# MONTANA ADMINISTRATIVE REGISTER



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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 8

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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

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NOTICE SECTION

**BEFORE THE DEPARTMENT OF FAMILY SERVICES OF THE STATE OF MONTANA**

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|---|---|
| In the matter of the amendment of Rule 11.7.313 pertaining to foster care payments. | NOTICE OF PROPOSED AMENDMENT OF RULE 11.7.313 PERTAINING TO FOSTER CARE PAYMENTS |

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 10, 1993, the Department of Family Services proposes to amend Rule 11.7.313 pertaining to foster care payments.

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

11.7.313 CLASSIFICATION MODEL Subsections (1) through (5) remain the same.

(6) The department's model rate matrix, effective ~~January 13, 1989~~, January 1, 1993, is hereby adopted and incorporated by this reference. Copies of the model rate matrix of the department are available upon request from the Administrative Support Division, Department of Family Services, P.O. Box 8005, Helena, Montana 59604. The department shall review and revise its model rate matrix at least once every two years.

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 provisions of the model rate matrix have been updated to accommodate additional levels of care created by recent rule-making. 1992 MAR p. 2728; 1993 MAR p. 147. The rule must be changed to allow for proper adoption and incorporation of the revised matrix. Section 2-4-307, MCA. The amendment adopting and incorporating the new matrix is reasonably necessary to implement a system for foster care payments. The department is authorized to implement through rules: child welfare services, the administration of foster care, and regulation of facilities providing care.

4. Interested persons may submit their data, views or arguments to the proposed amendment in writing to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than May 27, 1993.

5. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments, to the Office of Legal Affairs, Department

of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than May 27, 1993.

6. If the Department of Family Services receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, 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 are directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, April 19, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

| | |
|---|---|
| In the matter of the amendment of Rule 11.12.101 pertaining to the definition of youth. | NOTICE OF PROPOSED AMENDMENT OF RULE 11.12.101 PERTAINING TO THE DEFINITION OF YOUTH. |

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 10, 1993, the Department of Family Services proposes to amend Rule 11.12.101 pertaining to the definition of youth.

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

11.12.101 YOUTH CARE FACILITY, DEFINITIONS (1) The following definitions apply to all youth care facility licensing rules:

(a) Except in regard to age requirements under Montana medicaid programs which allow for participation of youth up to the age of 21 years, "child" or "youth" means any person under the age of 18 years, without regard to sex or emancipation.

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

3. ARM 11.12.101 provides definitions for subchapter 12. Subchapter 12 generally covers licensing requirements for facilities providing foster care to children in the custody of the department.

As a result of a recent rule-making (1992 MAR p. 2605), subchapter 12 also covers rules on medicaid services in therapeutic youth group homes. Federal law requires that children's medicaid services be provided for young persons up to the age of 21 years. The current definition of "youth" in ARM 11.12.101 conflicts with the federal requirement. The amendment proposed in this rule-making is reasonably necessary to eliminate the conflict.

Statutes cited herein authorize rules for implementing administration of state and federal funds for foster care, licensing for foster care, and provision of child welfare services.

4. Interested persons may submit their data, views or arguments to the proposed amendment in writing to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than May 27, 1993.

5. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments, to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than May 27, 1993.

6. If the Department of Family Services receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, 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 are directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, April 19, 1993.

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

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| In the matter of the amendment of rule 36.12.101, Definitions, 36.12.103, Application and Special Fees, 36.12.104 Issuance of Interim Permits, and new rule on testing and monitoring | NOTICE OF PROPOSED AMENDMENT AND ADOPTION<br><br>NO PUBLIC HEARING CONTEMPLATED |

To: All Interested Persons

1. On June 3, 1993 the Board of Natural Resources and Conservation proposes to amend rule 36.12.101 Definitions, 36.12.103 Application and Special Fees, 36.12.104 Issuance of Interim Permits and proposes to adopt new Rule I Testing or Monitoring.

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

"36.12.101 DEFINITIONS Unless the context requires otherwise, to aid in the implementation of the Montana Water Use Act and as used in these rules:

(1) . . .

(7) "Combined appropriation" means an appropriation of water from the same source aquifer by two or more groundwater developments, that are physically manifold into the same system. ~~the purpose of which, in the department's judgment, could have been accomplished by a single appropriation. Groundwater developments need not be physically connected nor have a common distribution system to be considered a "combined appropriation." They can be separate developed springs or wells to separate parts of a project or development. Such wells and springs need not be developed simultaneously. They can be developed gradually or in increments. The amount of water appropriated for the entire project or development from these groundwater developments in the same source aquifer is the "combined appropriation."~~

AUTH: 85-2-113, MCA; IMP: 85-2-113, 306, MCA;

36.12.103 APPLICATION AND SPECIAL FEES (1) A fee, if required, shall be paid at the time the permit, change, notice of completion, extension of time request, temporary change renewal, transfer certificate, exempt water right, or petition application (hereafter singularly or collectively referred to as application) is filed with the department. . .

(b) For ~~any request for~~ an Interim Permit, there shall be a fee of $10 in addition to ~~the rate schedules shown in~~ (a) ~~or (b)~~ above.

(c) For a Notice of Completion of Groundwater Development (for groundwater developments with a maximum use of 35 gpm or less not to exceed 10 acre-feet per year, Form No. 602, there shall be a fee of $~~15~~25. ~~The department shall collect an additional $10 fee to be deposited in the ground water assessment account as required by 85-2-306(5), MCA. The~~

~~total fee to be paid for the filing of a Form 602 shall be $25.~~

(d) . . .

AUTH: 85-2-113, MCA; IMP: 85-2-113, MCA;

36.12.104 ISSUANCE OF INTERIM PERMITS (1) Pending final approval or denial of an application for a provisional permit, the department may, in its discretion and upon proper application, issue an interim permit authorizing an applicant to begin appropriating water immediately ~~for testing purposes~~.

(2) . . ."

AUTH: 85-2-113, MCA; IMP: 85-2-113, 85-2-311 through 85-2-314, MCA

3. The proposed new rule provides as follows:

"RULE I TESTING OR MONITORING (1) Water testing or monitoring is not a beneficial use of water requiring the filing of a permit application.

(2) A permit is not required if the intent of a person is to conduct aquifer tests, water quality tests, water level monitoring or other testing or monitoring of a water source."

AUTH: 85-2-113, MCA; IMP: 85-2-113, MCA

4. Rule 36.12.101 is proposed to be amended so that the definition of combined appropriation is clearer to the public as to when wells of 35 gpm or less or 10 acre-feet or less, require a permit.

5. Rule 36.12.103 is proposed to be amended to maintain the Notice of Completion of Groundwater Development fee at $25 and deposit the total fee in the water rights earmarked revenue account. The department is required to deposit $10 of the fee in a groundwater assessment account until July 1, 1993. That requirement terminates on July 1, 1993. The fee at $25 is commensurate with other fees collected for processing similar documents and entering them in the centralized water rights records system.

6. Rule 36.12.104 is proposed to be amended to make the interim permit process correspond more closely with the intent of the law. That is, an interim permit is issued to allow a permit applicant to actually appropriate water prior to issuance or denial of his permit, not to conduct testing.

7. The new rule is proposed to clarify that a permit is not required to conduct testing or monitoring of water sources.

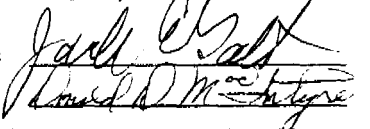
8. Interested persons may present their data, views, or arguments concerning the proposed amendment and adoption in writing to Ronald J. Guse, Department of Natural Resources and Conservation, 1520 E. 6th Avenue, Helena, MT. 59620. Any comments must be received no later than May 28, 1993.

9. If a person who is directly affected by the proposed amendment and adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must

make written request for a hearing and submit this request along with any written comments he has to Ronald J. Guse, Department of Natural Resources and Conservation, 1520 E. 6th Avenue, Helena, MT. 59620. A written request for hearing must be received no later than May 28, 1993.

10. If the agency receives requests for a public hearing on the proposed amendment and adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; 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.

Jack E. Galt, Chairman

By: 

Submitted to the Secretary of State on April 19, 1993.

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

| | | |
|---|---|---|
| In the Matter of Proposed Adoption, Amendment and Repeal of Rules Governing Minimum Filing Requirements and Procedures for Class Cost of Service and Rate Design. | ) ) ) ) ) ) ) | NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT OF RULES GOVERNING MINIMUM FILING REQUIREMENTS AND PROCEDURES FOR CLASS COST OF SERVICE AND RATE DESIGN AND REPEAL OF ARM 38.5.105 AND 38.5.178 |

TO: All Interested Persons

1. On Wednesday, May 19, 1993 at 10:00 a.m. in the Bollinger Hearing Room, Montana Public Service Commission, 1701 Prospect Avenue, Helena, Montana, a hearing will be held to consider the proposals identified in the above title and described in the following paragraphs.

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

38.5.102 APPLICATIONS FOR RATE INCREASES (1) Applications for rate increases exceeding one hundred thousand dollars annually shall include the cost of service to be supplied and shall include the additional material required in ARM 38.5.103 to 38.5.175 and 38.5.179 to 38.5.183, inclusive, minimally. Further or additional materials may be supplied by the utility if the utility ~~feels that~~ believes such ~~is~~ materials are necessary.

(2) Three copies of the letter of transmittal and three copies of all materials required in ARM 38.5.103 to 38.5.175 and 38.5.179 to 38.5.183, inclusive, shall be filed with the commission at the time of application. Montana consumer counsel shall receive two copies of the same materials.

(3) No changes. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

38.5.109 WORKING PAPERS TO BE FILED (1) In the statements described in ARM 38.5.121 to 38.5.180, inclusive, certain items are designated as "working papers." Three sets of such working papers are to be filed at the time the Statements A through N are filed with the commission whether filed pursuant to 38.5.102 or [Rule I]. Such working papers shall be available to intervenors on request. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

38.5.176 STATEMENT L -- ALLOCATED COST OF SERVICE (ACOS) ~~(1) Statement L shall show for the test period a summary by major functional category of service as allocated to the major classes for which the increased rates or charges are proposed. Testimony shall describe the principal determinants used for allocation purposes. Allocated cost of service per books and per claimed adjustments shall be shown separately. Working papers with respect to the overall cost of service shall show the following:~~

~~(a)--Grouping and allocation of various items of cost and credits to cost of service into functional totals;~~
~~(b)--Classification of items of cost and credits into demand, energy, customer or other appropriate categories;~~
~~(c)--In the event that the filing utility makes application to increase charges other than rate schedules, it shall also supply costing support related thereto;~~
~~(d)--Customer load data used in the allocation of costs;~~
~~(e)--Details of allocation of general or common or joint costs to various functions;~~
~~(f)--Sufficient detailed breakdown of operation and maintenance expense accounts and taxes to disclose how component items have been classified and allocated.~~

(1) Statement L shall present the cost of service results in detail for every customer class. Written testimony shall describe the development of these cost of service results. Included shall be the following:

(a) A general discussion of the purpose of the filing with goals and objectives of the allocated cost of service proposals. Industry standard terminology shall be used to describe and define allocated cost of service proposals. Where unique terms are used, they shall be defined in a separate glossary to be included as part of the filing.

(b) A benchmark allocated cost of service comparing the last commission-approved filing to the current filing. Any substantive deviation in procedures and/or methods used to prepare the current filing compared to the last commission-approved filing will be summarized and explained in the cost of service testimony.

(c) A generic allocated cost of service model which provides a basic understanding of the allocated cost of service study. The public service commission currently recognizes allocated cost of service based on marginal cost principles. Any utility testimony and exhibits on allocated cost of service should follow the format of the generic marginal cost model as described below.

(2) A generic marginal cost model shall also be provided. Marginal cost of service shall be determined for each of the following functions:

(a) Generation, transmission, substation, distribution, and customer for electric filings.

(b) Supply, storage, transmission, distribution, and customer for natural gas filings.

(3) Marginal costs shall be determined using the following additional steps:

(a) Classify the functionalized costs as energy (commodity), capacity, reactive power and/or customer related and compute the associated marginal unit costs.

(b) Multiply classified marginal unit costs by allocation factors to compute total marginal cost.

(4) Allocation factors, annualization factors, and adjustment factors (d) to (j) below, may be used at various times throughout the cost of service study. These do not necessarily apply to all utilities. An example is seasonal costs

since not all utilities have seasonal differences in costs. Inputs and factors include:

(a) Select the relevant time periods and compute relevant allocation factors;

(b) Select methods to determine and then compute relevant seasonal and time-of-day costs;

(c) Select methods to compute annualized costs and compute annualization factors;

(d) Select a loss method, compute loss percentages and then apply such loss estimates to energy and capacity cost estimates;

(e) Compute spatial energy and/or capacity transportation rates for the associated products;

(f) Select operation and maintenance marginal cost methods and compute factors;

(g) Select administrative and general marginal cost methods and compute factors;

(h) Select general and common plant marginal cost methods and compute factors; and

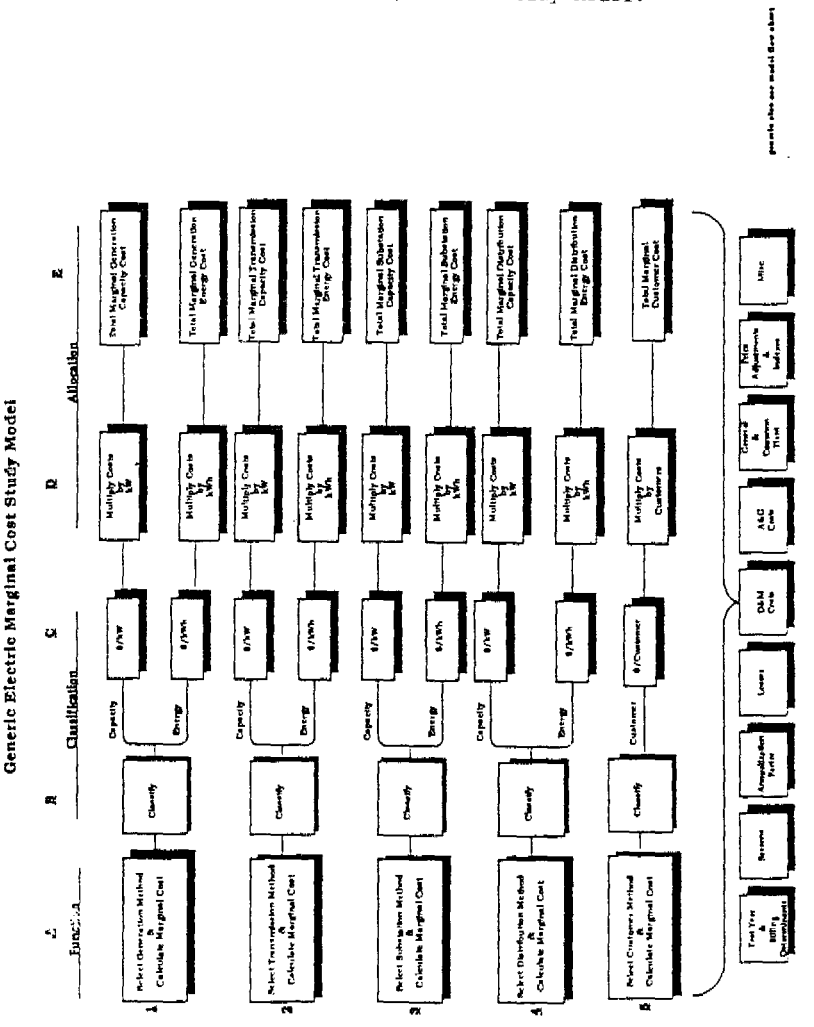
(i) Select price adjustments and indexes.

(5) The following models shall be followed when preparing a generic marginal cost model.

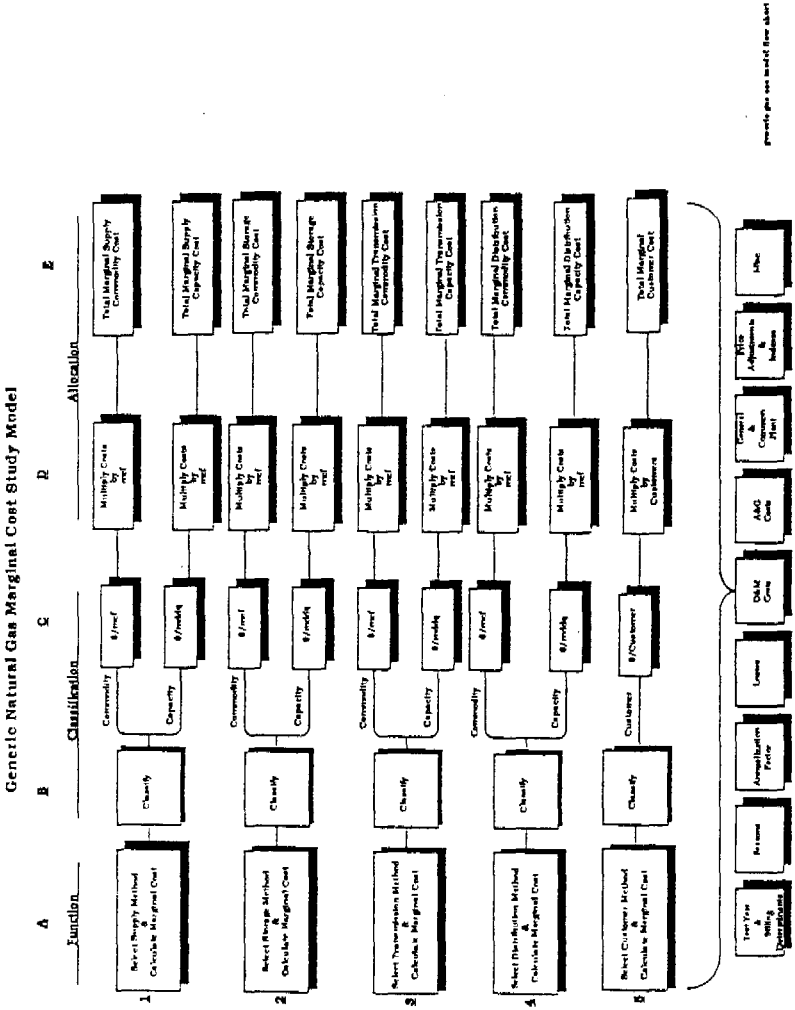
(a) Model 1. Generic electric margin cost study model.

(b) Model 2. Generic natural gas marginal cost study model.

Model 1. Generic Electric Margin Cost Study Model.



Model 2. Generic Natural Gas Marginal Cost Study Model.



(6) In addition to the use of the generic model, the following allocated cost of service guidelines should be followed:

(a) Year's dollars for computing costs of service should reflect costs two years beyond January 1st of the year in which the filing is submitted. For example, if a cost of service study is filed any time in calendar year 1992, costs will be computed in January 1, 1994 dollars.

(b) Relevant market value sources should be reflective of opportunities available to the utility's system. For example, electric generation and gas supply cost functions ought to reflect a resource's highest foregone use in the markets opened up by transmission access.

(c) Relevant time horizon for costs depends on the cost function and applications.

(d) Carrying charges should be used for the development of the marginal costs.

(e) Capacity and energy losses reflective of the utility's system should be developed and used to adjust relevant marginal costs.

(f) Proxy cost estimates, as necessary and appropriate, may be used for the marginal costs.

(g) If a production cost model is used by the utility, it should be identified and explained and its relative merit justified (e.g., chronological versus probabilistic).

(h) Distribution/customer costing should be reflective of the utility's system and included as appropriate. Line extension policies should be described and any changes explained.

(i) Administrative and general, operation and maintenance and general and common adders should be reflective of the utility's system and included as appropriate.

(j) Allocation of costs to customer classes should use allocation factors that reflect cost causation.

(k) Seasonal or time-of-day cost allocation should be supported in sufficient detail to fully analyze the result.

(l) The method of reconciliation used should be identified and explained. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

38.5.177 STATEMENT M -- ~~COMPARISON OF COST OF SERVICE~~ RATE DESIGN

~~(1) Statement M shall be provided with the initial application under these rules for a rate increase greater than one hundred thousand dollars, whenever a material change in rate structure is proposed, or whenever the Commission so orders. Statement M shall compare the allocated cost of service provided pursuant to ARM 38.5.105 with the revenues under the proposed rates by major classes. If the amount of revenue under the proposed new rates differs significantly from allocated cost of service, including allowances for claimed return and income taxes, working papers shall show the amounts available for return and taxes on income and shall show return expressed~~

~~as a percentage of rate base allocated to the service concerned.~~

(1) Written testimony shall describe the development and results, and provide supporting workpapers for each customer class rate design. Included shall be a general discussion of the purpose of the filing with the overall goals and objectives of the rate design proposals. Industry standard terminology shall be used to describe rate design proposals. Where unique terms are used, they shall be defined in a separate glossary to be included as part of the filing.

(2) The billing impact for each customer class must be provided. This analysis must indicate how many customers on each tariff would receive bill increases or decreases of various percentages and dollar amounts. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

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

RULE I. APPLICATION FOR ALLOCATED COST OF SERVICE AND RATE DESIGN CHANGES (1) Applications for allocated cost of service and rate design changes shall include the material required in ARM 38.5.103, 38.5.104, 38.5.109, 38.5.176 and 38.5.177, minimally.

(2) Each allocated cost of service and rate design application shall include an example and general explanation of each current bill format that is used by the utility for tariffed services. Copies of other billing information that are provided to large groups of customers should also be provided and briefly explained. Additional information may be provided at the discretion of the filing utility.

(3) Absent regular allocated cost of service and rate design filings, a marginal cost of service study shall be submitted to the commission for information purposes, minimally, every two years. If the utility files an integrated resource plan with the commission, cost information shall be submitted within six months following such filing, unless the cost information has been presented within the previous two years. At the time a marginal cost of service study is filed, the utility, at its own option, may submit an embedded cost of service study.

(4) A marginal cost of service study filed pursuant to this rule or in the context of a rate case must contain current allocation factors.

(5) Three copies of the letter of transmittal and three copies of all material required in ARM 38.5.176, 38.5.177 and 38.5.109 shall be filed with the commission at the time of application. Montana consumer counsel shall receive two copies of the same materials.

(6) All or any part of the requirements of these rules may be waived by the commission upon a showing of good cause. Waiver of any requirements, however, shall not preclude the commission from requiring the filing of specific cost data and material sufficient to support the application. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

RULE II. POST-FILING CONFERENCE FOR ALLOCATED COST OF SERVICE AND RATE DESIGN APPLICATIONS (1) Within 20 days after receipt of an application for allocated cost of service and rate design changes, the commission may, on its own motion or upon petition by any party, request the utility and all other interested parties to attend a conference for the purpose of identifying and clarifying potential issues associated with said application. Such conference shall be informal and without prejudice to the rights of the parties, and no statement or admission made at such conference shall be admissible in evidence in any formal hearing before the commission. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

4. Rule 38.5.105 proposed to be repealed can be found on page 38-438 of the ARM. AUTH: 69-3-103, MCA; IMP, 69-2-101, MCA

Rule 38.5.178 proposed to be repealed can be found on page 38-454 of the ARM. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

5. Interested parties may submit their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted (original and 10 copies) to Tim Sweeney, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601 no later than May 28, 1993.

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

Bob Anderson

Bob Anderson, Chairman

Reviewed By

CERTIFIED TO THE SECRETARY OF STATE APRIL 19, 1993.

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

| | | |
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| In the matter of the amendment of rules 46.12.583 and 46.12.584 pertaining to organ transplantation | ) ) ) ) | NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.583 AND 46.12.584 PERTAINING TO ORGAN TRANSPLANTATION |

TO: All Interested Persons

1. On May 24, 1993, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.583 and 46.12.584 pertaining to organ transplantation.

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

46.12.583 ORGAN TRANSPLANTATION, DEFINITIONS

Subsection (1) remains the same.

(2) Organ transplantation includes the transplant surgery and those activities directly related to the transplantation. These activities must be performed at a transplant facility if required by medicare. These activities may include:

Subsection (2)(a) remains the same.

(b) pre-transplant preparation including histocompatibility testing procedures;

Subsections (2)(c) through (3)(b) remain the same.

