager equals one year of experience.

(h) "Medical necessity statement" documents the moderate, ~~intermediate~~ campus based or intensive level of therapeutic youth group home services ordered by the physician, clinical psychologist, master level social worker (MSW), or licensed professional counselor (LPC).

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.413 YOUTH GROUP HOME, STAFF Subsections (1) through (6)(e) remain the same.

(7) ~~Intermediate~~ Campus based level therapeutic youth group home providers must meet additional minimum staffing requirements to provide a therapeutic environment and treatment interventions identified in the child's individual treatment plan as follows:

(a) Child/staff ratio must be no more than 4:1 each day for a fifteen hour period beginning at, or between, 7:00 a.m. and 7:30 a.m., (or beginning at or between some other reasonable morning half-hour which is approximately fifteen hours prior to the bed-time of the children), when children are in care.

(b) Child/awake staff ratio must be no more than 8:1 each night for a nine hour period beginning no earlier than fifteen hours from the time day-time staffing of 4:1 is initiated.

(c) Each program manager shall be responsible for no more than four children.

(d) There must be adequate staff to allow the LCS, the program manager and/or professional support staff who provide services under the supervision of a masters or higher level

clinician, to implement individualized treatment plans developed by the treatment team. Documentation of individual, group and family therapy must be completed for each session and be included in quarterly treatment summaries. Treatment plans shall include, but are not limited to:

(i) specific treatment plan objectives and interventions which are carried out in the treatment environment and documented by daily charting;

(ii) ~~two~~ one age-appropriate individual therapy session~~s~~ per week;

(iii) two age-appropriate group therapy sessions per week; and

(iv) family therapy sessions when appropriate and medically necessary.

(e) Individualized treatment plans are monitored weekly by the treatment team which includes but is not limited to, the directors of clinical services, operational services, and educational services, and the consulting child psychiatrist.

(f) Each LCS shall be responsible for no more than eight children.

(g) Each ~~intermediate~~ campus based level therapeutic youth group home shall either employ or contract for a ~~.33~~ .25 full time social worker for each eight children in care. The social worker shall meet the minimum qualifications of a bachelor's degree and two years of related experience. Under this subsection, ~~.33~~ .25 full time social worker means a social worker working a minimum of ~~13~~ 10 hours~~, twenty minutes~~ per week.

(h) Each ~~intermediate~~ campus based therapeutic youth group home shall either employ or contract for a ~~.33~~ .25 full time clinical director for each eight children in care. The clinical director shall be licensed by the Montana board of psychologists. Under this subsection, ~~.33~~ .25 full time clinical director means a clinical director working a minimum of ~~13~~ 10 hours~~, twenty minutes~~ per week.

(i) Each ~~intermediate~~ campus based level therapeutic youth group home shall either employ or contract for a ~~.33~~ .25 full time director of operations for each eight children in care. The director of operations position is a master's level position. Under this subsection, ~~.33~~ .25 full time director of operations means a director of operations working a minimum of ~~13~~ 10 hours~~, twenty minutes~~ per week.

(j) Each ~~intermediate~~ campus based level therapeutic youth group home shall either employ or contract for a .20 full time registered nurse for each eight children in care. The registered nurse shall be licensed by the Montana board of nursing. Under this subsection, .20 full time registered nurse means a registered nurse working a minimum of 8 hours per week.

~~(k) Each intermediate level therapeutic youth group home shall either employ or contract for a director of educational services. The director of educational services must possess a master's degree in education.~~

Subsection (8) remains the same.

(9) In addition to the 4 hours of orientation referenced

in subsection (4) above, child care staff in a moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home must receive 15 hours of initial training, and each year must complete 15 hours of additional in-service training in an area directly related to their duties. Initial and additional training must include the use of physical and non-physical methods of controlling children and adolescents to assure protection and safety of the client and staff.

(10) These rules do not preclude a medicaid eligible youth from receiving individual therapy services in addition to moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home services when there is compliance with medicaid requirements and reimbursement.

Subsection (11) remains the same.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.416 YOUTH GROUP HOME, CHILDREN'S CASE RECORDS

Subsection (1) remains the same.

(2) The case record of each child receiving moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home services must contain the following additional documentation:

(a) referral form/authorization for services;

(b) medical necessity statement;

(c) individual treatment plan, signed by the LCS, which documents the child's response to treatment (progress or lack of progress), and the staff's interaction and involvement with the client; and

(d) weekly clinical progress notes, reviewed and signed by the LCS, which summarizes the child's program participation and psychosocial/behavioral status and functioning.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.417 THERAPEUTIC YOUTH GROUP HOME, MEDICAL NECESSITY CRITERIA (1) Moderate, ~~intermediate~~ campus based and intensive level therapeutic youth group home services must be ordered by a licensed physician, a licensed clinical psychologist, a licensed master level social worker (MSW), or a licensed professional counselor (LPC), and must be authorized by the department.

Subsection (1)(a) remains the same.

(b) Providers of ~~intermediate~~ campus based level therapeutic youth group home services shall accept placement of only those children who meet at least four of the medical necessity criteria listed in subsection (2) below.

(c) Providers of intensive level therapeutic youth group home services shall accept placement of only those children who meet at least five of the medical necessity criteria listed in subsection (2) below.

Subsection (2) remains the same.

(3) Medical Necessity Statement and Referral/Authorization forms must be completed and placed in the client record at the time of moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home placement.

(4) The moderate, ~~intermediate~~ campus based or intensive level therapeutic youth group home provider shall ensure appropriate involvement of a lead clinical staff (LCS) in each child's care. This involvement shall include an assessment, development of the treatment plan, and medical necessity determination with redetermination at a minimum of six month intervals. Continued placement at the moderate, ~~intermediate~~ campus based or intensive level will be contingent upon medical necessity, achievement of treatment goals as outlined in the treatment plan, and other conditions as set out in the placement agreement required by ARM 11.12.415.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

3. The department has thoroughly considered all comments:

COMMENT: The department should not attempt to address the educational needs of students in this program. The Office of Public Instruction should determine educational programs.

RESPONSE: The department agrees and has deleted the provisions arguably constituting department regulation of educational needs.

COMMENT: Development of this program is part of an inter-agency effort to obtain federal funds for department programs. Previously, rules covering medicaid and department licensing have been amended to cover two levels of therapeutic group home services. While it may have been possible to allow for medicaid participation of Intermountain Children's Home as a residential treatment facility, or a moderate or intensive level group home, the best solution is to amend the rules to recognize a new level of treatment within the therapeutic group home level in line with the program existing at Intermountain. Otherwise, too many unwarranted changes to Intermountain's program would be required.

Requirements to allow for participation of Intermountain have been proposed in this rule-making under rules covering care provided in "intermediate level" group homes. The name should be changed to "campus based" level group homes to reflect the principal distinguishing characteristic of this level of care. In addition, changes should be made to account for Intermountain's plan to add another cottage for youths in October of 1993. The additional children served should not result in the hiring of additional staff in the positions of social worker, clinical director, and director of operations. The rate to be paid already reflects the reduction in required

staffing levels. The proposal contains a typographical error in regard to weekly individual therapy sessions for children. The proposal should say one rather than two such sessions are required.

RESPONSE: The department agrees and has amended the rule as suggested.

COMMENT: The department should not write rules to fit one provider. This practice, which previously occurred in developing moderate and intensive level services, has resulted in decisions lowering staff qualification requirements based on the needs of the existing intensive program. At the same time, moderate level providers were forced to increase their costs by hiring master's level staff to compensate for the lesser qualified line staff. In regard to the proposal here, the treatment requirements appear to mandate a program fitting better into the residential treatment facility rules than the group home rules. Moreover, the medical necessity requirements are too low. For example, probably all of the children in the Missoula Youth Homes program could meet the medical necessity criteria for the proposed intermediate level. Arguably, by hiring more directors, or reducing the number of children in the program, Missoula Youth Homes could be licensed as an intermediate level group home.

Institutional settings are inappropriate for licensure at the group home level. The group home level should be restricted to single, small group settings. Without appropriate restrictions in regard to the setting, the term "group home" loses its meaning. In reality, the program for which this rule-making is designed should be labeled "therapeutic campus-based treatment", and it should be implemented by rules outside the group home rules.

RESPONSE: The department disagrees that the requirements in this rule-making should not be tailored to the existing program at Intermountain. The alternative is to force unnecessary changes to the program, or to continue to disallow participation of the program in medicaid. The department agrees that the name of this level should be changed, however, the department disagrees that the group home program at Intermountain is more appropriately included in residential treatment facility licensure. The Intermountain program cannot be clearly categorized. However, after exploring the option of residential treatment facility licensing, the department has determined that fitting this new category of group home licensure to Intermountain is the best alternative. This was detailed in the rationale section of the proposal.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, July 2, 1993.

BEFORE THE BOARD OF CRIME CONTROL
DEPARTMENT OF JUSTICE
STATE OF MONTANA

In the Matter of the Adoption of Rules 23.14.501 and 23.14.502 relating to Montana Peace Officer Standards and Training	))))	NOTICE OF ADOPTION OF RULES 23.14.501 AND 23.14.502 REGARDING PUBLIC SAFETY COMMUNICATIONS OFFICERS

TO: All Interested Persons:

1. On April 15, 1993, the Board of Crime Control Peace Officer Standards and Training Council published notice to adopt the following rules concerning minimum standards and certification requirements of public safety communications officers at page 519 of the 1993 Montana Administrative Register, issue number 7.

2. The agency has adopted Rules 23.14.501 (RULE I) and 23.14.502 (RULE II), as proposed.

3. No comments were received.

BOARD OF CRIME CONTROL
EDWIN L. HALL, Executive Director

By: Edwin L. Hall
EDWIN L. HALL, Executive Director
BOARD OF CRIME CONTROL
DEPARTMENT OF JUSTICE

Certified to the Secretary of State, 4/18/93

Chris D. Tweeten
Rule Reviewer

BEFORE THE BOARD OF CRIME CONTROL
DEPARTMENT OF JUSTICE
STATE OF MONTANA

In the Matter of the Adoption of Rule 23.14.508 and 23.14.509 regarding Probation and Parole Officer Certification	))))	NOTICE OF ADOPTION OF RULE 23.14.508 and 23.14.509 REGARDING PROBATION AND PAROLE OFFICER CERTIFICATION

TO: All Interested Persons:

1. On April 15, 1993, the Board of Crime Control published notice to adopt the following rules related to the minimum qualifications for certification of probation and parole officers, at page 521 of the 1993 Montana Administrative Register, issue number 7.

2. The agency has adopted Rules 23.14.508 (RULE I) and 23.14.509 (RULE II) as proposed.

3. No comments were received.

BOARD OF CRIME CONTROL
EDWIN HALL, Executive Director

By: Edwin F. Hall
EDWIN HALL, Executive Director
BOARD OF CRIME CONTROL
DEPARTMENT OF JUSTICE

Certified to the Secretary of State, 6/18/93

Chris D. Tweeten
Rule Reviewer

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

In the matter of new rule to reject, modify, or condition permit applications in the Sharrott Creek Basin	))))	NOTICE OF ADOPTION OF ARM 36.12.1017 SHARROTT CREEK BASIN CLOSURE

TO: All Interested Persons

1. On May 27, 1993, the Department of Natural Resources and Conservation published a notice of public hearing on the proposed new rule to reject, modify, or condition permit applications in the Sharrott Creek Basin at page 1101, Montana Administrative Register, Issue number 10. Notices were also published on May 13, 20, and 27 in the Missoulian. Notices were mailed on April 26, 1993, to 16 water users in the proposed closure area.

2. On June 29, 1993, at 7:00 p.m. a public hearing was held at the Western Federal Savings Bank of Montana in Missoula, Montana. During the hearing and the prescribed comment period the Department received comments, oral and written, from the following persons: John E. Notti, Jr., Jo Ann Notti, Kay Cotton, Lonnie Ebel, Jenny Stewart, William Gilleard, and Joyce A. Moerkerke, all of Stevensville, Mt.

3. The proposed rules are being adopted exactly as proposed.

4. The Department has thoroughly considered all comments received. The comments and the Department's responses are as follows:

COMMENT: The Department has no uniform definition for nonconsumptive water use. We believe it will be impossible for the Department to fairly administer this rule without consistent definitions and uniform regulation for all cases. For this reason we ask that the Department be precluded from accepting any applications for nonconsumptive use in the Sharrott Creek Basin until uniform definitions and regulations are in place.

As an example of Departmental inconsistencies we note paragraphs 3(a) and 3(b) of 36.12.1014 Walker Creek Basin Closure require inflow and outflow measurements to verify all nonconsumptive uses. Paragraph 3 for 36.12.1013 Rock Creek Basin asks for "substantial credible evidence . . ." and does not require measurements. Paragraph 3 for the Sharrott Creek Basin requires "sufficient factual information" and no measurements. Clearly, the criteria and the method of verification for nonconsumptive use are different in all three rules.

RESPONSE: ARM 36.12.1010(5) (1991) defines nonconsumptive use as a beneficial use of water which does not cause a reduction in the source of supply, and where substantially all of the diverted water returns to the source

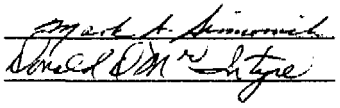
of supply with little or no delay and without adverse effect to the quality of water.

While the language may be different in each of the above-cited rules, the end result is the same: if an applicant does not provide sufficient factual information showing there will be no decrease in the source of supply, that the amount of water diverted will equal the amount returned to the source, or the inflow will be equal to the outflow, no permit will be issued.

All other comments by those in attendance at the hearing were in support of the proposed new rule.

5. No other written or oral comments of testimony were received.

Mark Simonich, Director

BY: 

Certified to the Secretary of State July 2, 1993.

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

In the matter of the amendment of rules 46.10.505 and 46.10.508 pertaining to specially treated income for AFDC	))))	NOTICE OF THE AMENDMENT OF RULES 46.10.505 AND 46.10.508 PERTAINING TO SPECIALLY TREATED INCOME FOR AFDC

1. On May 13, 1993, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.10.505 and 46.10.508 pertaining to specially treated income for AFDC at page 918 of the 1993 Montana Administrative Register, issue number 9.

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

46.10.505 DEFINITIONS Subsection (1) remains as proposed.

(2) "Unearned income" means all income that is not earned income as defined in ARM 46.10.505(3). Unearned income includes~~, but is not limited to~~ social security income benefits, veteran's benefits or payments, workers' compensation payments, unemployment compensation payments, ~~and~~ dividends paid on capital investments and up to $50 of the assistance unit's ~~share of~~ governmental rental or housing subsidy.

Subsections (2)(a) through (7) remain as proposed.

AUTH: Sec. 53-4-212 and 53-4-241 MCA
IMP: Sec. 53-4-211, 53-4-231, 53-4-241 and 53-4-242 MCA

46.10.508 SPECIALLY TREATED INCOME Subsection (1) remains as proposed.

(a) ~~I~~income tax refunds shall be considered toward the property resources limitation and not treated as income~~.~~; and

(b) the assistance unit's ~~share (up to $50) of~~ governmental ~~or~~ rental or housing subsidies (UP TO $50) is counted as unearned income.

AUTH: Sec. 53-4-212 and 53-4-241 MCA
IMP: Sec. 53-4-231, 53-4-241, and 53-4-242 MCA

3. The Department has thoroughly considered all commentary received:

COMMENT: There were several questions relating to why the department is amending this rule which allows a $50 reduction to the AFDC grant for those recipients receiving rent or housing subsidies.

RESPONSE: The Montana Legislature reduced the appropriations to the Department for the AFDC program. In order to stay within the budgeted appropriation, the department looked for a way to reduce benefit expenditures. Department personnel (Family Assistance Division) evaluated current program options. The elimination of the few options currently in place, would not generate the substantial savings required and were rejected for consideration.

Department personnel also researched federal regulations for other options to generate program savings. Only one federal regulation, which could be adopted by the state without applying for a waiver, met this criteria. The regulation allows states the option to count a portion of the governmental rent or housing subsidies against the AFDC grant. Estimated savings would be substantial.

A thorough discussion was held concerning the impact on current and future recipients of AFDC and governmental rent or housing subsidies and subsequent consequences if appropriations were exhausted before fiscal year end. It resulted in the Department's decision to recommend adoption of this option to avoid possible termination of the entire program.

The Appropriations Committee received many options from the Department for reduced general fund costs. One of the options was to reduce AFDC grants to households receiving subsidized housing benefits by $50 each month. The Committee endorsed this option due to the estimated reduction in general fund costs by $678,015 each month of the biennium. The Department had little choice but to adopt this regulation and amend the rule to comply with legislative direction.

COMMENT: There were several questions relating to notification of AFDC recipients.

RESPONSE: The Department is only required to send out notice of the rule amendment by means of publication in the Montana Administrative Register and mailings to those persons who request a copy of amendments to the rule. This notice was published in Issue #9, page 918. In addition, the Department has notified current AFDC recipients via a July 1 checkstuffer of the reduction in benefits which becomes effective August 1, 1993. The checkstuffer has been very effective in reaching all current AFDC recipients with information on policy changes, eligibility for additional services such as Women, Infant, and Children (WIC) assistance, and eligibility requirements. County office staff have received notice of this policy change and will include this information as part of client orientation upon application for assistance.

COMMENT: There were two questions referencing the poverty level of AFDC recipients affected by the $50 reduction to their monthly grant.