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

46.12.584 ORGAN TRANSPLANTATION, REQUIREMENTS

Subsections (1) and (2) remain the same.

(a) The transplantation must be ~~determined to be~~ medically necessary ~~by the attending physician and the transplant physician~~.

Subsections (2)(b) and (2)(c) remain the same.

(d) The medicaid program covers only the following organ transplantation services for persons over the age of 21, subject to the provisions of subsections (2)(e) ~~and (2)(f)~~:

Subsection (2)(d)(i) remains the same.

~~(ii) liver;~~

(~~iii~~ii) kidney, inclusive of thoracic duct drainage and dental exam;

~~(iv) heart;~~

(viii) cornea;

~~(vi) histocompatibility testing procedures;~~

(~~vii~~iv) lymphocyte immune globulin preparation.

(e) For purposes of establishing organ transplant requirements and to more specifically defining coverage or non-coverage of various types of organ transplantations, ~~including bone marrow, liver, kidney/renal, pancreas and neurovascular,~~ the department hereby adopts and incorporates by reference the following sections of the ~~Health Insurance Manual 10 and federal register notices~~ Medicare Coverage Issues Manual (HCFA-Pub. 6) published by the health care financing administration of the United States department of health and human services. A copy of the ~~cited~~ incorporated sections of the ~~Health Insurance Manual 10 and federal register notices~~ Medicare Coverage Issues Manual (HCFA-Pub. 6) may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210. The incorporated sections are as follows:

(i) HCFA-Pub. 6, ~~S~~section 35-30, as amended through ~~April 28, 1989, defining coverage of~~ March 1992, pertaining to allogenic and autologous bone marrow transplantation~~.~~;

(~~ii~~iii) ~~Final notice published at volume 56 of the federal register, no. 71, pages 15006 through 15018 dated April 12, 1991, defining coverage of~~ HCFA Pub.-6, section 35-53.1, as amended September 1991, pertaining to pediatric liver transplantation~~.~~;

(~~iii~~iv) HCFA-Pub. 6, ~~S~~section 35-58, as amended through April 1983, ~~defining~~ pertaining to thoracic duct drainage (TDD) as a covered service when furnished to a kidney transplant recipient or individual approved to receive a transplant~~.~~;

(vi) HCFA-Pub. 6, section 35-87, as amended through May 1989, pertaining to heart transplants;

(~~iv~~vii) HCFA-Pub. 6, ~~S~~section 50-23, as amended through ~~June 1981, defining~~ July 1990, pertaining to the safe and effective use of histocompatibility testing procedures~~.~~; and

(~~v~~ix) HCFA-Pub. 6, ~~S~~section 50-26, as amended through ~~July 1981, defining~~ May 1989, pertaining to dental exam as part of a comprehensive workup prior to a renal transplant surgery.

(~~vi~~vii) HCFA-Pub. 6, ~~S~~section 45-22, as amended through ~~February 1982, defining~~ June 1988, pertaining to FDA approval and use of lymphocyte immune globulin preparations~~.~~;

(~~vii~~v) HCFA-Pub. 6, ~~S~~section 35-82, as amended through ~~May 1985, defining~~ January 1988, pertaining to non-coverage of pancreas transplantation~~.~~;

(~~viii~~ii) HCFA-Pub. 6, ~~S~~section 35-50, as amended through ~~June 1984, defining~~ September 1991, pertaining to non-coverage of the medical procedure cochleostomy with neurovascular transplant for treatment of meniere's disease~~.~~;

~~(f) For coverage of heart transplants, the department hereby adopts and incorporates by reference the criteria published in volume 52, no. 65 of the federal register of Monday, April 6, 1987, at pages 10935 through 10951. The medicare limit of one year reimbursement for immunosuppressive drugs does not apply to this rule. A copy of pages 10935 through 10951 of the federal register dated April 6, 1987, may be obtained from the Department of Social and Rehabilitation~~

~~Services, Medicaid Services Division, 111 Sanders, Helena, Montana 59604-4210.~~

(3) The medicaid program covers organ transplantation services for persons 21 years of age or less as determined medically necessary, subject to the provisions of ARM 46.12.583 and subsections (2)(a) through (2)(e) of this rule.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-113, 53-6-131 and 53-6-141 MCA

3. The 1993 Montana Legislature (House Bill 2) has reduced funding for organ transplants under the Medicaid program. They have directed the department to eliminate coverage of all adult organ transplants, except for kidney, bone marrow and cornea. Thus, it is necessary to amend the department's current rules to comply with the legislative directive.

Adult organ transplants are an optional service for the Medicaid program. Organ transplantation services for children are mandatory as a program element for Medicaid. The proposed rule amendments segregate and define the covered organ transplants and requirements for children and adults permitted by the Montana Medicaid program.

The department is incorporating by reference several sections of Medicare's policy manual pertaining to requirements for organ transplants. These requirements were previously contained in the Health Insurance Manual-10 (HIM-10) but are now contained in the Medicare Coverage Issues Manual (HCFA-Pub. 6). Following Medicare policies is necessary to ensure that Medicare will be the primary payor rather than Medicaid. It will also promote administrative efficiencies for providers if both programs follow the same criteria.

Elimination of the organ transplants proposed by this rule will reduce Medicaid expenditures by $206,742 each year in state fiscal years 1994 and 1995.

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 May 27, 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 April 19, 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 PUBLIC HEARING ON 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 |

TO: All Interested Persons

1. On May 24, 1993, at 2:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed 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.

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

46.12.503 INPATIENT HOSPITAL SERVICES, DEFINITION

Subsections (1) through (5) remain the same.

(6) "Transferring hospital" is ~~the~~ a hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

(7) "Discharging hospital" is ~~the~~ a hospital, other than a transferring hospital, that formally ~~releases~~ discharges an inpatient ~~from a hospital~~. Release of a patient to another hospital, as described in ~~transferring hospitals~~ subsection (6), or a leave of absence from the hospital will not be recognized as a discharge. A patient who dies in the hospital is considered a discharge.

(8) "Day outlier" is an extended length of stay case that exceeds the day outlier thresholds as set forth in ARM 46.12.505 (~~116~~6).

(9) "Cost outlier" is an unusually high cost case that exceeds the cost outlier thresholds as set forth in ARM 46.12.505(~~67~~).

Subsection (10) remains the same.

~~(11) "Budget neutrality" means the DRG-based reimbursement system described at ARM 46.12.505 shall be adjusted to compensate in the aggregate, an equal amount for all inpatient hospital services as would have been expended, in the aggregate, under an allowable cost-based reimbursement system described at ARM 46.12.509(2) in the first year from the effective date.~~

(~~12~~11) "Disproportionate share hospital" means a hospital~~, including a psychiatric inpatient hospital facility,~~ which meets the following criteria:

Subsections (12)(a) through (14)(b) remain the same in text but are renumbered (11)(a) through (13)(b).

(~~15~~14) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area, as defined ~~by the federal executive office of management and budget~~ in 42 CFR 412.62(f)(2).

(15) "Large referral hospital" means an acute care hospital located in the state of Montana that serves as a referral center and has been determined by the department as of April 1, 1993 to have a case mix with a statistically demonstrated level of intensity of care which is higher than the norm for Montana acute care hospitals. Such facilities are Columbus Hospital (Great Falls), Deaconess Medical Center (Billings), Missoula Community Hospital, Montana Deaconess Medical Center (Great Falls), St. James Hospital (Butte), St. Patrick's Hospital (Missoula) and St. Vincent's Hospital (Billings).

(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) 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" or "very rural" by the United States department of agriculture under its rural-urban continuum codes for metro and nonmetro counties.

Subsection (17) remains the same.

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

46.12.504 INPATIENT HOSPITAL SERVICES, REQUIREMENTS

(1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.~~308~~309.

Subsections (2) through (4)(b) remain the same.

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

(1) ~~The department will reimburse f~~For inpatient hospital services, ~~compensable under~~ the Montana medicaid program will reimburse providers as follows:

(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 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~~ specified. Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system will be reimbursed, ~~I~~in addition to the prospective DRG rate, for the following ~~are reimbursable~~:

(i) capital-related costs as set forth in subsection (~~3~~4);

(ii) medical education costs as set forth in subsection (~~4~~5);

(iii) cost or day outliers as set forth in subsections (~~5~~6) and (~~6~~7);

~~(iv) for sole community providers and neonate DRG's (385-390), a stop-loss reimbursement as set forth in subsections (5) and (6);~~

(~~v~~iv) certified registered nurse anesthetist costs as provided in subsection ~~(13),~~ (15); and

(v) catastrophic case payments as provided in subsection (8).

(b) Inpatient hospital services provided in hospitals located outside the state of Montana, but ~~provided in an area~~ no more than 100 miles from the border and not in ~~(~~Canada, ~~excluded)~~ referred to in these rules as "border hospitals", will be reimbursed under the DRG prospective payment system ~~using the methodology~~ described in subsection (2). In addition to the prospective rate, ~~these providers~~ border hospitals will be reimbursed for day or cost outliers as set forth in subsections (~~5~~6) and (~~6~~7), and for capital costs as set forth in subsection (5), but shall not be reimbursed in addition to the DRG payment for medical education costs, neonatal intensive care stop-loss reimbursement or certified registered nurse anesthetist costs.

(c) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana and not in ~~(~~Canada ~~excluded) are limited to a ratio of usual and customary billed charges computed for each facility under medicare reimbursement principles. If the provider fails to submit financial information necessary to compute the rate, the provider will be reimbursed at 60% of its usual and customary billed charges.~~ will be reimbursed their actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 46.12.509(2). The department may waive retrospective cost settlement for such facilities which have received interim payments totalling 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 such period.

(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 providers 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. The department may adjust interim reimbursement rates to account for such increased charges.

(d) Inpatient hospital services provided in hospitals located in Canada will be reimbursed at 60% of usual and customary charges, converted at the current rate from Canadian to U.S. dollars.

(2) The department's DRG prospective ~~(DRG)~~ payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to diagnosis related groups (DRGS) ~~as set forth in subsection (11)~~. The procedure for determining the DRG prospective ~~(DRG)~~ payment rate is as follows:

(a) For recipients admitted on or after July 1, 1993, ~~T~~the department assigns a DRG to each medicaid discharge in accordance with the medicare grouper program version ~~4.0~~ 9.0, as developed by Health Systems International, Inc. The assignment of each DRG is based on:

(i) the ICD-9-CM princip~~le~~al diagnosis;

Subsections (2)(a)(ii) through (2)(a)(vi) remain the same.

(b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which reflects the cost of hospital resources used to treat cases in that DRG relative to the statewide average cost of all medicaid hospital cases. The relative weight for each DRG is ~~set forth in subsection (11)~~ available upon request from Medicaid Services Division, Social and Rehabilitation Services, 111 Sanders, P.O. Box 4210, Helena, MT 59604-4210.

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

(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective ~~(DRG)~~ payment rate for that discharge~~.~~ except:

(i) for those DRGs determined by the department to be "unstable", the prospective payment is subject to a stop-loss payment for all DRG hospitals except the large referral hospitals. For "unstable" DRGs, if the provider charges are less than 75% of the computed prospective payment or more than four times the computed prospective payment, the claim will be paid at the statewide cost to charge ratio as defined in subsection (13); and

(ii) where there is no weight assigned to a DRG, the DRG will be paid at the statewide cost to charge ratio as defined in subsection (13).

(3) For those Montana hospitals designated by the department as of April 1, 1993 as having neonatal intensive care units, reimbursement for neonatal DRG's 385 through 390 shall be at the facility-specific cost to charge ratio, determined by the department in accordance with medicare reimbursement principles. Such hospitals shall not receive any day or cost outlier payment or other add-on payment with respect to such discharges or services.

(34) The department shall reimburse inpatient hospital service providers for capital-related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, 1986. The department hereby adopts and incorporates by reference 42 CFR 412.113, sections (a) and (b), as amended through October 1, 1986, which set forth medicare cost reimbursement principles. Copies of this section may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, ~~Economic Assistance Division,~~ 111 Sanders, P.O. Box 4210, Helena, Montana 59604-4210.

Subsection (3)(a) remains the same in text but is renumbered (4)(a).

(i) The department shall identify the facility's total allowable medicaid inpatient capital-related costs from the facility's most recent~~ly~~ audited 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 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.

(~~ii~~iii) The department will make interim capital payments ~~at least monthly~~ with each inpatient hospital claim paid.

(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. 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.

Subsection (4)(a) remains the same in text but is renumbered (5)(a).

(i) The department shall identify the facility's total allowable medicaid inpatient medical education related costs from the facility's most recent~~ly~~ audited cost report. These costs will be used as a base amount for interim payments;

(ii) The department will make interim medical education related cost reimbursement payments ~~at least monthly~~ with each inpatient hospital claim paid.

(~~5~~6) In addition to the DRG payment, ~~the~~ providers reimbursed under the DRG prospective payment system may receive payment as provided in this subsection for day outliers for DRGs other than neonatal DRGs 385 through 390 provided by neonatal intensive care units described in subsection (3).

(a) To receive payment for a day outlier under subsection (1)(a)(iii), the medically necessary portion of the inpatient hospital stay, as determined by the department, ~~of a medicaid recipient~~ must exceed the day outlier threshold established by the department for the DRG ~~based on the medically necessary days reviewed by the department~~. ~~The day outlier thresholds the DRGs are set forth in subsection (11).~~

(b) The department determines the outlier reimbursement for day outliers for all hospitals and distinct part units, ~~except for neonate DRGs (385-390) and sole community providers by~~ entitled to receive day outlier reimbursement, as follows:

(i) computing the per diem amount for the DRG by dividing the DRG prospective ~~(DRG)~~ payment rate by the DRG average length of stay ~~set forth in subsection (11)~~; and

(ii) multiplying the per diem amount by 60% to establish the day outlier per diem rate for the DRG; and

(iii) subtracting the number of days at the threshold for the DRG ~~as set forth in subsection (11)~~ from the actual number of medically necessary inpatient days determined as ~~certified~~ provided in subsection ~~(5)(a)(iii)~~ (6)(a) to establish the number of outlier days; and

(iv) multiplying the day outlier per diem rate computed in subsection (~~5~~6)(b)(ii) by the number of outlier days computed in subsection (~~5~~6)(b)(iii) to establish the day outlier payment.

~~(c) The department determines the outlier reimbursement for day outliers for neonate DRGs (385-390) and providers who maintain sole community hospital designation for medicare as the greater of:~~

~~(i) the computed prospective (DRG) payment rate as set forth in subsection (2) and day outlier payment as set forth in subsection (5)(b); or~~

~~(ii) estimated marginal cost of the total stay computed by multiplying the total usual and customary charges of the stay charges by 60%.~~

(~~6~~7) In addition to the DRG payment, ~~the~~ providers reimbursed under the DRG prospective payment system may ~~request~~ receive payment as provided in this subsection for cost outliers for DRGs other than neonatal DRGs 385 through 390 provided by neonatal intensive care units described in subsection (3).

(a) To receive payment for a cost outlier, the combined cost of the medically necessary days and services of the inpatient hospital stay, as determined by the department, ~~of a~~

~~medicaid recipient must exceed 150% of the prospective (DRG) payment rate for the DRG or $12,000 as computed in subsection (2)(d) and not qualify as a day outlier under subsection (5)~~ must exceed the cost outlier threshold established by the department for the DRG.

(b) The department determines the outlier reimbursement for cost outliers for all hospitals and distinct part units, ~~except for neonate DRGs (385-390) and sole community providers by~~ entitled to receive cost outlier reimbursement, as follows:

(i) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in subsection (~~11~~13);

(ii) subtracting the ~~lesser of 150% of the prospective (DRG) payment rate or $12,000~~ cost outlier threshold amount from the estimated costs to compute the cost outlier amount; and

Subsection (6)(b)(iii) remains the same in text but will be renumbered (7)(b)(iii).

~~(c) The department determines the outlier reimbursement for cost outliers for neonate DRGs (385-390) and providers who maintain sole community hospital designation for medicare as the greater of:~~

~~(i) the computed prospective (DRG) payment rate as set forth in subsection (2) and the cost outlier payment as set forth in subsection (6); or~~

~~(ii) the estimated marginal cost of the total stay computed by multiplying the total usual and customary charges for the stay by 60%.~~

(8) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may request payment for catastrophic cases.

(a) To receive payment for catastrophic cases, the charges for the medically necessary days and services of the inpatient hospital stay, as determined by the department, must exceed $125,000.

(b) The medical necessity of the days and services of the inpatient hospital stay may be reviewed by the department or its designated agent prior to payment of the catastrophic case.

(c) The department determines the maximum catastrophic case reimbursement for all hospitals and distinct part units by:

(i) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in subsection (13); and

(ii) subtracting any previous payments for the case.

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

Subsection (7) remains the same in text but is renumbered (9).

(a) if it is determined that complications have arisen because of ~~an early~~ premature discharge and/or other treatment errors, then the DRG payment for the first admission shall be altered by combining the two admissions into one for payment purposes; or

Subsection (7)(b) remains the same in text but is renumbered (9)(b).

(~~8~~10) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for continuation of medical treatment between two hospitals, one of which is paid under the Montana medicaid prospective payment system.

(a) A transferring hospital reimbursed under ~~subsection (2)~~ the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate for each day of inpatient care determined by dividing the sum of the DRG payment for the case as computed in subsection (2) and the appropriate outlier as computed in subsections (~~5~~6) or (~~6~~7), if any, by the statewide average length of stay for the DRG ~~as set forth in subsection (11)~~; or

(ii) the sum of the DRG payment for the case as computed in subsection (2) and the appropriate outlier as computed in subsections (~~5~~6) and (~~6~~7), if any.

(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under subsection (2) is paid the full DRG payment plus any appropriate outliers.

Subsections (9) through (9)(b) remain the same in text but are renumbered (11) through (11)(b).

(c) designated by the department as a hospital resident as set forth in subsection (~~10~~12).

(~~10~~12) "Hospital resident" means a recipient whose medical condition requires treatment ~~who is unable to be cared for~~ in an ~~setting other than the acute care~~ inpatient hospital setting.

Subsections (10)(a) and (10)(a)(i) remain the same in text but are renumbered (12)(a) and (12)(a)(i).

(ii) recipients must have been an inpatient in an ~~acute care~~ inpatient hospital for a minimum of six ~~(6)~~ continuous months; and

(iii) providers will have the responsibility of determining whether the recipient's medical condition ~~services~~ could be ~~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 redetermination of nursing home or waiver availability must be made at least every six months.

Subsections (10)(b) and (10)(b)(i) remain the same in text but are renumbered (12)(b) and (12)(b)(i).

(ii) payment for the first 180 days of inpatient care will be the DRG payment for the case as computed in subsection (2) and any appropriate outliers and catastrophic payments as computed in subsection (~~5~~6), (7) or (~~6~~8); and

Subsection (10)(b)(iii) remains the same in text but is renumbered (12)(b)(iii).

(~~a~~13) tThe medicaid statewide average cost to charge ratio equals ~~.790825~~ .68;

(~~11~~14) ~~DRG relative weights, average lengths of stay, day outlier thresholds, and the statewide average cost to charge ratio are set forth as follows:~~ The Montana medicaid DRG relative weight values, average length of stay (ALOS), outlier thresholds and stop loss thresholds are contained in the DRG table of weights and thresholds (April 1993 edition). The DRG table of weights and thresholds is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the DRG table of weights and thresholds (April 1993 edition). Copies may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, 111 Sanders, P.O. Box 4210, Helena, Montana 59604-4210.