RESPONSE: The Legislature sets the benefit standard (maximum payment amount) as a percentage of the current year's federal poverty level (FPL). The standards represent the monthly grants to AFDC households with no other income. For fiscal year 1994, the standards were set at 40.5% of the FPL.

If the AFDC household (not receiving housing assistance) is eligible for the full benefit (no countable income), its income is 40.5% of the FPL. If the AFDC household (receiving housing assistance) is eligible for the full benefit (no countable income) less the $50, its income is 35.4%.

However, the household not receiving housing assistance must allocate a greater percentage of its benefit to shelter (approximately 70-80%) expenses than the household receiving housing assistance (approximately 33%). Thus, the household receiving housing assistance and the $50 reduction in AFDC benefits has more income available for other needs after its shelter obligation has been met.

For example, an AFDC household of three (3), with no other income, receives a monthly grant of $401. If the household receives housing assistance, the grant is $351. Both household's shelter expense is $360/month. The household without housing assistance pays $360 and has $41 of their grant available for other monthly expenses. The household with housing assistance pays 1/3 of its income ($351) or $105 and has $246 of their grant available for other monthly expenses.

4. Changes were made to both rules in this notice relating to defining which portion of the rent or housing subsidies is affected by this change - the assistance unit's portion or the government's portion. Federal regulation states that it is a portion of the governmental rent or housing subsidies that is counted and it may not exceed the amount for shelter established in its payment standards. The change was made to comply with federal regulation.

5. This rule amendment will be effective August 1, 1993.

Dawn Sliva
Rule Reviewer

Russell E. Carter, acting
Director, Social and Rehabilitation Services

Certified to the Secretary of State July 2, 1993.

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

In the matter of the amendment of rules 46.12.503 through 46.12.505, 46.12.508 and 46.12.509 pertaining to medicaid reimbursement for inpatient and outpatient hospital services	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.503 THROUGH 46.12.505, 46.12.508 AND 46.12.509 PERTAINING TO MEDICAID REIMBURSEMENT FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES

1. On April 29, 1993 the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.503 through 46.12.505, 46.12.508 and 46.12.509 pertaining to medicaid reimbursement for inpatient and outpatient hospital services at page 607 of the 1993 Montana Administrative Register, issue number 8.

2. The Department has amended rule 46.12.504 as proposed.

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

46.12.503 INPATIENT HOSPITAL SERVICES, DEFINITION

Subsections (1) through (15) remain as proposed

(16) "Rural hospital means"~~:~~

~~(a)~~ for purposes of determining disproportionate share hospital payments, an acute care hospital that is ~~not~~ located within a ~~metropolitan statistical~~ "rural area" as defined ~~by the federal executive office of management and budget~~, in 42 CFR 412.62(f)(iii)~~; or~~.

(~~b~~17) "ISOLATED HOSPITAL" MEANS for purposes of determining whether a hospital is a ~~rural hospital~~ exempt from the prospective payment system under ARM 46.12.505(1)(a), an acute care hospital that is located in a Montana county designated as of July 1, 1991, as ~~"rural"~~ CONTINUUM CODE 8 or ~~"very rural"~~ CONTINUUM CODE 9 by the United States department of agriculture under its rural-urban continuum codes for metro and nonmetro counties.

Subsection (17) remains as proposed but is renumbered (18).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

Subsection (1) remains as proposed.

(a) for ~~I~~inpatient hospital services provided within the state of Montana, providers will be reimbursed under the diagnosis related groups (DRG) prospective payment system ~~using the methodology~~ described in subsection (2) ~~of this rule~~ except as otherwise specified in these rules. Medicare ~~C~~certified

rehabilitation units, ~~rural~~ ISOLATED hospitals and medical assistance facilities will be reimbursed their actual allowable costs determined on a retrospective basis, with allowable costs determined according to ARM 46.12.509(2). ~~Subsequent references to rule subsections refer to subsections of this rule section unless otherwise specifically identified.~~ Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system will be reimbursed, ~~in~~ in addition to the prospective DRG rate, for the following ~~are reimbursable~~:

Subsections (1)(a)(i) through (1)(c) remain as proposed.

(i) Hospitals located more than 100 miles outside the borders of Montana and not in Canada will be reimbursed on an interim basis during each facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If a provider fails or refuses to submit the financial information, including the medicare cost report necessary to determine the cost to charge ratio, the provider's interim rate will be 60% of its usual and customary charges.

(ii) Hospitals located more than 100 miles outside the borders of Montana and not in Canada must notify the department within 60 days of any change in usual and customary charges THAT WILL HAVE A SIGNIFICANT IMPACT ON THE FACILITY COST TO CHARGE RATIO. A SIGNIFICANT IMPACT IS A CHANGE IN THE FACILITY COST TO CHARGE RATIO OF 2% OR MORE. THE DEPARTMENT WILL ADJUST REIMBURSEMENT RATES TO ACCOUNT FOR ADJUSTED CHARGES WHICH HAVE A SIGNIFICANT IMPACT ON THE FACILITY COST TO CHARGE RATIO. The department may adjust interim reimbursement rates to account for such increased charges.

Subsections (1)(d) through (2)(b) remain as proposed.

(c) The department computes a Montana average base price per case. This average base price per case is ~~$1,471.31~~ ~~$1,801.95~~ $1,811.77, effective beginning July 1, 19~~90~~93.

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

(i) The department shall identify the facility's total allowable medicaid inpatient capital-related costs from the facility's most recent~~ly~~ audited OR DESK REVIEWED cost report. These costs will be used as a base amount for interim payments. The base amount may be revised if the provider can demonstrate an increase in capital-related costs as a result of an approved certificate of need that is not reflected in the base amount;

(ii) All out-of-state hospitals, except those located in Canada, that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per ~~care~~ CASE is $298.92. Such rate shall be the final capital-related cost reimbursement for facilities' cost reporting periods with respect to which the department waives retrospective cost settlement in accordance with these rules.

Subsection (4)(a)(iii) remain as proposed.

(45) The department shall reimburse inpatient hospital service providers for medical education related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(b), as amended through October 1, ~~1986~~ 1992. 42 CFR 412.113(b), as amended through October 1, ~~1986~~ 1992, is hereby adopted and incorporated herein by reference. A copy of this regulation may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59604-4210.

Subsections (5)(a) through (8)(c)(ii) remain as proposed.

(d) The total catastrophic case funds available will be limited AS SPECIFIED IN SUBSECTION (iv). Catastrophic payments will be distributed ~~at the end of each fiscal year by June 30.~~ AS FOLLOWS: ~~The available catastrophic funds will be apportioned to the eligible cases, but no payment will exceed the maximum payment described in subsection (c).~~

(i) PROVIDERS WILL RECEIVE THE BASE DRG PAYMENT AND ANY APPROPRIATE OUTLIER PAYMENTS FOR EACH CATASTROPHIC CASE THROUGH THE REGULAR CLAIMS PAYMENT PROCESS, AND, SUBJECT TO SETTLEMENT AS PROVIDED IN SUBSECTIONS (ii) AND (iii), SHALL RECEIVE IN ADDITION WITHIN 15 DAYS OF SUBMISSION OF A CATASTROPHIC CASE CLAIM AN AMOUNT EQUAL TO 60% OF THE ESTIMATED COST FOR THE INPATIENT HOSPITAL STAY LESS THE BASE DRG PAYMENT AMOUNT AND ANY APPLICABLE OUTLIER PAYMENT AMOUNTS.

(ii) AFTER THE END OF THE STATE FISCAL YEAR AND BEFORE THE FOLLOWING SEPTEMBER 30, THE DEPARTMENT WILL DETERMINE THE TOTAL CATASTROPHIC CASE PAYMENT TO WHICH THE PROVIDER IS ENTITLED AS PROVIDED IN SUBSECTION (iii) FOR EACH CATASTROPHIC CASE CLAIM SUBMITTED DURING THE FISCAL YEAR, AND SHALL REIMBURSE PROVIDERS NO LATER THAN SEPTEMBER 30 FOR ANY UNDERPAYMENT, OR SHALL RECOVER ANY OVERPAYMENT AS PROVIDED IN ARM 46.12.509(6).

(iii) THE TOTAL AVAILABLE CATASTROPHIC FUNDS, WILL BE APPORTIONED TO THE ELIGIBLE CASES, EXCEPT THAT NO PAYMENT FOR ANY INDIVIDUAL CASE WILL EXCEED THE MAXIMUM PAYMENT DESCRIBED IN SUBSECTION (c). IF SUFFICIENT CATASTROPHIC CASE FUNDS ARE AVAILABLE, THE PROVIDER MAY RECEIVE AN ADDITIONAL PAYMENT FOR EACH CATASTROPHIC CASE CLAIM SUBMITTED FOR THE FISCAL YEAR, SO THAT THE PROVIDER RECEIVES A PROPORTIONATE SHARE OF THE REMAINING AVAILABLE CATASTROPHIC FUNDS FOR EACH CLAIM, SUBJECT TO THE MAXIMUM PAYMENT DESCRIBED IN SUBSECTION (c). PROPORTIONATE SHARES SHALL BE DETERMINED SO THAT ALL CLAIMS SUBMITTED BY PROVIDERS ARE REIMBURSED AT THE SAME PERCENTAGE OF THE ESTIMATED COST FOR THE INPATIENT STAY.