(b) A MEDICAID DRG RELATIVE WEIGHT VALUES, AVERAGE LENGTH OF STAY (ALOS) AND DAY OUTLIER THRESHOLDS

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 1 | Craniotomy Age Greater Than 17 Except for Trauma | 5.0618 | 17.11 | 37 |
| 2 | Craniotomy For Trauma Age Greater Than 17 | 5.0393 | 14.58 | 35 |
| 3 | Craniotomy Age Less Than 18 | 2.4490 | 9.39 | 29 |
| 4 | Spinal Procedures | 3.5563 | 14.45 | 34 |
| 5 | Extracranial Vascular Procedures | 2.8940 | 10.59 | 31 |
| 6 | Carpal Tunnel Release | 0.6413 | 2.41 | 10 |
| 7 | Periph Cranial Nerve Other Nerv Syst Proc Age 69/or C.C. | 2.6137 | 15.82 | 36 |
| 8 | Periph Cranial Nerve Other Nerv Syst Proc Age Less Than 70 w/o C.C. | 0.9958 | 3.73 | 22 |
| 9 | Spinal Disorders Injuries | 3.2323 | 19.30 | 39 |
| 10 | Nervous System Neoplasms Age Greater Than 69 and/or C.C. | 1.7875 | 9.60 | 30 |
| 11 | Nervous System Neoplasms Age Less Than 70 w/o C.C. | 1.2949 | 7.34 | 27 |
| 12 | Degenerative Nervous System Disorders | 1.9099 | 10.63 | 31 |
| 13 | Multiple Sclerosis Cerebellar Ataxia | 1.6395 | 9.65 | 30 |
| 14 | Specific Cerebrovascular Disorders Except TIA | 2.4871 | 12.21 | 32 |
| 15 | Transient Ischemic Attack and Precerebral Occlusions | 1.1779 | 5.98 | 26 |
| 16 | Nonspecific Cerebrovascular Disorders with C.C. | 1.6566 | 8.80 | 29 |
| 17 | Nonspecific Cerebrovascular Disorders w/o C.C. | 1.2876 | 6.87 | 27 |
| 18 | Cranial Peripheral Nerve Disorders Age Greater Than 69 and/or C.C. | 1.3943 | 8.49 | 28 |
| 19 | Cranial Peripheral Nerve Disorders Age Less Than 70 w/o C.C. | 1.1212 | 5.71 | 26 |
| 20 | Nervous System Infection Except Viral Meningitis | 1.8528 | 8.99 | 29 |
| 21 | Viral Meningitis | 0.7232 | 3.54 | 24 |
| 22 | Hypertensive Encephalopathy | 1.5381 | 6.91 | 27 |
| 23 | Nontraumatic Stupor Coma | 1.4846 | 6.19 | 26 |
| 24 | Seizure Headache Age Greater Than 69 and/or C.C. | 1.0728 | 5.52 | 26 |
| 25 | Seizure Headache Age 18-69 w/o C.C. | 0.8469 | 5.27 | 25 |
| 26 | Seizure Headache Age 0-17 | 0.6034 | 4.02 | 16 |
| 27 | Traumatic Stupor Coma, Coma Greater Than 1 HR | 2.0869 | 8.93 | 29 |
| 28 | Traumatic Stupor Coma, Coma 1 HR Age 69 &/or C.C. | 1.3648 | 6.21 | 26 |
| 29 | Traumatic Stupor Coma Less Than 1 HR Age 18-69 w/o C.C. | 0.8608 | 4.43 | 24 |
| 30 | Traumatic Stupor Coma Less Than 1 HR Age 0-17 | 0.4088 | 2.17 | 17 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 31 | Concussion Age Greater Than 69 and/or C.C. | 0.7329 | 3.40 | 22 |
| 32 | Concussion Age 18-69 w/o C.C. | 0.5306 | 2.49 | 13 |
| 33 | Concussion Age 0-17 | 0.3065 | 1.57 | 16 |
| 34 | Other Disorders of Nervous System Age Greater Than 69 and/or C.C. | 1.6497 | 8.61 | 29 |
| 35 | Other Disorders of Nervous System Age Less Than 70 w/o C.C. | 1.0552 | 5.34 | 25 |
| 36 | Retinal Procedures | 1.1752 | 4.12 | 16 |
| 37 | Orbital Procedures | 1.1233 | 3.97 | 21 |
| 38 | Primary Iris Procedure | 0.6871 | 2.62 | 12 |
| 39 | Lens Procedures With or Without Vitrectomy | 0.9596 | 3.40 | 10 |
| 40 | Extraocular Procedures Except Orbit Age Greater Than 17 | 0.6610 | 2.10 | 16 |
| 41 | Extraocular Procedures Except Orbit Age 0-17 | 0.4782 | 1.27 | 9 |
| 42 | Intraocular Procedures Except Retina, Iris-Lens | 1.1509 | 3.78 | 16 |
| 43 | Hyphema | 0.5353 | 3.98 | 15 |
| 44 | Acute Major Eye Infection | 0.7209 | 4.29 | 16 |
| 45 | Neurological Eye Disorders | 0.8800 | 4.32 | 24 |
| 46 | Other Disorders of the Eye Age Greater Than 17 with C.C. | 0.7577 | 4.32 | 24 |
| 47 | Other Disorders of the Eye Age Greater Than 17 w/o C.C. | 0.7175 | 3.83 | 24 |
| 48 | Other Disorders of the Eye Age 0-17 | 0.4556 | 2.54 | 14 |
| 49 | Major Head-Neck Procedures | 4.6556 | 16.89 | 37 |
| 50 | Sialoadenectomy | 1.0768 | 3.53 | 12 |
| 51 | Salivary Gland Procedures Except Sialoadenectomy | 0.7734 | 3.40 | 14 |
| 52 | Cleft Lip-Palate Repair | 0.8909 | 3.74 | 12 |
| 53 | Sinus-Mastoid Procedures Age Greater Than 17 | 0.9288 | 3.17 | 13 |
| 54 | Sinus-Mastoid Procedures Age 0-17 | 0.8819 | 2.84 | 23 |
| 55 | Miscellaneous Ear, Nose, Throat Procedures | 0.6490 | 2.08 | 13 |
| 56 | Rhinoplasty | 0.6455 | 2.14 | 6 |
| 57 | T-A Proc Except Tonsillectomy /or Adenoidectomy Only, Age 17 | 0.7487 | 3.18 | 16 |
| 58 | T-A Proc Except Tonsillectomy /or Adenoidectomy Only, Age 0-17 | 0.4645 | 1.37 | 5 |
| 59 | Tonsillectomy and/or Adenoidectomy Only Age Greater Than 17 | 0.5432 | 1.78 | 6 |
| 60 | Tonsillectomy and/or Adenoidectomy Only Age 0-17 | 0.4694 | 1.71 | 11 |
| 61 | Myringotomy With Tube Insertion Age Greater Than 17 | 0.3230 | 1.15 | 3 |
| 62 | Myringotomy With Tube Insertion Age 0-17 | 0.2794 | 1.03 | 3 |
| 63 | Other Ear, Nose, Throat O.R. Procedures | 1.1524 | 5.10 | 25 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 64 | Ear, Nose-Throat Malignancy | 1.8002 | 9.03 | 29 |
| 65 | Dysequilibrium | 0.7942 | 4.10 | 17 |
| 66 | Epistaxis | 0.6414 | 3.47 | 23 |
| 67 | Epiglottitis | 1.1739 | 4.44 | 18 |
| 68 | Otitis Media-URI Age Greater Than 69 and/or C.C. | 0.8671 | 4.45 | 19 |
| 69 | Otitis Media-URI Age 18-69 w/o C.C. | 0.6430 | 3.37 | 16 |
| 70 | Otitis Media-URI Age 0-17 | 0.4855 | 3.05 | 20 |
| 71 | Laryngotracheitis | 0.5062 | 1.82 | 15 |
| 72 | Nasal Trauma-Deformity | 0.5297 | 2.16 | 10 |
| 73 | Other Ear, Nose-Throat Diagnoses Age Greater Than 17 | 0.7513 | 3.72 | 24 |
| 74 | Other Ear, Nose-Throat Diagnoses Age 0-17 | 0.5713 | 2.65 | 22 |
| 75 | Major Chest Procedures | 3.9314 | 13.55 | 34 |
| 76 | Other Respiratory System O.R. Procedures with C.C. | 3.4339 | 15.46 | 35 |
| 77 | Other Respiratory System O.R. Procedures w/o C.C. | 2.1173 | 8.19 | 28 |
| 78 | Pulmonary Embolism | 2.2263 | 9.92 | 30 |
| 79 | Respiratory Infections-Inflammations Age Greater Than 69 and/or C.C. | 3.0303 | 14.35 | 34 |
| 80 | Respiratory Infections-Inflammations Age 18-69 w/o C.C. | 2.5667 | 11.00 | 31 |
| 81 | Respiratory Infections-Inflammations Age 0-17 | 1.2766 | 6.59 | 27 |
| 82 | Respiratory Neoplasms | 1.6354 | 8.27 | 28 |
| 83 | Major Chest Trauma Age Greater Than Age 69 and/or C.C. | 1.4274 | 6.65 | 27 |
| 84 | Major Chest Trauma Age Less Than 70 w/o C.C. | 0.9192 | 4.31 | 22 |
| 85 | Pleural Effusion Age Greater Than 69 and/or C.C. | 1.7906 | 9.75 | 30 |
| 86 | Pleural Effusion Age Less Than 70 w/o C.C. | 1.5465 | 7.20 | 27 |
| 87 | Pulmonary Edema-Respiratory Failure | 2.7473 | 9.55 | 30 |
| 88 | Chronic Obstructive Pulmonary Disease | 1.5445 | 9.65 | 30 |
| 89 | Simple Pneumonia-Pleurisy Age Greater Than 69 and/or C.C. | 1.9056 | 8.59 | 29 |
| 90 | Simple Pneumonia-Pleurisy Age 18-69 w/o C.C. | 1.2074 | 5.43 | 16 |
| 91 | Simple Pneumonia-Pleurisy Age 0-17 | 0.7330 | 4.27 | 12 |
| 92 | Interstitial Lung Disease Age Greater Than 69 and/or C.C. | 1.4103 | 7.44 | 27 |
| 93 | Interstitial Lung Disease Age Less Than 70 w/o C.C. | 1.1019 | 5.52 | 26 |
| 94 | Pneumothorax Age Greater Than 69 and/or C.C. | 1.5475 | 5.87 | 26 |
| 95 | Pneumothorax Age Less Than 70 w/o C.C. | 1.1013 | 5.15 | 21 |
| 96 | Bronchitis-Asthma Age Greater Than 69 and/or C.C. | 1.2886 | 6.02 | 26 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 97 | Bronchitis Asthma Age 18-69 w/o C.C. | 0.9724 | 4.57 | 11 |
| 98 | Bronchitis Asthma Age 0-17 | 0.6273 | 3.84 | 18 |
| 99 | Respiratory Signs Symptoms Age Greater Than 69 and/or C.C. | 1.3606 | 6.30 | 26 |
| 100 | Respiratory Signs Symptoms Age Less Than 70 w/o C.C. | 0.8580 | 4.05 | 24 |
| 101 | Other Respiratory System Diagnoses Age Greater Than 69 and/or C.C. | 1.4137 | 6.52 | 27 |
| 102 | Other Respiratory System Diagnoses Age Less Than 70 w/o C.C. | 0.9069 | 4.42 | 24 |
| 103 | Heart Transplant | 0.0000 | 0.00 | 0 |
| 104 | Cardiac Valve Procedure with Pump with Cardiac Cath | 9.2997 | 20.61 | 41 |
| 105 | Cardiac Valve Procedure with Pump w/o Cardiac Cath | 7.3683 | 13.48 | 33 |
| 106 | Coronary Bypass with Cardiac Cath | 7.0079 | 15.79 | 35 |
| 107 | Coronary Bypass w/o Cardiac Cath | 5.8524 | 11.13 | 31 |
| 108 | Other Cardiovascular or Thoracic Proc with Pump | 4.4764 | 10.60 | 30 |
| 109 | Cardiothoracic Procedures w/o Pump | 4.0904 | 10.75 | 31 |
| 110 | Major Reconstructive Vascular Proc w/o Pump Age 69 and/or C.C. | 5.1665 | 18.09 | 38 |
| 111 | Major Reconstructive Vascular Proc w/o Pump Age 70 w/o C.C. | 3.9538 | 12.96 | 33 |
| 112 | Vascular Procedures Except Major Reconstruction w/o Pump | 3.1434 | 11.24 | 31 |
| 113 | Amputation for Circ System Disorders Except Upper Limb Toe | 4.5607 | 22.07 | 42 |
| 114 | Upper Limb Toe Amputation for Circ System Disorders | 3.3924 | 16.75 | 37 |
| 115 | Perm Cardiac Pacemaker Implant With AMI, Heart Failure or Shock | 5.4763 | 15.27 | 35 |
| 116 | Perm Cardiac Pacemaker Implant w/o AMI, Heart Failure or Shock | 5.0465 | 10.24 | 30 |
| 117 | Cardiac Pacemaker Replace Revis Exc Pulse Gen Repl Only | 2.4163 | 7.16 | 22 |
| 118 | Cardiac Pacemaker Pulse Generator Replacement Only | 3.0251 | 5.33 | 24 |
| 119 | Vein Ligation Stripping | 1.1817 | 4.75 | 19 |
| 120 | Other Circulatory System O.R. Procedures | 3.3777 | 15.68 | 36 |
| 121 | Circulatory Disorders with AMI C.V. Comp. Disch. Alive | 2.2168 | 11.41 | 31 |
| 122 | Circulatory Disorders with AMI w/o C.V. Comp. Disch. Alive | 2.3042 | 7.35 | 19 |
| 123 | Circulatory Disorders with AMI, Expired | 2.0636 | 4.97 | 25 |
| 124 | Circulatory Disorders Exc AMI, with Card Cath Complex Diag | 1.8419 | 7.84 | 28 |
| 125 | Circulatory Disorders Exc AMI, with Card Cath w/o Complex Diag | 1.0059 | 3.16 | 21 |
| 126 | Acute Subacute Endocarditis | 4.5668 | 19.54 | 40 |
| 127 | Heart Failure Shock | 1.7668 | 7.88 | 18 |
| 128 | Deep Vein Thrombophlebitis | 1.4924 | 8.55 | 29 |
| 129 | Cardiac Arrest, Unexplained | 2.8298 | 8.68 | 29 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 130 | Peripheral Vascular Disorders Age Greater Than 69 and/or C.C. | 1.6347 | 9.33 | 29 |
| 131 | Peripheral Vascular Disorders Age Less Than 70 w/o C.C. | 1.2395 | 6.81 | 27 |
| 132 | Atherosclerosis Age Greater Than 69 and/or C.C. | 1.4521 | 3.49 | 36 |
| 133 | Atherosclerosis Age Less Than 70 w/o C.C. | 1.1995 | 4.85 | 25 |
| 134 | Hypertension | 1.1051 | 5.74 | 26 |
| 135 | Cardiac Congenital Valvular Disorders Age 69 and/or C.C. | 1.6845 | 8.61 | 29 |
| 136 | Cardiac Congenital Valvular Disorders Age 18-69 w/o C.C. | 1.1504 | 4.86 | 25 |
| 137 | Cardiac Congenital Valvular Disorders Age 0-17 | 1.1573 | 3.99 | 24 |
| 138 | Cardiac Arrhythmia Conduction Disorders Age 69 and/or C.C. | 1.4685 | 6.35 | 26 |
| 139 | Cardiac Arrhythmia Conduction Disorders Age 70 w/o C.C. | 1.0933 | 4.60 | 25 |
| 140 | Angina Pectoris | 1.2509 | 5.27 | 25 |
| 141 | Syncope Collapse Age Greater Than 69 and/or C.C. | 1.0368 | 4.92 | 25 |
| 142 | Syncope Collapse Age Less Than 70 w/o C.C. | 0.8144 | 3.91 | 22 |
| 143 | Chest Pain | 0.9447 | 3.21 | 16 |
| 144 | Other Circulatory System Diagnoses with C.C. | 1.7541 | 8.15 | 28 |
| 145 | Other Circulatory System Diagnoses w/o C.C. | 1.3323 | 5.76 | 26 |
| 146 | Rectal Resection Age Greater Than 69 and/or C.C. | 5.2304 | 19.75 | 40 |
| 147 | Rectal Resection Age Less Than 70 w/o C.C. | 3.2913 | 13.05 | 33 |
| 148 | Major Small Large Bowel Procedures Age Greater Than 69 and/or C.C. | 4.9836 | 16.84 | 37 |
| 149 | Major Small Large Bowel Procedures Age Less Than 70 w/o C.C. | 3.2128 | 11.99 | 32 |
| 150 | Peritoneal Adhesiolysis Age Greater Than 69 and/or C.C. | 3.7388 | 14.09 | 34 |
| 151 | Peritoneal Adhesiolysis Age Less Than 70 w/o C.C. | 2.0506 | 8.38 | 28 |
| 152 | Minor Small Large Bowel Procedures Age Greater Than 69 and/or C.C. | 2.2630 | 10.16 | 30 |
| 153 | Minor Small Large Bowel Procedures Age Less Than 70 w/o C.C. | 1.7078 | 7.82 | 28 |
| 154 | Stomach, Esophageal Duodenal Procedures Age 69 and/or C.C. | 3.9042 | 13.55 | 34 |
| 155 | Stomach, Esophageal Duodenal Procedures Age 18-69 w/o C.C. | 2.4734 | 9.67 | 30 |
| 156 | Stomach, Esophageal Duodenal Procedures Age 0-17 | 1.4275 | 6.60 | 27 |
| 157 | Anal and Stomal Procedures Age Greater Than 69 and/or C.C. | 1.4379 | 6.16 | 26 |
| 158 | Anal and Stomal Procedures Age Less Than 70 w/o C.C. | 0.9282 | 4.11 | 16 |
| 159 | Hernia Procedures Except Inguinal Femoral Age 69 and/or C.C. | 1.8626 | 7.65 | 28 |
| 160 | Hernia Procedures Except Inguinal Femoral Age 18-69 w/o C.C. | 1.1872 | 4.78 | 20 |
| 161 | Inguinal Femoral Hernia Procedures Age Greater Than 69 and/or C.C. | 1.4547 | 6.64 | 27 |
| 162 | Inguinal Femoral Hernia Procedures Age 18-69 w/o C.C. | 0.8908 | 3.25 | 11 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 163 | Hernia Procedures Age 0-17 | 0.5260 | 1.67 | 10 |
| 164 | Appendectomy with Complicated Princ. Diag. Age 69 and/or C.C. | 2.7725 | 10.33 | 29 |
| 165 | Appendectomy with Complicated Princ. Diag. Age 70 w/o C.C. | 1.8896 | 7.05 | 27 |
| 166 | Appendectomy w/o Complicated Princ. Diag. Age 69 and/or C.C. | 1.5940 | 5.83 | 20 |
| 167 | Appendectomy w/o Complicated Princ. Diag. Age Less Than 70 w/o C.C. | 1.0360 | 3.94 | 16 |
| 168 | Mouth Procedures Age Greater Than 69 and/or C.C. | 1.7290 | 6.83 | 27 |
| 169 | Mouth Procedures Age Less Than 70 w/o C.C. | 1.0245 | 3.81 | 21 |
| 170 | Other Digestive System O.R. Procedures Age 69 and/or C.C. | 4.0005 | 14.87 | 35 |
| 171 | Other Digestive System O.R. Procedures Age Less Than 70 w/o C.C. | 1.7744 | 6.73 | 27 |
| 172 | Digestive Malignancy Age Greater Than 69 and/or C.C. | 2.0031 | 11.43 | 31 |
| 173 | Digestive Malignancy Age Less Than 70 w/o C.C. | 1.4287 | 7.15 | 27 |
| 174 | G.I. Hemorrhage Age Greater Than 69 and/or C.C. | 1.6178 | 7.03 | 27 |
| 175 | G.I. Hemorrhage Age Less Than 70 w/o C.C. | 1.1266 | 4.94 | 25 |
| 176 | Complicated Peptic Ulcer | 1.7385 | 7.08 | 27 |
| 177 | Uncomplicated Peptic Ulcer Greater Than 69 and/or C.C. | 1.2335 | 6.21 | 26 |
| 178 | Uncomplicated Peptic Ulcer Less Than 70 w/o C.C. | 0.9710 | 4.95 | 22 |
| 179 | Inflammatory Bowel Disease | 1.4119 | 7.71 | 28 |
| 180 | G.I. Obstruction Age Greater Than 69 and/or C.C. | 1.4349 | 7.58 | 28 |
| 181 | G.I. Obstruction Age Less Than 70 w/o C.C. | 0.9821 | 5.18 | 25 |
| 182 | Esophagitis, Gastroent., & Misc. Digest. Dis. Age 69 and/or C.C. | 0.9936 | 4.64 | 14 |
| 183 | Esophagitis, Gastroent., & Misc. Digest. Dis. Age 18-69 w/o C.C. | 0.8014 | 3.45 | 23 |
| 184 | Esophagitis, Gastroenteritis, & Misc. Digest. Disorders Age 0-17 | 0.5417 | 3.07 | 18 |
| 185 | Dental & Oral Dis. Exc. Extractions & Restorations, Age 17 | 0.9411 | 4.07 | 24 |
| 186 | Dental & Oral Dis. Exc. Extractions & Restorations, Age 0-17 | 0.5170 | 2.69 | 10 |
| 187 | Dental Extractions & Restorations | 0.6345 | 2.22 | 9 |
| 188 | Other Digestive System Diagnoses Age Greater Than 69 and/or C.C. | 1.4652 | 7.01 | 27 |
| 189 | Other Digestive System Diagnoses Age 18-69 w/o C.C. | 0.7966 | 3.95 | 24 |
| 190 | Other Digestive System Diagnoses Age 0-17 | 0.5213 | 2.69 | 23 |
| 191 | Major Pancreas, Liver & Shunt Procedures | 6.4073 | 18.09 | 38 |
| 192 | Minor Pancreas, Liver & Shunt Procedures | 5.8857 | 22.91 | 43 |
| 193 | Biliary Tract Proc Exc Tot Cholecystectomy Age 69 and/or C.C. | 4.8314 | 17.31 | 37 |
| 194 | Biliary Tract Proc Exc Tot Cholecystectomy Age Less Than 70 w/o C.C. | 2.7228 | 10.52 | 31 |
| 195 | Total Cholecystectomy with C.D.E. Age Greater Than 69 and/or C.C. | 2.9854 | 12.03 | 29 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 196 | Total Cholecystectomy with C.D.E. Age Less Than 70 w/o C.C. | 2.4112 | 9.46 | 21 |
| 197 | Total Cholecystectomy w/o C.D.E. Age Greater Than 69 and/or C.C. | 2.2796 | 9.02 | 28 |
| 198 | Total Cholecystectomy w/o C.D.E. Age Less Than 70 w/o C.C. | 1.6580 | 7.06 | 13 |
| 199 | Hepatobiliary Diagnostic Procedure for Malignancy | 4.5847 | 18.55 | 39 |
| 200 | Hepatobiliary Diagnostic Procedure for Non-Malignancy | 2.7499 | 10.87 | 31 |
| 201 | Other Hepatobiliary or Pancreas O.R. Procedures | 4.2752 | 14.52 | 35 |
| 202 | Cirrhosis & Alcoholic Hepatitis | 1.8858 | 6.09 | 16 |
| 203 | Malignancy of Hepatobiliary System or Pancreas | 1.6460 | 8.42 | 28 |
| 204 | Disorders of Pancreas Except Malignancy | 1.2960 | 6.84 | 27 |
| 205 | Disorders of Liver Exc Malig, Cirr, Alc Hepa Age 69 and/or C.C. | 1.7611 | 8.50 | 28 |
| 206 | Disorders of Liver Exc Malig, Cirr, Alc Hepa Age 70 w/o C.C. | 1.0339 | 5.59 | 26 |
| 207 | Disorders of the Biliary Tract Age Greater Than 69 and/or C.C. | 1.2583 | 6.15 | 26 |
| 208 | Disorders of the Biliary Tract Age Less Than w/o C.C. | 0.8621 | 4.09 | 21 |
| 209 | Major Joint and Limb Reattachment Procedures | 3.8504 | 14.62 | 35 |
| 210 | Hip & Femur Procedures Except Major Joint Age 69 and/or C.C. | 3.8530 | 17.43 | 37 |
| 211 | Hip & Femur Procedures Except Major Joint Age 18-69 w/o C.C. | 3.1347 | 13.72 | 34 |
| 212 | Hip & Femur Procedures Except Major Joint Age 0-17 | 1.8793 | 8.83 | 29 |
| 213 | Amputations for Musculoskeletal System-Conn. Tissue Disorders | 2.7243 | 14.14 | 34 |
| 214 | Back-Neck Procedures Age Greater Than 69 and/or C.C. | 3.2401 | 15.18 | 35 |
| 215 | Back-Neck Procedures Age Less Than 70 w/o C.C. | 2.1931 | 9.80 | 30 |
| 216 | Biopsies of Musculoskeletal System-Connective Tissue | 2.3987 | 13.36 | 33 |
| 217 | Wnd Debrid-Skin Graft Exc Hand for Musculoskeletal-Conn Tissue Disorder | 2.2240 | 10.88 | 31 |
| 218 | Lower Extrem-Humer Proc Exc Hip, Foot, Femur Age 69 and/or C.C. | 2.6124 | 11.63 | 32 |
| 219 | Lower Extrem-Humer Proc Exc Hip, Foot, Femur Age 18-69 w/o C.C. | 1.7069 | 7.07 | 27 |
| 220 | Lower Extrem-Humer Proc Exc Hip, Foot, Femur Age 0-17 | 1.1775 | 4.64 | 23 |
| 221 | Knee Procedures Age Greater Than 69 and/or C.C. | 2.1493 | 13.36 | 33 |
| 222 | Knee Procedures Age Less Than 70 w/o C.C. | 1.0487 | 3.90 | 17 |
| 223 | Upper Extremity Proc Exc Humerus-Hand Age 69 and/or C.C. | 1.6050 | 7.32 | 27 |
| 224 | Upper Extremity Proc Exc Humerus-Hand Age Less Than 70 w/o C.C. | 1.0757 | 3.94 | 17 |
| 225 | Foot Procedures | 1.1175 | 2.99 | 13 |
| 226 | Soft Tissue Procedures Age Greater Than 69 and/or C.C. | 1.5484 | 10.30 | 30 |
| 227 | Soft Tissue Procedures Age Less Than 70 w/o C.C. | 0.8705 | 3.35 | 23 |
| 228 | Ganglion (Hand) Procedures | 0.5726 | 1.78 | 5 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 229 | Hand Procedures Except Ganglion | 0.7824 | 2.48 | 11 |
| 230 | Local Excision-Removal of Int Fix Devices of Hip-Femur | 1.0576 | 5.25 | 25 |
| 231 | Local Excision-Removal of Int Fix Devices Except Hip-Femur | 0.8150 | 3.49 | 22 |
| 232 | Arthroscopy | 0.6563 | 2.33 | 10 |
| 233 | Other Musculoskeletal Sys-Conn Tiss O.R. Proc Age 69 and/or C.C. | 2.3546 | 10.51 | 31 |
| 234 | Other Musculoskeletal Sys-Conn Tiss O.R. Proc Age 70 w/o C.C. | 1.1907 | 5.05 | 25 |
| 235 | Fractures of Femur | 1.9131 | 12.91 | 33 |
| 236 | Fractures of Hip-Pelvis | 1.8523 | 10.78 | 31 |
| 237 | Sprains, Strains-Dislocations of Hip, Pelvis-Thigh | 1.1307 | 5.57 | 26 |
| 238 | Osteomyelitis | 2.5900 | 15.95 | 36 |
| 239 | Pathological Fractures-Musculoskeletal Conn. Tiss. Malignancy | 1.4541 | 7.81 | 28 |
| 240 | Connective Tissue Disorders Age Greater Than 69 and/or C.C. | 1.6778 | 9.34 | 29 |
| 241 | Connective Tissue Disorders Age Less Than 70 w/o C.C. | 1.4041 | 7.66 | 28 |
| 242 | Septic Arthritis | 1.9061 | 10.05 | 30 |
| 243 | Medical Back Problems | 1.0242 | 7.11 | 27 |
| 244 | Bone Diseases-Specific Arthropathies Age 69 and/or C.C. | 1.2511 | 7.42 | 27 |
| 245 | Bone Diseases-Specific Arthropathies Age Less Than 70 w/o C.C. | 1.0098 | 5.60 | 26 |
| 246 | Non-Specific Arthropathies | 1.0839 | 6.03 | 26 |
| 247 | Signs-Symptoms of Musculoskeletal System Conn Tissue | 0.9008 | 4.89 | 25 |
| 248 | Tendonitis, Myositis-Bursitis | 0.8432 | 4.56 | 23 |
| 249 | Aftercare, Musculoskeletal System-Connective Tissue | 0.7627 | 4.42 | 24 |
| 250 | Fx. Sprns, Strns-Disl of Forearm, Hand, Foot Age 69 and/or C.C. | 0.9962 | 4.48 | 24 |
| 251 | Fx. Sprns, Strns-Disl of Forearm, Hand, Foot Age 18-69 w/o C.C. | 0.7138 | 3.11 | 20 |
| 252 | Fx. Sprns, Strns-Disl of Forearm, Hand, Foot Age 0-17 | 0.4701 | 1.73 | 16 |
| 253 | Fx. Sprns, Strns-Disl of Uparm, Lowleg Ex Foot Age 69 and/or C.C. | 1.1361 | 6.90 | 27 |
| 254 | Fx. Sprns, Strns-Disl of Uparm, Lowleg Ex Foot Age 18-69 w/o C.C. | 0.8125 | 4.18 | 24 |
| 255 | Fx. Sprns, Strns-Disl of Uparm, Lowleg Ex Foot Age 0-17 | 0.5511 | 2.82 | 16 |
| 256 | Other Diagnoses of Musculoskeletal System-Connective Tissue | 0.8971 | 4.43 | 24 |
| 257 | Total Mastectomy for Malignancy Age Greater Than 69 and/or C.C. | 2.2927 | 9.60 | 27 |
| 258 | Total Mastectomy for Malignancy Age Less Than 70 w/o C.C. | 1.9940 | 8.18 | 24 |
| 259 | Subtotal Mastectomy for Malignancy Age Greater Than 69 and/or C.C. | 1.7492 | 9.15 | 29 |
| 260 | Subtotal Mastectomy for Malignancy Age Less Than 70 w/o C.C. | 1.2515 | 5.39 | 25 |
| 261 | Breast Proc. for Non-Malignancy Except Biopsy-Local Excision | 0.9452 | 3.46 | 16 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 262 | Breast Biopsy-Local Excision for Non-Malignancy | 0.6661 | 2.30 | 14 |
| 263 | Skin Grafts and/or Debrid Ulcer or Cellulitis Age 69 and/or C.C. | 3.9076 | 21.32 | 41 |
| 264 | Skin Graft and/or Debrid Ulcer or Cellulitis Age 70 w/o C.C. | 2.9368 | 16.80 | 37 |
| 265 | Skin Graft and/or Debrid Exc Skin Ulcer or Cellulitis with C.C. | 1.8628 | 9.51 | 30 |
| 266 | Skin Graft and/or Debrid Exc Skin Ulcer or Cellulitis w/o C.C. | 1.3397 | 6.14 | 26 |
| 267 | Perianal-Pilonidal Procedures | 0.7957 | 3.24 | 11 |
| 268 | Skin, Subcutaneous Tissue Breast Plastic Procedures | 0.9026 | 3.88 | 24 |
| 269 | Other Skin, Subcut Tiss-Breast O.R. Proc Age 69 and/or C.C. | 2.1162 | 9.96 | 30 |
| 270 | Other Skin, Subcut Tiss-Breast O.R. Proc Age Less Than 70 w/o C.C. | 0.9991 | 3.98 | 24 |
| 271 | Skin Ulcers | 1.9279 | 11.34 | 31 |
| 272 | Major Skin Disorders Age Greater Than 69 and/or C.C. | 1.4541 | 9.59 | 30 |
| 273 | Major Skin Disorders Age Less Than 70 w/o C.C. | 1.2729 | 8.70 | 29 |
| 274 | Malignant Breast Disorders Age Greater Than 69 and/or C.C. | 1.5446 | 8.79 | 29 |
| 275 | Malignant Breast Disorders Age Less Than 70 w/o C.C. | 0.9089 | 4.78 | 25 |
| 276 | Non-Malignant Breast Disorders | 0.7067 | 3.48 | 19 |
| 277 | Cellulitis Age Greater Than 69 and/or C.C. | 1.4452 | 7.55 | 29 |
| 278 | Cellulitis Age 18-69 w/o C.C. | 1.0985 | 5.59 | 26 |
| 279 | Cellulitis Age 0-17 | 0.6835 | 3.90 | 16 |
| 280 | Trauma to the Skin, Subcut Tiss-Breast Age 69 and/or C.C. | 0.9002 | 4.56 | 25 |
| 281 | Trauma to the Skin, Subcut Tiss-Breast Age 18-69 w/o C.C. | 0.6315 | 2.90 | 20 |
| 282 | Trauma to the Skin, Subcut Tiss-Breast Age 0-17 | 0.4478 | 2.20 | 11 |
| 283 | Minor Skin Disorders Age Greater Than 69 and/or C.C. | 0.9388 | 5.34 | 25 |
| 284 | Minor Skin Disorders Age Less Than 70 w/o C.C. | 0.6981 | 3.81 | 24 |
| 285 | Amputation of Lower Limb for Endocrine, Nutrit & Metabolic Dis. | 4.6379 | 21.70 | 42 |
| 286 | Adrenal & Pituitary Procedures | 3.9848 | 13.85 | 34 |
| 287 | Skin Grafts and Wound Debride for Endoc, Nutrit and Metabolic Dis. | 3.6312 | 20.41 | 40 |
| 288 | O.R. Procedures for Obesity | 2.4693 | 8.54 | 22 |
| 289 | Parathyroid Procedures | 1.7613 | 7.62 | 23 |
| 290 | Thyroid Procedures | 1.3178 | 4.83 | 15 |
| 291 | Thyroglossal Procedures | 0.6839 | 2.13 | 6 |
| 292 | Other Endocrine, Nutrit & Metab O.R. Proc Age 69 and/or C.C. | 3.4415 | 14.49 | 34 |
| 293 | Other Endocrine, Nutrit & Metab O.R. Proc Age Less Than 70 w/o C.C. | 1.9705 | 9.03 | 29 |
| 294 | Diabetes Age Greater Than 35 | 1.3188 | 6.49 | 19 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 295 | Diabetes Age 0-35 | 1.0335 | 5.77 | 26 |
| 296 | Nutritional & Misc. Metabolic Disorders Age 69 and/or C.C. | 1.4525 | 7.55 | 28 |
| 297 | Nutritional & Misc. Metabolic Disorders Age 18-69 w/o C.C. | 1.1217 | 5.65 | 26 |
| 298 | Nutritional & Misc. Metabolic Disorders Age 0-17 | 0.8899 | 3.31 | 12 |
| 299 | Inborn Errors of Metabolism | 1.1653 | 5.31 | 25 |
| 300 | Endocrine Disorders Age Greater Than 69 and/or C.C. | 1.4489 | 7.60 | 28 |
| 301 | Endocrine Disorders Age Less Than 70 w/o C.C. | 0.9974 | 5.05 | 25 |
| 302 | Kidney Transplant | 8.9535 | 26.25 | 46 |
| 303 | Kidney, Ureter & Major Bladder Procedure for Neoplasm | 4.3216 | 15.36 | 35 |
| 304 | Kidney, Ureter & Maj Bladder Proc for Non-Neopl Age 69 and/or C.C. | 2.9479 | 12.18 | 32 |
| 305 | Kidney, Ureter & Maj Bladder Proc for Non-Neopl Age 70 w/o C.C. | 2.1331 | 8.69 | 29 |
| 306 | Prostatectomy Age Greater Than 69 and/or C.C. | 2.2468 | 14.66 | 35 |
| 307 | Prostatectomy Age Less Than 70 w/o C.C. | 1.6379 | 7.82 | 28 |
| 308 | Minor Bladder Procedures Age Greater Than 69 and/or C.C. | 1.8971 | 10.22 | 30 |
| 309 | Minor Bladder Procedures Age Less Than 70 w/o C.C. | 1.3406 | 6.00 | 26 |
| 310 | Transurethral Procedures Age Greater Than 69 and/or C.C. | 1.4957 | 7.01 | 27 |
| 311 | Transurethral Procedures Age Less Than 70 w/o C.C. | 1.1907 | 4.66 | 22 |
| 312 | Urethral Procedures, Age Greater Than 69 and/or C.C. | 1.1861 | 4.85 | 22 |
| 313 | Urethral Procedures, Age 18-69 w/o C.C. | 0.9699 | 4.06 | 19 |
| 314 | Urethral Procedures, Age 0-17 | 0.5612 | 1.91 | 9 |
| 315 | Other Kidney and Urinary Tract O.R. Procedures | 2.8856 | 10.71 | 31 |
| 316 | Renal Failure | 1.8614 | 7.89 | 28 |
| 317 | Admit for Rental Dialysis | 0.5465 | 1.91 | 13 |
| 318 | Kidney and Urinary Tract Neoplasms Age Greater Than 69 and/or C.C. | 1.9259 | 10.10 | 30 |
| 319 | Kidney and Urinary Tract Neoplasms Age Less Than 70 w/o C.C. | 1.1526 | 5.46 | 25 |
| 320 | Kidney and Urinary Tract Infections Age Greater Than 69 and/or C.C. | 1.3190 | 6.75 | 27 |
| 321 | Kidney and Urinary Tract Infections Age 18-69 w/o C.C. | 0.9426 | 4.56 | 14 |
| 322 | Kidney and Urinary Tract Infections Age 0-17 | 0.6491 | 3.47 | 14 |
| 323 | Urinary Stones Age Greater Than 69 and/or C.C. | 0.9526 | 4.75 | 25 |
| 324 | Urinary Stones Age Less Than 70 w/o C.C. | 0.7132 | 3.33 | 23 |
| 325 | Kidney and Urinary Tract Signs & Symptoms Age 69 and/or C.C. | 1.1390 | 5.78 | 26 |
| 326 | Kidney and Urinary Tract Signs & Symptoms Age 18-69 w/o C.C. | 0.8968 | 4.30 | 24 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 327 | Kidney and Urinary Tract Signs & Symptoms Age 0-17 | 0.6376 | 3.09 | 18 |
| 328 | Urethral Stricture Age Greater Than 69 and/or C.C. | 1.1261 | 5.53 | 26 |
| 329 | Urethral Stricture Age 18-69 w/o C.C. | 0.8464 | 3.68 | 21 |
| 330 | Urethral Stricture Age 0-17 | 0.4740 | 1.67 | 6 |
| 331 | Other Kidney & Urinary Tract Diagnoses Age 69 and/or C.C. | 1.3766 | 6.98 | 27 |
| 332 | Other Kidney & Urinary Tract Diagnoses Age 18-69 w/o C.C. | 1.0550 | 5.14 | 25 |
| 333 | Other Kidney & Urinary Tract Diagnoses Age 0-17 | 0.7559 | 3.55 | 24 |
| 334 | Major Male Pelvis Procedures with C.C. | 3.4140 | 13.87 | 34 |
| 335 | Major Male Pelvis Procedures w/o C.C. | 2.2648 | 11.18 | 31 |
| 336 | Transurethral Prostatectomy Age Greater Than 69 and/or C.C. | 2.1021 | 10.21 | 30 |
| 337 | Transurethral Prostatectomy Age Less Than 70 w/o C.C. | 1.5769 | 7.13 | 23 |
| 338 | Testes Procedures, for Malignancy | 1.5482 | 5.77 | 26 |
| 339 | Testes Procedures, Non-Malignant Age Greater Than 17 | 0.8384 | 2.87 | 12 |
| 340 | Testes Procedures, Non-Malignant Age 0-17 | 0.6076 | 1.94 | 6 |
| 341 | Penis Procedures | 0.9845 | 4.28 | 22 |
| 342 | Circumcision Age Greater Than 17 | 0.5190 | 1.82 | 6 |
| 343 | Circumcision Age 0-17 | 0.4006 | 1.31 | 5 |
| 344 | Other Male Reproductive System O.R. Procedures for Malignancy | 2.2155 | 9.55 | 30 |
| 345 | Other Male Reproductive System O.R. Proced. Except for Malignancy | 1.2368 | 5.36 | 24 |
| 346 | Malignancy, Male Reproductive System, Age 69 and/or C.C. | 1.5628 | 8.02 | 28 |
| 347 | Malignancy, Male Reproductive System, Age Less Than 70 w/o C.C. | 1.0702 | 5.63 | 26 |
| 348 | Benign Prostatic Hypertrophy Age Greater Than 69 and/or C.C. | 1.2199 | 5.64 | 26 |
| 349 | Benign Prostatic Hypertrophy Less Than 70 w/o C.C. | 1.0866 | 5.17 | 25 |
| 350 | Inflammation of the Male Reproductive System | 0.7259 | 3.86 | 18 |
| 351 | Sterilization, Male | 0.4140 | 1.31 | 6 |
| 352 | Other Male Reproductive System Diagnoses | 1.0729 | 2.38 | 14 |
| 353 | Pelvic Evisceration, Radical Hysterectomy & Vulvectomy | 2.3246 | 9.95 | 30 |
| 354 | Uterine, Adnexa Proc For Non-Ovar/Adnexa Malig Age 69 and/or C.C. | 2.3278 | 8.52 | 22 |
| 355 | Uterine, Adnexa Proc For Non-Ovar/Adnexa Malig Age 70 w/o C.C. | 1.5836 | 5.87 | 17 |
| 356 | Female Reproductive System Reconstructive Procedures | 1.4538 | 5.58 | 22 |
| 357 | Uterus & Adnexa Procedures, for Malignancy | 2.4985 | 10.45 | 29 |
| 358 | Uterus & Adnexa Proced. for Non-Malignancy Age 69 or C.C. | 1.9960 | 7.93 | 23 |
| 359 | Uterus & Adnexa Proced. for Non-Malignancy Age 70 w/o C.C. | 1.4984 | 6.31 | 14 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 360 | Vagina, Cervix & Vulva Procedures | 0.6676 | 2.46 | 20 |
| 361 | Laparoscopy & Incisional Tubal Interruption | 0.8100 | 2.40 | 21 |
| 362 | Endoscopic Tubal Interruption | 0.4734 | 1.30 | 14 |
| 363 | D&C, Conisation & Radio-Implant., for Malignancy | 0.7663 | 3.31 | 19 |
| 364 | D&C, Conisation Except for Malignancy | 0.5897 | 1.76 | 12 |
| 365 | Other Female Reproductive System O.R. Procedures | 1.5045 | 6.41 | 26 |
| 366 | Malignancy, Female Reproductive System Age 69 and/or C.C. | 1.5299 | 7.78 | 28 |
| 367 | Malignancy, Female Reproductive System Age Less Than 70 w/o C.C. | 0.8990 | 4.24 | 24 |
| 368 | Infections, Female Reproductive System | 0.8470 | 4.22 | 18 |
| 369 | Menstrual and Other Female Reproductive System Disorders | 0.5783 | 3.53 | 23 |
| 370 | Cesarean Section with C.C. | 1.7082 | 6.89 | 22 |
| 371 | Cesarean Section w/o C.C. | 1.3453 | 5.34 | 14 |
| 372 | Vaginal Delivery with Complicating Diagnoses | 0.9174 | 3.37 | 15 |
| 373 | Vaginal Delivery w/o Complicating Diagnoses | 0.7158 | 2.46 | 11 |
| 374 | Vaginal Delivery with Sterilization and/or D&C | 1.0246 | 3.25 | 14 |
| 375 | Vaginal Delivery with O.R. Proc Except Sterilization and/or D&C | 0.9258 | 2.41 | 11 |
| 376 | Postpartum and Postabortion Diagnoses w/o O.R. Procedure | 0.6176 | 2.99 | 12 |
| 377 | Postpartum and Postabortion with O.R. Procedure | 0.7471 | 2.32 | 12 |
| 378 | Ectopic Pregnancy | 1.2175 | 4.42 | 12 |
| 379 | Threatened Abortion | 0.4088 | 2.34 | 16 |
| 380 | Abortion w/o D&C | 0.3783 | 1.54 | 9 |
| 381 | Abortion with D&C, Aspiration Curettage or Hysterotomy | 0.5022 | 2.23 | 6 |
| 382 | False Labor | 0.2271 | 1.70 | 7 |
| 383 | Other Antepartum Diagnoses with Medical Complications | 0.5610 | 3.46 | 12 |
| 384 | Other Antepartum Diagnoses w/o Medical Complications | 0.5049 | 3.31 | 10 |
| 385 | Neonates, Died or Transferred | 1.0287 | 7.37 | 15 |
| 386 | Extreme Immaturity or Respiratory Distress Syndrome, Neonate | 6.3851 | 23.68 | 44 |
| 387 | Prematurity with Major Problems | 3.4706 | 17.98 | 35 |
| 388 | Prematurity w/o Major Problems | 2.7161 | 13.33 | 33 |
| 389 | Full Term Neonate with Major Problem | 1.1617 | 7.33 | 21 |
| 390 | Neonates with Other Significant Problems | 0.8817 | 5.54 | 20 |
| 391 | Normal Newborns | 0.2735 | 2.95 | 15 |
| 392 | Splenectomy Age Greater Than 17 | 3.1837 | 12.11 | 33 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 393 | Splenectomy Age 0-17 | 1.9682 | 6.52 | 16 |
| 394 | Other O.R. Procedures of the Blood and Blood Forming Organs | 1.0836 | 4.29 | 24 |
| 395 | Red Blood Cell Disorders Age Greater Than 17 | 1.1769 | 6.37 | 26 |
| 396 | Red Blood Cell Disorders Age 0-17 | 0.6781 | 3.69 | 19 |
| 397 | Coagulation Disorders | 1.0518 | 4.65 | 25 |
| 398 | Reticuloendothelial and Immunity Disorders Age 69 and/or G.C. | 1.2052 | 7.11 | 27 |
| 399 | Reticuloendothelial and Immunity Disorders Age 70 w/o G.C. | 0.8179 | 4.58 | 25 |
| 400 | Lymphoma or Leukemia with Major O.R. Procedure | 3.4464 | 13.19 | 33 |
| 401 | Lymphoma or Non-Acute Leukemia with Other O.R. Procedure with C.C. | 3.0884 | 16.92 | 32 |
| 402 | Lymphoma or Non-Acute Leukemia with Other O.R. Procedure w/o C.C. | 1.5972 | 6.54 | 28 |
| 403 | Lymphoma or Non-Acute Leukemia with C.C. | 1.8108 | 11.76 | 31 |
| 404 | Lymphoma or Non-Acute Leukemia w/o C.C. | 1.0759 | 5.97 | 27 |
| 405 | Acute Leukemia w/o Major O.R. Procedure Age 0-17 | 1.2286 | 16.39 | 26 |
| 406 | Myeloprolif Dis. or Poorly Diff Neopl. with Major O.R. Proc and C.C. | 4.0245 | 16.48 | 36 |
| 407 | Myeloprolif Dis. or Poorly Diff Neopl. with Major O.R. Proc w/o C.C. | 2.2293 | 8.72 | 29 |
| 408 | Myeloprolif Disorder or Poorly Diff. Neopl. with Other O.R. Proc | 1.3904 | 6.81 | 27 |
| 409 | Radiotherapy | 1.1421 | 6.47 | 26 |
| 410 | Chemotherapy | 0.5552 | 2.91 | 16 |
| 411 | History of Malignancy w/o Endoscopy | 0.8435 | 3.99 | 24 |
| 412 | History of Malignancy with Endoscopy | 0.6842 | 2.86 | 19 |
| 413 | Other Myeloprolif Dis. or Poorly Diff Neopl. Dx Age 69 and/or C.C. | 1.9479 | 10.30 | 30 |
| 414 | Other Myeloprolif Dis. or Poorly Diff Neopl. Dx Age 70 w/o C.C. | 1.1297 | 5.93 | 26 |
| 415 | O.R. Procedure for Infectious and Parasitic Diseases | 3.2096 | 14.19 | 34 |
| 416 | Septicemia Age Greater Than 17 | 2.8036 | 12.00 | 32 |
| 417 | Septicemia Age 0-17 | 0.9039 | 4.71 | 25 |
| 418 | Postoperative and Post-Traumatic Infections | 1.0511 | 6.28 | 26 |
| 419 | Fever of Unknown Origin Age Greater Than 69 and/or C.C. | 1.3009 | 6.66 | 27 |
| 420 | Fever of Unknown Origin Age 18-69 w/o C.C. | 0.9420 | 5.03 | 25 |
| 421 | Viral Illness Age Greater Than 17 | 0.7437 | 3.86 | 16 |
| 422 | Viral Illness and Fever of Unknown Origin Age 0-17 | 0.5102 | 2.93 | 10 |
| 423 | Other Infectious Parasitic Diseases and Diagnoses | 1.1905 | 6.47 | 26 |
| 424 | O.R. Procedures with Principal Diagnosis of Mental Illness | 2.0683 | 10.91 | 31 |
| 425 | Acute Adjust React & Disturbances of Psychosocial Dysfunction | 0.9698 | 5.85 | 24 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 426 | Depressive Neuroses | 1.0347 | 5.55 | 20 |
| 427 | Neuroses Except Depressive | 0.9117 | 5.52 | 26 |
| 428 | Disorders of Personality and Impulse Control | 1.1690 | 7.00 | 27 |
| 429 | Organic Disturbances and Mental Retardation | 1.2053 | 7.34 | 27 |
| 430 | Psychoses | 1.4710 | 10.36 | 30 |
| 431 | Childhood Mental Disorders | 1.3037 | 6.15 | 26 |
| 432 | Other Diagnoses of Mental Disorders | 1.1412 | 5.37 | 25 |
| 433 | Substance Use and Induced Organic Mental Disorders, Left AMA | 0.3897 | 2.77 | 10 |
| 434 | Subst Abuse, Intox Induc Mental Syn Exc Depend and/or Oth Sympt Trt | 0.8586 | 5.70 | 24 |
| 435 | Substance Dependence, Detox and/or Other Symptomatic Treatment | 0.7779 | 5.21 | 21 |
| 436 | Substance Dependence with Rehabilitation Therapy | 0.7762 | 6.44 | 26 |
| 437 | Substance Dependence, Combined Rehabilitation and Detox Therapy | 0.5424 | 2.70 | 12 |
| 438 | No Longer Valid | 0.0000 | 0.00 | 0 |
| 439 | Skin Grafts for Injuries | 2.1281 | 11.57 | 32 |
| 440 | Wound Debridements for Injuries | 1.6979 | 8.16 | 28 |
| 441 | Hand Procedures for Injuries | 0.9053 | 3.42 | 22 |
| 442 | Other O.R. Procedures for Injuries Age Greater Than 69 and/or C.C. | 2.9564 | 11.61 | 32 |
| 443 | Other O.R. Procedures for Injuries Age Less Than 70 w/o C.C. | 1.7994 | 6.47 | 26 |
| 444 | Multiple Trauma Age Greater Than 69 and/or C.C. | 1.2940 | 6.63 | 27 |
| 445 | Multiple Trauma Age 18-69 w/o C.C. | 0.7736 | 3.83 | 24 |
| 446 | Multiple Trauma Age 0-17 | 0.5431 | 2.65 | 23 |
| 447 | Allergic Reactions Age Greater Than 17 | 0.5852 | 3.03 | 23 |
| 448 | Allergic Reactions Age 0-17 | 0.3897 | 2.41 | 10 |
| 449 | Poisoning and Toxic Effects of Drugs Age 69 and/or C.C. | 1.0254 | 4.87 | 25 |
| 450 | Poisoning and Toxic Effects of Drugs Age 18-69 w/o C.C. | 0.7069 | 2.20 | 26 |
| 451 | Poisoning and Toxic Effects of Drugs Age 0-17 | 0.4166 | 1.62 | 18 |
| 452 | Complications of Treatment Age Greater Than 69 and/or C.C. | 1.3040 | 6.60 | 27 |
| 453 | Complications of Treatment Age Less Than 70 w/o C.C. | 0.6882 | 3.82 | 24 |
| 454 | Other Injuries, Poisonings and Toxic Eff Diag. Age 69 and/or C.C. | 1.4825 | 8.00 | 28 |
| 455 | Other Injuries, Poisonings and Toxic Eff Diag. Age 70 w/o C.C. | 0.6927 | 3.56 | 24 |
| 456 | Burns, Transferred to Another Acute Care Facility | 1.0855 | 2.02 | 8 |
| 457 | Extensive Burns w/o O.R. Procedure | 2.5298 | 10.53 | 46 |
| 458 | Non-Extensive Burns with Skin Grafts | 4.4784 | 18.13 | 38 |

| DRG | DESCRIPTION | WEIGHT | ALOS | DAY OUTLIER THRESHOLD |
|---|---|---|---|---|
| 459 | Non-Extensive Burns with Would Debridement and Other O.R. Procedure | 2.5962 | 12.30 | 32 |
| 460 | Non-Extensive Burns w/o O.R. Procedure | 1.2311 | 5.87 | 26 |
| 461 | O.R. Procedure with Diagnoses of Other Contact with Health Services | 1.3024 | 4.37 | 24 |
| 462 | Rehabilitation | 2.0134 | 16.31 | 36 |
| 463 | Signs and Symptoms with C.C. | 1.3384 | 7.46 | 27 |
| 464 | Signs and Symptoms w/o C.C. | 0.9820 | 5.11 | 25 |
| 465 | Aftercare with History of Malignancy as Secondary Diagnosis | 0.7287 | 3.98 | 21 |
| 466 | Aftercare w/o History of Malignancy as Secondary Diagnosis | 0.5864 | 3.16 | 22 |
| 467 | Other Factors Influencing Health Status | 0.6954 | 2.47 | 17 |
| 468 | Unrelated O.R. Procedure | 1.8747 | 13.59 | 34 |
| 469 | Primary Diagnosis Invalid as Discharge Diagnosis | 0.0000 | 0.00 | 0 |
| 470 | Ungroupable | 0.0000 | 0.00 | 0 |
| 471 | Bilateral or Multiple Major Joint Procedures of Lower Extremity | 3.8994 | 20.31 | 33 |
| 472 | Extensive Burns with O.R. Procedure | 15.0619 | 37.93 | 66 |
| 473 | Acute Leukemia w/o Major O.R. Procedure Age 17 | 3.1692 | 20.72 | 29 |

(~~12~~14) Disproportionate share hospitals shall receive an additional payment amount equal to the product of the hospital's prospective base rate times the adjustment percentage of:

Subsections (12) through (12)(c) remain the same in text but are renumbered (14) through (14)(c).