(iv) BASED ON THE ESTIMATE OF 26,844 DRG DISCHARGES IN STATE FISCAL YEAR 1994, THE FUNDS AVAILABLE FOR CATASTROPHIC CASES, INCLUDING THE BASE DRG, ADD-ONS AND OUTLIER AMOUNTS, IS ESTIMATED TO BE $4,441,000. FOR STATE FISCAL YEAR 1995, THE ESTIMATE IS 31,676 DRG DISCHARGES AND TOTAL CATASTROPHIC CASE FUNDS OF $5,502,000. SHOULD THE NUMBER OF DRG DISCHARGES VARY FROM THE ESTIMATE, THEN THE AVAILABLE CATASTROPHIC FUNDS WILL VARY PROPORTIONATELY. THE STATE IS UNDER NO OBLIGATION TO DISBURSE ALL AVAILABLE CATASTROPHIC CASE FUNDS IF THERE ARE AN INSUFFICIENT NUMBER OF CLAIMS THAT QUALIFY FOR THE PAYMENTS.

Subsections (9) through (11) remain as proposed.

(~~10~~12) "Hospital resident" means a recipient ~~whose medical condition requires treatment who is unable to be cared for~~ WHO IS UNABLE TO BE CARED FOR in an ~~setting other than the acute care~~ SETTING OTHER THAN THE ACUTE CARE ~~inpatient~~ hospital ~~setting~~.

Subsections (12)(a) through (12)(a)(ii) remain as proposed.

(iii) providers will have the responsibility of determining whether ~~the recipient's medical condition services~~ SERVICES could be ~~provided~~ PROVIDED ~~treated~~ in a skilled nursing care facility or by the home and community based waiver program to a medicaid recipient within the state of Montana ~~without regard to actual availability of a bed in such a facility~~. The provider will also be required to maintain written documentation consisting of written inquiries and responses to nursing homes and the home and community based waiver program case management team inquiring as to the present and future availability of openings in the nursing homes or programs and indicating if an opening is not available. In addition to an initial determination, a re-determination of nursing home or waiver availability must be made at least every six months.

Subsections (12)(b) through (15) remain as proposed.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT

Subsection (1) remains as proposed.

(a) ALL ~~f~~Facilities ~~located within the borders of the state of Montana or more than 100 miles from the Montana border and not~~ EXCEPT THOSE LOCATED in Canada will be reimbursed on a retrospective basis. Allowable costs will be determined in accordance with ARM 46.12.509 (2) and subject to the limitation specified in ARM 46.12.509(2) (a) and (b). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000 for hospital services provided to Montana medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the department waives retrospective cost settlement, the provider's interim payments for the cost report period shall be the provider's final payment for the period.

(b) ~~All other F~~facilities ~~located outside the borders of the state of Montana (except those located in Canada excluded) are limited to a ratio will be reimbursed a percentage of usual and customary billed charges, which percentage shall be the provider's cost to charge ratio determined by the department, computed for each hospital under medicare reimbursement principles based upon the provider's most recent medicare cost report. If the provider fails or refuses to submit the financial information necessary to compute determine the rate cost to charge ratio, the provider will be reimbursed at 60% of its usual and customary billed charges.~~

~~(c)~~ Outpatient hospital services provided in facilities located in Canada will be reimbursed at 60% of the usual and

customary charges, converted at the current rate from Canadian to U.S. dollars.

(2) ALL ~~F~~facilities EXCEPT THOSE LOCATED IN CANADA ~~located within the state of Montana described in subsection (1)(a)~~ will be reimbursed on an interim basis during the facility's fiscal year. The interim rate will be ~~based on~~ a percentage of USUAL AND customary charges. THE PERCENTAGE SHALL BE THE PROVIDER'S COST TO CHARGE RATIO ~~as~~ determined by the facility's medicare intermediary or by the department UNDER MEDICARE REIMBURSEMENT PRINCIPLES, BASED UPON THE PROVIDER'S MOST RECENT MEDICARE COST REPORT. IF A PROVIDER FAILS OR REFUSES TO SUBMIT THE FINANCIAL INFORMATION, INCLUDING THE MEDICARE COST REPORT, NECESSARY TO DETERMINE THE COST TO CHARGE RATIO, THE PROVIDER'S INTERIM RATE WILL BE 60% OF ITS USUAL AND CUSTOMARY CHARGES.

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

46.12.509 ALL HOSPITAL REIMBURSEMENT, GENERAL Subsection (1) remains the same.

(2) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the ~~HIM-15~~ MEDICARE PROVIDER REIMBURSEMENT MANUAL, HCFA PUB. 15 (REFERRED TO AS "PUB. 15"), subject to the exceptions and limitations provided in the department's administrative rules. The department hereby adopts and incorporates herein by reference the ~~HIM-15~~ PUB. 15, which is a manual published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the ~~HIM-15~~ PUB. 15 may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

Subsections (2)(a) through (3) remain as proposed.

(4) Facilities ~~described in ARM 46.12.508(1)(a)~~ LOCATED OUTSIDE THE STATE OF MONTANA AND NOT IN CANADA must upon department request submit a cost report for their fiscal year ending in 1991 to the Montana medicare intermediary by September 1, 1993. Upon receipt of the cost report, the department will instruct the medicare intermediary to perform a desk review or audit for the purpose of setting a base allowed cost per discharge for each facility.

Subsections (5) through (8) remain as proposed.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-111, 53-6-113 and 53-6-141 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: The proposed amendments will reduce hospital payments by about $3 million. Hospitals should not be expected to accept a reduction in payments. The Department should adjust the proposed base price to correspond to a "budget neutral" implementation.

RESPONSE: Montana Medicaid is required by federal law to pay rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The Department believes that the proposed rates, with the adjustment for the revised case mix described below, will exceed the minimum amounts required under that test. The Department does not agree that there is an anticipated $3 million reduction in payments. The Department has determined that at least $3 million of hospital operating costs are beyond those 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. Therefore, those costs are not included in the rate base. The amount of aggregate payments under the proposed system will be approximately the same as would be expected under the current system. However, we believe that the distribution of payments will be more equitable under the proposed system. The Department believes the proposed rates will meet or exceed all applicable laws and regulations, and the Department will not adjust the base price to make implementation budget neutral for hospitals.

COMMENT: We are concerned about the accuracy of data used to develop the payment system recommended by the study conducted by Abt Associates. The methodology for estimating costs and charges, as well as the impacts on hospitals, are questionable.

RESPONSE: The data used to determine charges was the raw hospital claim data from the claims processing system for 1988, 1989, 1990 and 1991, insofar as claims had been filed by February 1992. A random sample of the claims on the data file was compared to the paper claims, with virtually no errors identified. Therefore, we have a great degree of confidence in the charge information used to set DRG weights.

The cost information used was the most recent information available at the time it was needed. The provider advisory group was asked whether they preferred that Abt Associates use the audited and settled 1989 cost reports (the most recent settled year available) or the unaudited 1991 Medicare cost reports. The group agreed that it was important to use the most recent data available, and that Abt Associates should use the 1991 Medicare reports, extracting information applicable to

Medicaid. We believe that the methodology for estimating hospital costs applicable to Medicaid from these cost reports is statistically sound in the aggregate. We agree that there is an unavoidable margin of error in the data, particularly on the level of individual hospital estimates. The estimates as a whole, though, which are used to set the base rate, are statistically sound and appropriate. Further, subsequent cost settlement data tends to support the estimates.

In estimating the impacts of the proposed system on individual hospitals, Abt Associates used the individual hospital claims for 1991 in their data base. The actual charges and payments made on each claim were identified. Then each claim was processed through Grouper Nine, using the parameters of the proposed system. The expected payments for these same claims were identified and broken down by type, i.e., outliers, catastrophic, and stop-loss. This exercise was intended to give the hospitals only a general idea of the impact of the proposed system on their own facilities. However, since there is no guarantee that a hospital's case mix or Medicaid case load will remain stable, there is no way to guarantee what the impact of the new system will be on any hospital. The hospitals themselves are in a much better position to estimate the impacts, given that they have access to the most current information regarding their service areas and case mix.

The Department believes that the data used to develop the system is accurate, and that the methodologies used to estimate costs, charges and potential impacts were reasonable and valid for their intended purposes.

COMMENT: The Department should routinely produce progress reports which analyze the performance and impacts of the new system. These reports should be shared with hospitals. SRS should commit to adjust the system as needed based upon the analysis.