~~(i) This adjustment will be phased in over a three year period. One-third of the adjustment will be reimbursed with services provided on or after July 1, 1988, two-thirds will be reimbursed with services provided on or after July 1, 1989, and the full adjustment will be reimbursed with services on or after July 1, 1990.~~

Subsection (13) remains the same in text but is renumbered (15).

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 the same.

(a) Facilities located within the borders of the state of Montana or more than 100 miles from the Montana border and not 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) Facilities ~~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 customary charges as determined by the facility's medicare intermediary or by the department.

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 Subsections (1) and (2) remain the same.

(a) For each hospital which is not a sole community hospital, as defined in ARM 46.12.503, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with subsection (2), less ~~5.8%~~ 7.0% of such costs.

(b) For each hospital which is a sole community hospital, as defined in ARM 46.12.503, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with subsection (2), less 1.2% of such costs.

(3) Facilities ~~located within the state of Montana~~ described in ARM 46.12.508(1)(a) will be required to submit a medicare cost report in which costs have been allocated to the medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(4) Facilities described in ARM 46.12.508(1)(a) 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.

(~~4~~5) Facilities ~~located within the state of Montana~~ described in ARM 46.12.508(1)(a) will be required to file ~~the~~ a cost report with the Montana medicare intermediary within 90 days of the facility's fiscal year end or receipt of the department cost settlement detail reports, whichever is later. In the event a provider does not file within 90 days, or files an incomplete cost report, an amount equal to 10 percent of the provider's total reimbursement for the following month shall be withheld by the department. If the report is overdue or incomplete a second month, 20 percent shall be withheld. For each succeeding month the report is overdue or incomplete, the provider's total reimbursement shall be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report. Unavoidable delays may be reported with a full explanation and a request made for an extension of time limits prior to the filing deadline. However, there is a maximum limitation of one 30-day extension.

Subsections (5) through (7) remain the same in text but are renumbered (6) through (8).

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

3. The proposed changes to the medicaid hospital rules are necessary to:

A. implement revisions to the medicaid reimbursement methodology for inpatient hospital services, based upon a study of the current methodology;
B. implement revisions to the medicaid reimbursement methodology for both inpatient and outpatient hospital services provided by out-of-state facilities, as directed by the 1993 Montana Legislature (House Bill 2);
C. implement reduction in medicaid reimbursement for outpatient hospital services, as directed by the 1993 Montana Legislature (House Bill 2);
D. revise the current rules regarding payment to transferring and discharging hospitals to clearly specify the payment available to each hospital;
E. revise the rules regarding hospital "residents" to specify that residency must be based upon a medical need rather than upon a lack of available placement in an alternative setting;
F. revise the disproportionate share hospital rules to eliminate references to inpatient psychiatric hospitals, for which medicaid coverage is being eliminated as directed by the 1993 Montana Legislature (House Bill 2), and to specify that the disproportionate share hospital adjustment applies to the DRG base rate only; and
G. make miscellaneous housekeeping revisions to the rules to delete obsolete provisions and specify department policy affecting reimbursement and provider requirements.

A. The proposed amendments are necessary to implement revisions to the medicaid reimbursement methodology for inpatient hospital services. The 1991 Montana Legislature funded a study and evaluation of inpatient hospital reimbursement. The study was completed in September 1992 and recommended several improvements in the inpatient hospital reimbursement system. The proposed amendments implement a number of these changes and the department believes these changes will significantly improve the medicaid reimbursement system for inpatient hospital services.

The proposed rules will exempt rural hospitals from the DRG prospective payment system (PPS) and provide for their reimbursement on a retrospective cost basis. This is necessary because small rural hospitals do not experience the large, diverse case loads necessary to function efficiently under a prospective payment system. For purposes of this exemption, rural hospitals will be those hospitals located in Montana counties designated as of July 1, 1991 as rural or very rural by the U.S. Department of Agriculture under its rural-urban continuum codes for metro and non-metro counties. The exemption

of rural hospitals from PPS and payment on a retrospective basis will better allow rural hospitals to meet the especially challenging conditions which threaten their survival and the availability of hospital care in rural counties.

The definition of rural hospital for purposes of the disproportionate share hospital adjustment remains the same as in current rules, but has been reworded to refer specifically to the federal regulation which defines "urban" and "rural" hospitals. The definition of "urban hospital" has also been reworded for the same purpose.

The proposed rules also provide for increased reimbursement to certain large referral hospitals. These hospitals receive referrals of more difficult cases from large surrounding rural areas and provide a greater intensity of service than other hospitals. Increased reimbursement will result from the application of higher DRG relative weights which are specified in the tables contained in proposed ARM 46.12.505(13). This proposed rule will recognize and address the higher cost of care provided by large referral hospitals.

Large referral hospitals will be defined as Montana hospitals that serve as referral centers and which have been determined by the department as of April 1, 1993 to have a case mix with a statistically demonstrated higher level of intensity than normal for Montana hospitals. These hospitals were identified through the recently-completed hospital study. New large, referral hospitals will be designated only at such times as the department recalibrates the DRG system. Current large, referral hospitals are specifically identified in the proposed rule.

The proposed changes are necessary to provide higher reimbursement for services provided in neonatal intensive care units in Montana hospitals. Current reimbursement rates encourage Montana hospitals to send newborns out-of-state because Montana hospitals do not believe they receive adequate reimbursement for such cases. The proposed amendments will encourage several Montana hospitals which operate neonatal intensive care units to provide care for newborns in Montana. The proposed rule will allow the three hospitals in Montana which operate neonatal intensive care units to receive reimbursement at the facility-specific cost-to-charge ratio for neonatal DRGs 385 through 390. Such hospitals will not be entitled to receive day or cost outlier payments for such DRGs reimbursed at the cost-to-charge ratio. Current provisions allowing special day outlier reimbursement for neonatal DRGs are replaced by these changes and therefore are deleted in the proposed rules.

The proposed amendments are necessary to update and recalibrate the DRG system. The proposed rules specify new DRG weights, a new DRG grouper version, a new base rate and new thresholds for reimbursement calculations. The statewide average cost-to-charge ratio is also updated. These changes are necessary to

take into account new cost data, service intensity data, length of stay data and procedures.

The proposed amendments are also necessary to revise the rule regarding frequency of capital cost payments. The current rule requires payment at least monthly. The proposed rule would establish a statewide average capital cost per case, which amount would be paid with each claim. This is necessary because this is actually how the claims processing system works now. While the current rule requires payments at least monthly, the department has found that it is more efficient and economic to make interim payments as an add on to each claim.

The proposed rules are also necessary to provide special reimbursement rules for catastrophic cases, which are those cases for which the cost of medically necessary days and services exceeds $125,000. Aggregate reimbursement for catastrophic cases will be limited each fiscal year. The available funding will be apportioned among all eligible cases by June 30 of each year, but payment for any one case will not exceed the estimated cost for the stay multiplied by the statewide average cost-to-charge ratio, less any previous payments for the care. Providers may bill and receive payment for the services under the usual DRG system, and then may request the additional catastrophic case payment as provided in the proposed rule.

These revisions to the inpatient hospital payment methodology are necessary to implement the department's statutory authority and responsibility to set rates for medicaid services and to supervise and administer the medicaid program.

B. The proposed changes are necessary to implement revisions to the medicaid reimbursement methodology for both inpatient and outpatient hospital services provided by out-of-state facilities. Under the current methodology, there is no limit on the rate of increase in costs allowed in out-of-state hospitals. Hospitals are paid a percentage of charges and no cost settlement is done to determine overpayments or underpayments for the fiscal year. Under the proposed rule, out-of-state hospitals will be reimbursed on a retrospective cost basis, with cost increases limited to the Tax Equity and Fiscal Responsibility Act (TEFRA) increase rate as set forth in the Health Insurance Manual 15 (HIM-15). Costs will be settled on an annual basis. The department may waive cost settlement for facilities which receive less than $100,000 per year in interim payments for hospital services and items provided to Montana medicaid recipients. Such hospitals will be entitled, upon request, to have the department perform a cost settlement. Requests for cost settlement must be received by the department within 90 days of the end of the fiscal year.

C. The proposed changes are necessary to implement reductions in medicaid reimbursement for outpatient hospital services. The 1993 Montana Legislature (House Bill 2) directed a decrease in reimbursement. Under the current rules, there is no limit on the rate of increase in costs which are recognized for reimbursement. Under the proposed changes, reimbursement for outpatient hospital services will be reduced by 1.2% for all hospitals.

OBRA 90 requires the department to reduce the payments for outpatient services in non sole community hospitals by 5.8%. The two tier reimbursement system for outpatient hospital services was established in accordance with these federal requirements.

D. The proposed changes are necessary to revise the current rules regarding how transferring and discharging hospitals are reimbursed when a patient is transferred to a second hospital part way through a hospital stay. The proposed rule revises the definitions of "transferring hospital" and "discharging hospital" to clearly distinguish between the two. The proposed rule clearly specifies how the amount of reimbursement is determined for each hospital.

E. The proposed changes are necessary to revise the rates regarding hospital "residents" to specify that residency must be based upon medical need. Under the current rule, the department's policy is unclear as to whether the lack of an available bed in an alternative placement would justify hospital residency. The proposed rule specifies that the resident's treatment in a hospital setting must be medically necessary. This change is necessary to exercise the department's statutory responsibility to administer and supervise the medicaid program.

F. The proposed changes are necessary to revise the disproportionate share hospital rules to eliminate references to inpatient psychiatric hospitals. Medicaid coverage of such hospitals, which provide services to patients under age 21, will be eliminated effective July 1, 1993 as directed by the 1993 Montana Legislature (House Bill 2). Since no coverage is provided, such hospitals no longer will be entitled to disproportionate share hospital adjustments.

The disproportionate share hospital (DSH) rules are also being revised to specify that the DSH adjustment is calculated based upon the DRG base rate only, not upon the base rate plus any additional payments such as outliers.

G. The proposed changes are necessary to delete obsolete provisions in the rules, including the budget neutrality requirement which no longer applies and the phase in of disproportionate share hospital adjustments which has been completed. The proposed amendments are also necessary to clearly distinguish the reimbursement rules and methodologies

which apply to each type of hospital (e.g., neonatal intensive care) and hospital location (e.g., within Montana, border hospitals, Canada).

The department is incorporating by reference the DRG table of weights and thresholds. The new table is in excess of 80 pages in length in comparison with the previous table of 15 pages which was contained in ARM 46.12.504. The expanded length of the table and the resulting cost of publication has necessitated the incorporation of this table by reference rather than the actual placement of the table itself in the rule. Copies of this table will be provided by the department upon request.

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 May 27, 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 April 19, 1993.

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

| | | |
|---|---|---|
| In the matter of the amendment of rules 46.10.807, 46.10.808, 46.10.811, 46.10.813, 46.10.815, 46.10.819, 46.10.823, 46.10.825, 46.10.827, 46.10.833 and 46.10.843 and the repeal of rules 46.10.821 and 46.10.845 pertaining to AFDC JOBS program | ) | NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.10.807, 46.10.808, 46.10.811, 46.10.813, 46.10.815, 46.10.819, 46.10.823, 46.10.825, 46.10.827, 46.10.833 AND 46.10.843 AND THE REPEAL OF RULES 46.10.821 AND 46.10.845 PERTAINING TO AFDC JOBS PROGRAM |

TO: All Interested Persons

1. On May 21, 1993, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.10.807, 46.10.808, 46.10.811, 46.10.813, 46.10.815, 46.10.819, 46.10.823, 46.10.825, 46.10.827, 46.10.833 and 46.10.843 and the repeal of rules 46.10.821 and 46.10.845 pertaining to AFDC JOBS program.

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

46.10.807 ~~SERVICES~~ JOBS ACTIVITIES (1) ~~The following services may be provided to a p~~Participants in the regular (not unemployed parent track) JOBS program may participate in the following activities in accordance with their employability plan and subject to the approval of their case manager:

(a) educational activities below the post-secondary level ~~determined by the case manager to be appropriate to the participant's employment goal~~;

(b) job readiness training;

Subsections (1)(b) through (1)(e) remain the same in text but are renumbered (1)(c) through (1)(f).

(~~f~~g) ~~community~~ alternative work experience program (AWEP);

(~~g~~h) work supplementation;

(~~h~~i) post-secondary training ~~services in a post-secondary setting;~~ or education; and

~~(i) supportive services; and~~

(j) self-initiated education and training.

(2) Participants in the unemployed parent track of the JOBS program may participate in the following activities in accordance with their employability plan and subject to the approval of their case manager:

(a) job readiness training;

(b) job skills training for a period not to exceed six months;

(c) job development and placement;

(d) individual or group job search, not to exceed 320 hours in any period of twelve consecutive months;

(e) on-the-job training;

(f) alternative work experience program (AWEP);

(g) work supplementation;

(h) educational activities as follows:

(i) activities to qualify for a high school diploma or equivalency and remedial adult educational activities as determined appropriate by the case manager; and

(ii) post-secondary education only if the recipient is enrolled in the course or program of study under a Job Training Partnership Act (JTPA), Vocational Rehabilitation, Trade Adjustment Act or refugee assistance center program, or if the recipient was in a self-initiated course or program approved by the recipient's case manager prior to July 1, 1991, and have received AFDC-UP benefits continuously since July 1, 1991 in which case the recipient may complete the course or program approved in the recipient's employability plan.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-715 and 53-4-720 MCA

46.10.808 ALTERNATIVE WORK EXPERIENCE PROGRAM (AWEP)

(1) The alternative work experience program (AWEP) is a component of the JOBS program designed to improve the employability of participants by assigning a participant to work in a nonprofit organization or public agency. The specific purposes of AWEP are to:

Subsections (1)(a) through (1)(d) remain the same.

(2) The department shall determine whether the participant shall participate in the alternative work experience program (AWEP) rather than ~~the community work experience program or~~ in some other JOBS component, what work site the participant will be assigned to and how many hours per week the recipient shall be required to participate. However, participants may not be required to participate more than 40 hours per week in AWEP.

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

(b) the participant may request a reassignment at any time which may be granted at the discretion of the participant's case manager;

Subsections (3)(c) through (4) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-703 and 53-4-705 MCA

46.10.811 UNEMPLOYED PARENTS TRACK PARTICIPATION AND OTHER REQUIREMENTS (1) In an unemployed parent assistance unit, each spouse must attend JOBS-UP orientation, assessment, and employability planning unless that spouse is specifically exempt under ARM 46.10.805. Failure to attend orientation or assessment by a spouse who is not exempt will result in the sanction of that spouse as provided in ARM 46.10.839.

(~~1~~2) In an unemployed parent assistance unit, the primary wage earner ~~will~~ may at the department's discretion be required to participate in JOBS-UP activities as provided in subsection (6)(a) and (b). ~~the unemployed parent track of the JOBS program,~~ unless specifically exempt under one of the exemptions set forth in ARM 46.10.805.

Subsections (1)(a) through (3)(b) remain the same in text but are renumbered (2)(a) through (4)(b).

(~~4~~5) The unemployed parent track shall be limited to the ~~following~~ activities set forth in ARM 46.10.807(2)(a) through (2)(h):

~~(a) job search, which shall not exceed eight weeks in any period of twelve (12) consecutive months;~~

~~(b) community work experience;~~

~~(c) alternative work experience; and~~

~~(d) educational activities as follows:~~

~~(i) in the case of a parent under age 25 who has not completed high school or an equivalent course of education, high school education or education designed to prepare a person to qualify for a high school equivalency certificate; or~~

~~(ii) as determined appropriate by the case manager after assessment and development of an employability plan.~~

(~~5~~6) Hours of participation required of an unemployed parent are as follows:

(a) a total of 40 hours per week in a county having a complete JOBS program~~;~~ or

~~(b) a total of~~ 20 hours per week in a county having a minimal JOBS program~~;~~; and

(b) of the total hours required in subsection (5)(a), a minimum of 16 hours per week must be spent in the alternative work experience program, on-the-job training or work supplementation. Actual gainful employment other than on-the-job training or work supplementation does not count toward the required 16 hours.

(~~6~~7) Supportive services as set forth in ARM 46.10.825 ~~will~~ may be ~~available~~ provided to persons participating in the unemployed parent track of the JOBS program.

(8) Primary wage earners who were enrolled in an approved self-initiated education or training program prior to July 1, 1991, have received AFDC-UP benefits continuously since July 1, 1991, and meet the requirements of ARM 46.10.813 as to satisfactory progress may fulfill their JOB-UP track obligation by participating in self-initiated training and education.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-706, 53-4-707 and 53-4-720 MCA

46.10.813 REQUIREMENTS FOR SATISFACTORY PROGRESS IN EDUCATIONAL AND WORK AND TRAINING ACTIVITIES Subsections (1) through (2) remain the same.

(a) attendance at activities scheduled for the program the person is participating in; ~~and~~

(b) completion within the time periods specified in the employability plan~~.~~; and

(c) satisfactory achievement as defined by the activity instructor, supervisor or case manager.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-708, 53-4-715 and 53-4-720 MCA

46.10.815 JOB SEARCH (1) Participants may be required to participate in individual or group job search a maximum of ~~eight weeks or its equivalent~~ 320 hours in a twelve month period.

~~(2) If a family becomes ineligible for AFDC and subsequently reapplies and is determined eligible, the JOBS participant may be required to complete another 8-week job search if determined necessary by the case manager.~~

(32) However, ~~A~~additional job search beyond the 320 hour maximum may be required in conjunction with some other education, training, or employment activity which is designed to enhance the participant's employment prospects.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-706, 53-4-715 and 53-4-720 MCA

46.10.819 TRAINING SERVICES--POST SECONDARY (1) A regular JOB participant may be allowed to participate in a post-secondary education program ~~is appropriate for a participant~~ if:

Subsections (1)(a) through (1)(c) remain the same.

(d) the program is consistent with the participant's ~~employment goals~~ employability plan which has been approved by the participant's case manager.

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

(3) A participant attending a JOBS approved post-secondary education program may be eligible for supportive services deemed necessary for participation, including child care, in accordance with ARM 46.10.825.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-708, 53-4-715 and 53-4-720 MCA

46.10.823 SELF-INITIATED EDUCATION OR TRAINING (1) An AFDC recipient ~~person~~ already engaged in education or training at the time that that person would otherwise begin participation in the regular JOBS program is considered to have self-initiated an education or training program. A recipient of AFDC-UP who was enrolled in an approved education or training program prior to July 1, 1991, has received AFDC-UP continuously since July 1, 1991, and meets the requirements of ARM 46.10.813 as to satisfactory progress is considered to have self-initiated an education or training program.

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

AUTH: Sec. 53-4-212, 53-4-703, 53-4-719 and 53-4-720 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-706, 53-4-708 and 53-4-720 MCA

46.10.825 SUPPORTIVE SERVICES AND ONE TIME WORK-RELATED EXPENSES AVAILABILITY Subsections (1) through (1)(d) remain the same.

(e) medical services including physical, prescription eyeglasses, drugs, immediate dental care can be provided if not available through medicaid or another source, not to exceed ~~$150.00 during the twelve (12) months following enrollment in the program and any twelve months of any successive twelve month enrollment period in the program~~ $50.00 per month;

Subsections (1)(f) through (8) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-715, 53-4-716 and 53-4-720 MCA

46.10.827 AVAILABILITY OF SERVICES AFTER LOSS OF AFDC ELIGIBILITY (1) A JOBS participant who loses AFDC eligibility for any reason other than being sanctioned pursuant to ARM 46.10.839 may receive case management activities and supportive services for up to 90 days from the date AFDC closes.

Subsection (2) remains the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-716 and 53-4-720 MCA

46.10.833 PARTICIPANTS EMPLOYABILITY PLAN AND JOBS CONTRACT (1) The employment plan consists of the employment goal or goals and the components designed to place the participant in employment. The employability plan must:

Subsections (1)(a) through (1)(f) remain the same.

(2) The JOBS contract is the agreement between the department and the participant and specifies the rights and responsibilities of each party. The ~~participant's~~ JOBS contract ~~entered into between the department, its designee lead agency, and the participant~~ must specify the following:

Subsections (2)(a) through (2)(e) remain the same.

(3) The employability plan is not a contract between the participant and the department. However, failure to comply with the employability plan without good cause will result in the participant being sanctioned under ARM 46.10.839.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-715 and 53-4-720 MCA

46.10.843 FAIR HEARING PROCEDURE Subsections (1) and (1)(a) remain the same.

(b) on-the-job working conditions; and

~~(c) workers' compensation coverage, but not for purposes of adjudicating the recipient's workers' compensation claim; and~~

Subsection (1)(d) remains the same in text but is renumbered (1)(c).

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

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-2-606, 53-4-211, 53-4-215, 53-4-703 and 53-4-720 MCA

3. The rule 46.10.821 as proposed to be repealed is on pages 46-862 through 46-864 of the Administrative Rules of Montana.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-715 and 53-4-720 MCA

The rule 46.10.845 as proposed to be repealed is on pages 46-896 through 46-897 of the Administrative Rules of Montana.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-718 and 53-4-720 MCA

4. These rules pertaining to the Job Opportunity and Basic Skills (JOBS) program for recipients of Aid to Families with Dependent Children (AFDC) are being amended in large part to clarify rather than to change the Department's policies governing this program. For example, in some rules language has been added and they have been re-organized to distinguish the treatment of "unemployed parent" track (JOBS-UP) participants from regular JOBS participants. This is not a change in policy but will make the Department's existing policies less likely to be interpreted differently.

Subsections (4)(a) through (d)(ii) of ARM 46.10.811, which specify the activities in which JOBS-UP participants may participate, are being deleted because this is now set forth in ARM 46.10.807(2). Subsection (2)(h)(ii) of ARM 46.10.807 now specifies that post-secondary education is not an acceptable activity except for participants who were enrolled in that activity prior to July 1, 1991 and meet certain other conditions and participants who are enrolled in an educational program under the Job Training Partnership Act (JPTA) or several other specified programs. A cut-off date is necessary to phase-out post-secondary education assistance.