RESPONSE: The Department, in conjunction with Abt Associates, has developed a series of quarterly reports which will be generated from the paid claims files. These quarterly reports will monitor all aspects of the proposed payment system. The expected implementation date of the system needed to generate these reports is mid-August 1993. These completed quarterly reports will be made available to the hospitals and interested provider groups upon request. Due to the high cost of postage and the likelihood that many hospital administrators will not be interested in the detailed reports, there is no general quarterly mailing planned. The Department intends to adjust the system if and when it determines that adjustments are warranted.

COMMENT: SRS should consider additional exemptions for other low volume hospitals for whom the DRG methodology is inappropriate. The commentor stated that this suggestion was made early

in the study, but that no formal response was ever received from SRS.

RESPONSE: The Department has chosen to use an objective measure to identify communities with the potential to experience problems of access to hospital care in rural communities in Montana. After much discussion with the provider advisory group, we were not able to find a method of identification of vulnerable facilities that would exempt every hospital that everyone on the advisory group would like to exempt. Therefore, the Department has decided to accept the recommendation of Abt Associates for the identification of rural and very rural communities. Hospitals in those identified communities will be exempt from the prospective payment system. The Department believes that this approach is reasonable and will meet the Department's goals in exempting certain hospitals from the DRG system. The Department did in fact provide a formal response to the commentor on this issue in a letter from Nancy Ellery, Administrator of the Medicaid Services Division of the Department, dated November 6, 1992.

COMMENT: The Department should also consider programming the payment system to accept and group new diagnosis and procedure codes until new grouper versions can be adopted.

RESPONSE: A majority of new diagnosis and procedure codes can be accepted and grouped correctly by the claims processing system. Those few diagnosis and procedure codes that cannot be systematically processed will be identified in the claims payment system and will continue to be processed by hand. With the shift to Grouper Nine, the number of claims requiring hand processing will drop dramatically. We are limited by the grouper program itself to grouping only to DRGs that exist within the grouper that is in use. The Department uses the services of a medical records consultant to advise us on the appropriate treatment of new diagnosis and procedure codes. We are confident that the new codes are being handled appropriately.

COMMENT: Commentor is concerned that the DRG weights are not final. The study ended over 6 months ago, but the final version of the weights was not available for review prior to the public hearing on this rule. Commentor questions whether the Department can adopt by reference a document which is not complete or available to the public.

RESPONSE: The Department apologizes for the delay in distributing complete DRG tables. The tables were prepared before the public hearing. However, around May 1, 1993, we recognized that the grouper used to group claims data prior to weighting had incorrectly grouped any case using a procedure code with a leading zero. This resulted in the inappropriate grouping of a significant number of cases. The Department instructed the contractor to correct the problem and to go through the entire

grouping and weighting process again. That process was completed on May 21, 1993. The completed tables were then distributed to hospital administrators and the Montana Hospital Association on May 26, 1993. These parties were notified that the comment period on the DRG tables was extended to June 8, 1993, to give interested parties an opportunity to examine the proposed weights and thresholds.

The changes to the weights resulted in a slight decrease in the overall projected statewide case mix index. In order to fairly compensate for this overall reduction in weights, the Department has revised the final rule to increase the base price from $1801.95 (as proposed) to $1811.77 effective July 1, 1993.

COMMENT: Hospitals are very concerned that SRS is proposing to reduce payments for delivering babies. In a state already suffering a lack of access to prenatal services, state efforts to reduce payments to hospitals for these crucial services is alarming. Even though the reduction is accomplished through calibration of new weights, the decision to reduce hospital payments by over $3 millon dollars from the 1991 level also affects the price paid for these services. SRS should reconsider adoption of the reduced payments for newborn and maternal services.

RESPONSE: The Department believes that the proposed payments for delivery of babies are appropriate. Weights for delivering babies were set in the same way as weights for all other DRGs. The weights reflect the average charges for these services statewide, relative to charges for other services. It would defeat the purpose of a prospective system to artificially inflate these weights. One of the objectives of the Abt Associates study was to determine which DRGs were being overpaid and which were being underpaid, and to adjust the weights to reflect average charges. The Department does not believe that the DRGs for delivering babies should be deliberately overpaid, as this would be counter-productive to the goal of achieving efficiency and economy in hospitals.

COMMENT: Hospitals are especially concerned about the proposed changes to psychiatric DRGs for children. Subsequent to the completion of the Abt Associates study, the Legislature eliminated Medicaid coverage of children's psychiatric services in freestanding psychiatric hospitals. These hospitals provided inpatient treatment for periods greatly exceeding the average length of stay provided in a psychiatric unit of a general acute care hospital. SRS is very much aware that hospital-based psychiatric units are not available for long term care, and do not have programs similar to those previously offered at the freestanding hospitals. Similarly, Montana has no institutional facility to place children who need ongoing hospital care, but who are not appropriate for community services.

COMMENT: Does the Department agree that the proposed DRGs are intended to cover medical stabilization of psychiatric conditions, but not active treatment on par with that previously offered at Rivendell and Shodair Hospitals?

RESPONSE: These proposed DRGs are designed to cover medically necessary psychiatric services in acute care facilities. Under the proposed system, the reimbursement for pediatric psychiatric admissions for neuroses and psychoses has more than doubled. However, these DRGs are based on average acute care hospital stays, rather than upon freestanding psychiatric hospital stays, and accordingly were not designed for reimbursement of average stays in freestanding facilities. The particular type of treatment of psychiatric disorders necessary or appropriate in this setting would depend upon the circumstances of each case.

COMMENT: Does the Department intend for psychiatric units to develop, implement and provide services on par with those previously offered by Rivendell and Shodair Hospitals? Does the Department intend for hospitals to expand the capacity to treat children on an inpatient basis since the closure of the children's psychiatric benefit?

RESPONSE: The Department has no agenda regarding the development of services in acute care facilities. The Department expects that hospital providers will monitor the market place and occupancy trends, and if deemed appropriate, will design, develop and implement services accordingly. The Department also expects that DFS, DCHS and SRS working together and with providers will be proposing models for assuring that medically necessary services are available for severely emotionally disturbed children. Such models may or may not involve the development or expansion of such services by hospital providers.

COMMENT: Will the Department amend the proposed DRG relative weights to include service data from Rivendell and Shodair Hospitals?

RESPONSE: The information on those admissions was not factored into the DRG weights because those services were not provided in acute care hospitals. The Department has no intention at this time of revising the DRG weights for psychiatric admissions. The Department will monitor and assess the utilization of psychiatric DRGs.

COMMENT: How will SRS reimburse hospitals who admit children for medical stabilization, but who are denied admission in community or residential treatment programs? Will SRS allow outlier payments in these cases? Does SRS consider services beyond crisis stabilization to be part of the DRG payment system, or are they billable outside the Medicaid program?

RESPONSE: Outlier thresholds are clearly stated for all DRGs in the DRG tables. Cases that exceed those outlier thresholds will

be eligible for outlier payments. Children who are admitted for medical stabilization should remain in the hospital as long as is medically necessary. Certainly, crisis stabilization is not the only function of the psychiatric units. Services beyond crisis stabilization are part of the DRG payment system, as long as the services are medically necessary. Services to Medicaid recipients should be billed to other third party payers prior to billing Medicaid, according to ARM 46.12.304. The Medicaid reimbursement provided in these rules is payment in full.

COMMENT: We support the adoption of a catastrophic payment policy, but oppose the decision to withhold payments until year end. Hospitals cannot accept the shift of financial responsibility for catastrophic events onto the hospitals. The Department has already reduced other payments to estimate the pool of dollars need to make catastrophic payments. If, during the year, the actual experience incurred by hospitals is even more catastrophic than anticipated by the Department, not paying for treatment is patently unfair. SRS cannot argue this proposal in total provides adequate payments, if the catastrophic payment policy fails to fairly compensate hospitals for very large cases. If the Department refuses to amend this portion of the rule, we will withdraw support of the DRG amendments, and will ask the Regional Office of the Health Care Financing Administration to refuse approval of the state plan.

RESPONSE: The Department has adopted the catastrophic payment recommendation in recognition of the occasional extremely high cost cases which until now primarily have been the burden of the hospitals. The Department, in adopting this policy, is assuming a great deal of the risk for these cases. The Department is making a good faith effort to implement a reimbursement system that more equitably reimburses all hospitals in Montana. The Department will not make unlimited funds available for this purpose. Language has been added in the final rule to specify the estimated amount of funds for each year of the biennium.

The Department has amended the language in the final rule to allow for hospitals to receive most of the catastrophic payment during the normal payment cycle for all claims. Since the pool of funds available for catastrophic claims is limited, the Department has attempted to take an approach that is most fair to all the hospitals in the disbursement of the balance of the catastrophic funds. We can only estimate the number and cost of catastrophic cases based on recent history. To assure that all hospitals will receive a catastrophic case payment covering the same percentage of the estimated cost for the inpatient stay, the total amount of catastrophic payment to which each provider is entitled will be determined after the end of the fiscal year when all catastrophic claims have been received. Language has been added in the final rule to establish a process for settlement of catastrophic claims.

The methodology for estimating the size of the catastrophic pool will be reviewed at the end of state fiscal year 1994. If the estimate of the number and cost of the cases varies significantly from actual experience, then the methodology and the size of the catastrophic case pool for following years will be adjusted. This will result in a subsequent adjustment to the allowable cost base used to determine the base price.

COMMENT: SRS also proposes amending the language governing payments for hospital residents. These persons are not able to leave a hospital for treatment in an alternative setting. Hospitals provide the final safety net for such persons, and should be adequately compensated for their care. MHA opposes the adoption of language which restricts payments for persons who theoretically could be served in alternative settings regardless of the availability of those settings.

RESPONSE: The Department does not intend to change the way in which it has historically enforced this rule, and accordingly the proposed amendments to this section have been eliminated in the final rule.

COMMENT: Commentor suggests the Department amend the proposed rule on outpatient hospital reimbursement to provide allowable cost reimbursement and retrospective cost settlements for all hospitals located outside Montana, not just those over 100 miles from Montana. The $100,000 threshold still allows the Department to not settle immaterial cost report amounts.

RESPONSE: The Department agrees with this comment and will amend the proposed rule accordingly. All out of state hospitals, except those located in Canada, will be reimbursed for outpatient hospital services on the same basis. The department also has added language to the final rule to clarify how interim rates are determined for outpatient hospital services provided by such facilities.

COMMENT: Commentor suggests that ARM 46.12.503(15) be changed to specify the case mix criteria which differentiates the large referral hospitals from other hospitals, rather than naming the qualifying hospitals in the rule. Commentor is seeking to avoid continually changing this regulation as Montana hospitals qualify, and lose their qualification, for inclusion as a large referral hospital.

RESPONSE: Hospitals will have an opportunity to qualify as a large referral hospital only at the time of recalibration of the DRG system. That process is planned to occur every three years. At that time, the rules will need to be amended, and the list of referral hospitals updated. Case mix was not the only criterion for designation as a large referral hospital. There were four criteria used. To qualify as a large referral hospital, the facility had to be in the top ten hospitals in at least three of

the four categories. The four tests were: size, referral ratios, average CMI, and volume of Medicaid business.

COMMENT: Commentor disagrees with the exemption of hospitals from the prospective payment system based on their inclusion in a particular county. Commentor indicates that the goal of protecting access to care is better met by developing criteria related to a facility's distance from another facility. Commentor also suggests using the specific USDA codes of "8" and "9" rather than "rural" and "very rural" as there are several codes that fall into the "rural" category.

RESPONSE: The Department believes that the goal of protecting access to care in rural areas is met by exempting hospitals in the specified counties from the prospective payment system. The Department agrees that the class code numbers more clearly identify the exempted hospitals and the language of the final rule has been amended to specifically refer to the USDA codes "8" and "9" on the urban-rural continuum.

COMMENT: Commentor recommends that ARM 46.12.505(1)(c)(i) be modified to insert the phrase "using Medicaid specific settlement data" when referring to the basis for interim rates for out of state hospitals. Commentor states that using "medicare cost" instead of "Medicaid cost" in calculating cost to charge ratio will result in over reimbursing out-of-state facilities for treating Medicaid patients.

RESPONSE: Since this rule section applies only for purposes of determining interim rates for facilities reimbursed on a retrospective allowable cost basis, any actual "over-reimbursement" will be corrected in the settlement process. The suggested changes will not be adopted.

COMMENT: Commentor states that ARM 46.12.505(1)(c)(ii) will create an administrative burden for the state, since each hospital typically has thousands of charge items, and typically changes charges more frequently than once a year. Commentor recommends requiring out of state facilities to notify the State three times a year of estimated changes in the cost to charge ratio.

RESPONSE: The subsection will be amended to read "Hospitals . . . must notify the Department within 60 days of any change in usual and customary charges that will have a significant impact on the facility cost to charge ratio. A significant impact is a change of 2% or more. The Department will adjust interim reimbursement rates to account for adjusted charges which have a significant impact on the facility cost to charge ratio." The administrative emphasis will be placed on those hospitals that are not expected to cost settle. Overpayments to hospitals that do not cost settle are less likely to be recovered, and therefore must more strenuously be avoided.

COMMENT: Commentor recommends the language in ARM 46.12.505(2) be changed to "the medicare grouper program version used to pay Medicaid claims shall be no more than two versions removed from the most current medicare grouper version being used to pay medicare claims as of July first of each year."

RESPONSE: While it is the intention of the Department to recalibrate the DRG weights and update the grouper every three years, we cannot guarantee such will be done.

COMMENT: Commentor suggests that rather than stating the actual base price in the rule, that the methodology for establishing the base price be inserted.

RESPONSE: While it is the intention of the Department to update the base price every fiscal year to account for inflation, the Department prefers to make the changes annually rather than committing to particular changes in future years without knowledge of all circumstances which may affect the rules.

COMMENT: Commentor states that the payment policy for unstable DRGs does not involve an equal risk sharing between hospitals and the state. Commentor recommends either lowering the upper threshold or lowering the lower threshold. Commentor states that the policy as it stands creates "inequitable risk sharing (that) is unacceptable."

RESPONSE: While the thresholds for unstable DRGs may appear inequitable when stated as a percentage of the DRG, these thresholds were set by using a standard deviation calculation. These DRGs are unstable because there are frequently cases where charges fall significantly above or below the norm. The hospital study shows that, in general, there are more cases and more payments that will exceed the upper threshold than those that will meet the lower threshold. Statistically, the risk is more equitably shared than might seem apparent. Lowering the upper threshold would increase the cost of unstable DRGs, which would then require a decrease in the cost pool used to set the base price, decreasing the base price. The Department does not believe such is warranted.

COMMENT: Commentor states that ARM 46.12.505(4)(i) is weak, in that there is no time requirement established for having cost reports audited. Commentor suggests that this section be changed to add after "audited" the words "or reviewed". Commentor also suggests using costs from the most recently filed cost report if the most recently audited or reviewed report is more than two years old.

RESPONSE: In general, neither the facilities nor the Department have much control over when cost reports will be audited. The Department relies on the Medicare intermediary to perform the audits and reviews of cost reports. It would be impractical and unenforceable to set a time requirement for the facilities to

produce an audited or reviewed cost report. Capital-related costs for in-state hospitals are cost settled. The interim rates for capital payments will be updated prior to the beginning of each state fiscal year, using the most current cost information available. The Department does not intend to use "as filed" cost report information to set rates. The rule will be amended as recommended to include the phrase "or desk reviewed".

COMMENT: Commentor recommends that the formula used to calculate the thresholds be placed in regulation. Commentor states that the thresholds are a material element in the reimbursement system and the manner in which they are calculated should not be changed without going through the public process and state plan amendment process.

RESPONSE: Outlier thresholds are calculated using a standard deviation test. Once set, the cost outlier thresholds are to be updated annually to reflect the average statewide increase in charge levels. Providers have received a complete copy of all thresholds, and will receive an updated table of weights and thresholds prior to the beginning of each fiscal year. The outlier payment calculation is in the rule at ARM 46.12.505 subsections (6) and (7).

COMMENT: Commentor expressed discomfort with the State's ability to make determinations of medical necessity. Commentor recommends insertion of the following phrase: "Hospitals have the right to appeal decisions made as to medical necessity of services. The state will contract with a federally approved Peer Review Organization (PRO) to review appeals of medically necessary services."

RESPONSE: Provider appeal rights are clearly stated in ARM 46.12.509A. Determinations of medical necessity are made by qualified medical professionals. The issue of responsibility for determination of medical necessity is addressed elsewhere in the administrative rules. It is not necessary to address that question in this subsection.

COMMENT: Commentor has concerns about the Department's intention to reimburse hospitals with interim payments over $100,000 per year under the TEFRA methodology. Commentor's facility falls into this category, with annual interim payments between $400,000 and $900,000. The patients sent to this facility from Montana tend to be a small number of highly complex cases in which for various reasons it is considered medically necessary that they be seen at this institution. The number is still small enough with highly variable circumstances so that an "average cost per discharge" which the TEFRA would impose makes no sense. The average cost of actual Montana cases at this facility varies widely from year to year. It is the position of the commentor that an annual medicare cost report settlement based on the ratio of cost to charges, without

imposing the TEFRA limit, would be a reasonable treatment of out-of-state providers, where volumes and acuity vary widely.