Subsection (1) has been added to ARM 46.10.811 to require that in an unemployed parent assistance unit both spouses must attend JOBS orientation, assessment, and employability planning as long as they are not exempt from participation in JOBS, although only the primary wage earner will have to participate in additional JOBS activities. The department previously has requested such

participation by both spouses but did not have the ability to sanction spouses who did not participate because the rules did not address this requirement. This amendment will give the department the authority to enforce such participation by both spouses.

Also, in Rule 46.10.811 subsection (6)(c) has been added to require that a JOBS-UP participant spend at least 16 hours per week in work-related activities such as AWEP, on-the-job training, or work supplementation. This change is necessary to comply with federal regulations at 45 CFR 250.33.

Language has been added throughout the JOBS rules to emphasize that the participant's case manager rather than the participant is the final authority on decisions about participation in the JOBS program. For example, the case manager has the authority to decide whether the employability plan is acceptable and what activities the participant will be placed in and what supportive services he or she will receive. This is not a change in policy.

ARM 46.10.813 is being amended to add the requirement that satisfactory achievement as defined by the participant's instructor, supervisor, or case manager is necessary to fulfill the requirement of satisfactory progress in an educational or work and training activity. The Department has determined that the present requirements of merely attending and completing a program in the specified time are not stringent enough.

In ARM 46.10.815 pertaining to job search, the maximum hours for a twelve month period is being changed from eight weeks to 320 hours. Since eight weeks times 40 hours is equivalent to 320 hours, this does not change the maximum. Required participation can extend beyond eight weeks but no more than 320 hours in a twelve month period.

Rule 46.10.821 pertaining to the Community Work Experience Program (CWEP) is being repealed and references to CWEP throughout the rules are being deleted because that program has been replaced by the Alternative Work Experience Program (AWEP). This is necessary to allow the Department the ability to expand the number of work hours required for participation in the program.

In subsection (1)(e) of ARM 46.10.825 regarding supportive services the maximum amount for medical expenses is being increased from $150 per year to $50 per month because the current amount is not adequate to meet the needs of all recipients.

ARM 46.10.827 is being amended to specify that a person who becomes ineligible for AFDC due to being sanctioned for failure to meet JOBS requirements is not entitled to case management activities and supportive services for 90 days after AFDC

closure. It was never the Department's intention to allow such services for sanctioned individuals, but the rule previously failed to state that such persons were not eligible for these services.

ARM 46.10.833 is being amended to make clear the difference between the JOBS contract and the participant's employability plan and that an employability plan is not a contract between the department and the participant, although the participant must comply with the plan or be subject to sanction under ARM 46.10.839.

Subsection (1)(c) is being deleted from ARM 46.10.843 because it provides for a right to a fair hearing on the issue of worker's compensation coverage. Pursuant to a recent ruling from the legal staff of the State Fund that JOBS participants are not employees of the department within the scope of 39-71-118, MCA, the department no longer provides worker's compensation coverage to recipients participating in AWEP, on-the-job training, or work supplementation.

The department is repealing ARM 46.10.845 pertaining to performance standards for providers of services to JOBS participants because this relates to matters between providers and the department which are governed by contract and do not need to be addressed in rule.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to 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 May 27, 1993.

6. 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 April 19, 1993.

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

| | | |
|---|---|---|
| In the matter of the amendment of rules 46.12.590 through 46.12.593 and 46.12.595 pertaining to inpatient psychiatric services | ) ) ) ) ) | NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.590 THROUGH 46.12.593 AND 46.12.595 PERTAINING TO INPATIENT PSYCHIATRIC SERVICES |

TO: All Interested Persons

1. On May 25, 1993, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.590 through 46.12.593 and 46.12.595 pertaining to inpatient psychiatric services.

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

46.12.590 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, PURPOSE AND DEFINITIONS (1) The purpose of the following rules is to specify provider participation and program requirements and to define the basis and procedure the department will use to pay for ~~inpatient psychiatric~~ residential treatment services for individuals under age 21. Facilities in which these services are available are hereinafter referred to as providers.

~~(a) These rules implement Title XIX of the Social Security Act and 42 CFR sections 447.1 through 447.45, 447.300 through 447.304 and 447.325, and allow the department to pay for inpatient psychiatric hospital services for persons under the age of 21 through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with applicable Montana and federal laws, regulations, and quality and safety standards. The department hereby adopts and incorporates by reference 42 CFR sections 447.1 through 447.45, 447.300 through 447.304, and 447.325. Copies of these federal regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210.~~

Subsection (2) remains the same.

(a) "~~Inpatient psychiatric~~ Residential treatment services" means services that are provided in accordance with 42 CFR sections 440.160 and 441.150 through 441.156, which provide definitions and program requirements and which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. ~~Inpatient psychiatric~~ Residential

treatment services are services that meet those provisions and are provided in ~~an inpatient hospital facility or~~ residential treatment facility that is devoted to the provision of residential psychiatric ~~services~~ care for persons under the age of 21.

(b) "Devoted to the provision of residential psychiatric ~~services~~ care for persons under the age of 21" means a ~~hospital facility or~~ residential treatment facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.

~~(c) "Efficient and economic provision of services" means providers that refuse to pay more than market price for required services or items and also that seek to minimize costs to the extent possible. Providers will be considered to be operating efficiently if they can operate within the maximum rate allowed under ARM 46.12.592.~~

Subsections (2)(d) through (2)(j) remain the same in the text but are renumbered (2)(c) through (2)(i).

~~(k) "Hospital inpatient psychiatric care" means hospital based active psychiatric treatment provided under the direction of a physician. The individual's psychiatric condition must be of such a nature as to pose a significant danger to self, others, or the public safety, or one which has resulted in marked psychosocial dysfunction or grave disability of the individual. The therapeutic intervention or evaluation must be designed to achieve the patient's discharge from inpatient hospital status to a less restrictive environment at the earliest possible time.~~

Subsection (2)(l) remains the same in text but is renumbered (2)(j).

~~(m) "Inpatient hospital facility" means a hospital facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.~~

(~~n~~k) "Residential treatment facility" means a facility ~~operated for the primary purpose of providing residential psychiatric care to persons under 21 years of age~~ licensed by the department of health and environmental sciences, or the equivalent agency in the state in which the facility is located, as a residential treatment facility as defined in 50-5-103, MCA or the equivalent category in the state where the facility is located.

(~~o~~l) Payment for ~~inpatient psychiatric~~ residential treatment services provided outside the state of Montana is subject to the requirements of ARM 46.12.502(3).

(~~p~~m) "Emergency admission" means an admission for treatment of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that ~~the absence of~~ immediate medical attention ~~could reasonably be expected to result in serious dysfunction of a bodily organ or part or in the death of the individual or in harm to another person by the individual~~ in a residential treatment facility is required.

Subsection (2)(q) remains the same in text but is renumbered (2)(n).

(o) "Occupancy rate" means the total number of days of service to all patients in the cost reporting period divided by

the product of the average number of beds available during the cost reporting period and the total number of days in the cost reporting period.

(p) "Beds available" means the number of beds for which the facility has been licensed by the department of health and environmental sciences.

~~(r) "Disproportionate share hospital" means a hospital, including a psychiatric inpatient hospital facility, which meets the following criteria:~~

~~(i) it has a medicaid inpatient utilization rate of at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state, or a low income utilization rate exceeding 25 percent;~~

~~(ii) urban hospitals must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to medicaid patients. Rural hospitals must have at least two physicians with staff privileges to perform non-emergent obstetric procedures who have agreed to provide obstetric services to medicaid recipients; and~~

~~(iii) subsection (ii) does not apply to hospitals which:~~

~~(A) serve inpatients who are predominantly individuals under 18 years of age; or~~

~~(B) do not offer non-emergent obstetric services as of December 21, 1987.~~

~~(s) "Medicaid inpatient utilization rate" means the hospital's percentage rate computed by dividing the total number of medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period. The period used will be the most recent calendar year for which final cost reports are available for all hospital providers, including psychiatric inpatient hospital facilities.~~

~~(t) "Low income utilization rate" is the percentage rate computed as follows:~~

~~(i) (A + B)/C + (D/E) where:~~

~~(A) "A" is the total medicaid payments to the hospital for patient services in the hospital's fiscal year;~~

~~(B) "B" is the cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year;~~

~~(C) "C" is the total revenues of the hospital for patient services, including the amount of such cash subsidies in the hospital's fiscal year;~~

~~(D) "D" is the total hospital charges for inpatient hospital services attributable to charity care in the hospital's fiscal year. This amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for public assistance); and~~

~~(E) "E" is the hospital's total charges for inpatient hospital services in the hospital's fiscal year.~~

~~(ii) The above amounts used in the formula must be from the hospital's most recent fiscal year for which costs have been settled with the department.~~

~~(u) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area as defined by the federal executive office of management and budget.~~

~~(v) "Rural hospital" means an acute care hospital that is not located within a metropolitan statistical area as defined by the federal executive office of management and budget.~~

(3) Medicaid payment is not allowable for services provided in ~~an inpatient psychiatric hospital that do not meet the definition of acute psychiatric inpatient care set forth in ARM 46.12.590(2)(k) or for services provided in~~ a residential treatment facility that does not meet the definition of residential psychiatric care set forth in ARM 46.12.590(2)(~~i~~j).

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

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

46.12.591 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, PARTICIPATION REQUIREMENTS (1) These requirements are in addition to those contained in ARM 46.12.301 through 46.12.309.

(~~1~~2) Providers of ~~inpatient psychiatric~~ residential treatment services are eligible for reimbursement under the Montana medicaid program if they meet the following requirements:

(a) maintain a current license as a ~~hospital or a~~ residential treatment facility under the rules of the department of health and environmental sciences to provide ~~inpatient~~ residential psychiatric ~~services~~ care, or, if the provider's facility is not located within the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the facility is located;

(b) maintain a current certification for Montana medicaid under the rules of the department of health and environmental sciences to provide ~~inpatient~~ residential psychiatric ~~services~~ care, or, if the provider's facility is not located within the state of Montana, meet the requirements of subsections (~~h~~g) and (~~i~~h);

(c) maintain a current agreement with the department to provide ~~inpatient psychiatric~~ residential treatment services, including a provider enrollment form, or, if the provider's facility is not located within the state of Montana, maintain a current provider enrollment form with the department's fiscal agent;

Subsections (1)(d) and (1)(e) remain the same in text but are renumbered (2)(d) and (2)(e).

(f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used only for those purposes for which the patient, legal guardian, or personal representative of the patient has given written ~~delegation~~ authorization. A provider may not borrow funds from these accounts for any purpose;

~~(g) for hospital providers:~~

~~(i) comply with 42 CFR sections 482.1 through 482.62 and meet the requirements of section 1861(f) of the Social Security Act, which are federal regulations and statutes setting forth requirements for psychiatric hospitals. The department hereby adopts and incorporates by reference the above-cited regulations and statutes. Copies of these regulations and statutes may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210; or~~

~~(ii) be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit psychiatric hospitals for medicaid participation.~~

(~~h~~g) ~~for residential treatment facility providers, be accredited~~ maintain accreditation as a residential treatment facility by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit ~~inpatient psychiatric facilities, including~~ residential treatment facilities, for medicaid participation;

(~~i~~h) ~~for hospital providers electing to meet the requirement of subsection (g)(ii) rather than (g)(i) and for all residential treatment facility providers,~~ submit to the department prior to receiving initial reimbursement payments and thereafter within 30 days after receipt, all accreditation determinations, findings, reports and related documents issued by the accrediting organization to the provider;

(~~j~~i) provide ~~inpatient~~ residential psychiatric ~~services~~ care according to the service requirements for individuals under age 21 specified in Title 42 CFR, part 441, subpart D (October 1, 1992), which is a federal regulation which is herein incorporated by reference. A copy of these regulations may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210;

(~~k~~j) agree to indemnify the department in the full amount of the state and federal shares of all medicaid ~~inpatient psychiatric~~ residential treatment reimbursement paid to the facility during any period when federal financial participation is unavailable due to facility failure to meet the conditions of participation specified in ~~section 1861(f) of the Social Security Act~~ these rules, or due to other facility deficiencies or errors.

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

46.12.592 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, REIMBURSEMENT (1) The reimbursement period will be the provider's fiscal year. Reimbursement for services will be at cost per day on a retrospective basis, subject to an upper limit which will be the lesser of:

(a) the per day amount charged to the medicaid program;

(b) medicaid allowable costs per day as ~~described in subsection (2)~~ determined in accordance with this section, subject to the ceiling ~~described~~ established in this ~~sub~~section ~~(5); or, if applicable,~~.

~~(c) the medicare rate.~~

(2) Allowable cost will be determined in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants, subject to the provisions of ~~the health insurance manual 15 (HIM-15)~~ medicare coverage issues manual (HCFA-Pub. 15) except where further restricted in this administrative rule. The department hereby adopts and incorporates herein by reference the ~~HIM-15~~ medicare coverage issues manual (HCFA-Pub. 15), which is a manual published by the United States department of health and human services, social security administration, which provides guidelines and policy 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~~ medicare coverage issues manual (HCFA-Pub. 15) may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, ~~Medicaid Services Division,~~ P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

(a) Return on equity capital ~~shall~~ is not ~~be~~ an allowable cost.

(b) Bad debt expense ~~shall~~ is not ~~be~~ an allowable cost.

(c) Educational and vocational training costs are not an allowable cost except to the extent such costs qualify for federal financial participation under the provisions of 42 CFR 441.13(b), as amended effective December 21, 1992.

(3) Providers located within the state will be reimbursed on an interim basis during the provider's fiscal year, subject to retrospective settlement according to these rules. The interim rate will be a percentage of customary charges as determined by the department. The percentage shall be the provider's cost to charge ratio determined by the department or its designee based upon the provider's most recent cost report and according to medicare principles as limited by these rules.

~~(a) Reimbursement will be made to a provider for reserving a bed while the recipient is temporarily absent if the recipient's plan of care provides for therapeutic home visits. A total of 24 days annually will be allowed for therapeutic home visits. The provider is responsible for notifying the department on a form provided by the department when a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the form is filed with the department. Absences are restricted to no more than 72 consecutive hours per absence. Longer hours per absence may be allowed if determined medically appropriate and prior authorized by the director of the department or his designee.~~

(4) Reimbursement for services provided to medicaid patients ~~by providers~~ in facilities located outside ~~of~~ the state of Montana will be limited to the ~~lowest~~ lesser of:

(a) 60% of the provider's usual and customary charge or, upon submission of adequate financial documentation reflecting the facility's costs and charges, a lessor or greater rate determined by the department in accordance with ~~these rules~~ ARM 46.12.592; or

(b) ~~the medicare percentage of customary charges; or~~ the provider's medicaid rate for the same period paid by the state in which the provider's facility is located.

~~(c) the medicaid rate established under the respective state's medicaid regulations.~~

~~(5) Reimbursement to providers will be subject to a ceiling on the rate of increase of operating costs per day for services that will be recognized as reasonable for purposes of determining medicaid reimbursement.~~

(~~6~~5) The provider's base period will be the first full 12-month cost reporting period ending after June 30, 1985. No exceptions to this rule will be granted and the exception provisions contained in the HCFA-Pub. 15 and medicare regulations do not apply for purposes of determining the base period under these rules.

(a) For providers previously participating as hospital providers which convert their facilities to residential treatment facilities, the base period shall be the providers first full 12-month cost reporting period of participation in the Montana medicaid program as a residential treatment facility.

(b) Base period costs will be determined on a per day basis.

(c) Base period operating costs exclude the costs of malpractice insurance and capital-related costs described in 42 CFR 413.130 (October 1, 1992), which is a federal regulation which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210.

(6) Reimbursement to providers for all periods subsequent to the base period will be subject to a ceiling on the rate of increase of operating costs per day for services that will be recognized as reasonable for purposes of determining medicaid reimbursement.

(~~b~~a) Ceilings established under this section will be applied to all full 12-month cost reporting periods that follow a base period as described in subsection (5)~~(a)~~. For purposes of determining base period reimbursement, allowable cost shall be determined in accordance with subsection (2), without application of the ceiling established in this section.

(~~c~~b) Ceilings established under this section will not apply to cost reporting periods of fewer than 12 months that occur along with a change in operations of the providers as a result of changes in ownership, merger, or consolidation. However, ceilings will apply to cost reporting periods of fewer than 12 months which result solely from the approval of a provider's request for a change in accounting cycle. In the

case of such periods, the applicable percentage rate of increase will be adjusted downward by a monthly factor corresponding to the annual percentage rate to reflect fewer months. ~~Ceilings established under this section will apply to cost reporting periods of greater than 12 months with the percentage rate of increase adjusted upward by a monthly factor corresponding to the annual percentage rate to reflect the additional months.~~

(~~d~~c) The cost per day ceiling established under this section applies to operating costs incurred by a provider in furnishing inpatient services. These operating costs exclude the costs of malpractice insurance and capital-related costs described in ~~42 CFR 413.130, which is a federal regulation which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210~~ subsection (5)(c).

(~~e~~d) Base period operating ~~c~~costs and subsequent operating costs subject to the ceiling ~~as~~ described in ~~subsection (5)(d) of~~ this subsection will be determined on a cost per day basis. Allowable medicaid costs as defined in subsection (2) will be divided by the total number of medicaid inpatient days to determine the cost per day.

(~~f~~e) The ~~target rate~~ maximum increase percentage for each ~~calendar year~~ provider's cost reporting period will equal the prospectively estimated ~~increase in the~~ market basket index for ~~that calendar year~~ hospitals and hospital units excluded from the medicare prospective payment system, most recently published in the federal register prior to the start of the provider's cost reporting period. The market basket index is a hospital wage and price index that incorporates ~~appropriately~~ approximately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of inpatient hospital operating cost subject to the ceiling ~~as described in subsection (5)(d) of~~ established under this subsection. The maximum increase percentage is not the upper limit set forth in the federal law commonly referred to as the Tax Equity and Fiscal Responsibility Act (TEFRA) update factor.

(~~g~~7) For each provider a ceiling will be established on the reimbursable operating costs per day of that provider. The ceiling for each 12-month cost reporting period, which is the maximum medicaid allowable cost per day, will be set ~~at a target amount determined~~ as follows:

(a) For the first 12-month cost reporting period to which this ceiling applies, the ~~target amount~~ ceiling will equal the provider's allowable operating cost per day for the provider's base period increased by the ~~target rate~~ maximum increase percentage for the subject period.

~~(b) In calculating the base period operating cost per day the number of days shall be the greater of:~~

~~(i) actual days of service; or~~

~~(ii) days of service representing 80% utilization.~~

(~~c~~b) For subsequent 12-month cost reporting periods, the ~~target amount~~ ceiling will equal the provider's ~~target amount~~ ceiling for the previous 12-month cost reporting period increased by the ~~target rate~~ maximum increase percentage for the subject cost reporting period.

(~~7~~8) The ~~target rate~~ maximum increase percentage increase applicable to each 12-month cost reporting period will be used to determine the ceiling on the allowable rate of cost increase under this section.

~~(a) When a cost reporting period spans portions of two calendar years, an appropriate prorated percentage rate will be calculated based on the published calendar year percentage rates.~~

(~~b~~a) The applicable ~~target rate~~ maximum increase percentage will be as specified in subsection (6)(e). ~~the prospectively determined percentage published by the federal health care financing administration (HCFA). HCFA will publish quarterly "Federal Register" notices, beginning in 1983, including the applicable estimate of the market basket rate of increase and the resulting target rate percentage for the next two calendar years.~~ The ~~target rate~~ maximum increase percentage for each provider applicable for the beginning of the provider's cost reporting period~~,~~ will be applied prospectively, ~~and will be prorated, in accordance with subsection (7)(a) of this section,~~ but will not be retroactively adjusted if the actual market basket rate of increase differs from the estimate. ~~Copies of the federal register notices may be obtained through the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.~~

(~~8~~9) At the end of each 12-month cost reporting period subject to this section, the provider's allowable medicaid cost per day is compared with that provider's ~~target amount~~ ceiling for that period.

(a) The provider will receive the actual allowable medicaid cost per day or the provider's ~~target amount~~ ceiling amount for that period, whichever is less.

(b) Exceptions to the ceiling on ~~the rate of~~ operating cost increases may be allowed as described in 42 CFR 413.40(g) (October 1, 1992) which is a federal regulation which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Medicaid Services Division, Department of Social and Rehabilitation Services, ~~Medicaid Services Division,~~ P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. Requests for exceptions must be submitted to the department in writing along with supporting documentation. The department will determine whether the provider is entitled to an exception and will notify the provider in writing of its determination.

(c) Providers will receive no TEFRA incentive payments even though costs per day may be less than the ceilings established.

(d) Providers will receive no reimbursement for costs incurred in excess of the ceilings established under this rule.

~~(9) Disproportionate share hospitals shall receive an additional payment amount equal to the product of the hospital's rate times the adjustment percentage of:~~

~~(a) 4 percent for rural hospitals; and~~

~~(b) 5 percent for urban hospitals having less than 100 beds.~~

(10) For purposes of calculating allowable capital costs for purposes of reimbursement in all cost reporting periods, the number of days of service shall be the greater of:

(a) actual days of service; or

(b) days of service representing 80% occupancy.

(11) Reimbursement will be made to a provider for reserving a bed while the recipient is temporarily absent only if:

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

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

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

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

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

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

46.12.593 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, COST REPORTING AND AUDITS Subsection (1) remains the same.

(a) ~~Generally accepted accounting principles shall be used by each provider to record and report costs. As part of the cost report these costs will be adjusted in accordance with these rules to determine includable costs.~~ The facility must record and report costs in accordance with these rules and generally accepted accounting principles as defined by the American institute of certified public accountants. The facility must maintain appropriate accounting records which will enable the facility to fully complete the cost report in the form required by the department.

(b) Providers must use ~~T~~the accrual method of accounting ~~shall be employed~~ for recording and reporting costs, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(c) Cost finding means the process of ~~allocating and prorating~~ redistributing the data derived from the accounts ordinarily kept by a ~~provider~~ facility to ascertain its costs of ~~the~~ various services provided. Cost finding is the resolution of the costs by allocation of direct costs and proration of indirect costs. In preparing cost reports, all providers ~~shall utilize~~ must use the methods of cost finding described at 42 CFR 413.24 (1991) which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 (1991) is a federal regulation setting forth methods ~~for allocating costs~~ of cost finding. A copy of the regulation may be obtained from the Medicaid Services Division, Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210.

(d) Provider costs ~~are to~~ must be reported based upon the provider's fiscal year using the financial and statistical report form provided by the department. The use of the department's financial and statistical report form is mandatory for participating facilities. These reports ~~shall~~ must be complete and accurate~~;~~. ~~I~~Incomplete reports or reports containing inconsistent data will be returned to the provider for correction. The department will not accept or use for any purpose a cost report for any period greater than 12 months.

(i) ~~Cost reports must be filed within 90 days after the end of the provider's fiscal year.~~ The provider must file its cost report and supporting documents with the department within 90 days of the closing date of its fiscal year.

(ii) In the event a provider does not file a complete cost report complying with these rules within 90 days of the closing date of its fiscal year, ~~or files an incomplete cost report,~~ an amount equal to 10 percent of the provider's total reimbursement for the following month shall be withheld by the department. If the report is overdue or incomplete ~~a second month~~ for more than 30 days, 20 percent shall be withheld. For each succeeding ~~month~~ 30 days the report is overdue or incomplete, the provider's total reimbursement shall be withheld. All amounts so withheld will be payable to the provider upon submission of a ~~complete and accurate~~ cost report which complies with these rules. Unavoidable delays may be reported with a full explanation and a request made for an extension of time limits prior to the filing deadline. However, there is a ~~maximum~~ limit~~ation~~ of one 30-day extension per cost report.

(iii) Failure to submit a cost report will result in recovery by the department of all amounts paid by the department for the fiscal year covered by the cost report.

(~~iii~~iv) Cost reports ~~shall~~ must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports ~~shall~~ must sign under penalties of false swearing, that he has examined the report including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared consistent with governing laws~~,~~ ~~and~~ regulations and accounting principles.