RESPONSE: The Montana Legislature has directed the Department to use the TEFRA methodology when reimbursing out of state facilities with over $100,000 per year in reimbursements from Montana Medicaid. The key objective is restricting the rate of allowed increases in costs in these facilities for Montana Medicaid patients. Reimbursing the "average cost of actual Montana cases" would not accomplish the goal of restricting the rate of increase in costs. Since these out-of-state facilities receive only the most complex cases from Montana, we fully expect the "average cost per discharge" to be significantly higher for Montana Medicaid patients than for the general hospital population. Additionally, since there are a relatively small number of cases in each facility each year, the Department will exclude cases determined by the Department to be atypical from the allowed cost per discharge calculation.

COMMENT: Under TEFRA methodology, we are paid a "cost per discharge" amount, with no outlier provisions included. Your proposal, as we understand it, will reimburse our hospital based on the same TEFRA methodology, a "cost per discharge." Under Medicare regulations, the TEFRA rate may be appealed based on certain criteria such as "atypical service intensity", new services and others. Your proposed regulations do not provide a definition of "atypical' nor does it provide for payment of "atypical" cases. We anticipate we will have at least an occasional transplant (Heart, Kidney or Liver) from your program, not to mention other cases that we consider to be "atypical" or an outlier case. The Department should define atypical cases in the rule.

RESPONSE: The proposed rule adopts the TEFRA methodology, including the right to appeal the reimbursement for atypical cases. Cases that are determined to be atypical will be reimbursed outside the TEFRA limitations. Designation of atypical cases will depend on both the composition of the case mix in the facility base year, and on the nature of the services provided in comparison to services provided in like institutions. Montana Medicaid does not intend, at this time, to implement any outlier provisions for TEFRA based facilities.

COMMENT: Commentor feels the administrative burden on the program as well as providers to appeal the base rate on a nearly annual basis would be counter-productive and not an effective use of resources.

RESPONSE: An appeal of the base rate would have to be based on an increase or change in the intensity of services provided to Montana Medicaid recipients. Since commentor's facility and others like it are already receiving Montana's most intense and complex cases, it is unlikely that there would be a demonstrably significant overall change in intensity from year to year,

particularly when atypical cases are excluded. Commentor's base rate for Montana Medicaid should be somewhat higher than for its general hospital population. The Department will consider requests, by such hospitals that can demonstrate that FY1991 does not represent a typical year of service, that a different year be used as their base year for TEFRA targets.

COMMENT: Please clarify the application of disproportionate share qualification and payment for out of state hospitals.

RESPONSE: The Department does not make DSH payments to out-of-state hospitals. However, we believe your Montana Medicaid utilization may be used to help you qualify for DSH payments from your home state.

COMMENT: Does the state's proposal limit increases to the TEFRA limit, or is there some adjustment as allowed by Medicare?

RESPONSE: When costs are greater than or lower than the TEFRA target, the reimbursable amount will be calculated using Medicare's methodology.

COMMENT: Is the TEFRA target intended to cover operating costs only (as with Medicare), or does the target include capital costs?

RESPONSE: The TEFRA target is intended to cover only operating costs.

COMMENT: The notice makes mention of the availability of a 30-day administrative review. Please provide additional detail. Since the reimbursement is proposed to be based on an average admission, a change in case mix could seriously and unfairly disadvantage the hospital. The review process should allow for the target base to be revised as changes in average case acuity and/or average length of stay occur.

RESPONSE: The administrative review process is detailed in ARM 46.12.509A. See response to above commentor regarding revision of targets and changes in case mix.

COMMENT: The amendments propose deletion of reference to psychiatric inpatient hospital facilities, on the ground that Medicaid coverage for these facilities is being eliminated pursuant to directions by the Montana Legislature. The commentor does not agree with the elimination of these services, because it is the commentor's belief that a state may not choose to fund only part of the facilities for which Medicaid funding is available under the Under-21 program. In addition, it is our belief that elimination of funding for the youth psychiatric hospitals will result in a lack of ability to provide medically necessary services to Medicaid-eligible children, and that this will result in a violation of federal law.

RESPONSE: The proposed rules do not pertain to services or reimbursement under the under-21 program. The elimination of Medicaid benefits in freestanding psychiatric hospitals is not at issue in this rule. The Department has deleted a reference in the disproportionate share rule to psychiatric hospital facilities to correspond to the elimination of psychiatric hospital coverage which is being implemented through a separate rule proceeding. Similar comments have been addressed in that separate rule proceeding.

COMMENT: Although not addressed in the proposed rules, commentor believes it would be appropriate to extend DRG reimbursement to the youth psychiatric hospitals, and that the rules should be amended to allow for this reimbursement.

RESPONSE: Federal law prohibits coverage of youth psychiatric hospitals under the inpatient hospital program. Federal regulation defines inpatient hospital services as "services that are furnished in an institution that is maintained primarily for the care and treatment of patients with disorders other than mental diseases." (CFR 42.440.10(a)(3)(i)). This regulation prohibits Montana Medicaid from including youth psychiatric hospitals in the inpatient hospital program.

COMMENT: Commentor understands that the study which the proposed rules will implement did not include consideration of the children hospitalized in the Shodair and Rivendell facilities. We believe that the implementation of DRG reimbursement rates for psychiatric services for youth must include a study of these children, otherwise the DRG reimbursement rates will not be accurate.

RESPONSE: The Department disagrees. The services provided by Shodair and Rivendell were not considered in development of the DRG because the DRG system is not designed to reimburse services provided in those facilities.

COMMENT: There are only three med/surg hospitals in the state with psych units that accept persons under the age of 21, Billings Deaconess, Montana Deaconess and St. Patrick Hospitals. During the legislative session and I suspect currently, those hospitals had approximately 20 vacant beds to which additional youth could be treated. And only one of those, Billings Deaconess Hospital, will admit children under the age of 12. The limited number of available beds will prove to be insufficient to serve the number of youth who will need services.

RESPONSE: This rule proceeding does not address the elimination of hospital coverage in the under 21 psychiatric program. The elimination of psychiatric hospital coverage is being implemented through a separate rule proceeding. Similar comments have been addressed in that separate rule proceeding.

COMMENT: Resources to provide short-term stabilization and crisis intervention services to seriously emotionally disturbed youth will be scarce and poorly distributed geographically. The Rivendell Psychiatric Centers and Shodair Hospital are uniquely qualified to provide those services but will be precluded from doing so because of your agency's policy reflected in your current rules and the proposed amendments not to allow DRG reimbursement for services at these facilities. This policy does not seem to be based on any reasonable or logical grounds.

Commentor requests that your agency include a provision in the amendments to the DRG rules, which will allow for DRG reimbursement for short-term stabilization and crisis intervention treatment services provided to Medicaid eligible youth by freestanding psychiatric hospitals. If you elect not to include such a provision, we request that you provide a specific rationale why and how you can discriminate between identical services provided in a med/surg hospital psych unit and a freestanding psychiatric hospital.

RESPONSE: Federal law prohibits coverage of youth psychiatric hospitals under the inpatient hospital program. Federal regulation defines inpatient hospital services as "services that are furnished in an institution that is maintained primarily for the care and treatment of patients with disorders **other than mental diseases.**" (CFR 42.440.10(a)(3)(i)). This regulation prohibits Montana Medicaid from including youth psychiatric hospitals in the inpatient hospital program.

The Department's position is not that these hospitals cannot be paid with DRGs, but rather that they **cannot be paid under the inpatient hospital rule,** which utilizes this DRG system. It is our belief that psychiatric hospitals **could** be reimbursed using DRGs, if a DRG system were devised within the psych under 21 program, using cost and charge information only from the hospitals that were to be reimbursed under the proposed system. However, this is not possible now, since the Legislature has eliminated the psych under 21 benefit for hospitals. Federal regulations are separate and distinct for med-surge hospitals and freestanding psychiatric hospitals. The Department is not attempting to discriminate, but rather to comply with the federal regulations that govern Medicaid reimbursement.

COMMENT: The definition of "rural hospital" is confusing because it uses the term in two different ways.

RESPONSE: The Department agrees and has changed the term to "isolated hospital" for one of these uses.

COMMENT: The reference in ARM 46.12.505(5) to the October 1, 1986 CFR section appears to be an error.

RESPONSE: The Department agrees and has corrected the error.

COMMENT: The reference to the "HIM-15" in ARM 46.12.509(2) is incorrect. The publication is actually called the "Medicare Provider Reimbursement Manual, HCFA Pub. 15-1."

RESPONSE: The Department agrees and has corrected the reference.

5. These rule amendments apply to inpatient and outpatient hospital services provided on or after July 1, 1993.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 2, 1993.

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

In the matter of the amendment of rules 46.12.516 and 46.12.517 pertaining to medicaid coverage of intermediate level therapeutic youth group home treatment	))))	NOTICE OF THE AMENDMENT OF RULES 46.12.516 AND 46.12.517 PERTAINING TO MEDICAID COVERAGE OF INTERMEDIATE LEVEL THERAPEUTIC YOUTH GROUP HOME TREATMENT

TO: All Interested Persons

1. On May 27, 1993, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.516 and 46.12.517 pertaining to medicaid coverage of intermediate level therapeutic youth group home treatment at page 1106 of the 1993 Montana Administrative Register, issue number 10.

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

46.12.516 KIDS COUNT/EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), ADDITIONAL SERVICES

Subsections (1) through (1)(e)(i) remain as proposed.

(ii) The therapeutic portion of ~~intermediate level~~ CAMPUS BASED therapeutic youth group home treatment, as defined in DFS rules, is covered when provided by a therapeutic youth group home, licensed by DFS to provide ~~intermediate level~~ CAMPUS BASED therapeutic youth group home services, to a child who meets DFS medical necessity criteria for placement at the ~~intermediate~~ CAMPUS BASED level of treatment.

Subsections (1)(e)(iii) through (1)(g) remain as proposed.

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

46.12.517 KIDS COUNT/EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT

Subsections (1) through (3)(b) remain as proposed.

(c) Reimbursement for the therapeutic portion of intensive, ~~intermediate~~ CAMPUS BASED and ~~or~~ moderate level therapeutic youth group home treatment services shall be as specified in a fee schedule set and maintained by the department as follows:

Subsection (3)(c)(i) remains as proposed.

(A) For purposes of setting the initial fee for intensive and moderate level therapeutic youth group home treatment services, the DFS per diem rate shall be the DFS per diem rate effective January 1, 1993. For purposes of setting the initial fee for ~~intermediate level~~ CAMPUS BASED services, the DFS per diem rate shall be the DFS per diem rate effective July 1, 1993.

Subsections (3)(c)(i)(B) through (6) remain as proposed.

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

3. These amendments will be applied retroactively to July 1, 1993.

4. No written comments or testimony were received. The Department has changed all occurrences of the title "intermediate level" to read "campus based." The change was necessary since the Department of Family Services has changed the title of this service to "campus based." The new title is more descriptive of services provided at this level. The change does not alter the scope or effect of the rule amendment.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 2, 1993.

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

In the matter of the adoption of [Rule I] 46.12.4206 pertaining to specified low income medicare beneficiaries	))))	NOTICE OF THE ADOPTION OF [RULE I] 46.12.4206 PERTAINING TO SPECIFIED LOW INCOME MEDICARE BENEFICIARIES

TO: All Interested Persons

1. On May 27, 1993, the Department of Social and Rehabilitation Services published notice of the proposed adoption of [Rule I] 46.12.4206 pertaining to specified low income medicare beneficiaries at page 1103 of the 1993 Montana Administrative Register, issue number 10.

2. The Department has adopted [Rule I] 46.12.4206, SPECIFIED LOW INCOME MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID as proposed.

3. No written comments or testimony were received.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State July 2, 1993.

VOLUME NO. 45 OPINION NO. 8

BONDS - When obligation on school bonds attaches;
PUBLIC FUNDS - School bonds binding on date of delivery;
SCHOOL DISTRICTS - School bonds binding on date of delivery;
MONTANA CODE ANNOTATED - Sections 20-6-411, 20-9-401 to -471, 20-9-411.

HELD: School bonds become binding upon taxpayers on the date bonds are delivered.

June 21, 1993

Mr. Blair Jones
Stillwater County Attorney
P.O. Box 179
Columbus, MT 59019-0179

Dear Mr. Jones:

You have asked my opinion on a number of questions concerning school districts. Your first two questions concern a geographic area designated as 55-6 which historically has been part of both Columbus Elementary School District 6 and Reed Point High School District 9-9. Some residents of 55-6 have asserted that their property was transferred out of Reed Point High School District 9-9 to Columbus High School District 6 under an order from a former Stillwater County Superintendent of Schools dated December 22, 1961. You have asked whether the area known as 55-6 should have been transferred in 1961 and, if so, whether the order could be lawfully enforced today. You have attached numerous exhibits to aid in interpreting the order.

The proper interpretation of the order and attached exhibits involves numerous factual determinations which are not appropriate for an Attorney General's Opinion, since my statutory authority is limited solely to questions of law. MCA § 2-15-501(6). I must therefore decline to answer your first two questions.

You have also asked:

> At what time do taxpayers who own real property within a school district incur the obligations attendant with the issuance of bonds for financing the construction of school facilities?

The procedures that must be followed for a school district to incur bonded indebtedness are set forth in MCA §§ 20-9-401 to -471 and, generally, are initiated when the school district's board of trustees adopts a resolution calling for an election among qualified electors in the district upon proper ballot

preparation and notice. MCA §§ 20-9-421, -422. If the canvass of votes indicates approval of the school bond proposition, the district board of trustees issues a certificate proclaiming passage of the bond proposition. MCA § 20-9-428(2). The trustees must, within 60 days, adopt a resolution providing for the issuance of the bonds and give notice of the bond sale. MCA §§ 20-9-429, -430. The trustees then meet to consider bids on the bond sale and must accept the bid they believe to be most advantageous to the district, MCA § 20-9-432, and the bonds are then printed and executed, MCA § 20-9-433. Once the bonds are registered by the county treasurer, they are delivered to the purchaser when full payment is received. MCA § 20-9-435.

It has long been held that "[t]he act of delivery is essential to the existence of any deed, bond or note. Although drawn and signed, so long as it is undelivered it is a nullity; not only does it take effect only *by* delivery, but also only *on* delivery." Young v. Clarendon Township, 132 U.S. 340, 353 (1889) (emphasis in original). Thus, the general rule is that "[a] bond does not become binding until delivery." McQuillin, Municipal Corporations § 43.50; see also 64 Am. Jur. 2d Public Securities and Obligations § 213 (the act of delivery is essential to the very existence of public bonds as obligations binding on their issuers). This general rule is supported by the well-grounded rationale that an obligation is binding once payment is actually made; in the context of bonds, payment occurs upon delivery. MCA § 20-9-435; Mistler v. Eye, 231 P. 1045, 1047 (Okla. 1925) ("There is no indebtedness until the money is received by the district. The money is not received until the bonds are issued, approved as required by law, and delivered to the purchasers").

It has been suggested that in the context of a transfer of property out of a school district the obligation arises upon the date of "issuance" of the bonds, which is not necessarily the same as the date of delivery. This suggestion is based upon the language of MCA § 20-6-411 which provides that the existing bonded indebtedness of a transferred territory remains with the "original territory against which such bonds were issued." This phrase in MCA § 20-6-411, however, does not describe when the obligation attaches to the transferred property, but rather describes generally the property to which the obligation attaches.

It is further suggested that because the date of issuance of the bonds may be different from the date of delivery, the obligation arises on the date of issuance rather than delivery. MCA § 20-9-411 does provide for backdating bonds in order to have payment of interest on the bonds coincide with the largest monthly tax collections. Nonetheless, this section also provides:

> [N]o interest shall be charged on these bonds before they have been delivered to the purchaser and payment

> has been made by the purchaser. Interest accrued on such bonds according to their terms at the time of delivery shall either be refunded by the purchaser or deducted from the first interest payments.

MCA § 20-9-411. This language clearly indicates that it is the date of delivery that triggers the date of obligation, because the date of delivery also triggers calculation of the interest.

Further, even if the date of issuance were relevant to your inquiry, that concept has dual meaning in the context of bonded indebtedness. As McQuillin states, "[t]he word 'issue,' as applied to bonds, generally includes delivery, but it does not invariably do so." 15 McQuillin, Municipal Corporations § 43.48, at 690. In Whetstone v. City of Stuttgart, 193 Ark. 88, 97 S.W.2d 641 (1936), the Arkansas Supreme Court described the dual meaning of the word "issue":

> In financial parlance the term "issue" seems to have two phases of meaning. "Date of issue," when applied to notes, bonds, etc., of a series, usually means the arbitrary date fixed as the beginning of the term for which they run, without reference to the precise time when convenience or the state of the market may permit of their sale or delivery[.]

The "date of issue" in MCA § 20-9-411 is a date fixed for convenience in order to simplify tax collections. In MCA § 20-6-411 the indebtedness of an original territory "against which the bonds were issued" refers to the entire bond procedure including the time at which the obligation occurred. See Baker v. Unified Sch. Dist. No. 346, 206 Kan. 581, 480 P.2d 409, 413 (1971) (municipal bonds are not issued until they are sent out, delivered or put into circulation). Thus, the date of issuance does not trigger the date of obligation; rather, the obligation arises, as provided in the general rule, when the bonds are delivered.

THEREFORE, IT IS MY OPINION:

> School bonds become binding upon taxpayers on the date bonds are delivered.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/elg/dlh

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition, the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt or amend a rule.

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

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

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

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

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1. Consult ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.
Statute Number and Department	2. Go to cross reference table at end of each title which lists MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1993. This table includes those rules adopted during the period April 1, 1993 through June 30, 1993 and any proposed rule action that is pending during the past 6 month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1993, this table and the table of contents of this issue of the MAR.

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