(e) Records of financial and statistical information supporting cost reports ~~shall~~ must be maintained by the provider and the department for three years after the date a cost report is filed, ~~or~~ the date the cost report is due or the date upon which a disputed cost report is finally settled, whichever is later.

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

(ii) ~~To support includable costs, all b~~Business records of any related party, including any parent or subsidiary firm, ~~which~~ related to a provider ~~under audit, shall~~ must be available at the facility ~~for audit. T~~to support ~~includable~~ allowable costs~~,~~. ~~t~~The owner's or related party's personal financial records relating to the facility ~~shall~~ also must be ~~made~~ available ~~for audit~~ at the facility to support allowable costs. Any costs not so supported will not be ~~includable~~ allowable.

(f) The department or its designee may perform a desk review of cost reports and may conduct on-site audits of provider records. Audits will meet generally accepted auditing standards as defined by the American institute of certified public accounts.

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

(~~iv~~ii) All of the above records and documents ~~shall~~ must be available at the facility at all reasonable times after reasonable notice and subject to inspection, review or audit by the department, the federal department of health and human services, the Montana legislative auditor, and other ~~appropriate~~ authorized governmental agencies.

(iii) Upon refusal of the provider to make available ~~and~~ or allow access to the above records and documents, all payments made by the department during the provider's fiscal year to which those records relate shall be recovered in full by the department. ~~Failure to submit a cost report will result in recovery by the department of all amounts paid by the department for the fiscal period covered by the cost report.~~

(g) In addition to the requirements of subsection (1)(f), the department may require out-of-state providers to submit a

copy of their most recent audit report in those instances where the provider has not prepared or is not required to prepare a HCFA form 2552. The audit report must have been performed in accordance with generally accepted auditing standards as defined by the American institute of certified public accountants.

~~(2) The department or its designee may perform a desk review of cost reports and may conduct on-site audits of provider records. On-site audits may be made to assure validity of reports, cost and statistical information. Audits will meet generally accepted auditing standards. Audits of providers' cost reports, financial records and other pertinent data will be adequate to verify that the provider has included only those expense items that are includable services, and that the provider's includable costs are reasonable.~~

Subsection (3) remains the same in text but is renumbered (2).

~~(4) The department, or its designee, will determine whether overpayment or underpayment has resulted. The provider will be notified of the department's findings.~~

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

46.12.595 ~~INPATIENT, PSYCHIATRIC SERVICES, OVERPAYMENT AND UNDERPAYMENT~~ RESIDENTIAL TREATMENT SERVICES, COST SETTLEMENT PROCEDURES ~~(1) Where the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.~~

~~(2) Within 30 days of the day the department notifies the provider that an overpayment exists, the department will arrange to recover the overpayment by set-off against amounts paid for medical assistance or by repayments by the provider. (3) If an agreement has not been reached, within 30 days of notifying the provider of the overpayment, which provides for full repayment within 60 days of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete recovery within sixty (60) days from the date of the initial request for payment or as soon thereafter as possible. The sixty (60) day recovery period coincides with requirements of section 1903(d)(2) of the Social Security Act, as amended. This section requires states to repay the federal share of medicaid payments within sixty (60) days of determination of a medicaid overpayment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment. A request for administrative review or fair hearing shall not entitle a provider to delay repayment of any overpayment determined by the department.~~

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

~~(5) Court or administrative proceedings for collection of overpayment or underpayment shall be commenced within five years~~

~~following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.~~

~~(6) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets.~~

(1) For facilities located in Montana, the department will perform cost settlements and correct overpayments and underpayments in accordance with the provisions of ARM 46.12.509.

(2) The department may determine, through the cost settlement process, whether overpayments or underpayments have resulted to out-of-state providers receiving Montana medicaid reimbursements in excess of $50,000 per year. Where the department performs a cost settlement for an out-of-state facility, the provisions of ARM 46.12.509 shall apply.

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

3. The department proposes to revise ARM 46.12.590 through 595 based on action taken by the 53rd Session of the Montana State Legislature which eliminated appropriations for inpatient psychiatric hospital services for individuals under twenty one (21) years of age. In addition, the department is clarifying language in the rule concerning reimbursement for residential treatment services.

The legislature in House Bill No. 2 has eliminated funding for coverage of inpatient psychiatric hospital services for individuals under 21. These proposed rule changes are necessary to implement the legislative action. Individuals who require hospitalization to stabilize a severe psychiatric condition will be treated in an acute care hospital. Upon discharge, the patient may be placed in a less restrictive environment including residential treatment centers or other community based programs as determined medically appropriate.

The proposed changes in the rule include:

1. Educational and vocation expenses will not be an allowable cost unless they are required as a part of an individual's active treatment program. This change is being made in order to comply with the public rule notice published in the Federal Register on November 20, 1992 by the Health Care Financing Administration (HCFA). The federal rule became effective December 21, 1992. This change is indicated in ARM 46.12.592(2)(c).

2. The proposed rule clarifies reimbursement procedures for both in-state and out-of-state providers. References to Medicare rates have been removed from ARM 46.12.592(1)(c)

and (4)(B) since residential treatment facilities are not certified by Medicare.

3. The proposed rule defines the establishment of the base period which is used to index costs forward to determine a future rate period. The base period will be the first full 12-month cost reporting period ending after June 30, 1985, with no exceptions. New procedures have been developed for settling cost report periods and adjusting the cost per day ceiling which are less than or greater than twelve months. For facilities which convert from an Inpatient Psychiatric Facility to a Residential Treatment Center, the base period will be the first full twelve month cost reporting period as a residential treatment period. These changes are necessary to eliminate confusion with respect to additional rules which Medicare addresses and Medicaid does not. These changes have been added to ARM 46.12.592(5).

4. The proposed rule changes the definition of the ceilings on rate increases and the application of the ceiling to the cost report for rate setting. The proposed rule removes references to "target rate percentages" and replaces the term with "maximum increase percentage". Clarification has been added to delineate that the market basket index will be used and not the limit in the Federal Tax Equity and Fiscal Responsibility Act (TEFRA). The department has determined that the market basket index for hospitals and hospital units excluded from the medicare prospective payment system is the most appropriate inflationary index to apply for cost containment purposes. The changes are indicated in ARM 46.12.592(6).

5. The proposed rule change removes the eighty percent occupancy requirement from operating costs. The eighty percent occupancy requirement will be applied to property costs only, however, it will be applied for all cost reporting periods. This change is necessary to ensure that Medicaid does not pay for certain capital costs of under utilized facilities. This change is stated in ARM 46.12.592 (10)(b).

6. A definition of occupancy has been added to prevent confusion over whether occupancy should be based on the number of beds the facility has staffed and maintained or the number of beds available in the facility. The proposed rule has also been clarified to state that incentive payments which are allowable under TEFRA, will not be paid. Occupancy is defined in ARM 46.12.590(2)(o) and the exclusion of TEFRA is stated in ARM 46.12.592(6)(e).

7. References to disproportionate share hospital (DSH) payments are being removed from the rule since residential treatment centers are not eligible to receive DSH payments.

This information was previously defined in ARM 46.12.590(2)(r) and implemented in ARM 46.12.592(9).

8. ARM 46.12.593 explains the cost reporting requirements of the facility. The rule indicates that cost must be reported in accordance with generally accepted accounting principles as modified by the Health Care Financing Administration Publication 15 or as modified by this rule. The rule clarifies reporting and filing requirements for the cost report by the facility.

9. ARM 46.12.595 redefines the cost settlement process. Rather than duplicating the inpatient hospital cost settlement rule, the department has referred back to this rule for consistency. Also the proposed rule includes a new cost settlement provision which will allow the department to cost settle with out-of-state providers receiving more than $50,000 in medicaid reimbursement. These changes are necessary to enable the program to recover any excessive payments.

In summary, the proposed rule changes implement the action taken by the 1993 Legislature to eliminate inpatient hospital psychiatric services while retaining residential treatment services. The proposed rule also changes the rate setting methodology, establishment of the base period, indexing of operating costs, cost reporting and cost settlement processes.

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 May 27, 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 April 19, 1993.

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

| | | |
|---|---|---|
| In the matter of the amendment of rules 46.12.1222, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1235, 46.12.1237, 46.12.1243, 46.12.1246, 46.12.1249, 46.12.1258 and 46.12.1260 pertaining to medicaid nursing facility reimbursement | ) | NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.1222, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1235, 46.12.1237, 46.12.1243, 46.12.1246, 46.12.1249, 46.12.1258 AND 46.12.1260 PERTAINING TO MEDICAID NURSING FACILITY REIMBURSEMENT |

TO: All Interested Persons

1. On May 21, 1993, at 1:30 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.1222, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1235, 46.12.1237, 46.12.1243, 46.12.1246, 46.12.1249, 46.12.1258 and 46.12.1260 pertaining to medicaid nursing facility reimbursement.

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

46.12.1222 DEFINITIONS Subsections (1) through (8) remain the same.

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

(a) The licensed to non-licensed ratio will be computed using information from the most recent cost report on file as of April 1 immediately prior to the rate year, or if the hourly component of such information is not available from the cost report, from the staffing reports filed pursuant to ARM 46.12.1232 for the period corresponding to the cost report period from which wage and benefit information is used to set the ratio. If the necessary information for a particular facility is not available from a cost report and/or staffing

report, the wages, benefits and hours from that facility will not be used to set the ratio.

Subsections (10) through (14)(e)(xxi) remain the same.

(xxii) personal hygiene items and services, including but not limited to:

(A) bathing items and services, including but not limited to towels, washcloths and soap;

(B) hair care and hygiene items, including but not limited to shampoo, brush and comb;

(C) incontinence care and supplies;

(D) miscellaneous items and services, including but not limited to cotton balls and swabs, deodorant, hospital gowns, sanitary napkins and related supplies, and tissues;

(E) nail care and hygiene items;

(F) shaving items, including but not limited to razors and shaving creme;

(G) skin care and hygiene items, including but not limited to bath soap, moisturing lotion, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; and

(H) tooth and denture care items and services, including but not limited to toothpaste, toothbrush, floss, denture cleaner and adhesive;

Subsections (14)(e)(xxii) through (xxix) remain the same in text but are renumbered (14)(e)(xxiii) through (xxx).

(xxxi) ~~the following~~ over-the-counter ~~medications~~ drugs (or their equivalents), including but not limited to:

Subsections (14)(e)(xxx)(A) and (B) remain the same in text but are renumbered (14)(e)(xxxi)(A) and (B).

(C) cough syrups;

Subsections (14)(e)(xxx)(C) through (C)(V) remain the same in text but are renumbered (14)(e)(xxxi)(D) through (D)(V).

(E) vitamins, multivitamins, vitamin supplements and calcium supplements; and

(F) nasal decongestants and antihistamines;

Subsections (14)(e)(xxxi) through (xxxix) remain the same in test but are renumbered (14)(e)(xxxii) through (xl).

Subsections (14)(f) through (20) remain the same.

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

46.12.1226 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this section, minus the amount of the medicaid recipient's patient contribution. The per diem rate shall be subject to the maximum level, if any, specified in subsections (3) through (3)(c). Except as provided in subsection (4), the per diem rate is the sum of the following components:

Subsections (1)(a) through (3)(a) remain the same.

(b) A provider's per diem rate for rate years beginning on or after July 1, 1993 shall not be subject to any minimum or maximum amount of increase from the provider's previous rate or previous average rate.

(c) A provider's per diem rate effective July 1 of the rate year shall not exceed the provider's per diem private pay rate for a semi-private bed, as specified by the provider in the department's survey of private pay rates conducted annually between April 1 and July 1 prior to the rate year. Providers who do not respond to the department's survey by July 1 of the rate year, will be subject to withholding of their medicaid reimbursement in accordance with ARM 46.12.1260.

(i) Upon request, providers must provide the department or its agents with records and information regarding the private pay rates charged to residents. If the department determines after desk review or audit that the provider's private pay rate has decreased from or that the provider has in fact customarily charged private paying residents less than the rate specified in the department's survey described in subsection (c), the department will decrease the provider's medicaid per diem rate, retroactive to July 1 of the rate year, to the amount of the decreased or actual private pay rate customarily charged to private paying residents during the rate year, and any overpayment will be collected as provided in ARM 46.12.1261.

(ii) The medicaid per diem rate will not be increased as a result of increases in private pay rates from the private pay rate specified in the department's survey described in subsection (c).

Subsections (4) through (13) remain the same.

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

46.12.1229 OPERATING COST COMPONENT Subsections (1) through (2)(a)(ii) remain the same.

(iii) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, 1993, the base period is the provider's cost report period of at least six months with a fiscal year ending between January 1, 1992 and December 31, 1992 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least six months on file with the department as of April 1 immediately preceding the rate year.

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

(ii) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least six months with ~~a fiscal year ending between January 1, 1991 and December 31, 1991 inclusive~~ respect to the base period specified in subsection (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the median operating costs. A cost report which is not timely filed in accordance with ARM 46.12.1260 as of April 1 immediately preceding the rate

year shall not be considered filed for purposes of inclusion in the array.

Subsections (2)(e) through (3) remain the same.

(4) The operating cost limit is ~~110%~~ 115% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with subsection (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of ~~5%~~ 10% of median operating costs or 40% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

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

46.12.1231 DIRECT NURSING PERSONNEL COST COMPONENT Subsections (1) through (2)(a)(ii) remain the same.

(iii) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, 1993, the base period is the provider's cost report period of at least six months with a fiscal year ending between January 1, 1992 and December 31, 1992 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least six months on file with the department as of April 1 immediately preceding the rate year.

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

(ii) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least six months with ~~a fiscal year ending between January 1, 1991 and December 31, 1991 inclusive~~ respect to the base period specified in subsection (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the statewide median average wage. A cost report which is not timely filed in accordance with ARM 46.12.1260 as of April 1 immediately preceding the rate year shall not be considered filed for purposes of inclusion in the array.

Subsection (3) remains the same.

(4) The direct nursing personnel cost limit is ~~125%~~ 130% of the statewide median average wage, multiplied by the provider's most recent average patient assessment score, determined in accordance with ARM 46.12.1232.

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

46.12.1235 OBRA COST REIMBURSEMENT Subsections (1) through (3)(b)(iv) remain the same.

(A) For the period April 1, 1992 through June 30, 1993, ~~T~~the facility's medicaid utilization percentage will be determined based upon the form MA-15 staffing reports on file with the department for the period of November 1991 through January

1992, by dividing the total medicaid patient days reflected in the staffing reports for such period by the total patient days reflected in the staffing reports for such period.

(B) For rate years beginning on or after July 1, 1993, the facility's medicaid utilization percentage will be determined based upon the form MA-15 staffing reports on file with the department for the period of January 1993 through March 1993, by dividing the total medicaid patient days reflected in the staffing reports for such period by the total patient days reflected in the staffing reports for such period.

Subsection (3)(b)(v) remains the same.

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

46.12.1237 CALCULATED PROPERTY COST COMPONENT Subsections (1) through (2)(a) remain the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1992~~ 1993, the base period is the provider's cost report period of at least six months with a fiscal year ending between January 1, ~~1991~~ 1992 and December 31, ~~1991~~ 1992 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least six months on file with the department before April 1 immediately preceding the rate year.

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

(i) For rate years beginning on or after July 1, ~~1992~~ 1993, the property rate cap is ~~$9.47~~ $9.64.

(e) "~~1992~~ 1993 property component" means the provider's calculated ~~or grandfathered~~ property component determined for rate year ~~1992~~ 1993 in accordance with ARM 46.12.1237 ~~or 46.12.1240~~.

(i) For any provider providing nursing facility services in a facility constructed prior to June 30, 1982 and for whom a calculated ~~or grandfathered~~ property component has not been determined by the department in accordance with ARM 46.12.1237 ~~or 46.12.1240~~ for rate year ~~1992~~ 1993, the ~~1992~~ 1993 property component shall equal the June 30, 1985 property rate computed for the facility according to the rules in effect as of June 30, 1985 and indexed forward to the 1992 rate year according to the rules in effect for rate year 1992.

(3) For rate years beginning on or after July 1, ~~1992~~ 1993, the provider's calculated property cost component is as follows:

(a) If the provider's ~~1992~~ 1993 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's ~~1992~~ 1993 property component or the property rate cap of ~~$9.47~~ $9.64.

(b) If the provider's base year per diem property costs exceed the provider's ~~1992~~ 1993 property component by more than ~~$0.57~~ $0.17, then the provider's calculated property cost

component is the sum of the provider's ~~1992~~ 1993 property component plus ~~$0.57~~ $0.17.

(c) If the provider's base year per diem property costs exceed the provider's ~~1992~~ 1993 property component by ~~$0.57~~ $0.17 or less, then the provider's calculated property cost component is the provider's base year per diem property costs.

Subsection (4) remains the same.

(a) the adjusted component shall be the lesser of ~~$9.47~~ $9.64 or a blended rate determined by dividing the sum of the product of pre-construction square footage and the provider's July 1 calculated property cost component and the product of the additional constructed square footage and ~~$9.47~~ $9.64, by the total square footage after construction.

Subsection (5) remains the same.

(a) the adjusted component shall be the lesser of ~~$9.47~~ $9.64 or the existing component plus a per diem amount determined by amortizing 80% of the amount derived by dividing the total allowable remodeling cost by the number of licensed beds after remodeling. Such amount shall be amortized over 360 months at 12% per annum. A per diem amount shall be determined by multiplying the monthly amortization amount by 12 months and dividing the result by 365.

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

46.12.1243 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS Subsections (1) through (2)(a) remain the same.

(b) As a new provider resulting from a change in provider as defined in ARM 46.12.1241, the new provider's interim rate will be determined in accordance with ARM 46.12.1226, 1229, 1231 and 1237, based upon the most recent medicaid cost report covering a period of at least six months as filed by the previous provider, and subject to ~~the~~ any applicable minimum or maximum rate under the provisions of ARM 46.12.1226(3) through (3)(c), as applied to the facility's average per diem rate in effect for the entire previous rate year, as if no change in provider had occurred.

Subsection (2)(c) remains the same.

(d) The provider's interim rate shall remain in effect until the provider has filed with the department in accordance with ARM 46.12.1260 a complete and accurate cost report covering a period of ~~at least~~ six months participation in the medicaid program in a newly constructed facility, as a new provider or following a change in provider as defined in ARM 46.12.1241. Subject to subsection (2)(d)(iv), ~~T~~the interim rate will be adjusted only upon computation of a new interim rate effective July 1 of each rate year, or following a rate adjustment request by a new provider with an interim rate set using a previous provider's cost report, as follows:

Subsections (2)(d)(i) through (2)(d)(iii) remain the same.

(iv) the new provider's ~~adjusted~~ interim rate ~~is subject to a rate increase cap of~~ shall be set as follows:

(A) ~~the applicable maximum rate under the provisions of ARM 46.12.1226, as applied to the facility's average per diem rate in effect for the entire previous rate year, as if no change in provider had occurred; or~~ if the previous owner's rate was less than or equal to the bed-weighted median rate for all facilities for the current year, then the new provider's interim rate shall be the lesser of:

(I) the previous owner's rate adjusted by an amount, if any, determined in accordance with subsections (2)(d)(i) through (iii); or

(II) the bed-weighted median rate for all facilities for the current year.

(B) ~~the bed-weighted median rate for all facilities, whichever is less.~~ if the previous owner's rate was greater than the bed-weighted median rate for all providers for the current year, then the new provider's interim rate shall be the previous owner's rate.

Subsections (2)(e) through (3)(b) remain the same.

(i) The department or its agents will monitor the provider's abstracts from a month during the provider's first three months in the medicaid program. If no abstract information is available for the first three months of participation in the medicaid program, the provider's direct nursing personnel cost component shall be calculated using the statewide average patient assessment score.

Subsections (3)(b)(ii) and (iii) remain the same.

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

46.12.1246 ITEMS BILLABLE TO RESIDENTS Subsection (1) remains the same.

(a) ~~vitamins, multivitamins~~ gifts purchased by residents;

(b) ~~calcium supplements~~ social events and entertainment outside the scope of the provider's activities program;

~~(c) nasal decongestants and antihistamines;~~

~~(d) shaving soap;~~

~~(e) toothpaste, toothbrush;~~

(~~f~~c) cosmetics;

~~(g) hair combs;~~

~~(h) brushes;~~

(~~i~~d) tobacco products and accessories;

(~~j~~e) personal dry cleaning;

(~~k~~f) beauty shop services;

(~~l~~g) television and private telephone rental;

(~~m~~h) less-than-effective drugs (exclusive of stock items); and

(~~n~~i) the difference between the cost of items usually reimbursed under the per diem rate ~~but for which the resident requests a specific item or brand~~ and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers)~~; and~~.

~~(c) over-the-counter drugs other than the routine stock items, such as acetaminophen, aspirin, and therapeutic class 1 and class 6 antacids and laxatives including but not limited to milk of magnesia, mineral oil, suppositories for evacuation, maalox and mylanta, which are reimbursed as part of the per diem rate.~~

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

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

46.12.1249 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED Subsections (1) through (2)(f) remain the same.

(g) For fiscal years ending after June 30, 1993 and on or before June 30, 1994, the payment rate will not exceed total allowable costs per day for the 12-month period ended June 30, with increases in subsequent years indexed to June 30 of the rate year by an index not to exceed the final medicare market basket index applicable to the rate year.

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

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

46.12.1258 ALLOWABLE COSTS Subsections (1) through (3)(i) remain the same.

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

Subsections (3)(j)(i) and (ii) remain the same.

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

Subsections (3)(j)(iv) through (4) remain the same.

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

46.12.1260 COST REPORTING, DESK REVIEW AND AUDIT Subsections (1) through (4) remain the same.

(a) A provider must file its cost report:

(i) within 90 days after the end of its designated fiscal year;

(ii) within 90 days after the effective date of a change in provider as defined in ARM 46.12.1241; or

(iii) within 90 days after six months participation in the medicaid program for providers with an interim rate established under ARM 46.12.1243. Subsequent cost reports are to be filed in accordance with section (i) above and subsequent cost reports shall not duplicate previous cost reporting periods.

Subsections (4)(b) through (7) remain the same.

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

3. The proposed changes to the medicaid nursing facility reimbursement rule are necessary to:

(a) implement legislative funding increases for nursing facility reimbursement for state fiscal year 1994;
(b) rebase rate formula components to more current cost report data;
(c) adjust rate formula components, percentages and caps to take into account new base year cost information;
(d) modify the time period used for computing the medicaid utilization percentage for reimbursement for the nurse aide testing and competency evaluation programs;
(e) update the property cost component based upon prior reimbursement levels and costs and revise the property cost component upper limit to account for new construction cost information;
(f) establish fiscal year 1994 as a new base period for purposes of calculating ICF/MR reimbursement limits;
(g) implement reimbursement methodology limiting medicaid reimbursement to a facility's private pay rate if the private pay rate is less than the calculated medicaid rate;
(h) modify the methodology to compute the licensed to non-licensed ratio for the patient assessments system by utilizing cost report information rather than survey information;
(i) revise the methodology for interim rates to require a six month cost report from a facility for the retroactive settlement of the interim rate;
(j) incorporate recent federal regulations regarding items and services that are included in the medicaid per diem rate that cannot be charged to the residents personal resources and items and services that are allowed to be charged to residents; and
(k) make miscellaneous clarifications to the department's rules.

The proposed rule changes are necessary to implement legislative funding increases for nursing facility reimbursement for state fiscal year 1994. The 1993 legislature appropriated funds under

House Bill 2 and House Bill 333 for increases in medicaid rates to nursing facilities. House Bill 2, in addition to the base funding for nursing facility reimbursement, appropriated increases for "rebasing" of the nursing facility reimbursement system. House Bill 333 provides additional funding from a provider bed fee for fiscal year 1993 of $2.00 per patient day on all payors.

The funding appropriated by the 1993 legislature results in aggregate fiscal year 1994 reimbursement to nursing facilities in the amount of $74.55 per patient day (PPD) or a total of $105,538,270 of combined state funds, federal funds, and patient contributions. This represents an aggregate increase in reimbursement of $5.01 PPD over the fiscal year 1993 reimbursement level.

The proposed rule changes are necessary to implement rebasing to more current cost report data and to adjust rate formula components, percentages and caps to take into account new base year cost information. The department's rules will provide that fiscal year 1994 rates will be set using 1992 cost report information. As part of the negotiations regarding modification and adoption of the revised rule for 1993, the department agreed to this rebasing. The department proposes to implement this rebase and to continue to use the new reimbursement methodology with modifications to the operating, direct nursing, and property cost components.

For purposes of determining fiscal year 1994 nursing facility reimbursement rates, the department proposes the following modifications to the current methodology. The amendments are necessary to implement 1992 as a new base year to establish reimbursement for fiscal year 1994 rates. The base period will be the provider's medicaid cost report, of at least six months, with a fiscal year ending during calendar year 1992. If no such cost report is available, the facility's most recent cost report for a period which includes at least six months participation by the provider will be used. If no such cost report is available, the provider would receive an interim rate.

The proposed amendments are necessary to specify the combination of components, percentages and caps which take into account the new base year cost information. Because new base year cost information will be used to set rates, the department proposes to adjust the percentage amounts used to set rate limits in the operating and direct nursing components and the rate increase cap. These components, percentages and caps must be set in combination to assure that the reimbursement system and levels of reimbursement furthers the department's goals.

The proposed 1994 reimbursement formula utilizes a methodology which determines indexed bed weighted median cost components for the operating and direct nursing cost components and applies limits at 115% and 130% respectively. The formula also provides

for an operating incentive at 40% of the difference between the provider's indexed cost and the operating cost limit, or 10% of the indexed median operating cost, whichever is lower.

The proposed amendments are necessary to adjust the time period used to compute the medicaid utilization percentage for the reimbursement methodology for nurse aide testing and competency evaluation programs. The medicaid share of costs for such testing and evaluation will continue to be reimbursed through a separate payment system based upon information provided to the department from the testing entity. The department will continue to reimburse the medicaid share of the full cost of testing charged by the testing entity to the facility.

The proposed amendments are necessary to update the property cost component based upon prior reimbursement levels and costs, and revise the property cost component upper limit to account for new construction cost information. The department proposes to modify reimbursement for the property cost component using property reimbursement levels set for 1993 and per diem costs per day as computed from the 1992 medicaid cost reports. This methodology would increase the new construction rate from $9.47 to $9.64. The proposed property reimbursement methodology will provide for rate increases of up to 17¢ per patient day. Provider's will either remain at their 1993 property reimbursement level or receive an increase in property reimbursement up to the lower of their cost per day or 17¢ based upon their 1992 cost reports.

The proposed amendments are necessary to establish fiscal year 1993 as a new base period for purposes of calculating ICF/MR reimbursement limits. The proposed rule is necessary to allow the department to reimburse ICFs/MR for actual allowable costs during fiscal year 1994. It is appropriate that ICF/MR costs be rebased in fiscal year 1994 to take into account increasing and changing costs for these facilities, rather than being subject to a medicare market basket upper limit based upon different operating conditions in prior years.

The proposed amendments are necessary to implement a limit on medicaid reimbursement if a facility's private pay rate is lower than the computed medicaid rate. The amendment would specify that the department will survey nursing facilities to determine the private pay rate effective July 1, 1993. If the private pay rate is less than the computed July 1 rate, per the reimbursement formula, then the facility's medicaid reimbursement is limited to the facility private pay rate for the entire rate year. This proposed rule would implement legislative cost containment amendments included in House Bill 2.

The proposed amendments are necessary to modify the methodology used to compute the licensed to non-licensed ratio. The proposed rules will be changed to use cost reports as the source of information for ratio computations rather than a survey of

providers. This amendment will eliminate the one month survey of wage and hourly information from providers and utilize cost report information that contains 12 months of data.

The proposed amendments would revise the methodology for interim rate settlements to require providers to submit six month cost reports after six months participation in the medicaid program. This six month cost report will be used as the base period cost report to settle the interim rate. This will speed up the settlement process for interim rate providers.

The proposed amendments are necessary to make changes to incorporate regulations contained in the Federal Register, (157 FR 53572 (11/12/92). These changes protect the personal funds of residents by setting forth the items and services that are included in the per diem payment and those for which a facility may charge a resident. These regulations will be implemented July 1, 1993.

The proposed amendments are necessary to make additional minor miscellaneous clarifications and corrections to the department's rules. These changes include changes to patient assessment score (PAS) for a new provider with no patient abstracts to set the PAS at the statewide average

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 May 27, 1993.

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

Dawn Sliva
Rule Reviewer

Russell E. Cater for
Director, Social and Rehabilitation Services

Certified to the Secretary of State April 19, 1993.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

| | | |
|---|---|---|
| In the matter of the proposed adoption of Rules I through IV prohibiting unfair discrimination for previously uninsured personal automobile insurance applicants. | ) ) ) ) | NOTICE OF ADOPTION OF NEW RULES I THROUGH IV (6.6.3301 THROUGH 6.6.3304) |

TO: All Interested Persons.

1. On November 12, 1992, the state auditor and commissioner of insurance of the state of Montana, Montana Insurance Department, published notice of proposed adoption of new Rules I through IV, inclusive, prohibiting unfair discrimination against previously uninsured personal automobile insurance applicants at page 2436 of the 1992 MAR, Issue No. 21.

2. Oral comment was taken at a public hearing on December 2, 1992, at 9:00 a.m., at the east conference room of the Mitchell Building, 126 North Sanders, Helena, Montana. Written comments were received through December 10, 1992. Comments to the proposed rules are summarized below.

3. The agency has adopted new Rules I and II as proposed.

The agency has adopted new Rules III and IV with the following changes (new material is underlined; material to be deleted is interlined);

**RULE III DISCRIMINATION IN DETERMINING ELIGIBILITY FOR INSURANCE PROHIBITED** (1) Except as provided in (1)(a), (1)(b), and (3) below, an insurer shall not reject an applicant for insurance solely on the basis that the applicant cannot or does not demonstrate the existence of prior insurance continuously for the past three years. This section does not prohibit an insurer from rejecting an applicant with no prior insurance ~~if~~under the following circumstances:

(a) ~~t~~The insurer can demonstrate through driving records or other objective means that the applicant has at any time in the immediately prior three years been operating a motor vehicle in violation of any state's compulsory auto insurance laws.

(b) If on the application for coverage the applicant represents that prior insurance existed, but fails to provide to the insurer, or fails to assist the insurer in securing, evidence to establish that the applicant has been insured within the 30-day period prior to the application.

(2) If an insurer has filed with the Montana insurance department multiple pricing programs designed to reflect the risk quality of individual applicants (a "preferred" program for "better than average" risks, a "standard" program and a "sub-standard" program for "worse than average" risks, for example), the insurer shall not deem an applicant to be a "sub-standard" risk (and thus ineligible for the "standard" program) in the absence of supportive evidence in the driving

records of the applicant, or other underwriting criteria that are applied to all applicants for coverage.

(3) Nothing in these rules is intended to require that an applicant with no prior insurance be eligible for an insurer's "preferred" program for "better than average" risks. The insurer may require that such eligibility be "earned" by the policyholder through satisfactory driving records under an insurance policy.

AUTH: 33-1-313, 33-18-102, MCA IMP: 33-18-210, MCA

**RULE IV DISCRIMINATION IN PRICING PROHIBITED**

(1) Except as provided in paragraphs (2) and (3) below, once program eligibility has been established, the existence or non-existence of prior insurance for a policyholder shall not be considered in determining the premium for a policy. The premium charged by an insurer for a policyholder with no prior insurance shall be the same as if the policyholder had prior insurance and was insured in the same program.

(2) An insurer may impose a surcharge in accordance with its filed pricing structure on an insured who has received a citation within the immediately prior three years for driving in violation of any state's mandatory insurance law.

(3) An insurer may impose a surcharge, not to exceed the surcharge permitted in paragraph (2) above, on an insured who in the immediately prior three years has driven in violation of any state's mandatory insurance law but did not receive a citation for such. The surcharge must be in accordance with the insurer's filed pricing structure, and the insurer must maintain in the insured's file evidence sufficient to demonstrate that the insured operated a motor vehicle in violation of a state's mandatory auto insurance law.

AUTH: 33-1-313, 33-18-102, MCA IMP: 33-18-210, MCA

4. At the hearing on these proposed rules, opponents included representatives from three insurers and two insurer organizations. The only proponent present at the hearing was an independent insurance agent. Subsequent to their oral testimony at the hearing, these six entities submitted written comments. Six additional proponents submitted written comments, each identifying personal experiences related to the "no prior insurance" issue, in which they felt they were treated unfairly by an insurer or by insurers.

The agency thoroughly considered all written and oral comments and responds as follows:

COMMENT:

Add to the end of proposed Rule III (2): ". . ., or other underwriting criteria that is applied to all applicants for coverage."

RESPONSE:
This is consistent with the intent of the rule. The change is adopted.

COMMENT:
Amend proposed Rule III(1) to read as follows:
(1) Except as provided in (1)(a), (1)(b), and (3) below, an insurer shall not unfairly discriminate against any applicant on the basis that the applicant can develop no proof of having prior insurance. This section does not prohibit an insurer from rejecting an applicant with no prior insurance under the following circumstances:
(a) The insurer can demonstrate through driving records or other objective means that the applicant has at any time in the immediately prior three years been operating a motor vehicle in violation of any state's compulsory automobile insurance laws.
(b) The applicant fails to provide to the insurer, or fails to assist the insurer in securing, evidence to establish that the applicant has been insured within the 30 day period prior to the application.

RESPONSE:
Rule III addresses eligibility for coverage; Rule IV addresses pricing. The phrase ". . . shall not unfairly discriminate against . . ." relates to either or both. To keep the topic of Rule III clear, the phrase ". . . shall not reject an applicant . . ." is retained, and this portion of the suggested wording is rejected.
However, the inclusion of the provision requiring the applicant's cooperation is reasonable and consistent with the intent of these rules, as is the "30-day period" (since it accommodates monthly, quarterly, semi-annual, or annual prior insurance policies). Proposed Rule III(1) therefore is changed accordingly.

COMMENT:
Loss experience supports a higher rate for previously uninsured drivers than for previously insured drivers. The rules ignore actuarially demonstrated fact. Proposed Rule IV should be deleted.

RESPONSE:
The proposed rules make a clear distinction between two "groups" of applicants for insurance: Those who had no need for insurance in the past, and those who did. For those who did have a need for insurance and were operating a motor vehicle in violation of compulsory auto insurance laws, the rules, as adopted, clearly allow the insurer to take that "moral hazard" into consideration, both in eligibility for coverage and in pricing.
Information provided from the three insurers did not address these two groups separately. No information has been provided which indicates that those who had no prior need for

insurance represent greater risk to the insurer. In fact, if the companies truly treat those with no prior need for insurance differently (stated above), the provided data would likely completely exclude them, and would represent only the group of past applicants with no prior insurance who were driving in violation of state compulsory insurance laws. The information provided thus does not support a conclusion as to whether those with no prior need for insurance represent higher risk to the insurer.

The one proponent who testified at the hearing commented that based on data he provided, the loss experience statistics of previously uninsured drivers do not support the surcharges which have been assessed.

Nevertheless, it is generally recognized within the industry and supported by statistics that those who in fact violate the law present greater risks to insurers. Proposed Rule IV is thus changed to allow insurers to reflect in their pricing structures these demonstrably increased risks.

COMMENT:

The commissioner does not have statutory authority to adopt these rules. Section 33-1-313, MCA, states in part: "No such rule shall extend, modify or conflict with any law of this state or the reasonable implications thereof." The proper procedure is outlined in section 33-18-1003, MCA.

RESPONSE:

In addition to the provision identified above, section 33-1-313, MCA provides: "The commissioner may make reasonable rules necessary for or as an aid to effectuation of any provision of this code." The commissioner has the authority to adopt these rules, which do not extend, modify or conflict with any substantive Montana statutes. Section 33-18-1003, MCA, is a procedural statute, not a substantive statute. The proposed rules are consistent with substantive statutes and reasonably necessary to carry out their intent.

COMMENT:

The proposed rules conflict with statutes relating to uninsured motorist coverage, and with the efforts of a task force of the Attorney General.

RESPONSE:

These rules prohibit insurers from restricting coverage availability only in cases where there is no evidence that the applicant was violating Montana's compulsory auto laws. The above comment relates to individuals driving with no insurance, in violation of Montana's compulsory auto laws. These rules do not mandate any preferred treatment for such persons, as discussed earlier. There is no conflict with uninsured motorist statutes nor the Attorney General's efforts.

COMMENT:
The department has not undertaken any fact finding.

RESPONSE:
This is an incorrect assertion. A letter was sent to all Montana auto insurers on February 1, 1990. An item in that letter stated: "Please provide information in your possession which indicates that the absence of 'prior insurance' legitimately predicts future losses for purposes of classifying risks." Of 140 responses received, only 5 provided such information. In each of those 5 instances, the data included were too sparse or unexplained to be conclusive.

In addition, one of the purposes of the hearing in this matter was to allow concerned parties to present such information. The three insurers in attendance did provide information which has been duly considered.

Finally, several complaints and reports of inappropriate treatment of insurance applicants have been received by the department in the past few years. In addition, six written responses to the notice also alleged inappropriate treatment by insurers of consumers without prior insurance. The insurance department has sufficient cause to conclude that these rules are necessary and appropriate.

COMMENT:
The proposed rules provide a disincentive for complying with the mandatory insurance requirement, or remove an economic disincentive for a driver to remain uninsured. If there is no discrimination between a "law-breaker" who drives without insurance and a person who has been driving as a law abiding citizen, there's no incentive for people to become insured.

RESPONSE:
Under the proposed rules, the insurance-related financial disincentive for uninsured drivers continues to exist, since the rules would allow rejection of such "law-breakers'" applications for coverage, or writing coverage in a sub-standard program, and/or at surcharged rates.

This is not a valid argument for an insurer to make. It is not the function of insurance to provide financial incentives or disincentives for obeying or failing to obey the law. Legal disincentives (fines for citations) perform that function.

COMMENT:
The proposed rules unreasonably restrict underwriting.

RESPONSE:
The department disagrees. Each of the insurer representatives explained how his/her company treats applicants with no prior insurance. The insurers' current underwriting treatments of such applicants (as described at the hearing) do not appear to conflict with these rules as

adopted. Furthermore, there were statements by proponents that refute this contention.

COMMENT:
The proposed rules do not affect all companies equally. More "visible" companies which advertise more may attract more of these applicants than a less aggressive, less visible company.

RESPONSE:
A more visible company should be expected to attract more of all types of applicants. And again, applications for coverage from those who have violated compulsory auto insurance laws can be rejected under these proposed rules.

COMMENT:
"Preferred," "standard," and "sub-standard" are not commonly accepted terms in the industry.

RESPONSE:
The one proponent who testified at the hearing indicated that these terms are generally accepted terms in the industry. He provided a copy of an insurer's "List of Substandard Carriers." He also provided other insurer pages which clearly reference "preferred," "standard," and "sub-standard" insurers. (A "carrier" is an insurer.)
In addition, many personal auto rate filings received by the department use these terms in describing the target market of the program(s) being filed.

COMMENT:
The proposed rules would result in rate increases, because companies would have to accept risks they would normally reject, and the loss expectation of those risks is worse than contemplated by the current pricing structure.

RESPONSE:
This would likely be true if the rules required the acceptance of all previously uninsured drivers, including those who have historically driven in violation of compulsory auto insurance laws. But the rules as adopted clearly distinguish between those who were not required to be insured and those who were. No evidence has been provided to suggest that this target group represents worse loss exposure than contemplated in the current insured marketplace.

COMMENT:
The department should form a committee to work on the final language of the rules.

RESPONSE:
The department believes the proposed rules are clear and enforceable, and that such a committee made up of "special interest" representatives could result in ineffective rules. This suggestion is rejected.

COMMENT:
Applicants should prove that they have been previously insured (if that is their representation) rather than insurers being required to prove they haven't been. Rule III should be interpreted broadly rather than narrowly. An applicant's inability to prove a representation should constitute objective evidence.

RESPONSE:
This concern was partially addressed earlier in the amendment to proposed Rule III(1), where the applicant's cooperation is mandated.

But the burden is on the insurer or its producer to maintain information on file explaining why an applicant was rejected. (This information would be needed in the event of a consumer complaint.) Under these rules, if the insurer concludes ("suspects" is not good enough) that the applicant has been driving in violation of compulsory auto insurance laws, the file should contain information on how that conclusion was arrived at.

Section 33-18-401, MCA, gives the insurer recourse if false or fraudulent statements are knowingly or willfully made on an application for insurance.

COMMENT:
A prior insurance policy would help an insurer in determining whether an applicant is preferred, standard, or sub-standard. "This can provide clues as to the previous company's experience with this driver (i.e., if the driver was in a substandard program there may have been a poor loss history)."

RESPONSE:
The insurer is entitled to ask in the application for insurance about the previous three years of driving experience. If an insurer is using information about the previous carrier as an indication about experience older than three years, the insurer may be violating section 33-16-201(4) and/or 33-18-210(9), MCA.

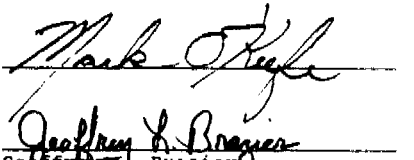
Permissible information can be gathered from the applicant in the insurer's application for insurance (and verified through a previous carrier, if available). Again, section 33-18-401, MCA, is the insurer's recourse if false or fraudulent information is knowingly or willfully provided by the applicant.

COMMENT:
A written comment suggested that in the definition of "prior insurance" (Rule II[1]), "three years" be amended to "30 days."

RESPONSE:
This suggestion is rejected. A 30-day period would be arbitrary and insufficient to disclose a pattern of conduct affecting either the public or the industry.

In addition, the second sentence in proposed Rule III(1) is relevant: "This section does not prohibit an insurer from rejecting an applicant with no prior insurance if the insurer can demonstrate . . . that the applicant has **at any time** in the immediately prior three years been operating a motor vehicle in violation of any state's compulsory automobile insurance laws."

STATE AUDITOR AND
COMMISSIONER OF INSURANCE

By: 

Geoffrey L. Brazier
Rules Reviewer

Certified to the Secretary of State this 16 day of April, 1993.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

| | | |
|---|---|---|
| In the matter of the amendment of Accreditation Standards | ) | NOTICE OF AMENDMENT OF ARM 10.55.601 ACCREDITATION STANDARDS: PROCEDURES |

To: All Interested Persons

1. On December 24, 1992, the Board of Public Education published a notice of proposed amendment concerning ARM 10.55.601 Accreditation Standards: Procedures on pages 2690-2691 of the Montana Administrative Register, issue #24.

2. The board has amended the rule as proposed with the following changes:

10.55.601 ACCREDITATION STANDARDS: PROCEDURES (1) through (2) will remain the same.

(3) Effective on July 1, 1989, schools are required to maintain present programs that meet current standards until such standards are superseded. In addition, schools are expected to maintain current programs that conform to standards which have been adopted but have a delayed effective date.

(4)(a) Effective January 1, 1992, schools unable, for financial reasons, to meet the requirements of ARM 10.55.705 (1)~~(2)~~(d), 10.55.712 (2)(a) or 10.55.904 (4)(h) may file an initial notice of deferral with the office of public instruction.

(4)(b) through (f) will remain the same.

AUTH: Sec. 20-4-114, MCA IMP: Sec. 20-2-121, MCA

3. The board proposed the amendment because the board has determined that under the current rule a number of schools have requested deferral even though the rule was not slated to go into effect for several years in the future. This rule change would prevent schools from applying for deferrals prior to the year in which the rule becomes effective.

Wayne Buchanan
Executive Secretary
Board of Public Education

Certified to the Secretary of State on April 19, 1993.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

| | | |
|---|---|---|
| In the matter of the amendment of Student Assessment | ) ) ) | NOTICE OF AMENDMENT OF ARM 10.56.101 STUDENT ASSESSMENT |

To: All Interested Persons

1. On December 24, 1992, the Board of Public Education published a notice of proposed amendment concerning ARM 10.56.101, Student Assessment on pages 2693-2694 of the Montana Administrative Register, issue #24.

2. The board has amended rule 10.56.101 as proposed.

3. The board proposed this amendment to this rule to address that many schools grade kindergarten through third are multigrade classrooms and therefore may not have identifiable third graders. The rule change would allow testing to begin in fourth grade, which in every case schools would have students identified as fourth graders.

Wayne Buchanan,
Executive Secretary
Board of Public Education

Certified to the Secretary of State April 19, 1993

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

| | | |
|---|---|---|
| In the matter of the amendment of Transportation | ) | NOTICE OF AMENDMENT OF ARM 10.64.301 DEFINITIONS, 10.64.354 BUS CHASSIS, 10.64.355 BUS BODY, 10.64.356 SPECIAL EDUCATION VEHICLE, AND REPEAL OF 10.64.357 LP GAS MOTOR FUEL INSTALLATION, 10.64.601 GENERAL, 10.64.602 APPLICATION, 10.64.603 SPECIAL EQUIPMENT, 10.64.604 INSPECTIONS AND NEW RULES 10.64.341 INTERPRETATIONS, 10.64.342 REPLACEMENT PARTS, 10.64.358 ALTERNATE FUEL POWERED SCHOOL BUSES. |

To: All Interested Persons

1. On March 18, 1993, the Board of Public Education held a hearing on the proposed amendments to ARM 10.64.301 Definitions, 10.64.354 Bus Chassis, 10.64.355 Bus Body, 10.64.356 Special Education Vehicle and Repeal of 10.64.357 LP Gas Motor Fuel Installation, 10.64.601 General, 10.64.602 Application, 10.64.603 Special Equipment, 10.64.604 Inspections and New Rules 10.64.341 Interpretations, 10.64.342 Replacement Parts, 10.64.358 Alternate Fuel Powered School Buses on pages 207-214 of the Montana Administrative Register, issue # 3.

2. The board has amended rule 10.64.301, 10.64.354, 10.64.355, and 10.64.356 and repealed rules 10.64.357, 10.64.601, 10.64.602, 10.64.603, 10.64.604 and adopted new rules 10.64.341, 10.64.342 and 10.64.358 as proposed.

3. The board proposed these amendments, repeals and new rules to update the rules with the current edition of the National Standards for School Buses dated 1990.

Wayne Buchanan,
Executive Secretary
Board of Public Education

Certified to the Secretary of State April 19, 1993

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

| | | |
|---|---|---|
| In the matter of the amendment of rules 46.12.1226 and 46.12.1229 pertaining to nursing facility reimbursement | ) ) ) ) | NOTICE OF THE AMENDMENT OF RULES 46.12.1226 AND 46.12.1229 PERTAINING TO NURSING FACILITY REIMBURSEMENT |

TO: All Interested Persons

1. On January 14, 1993, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.1226 and 46.12.1229 pertaining to nursing facility reimbursement at page 8 of the 1993 Montana Administrative Register, issue number 1.

2. The Department has amended rules 46.12.1226 and 46.12.1229 as proposed.

COMMENT: The nursing facility bed fee is a cost which must be incurred by all Montana nursing facilities and should be fully accounted for in the rate setting process.

RESPONSE: The department agrees that under the proposed amendments, the bed fee costs incurred by facilities would be accounted for fully in the rate setting process.

COMMENT: There is no legal justification for the rate increase cap and it should be eliminated entirely. Raising the overall rate increase cap from $6.00 to $9.00 is a step in the right direction. We applaud the department for agreeing to do so in future rule changes to be effective July 1, 1993.

RESPONSE: The legality of a rate system and the resulting rates cannot be judged solely based upon any single feature of the system. As the department has stated in previous rule proceedings, when viewed together with all other parameters and features of the rate system, the cap is reasonable and results in rates which comply with all legal requirements. We believe the proposed $9.00 cap is an improvement in the system. The proposed rate increase cap of $9.00 will allow more of the facilities' increased costs from 1992 to 1993, including increased bed fee costs, to be reflected in 1993 reimbursement rates. SRS has agreed, contingent upon legislative approval of certain legislation, to remove the rate increase cap entirely beginning in rate year 1994.

COMMENT: The current system is faulty. It rewards inefficiency and penalizes efficient and economic providers. As predicted, the flaws inherent in the design of this methodology have

resulted in total costs far exceeding the amounts which would have been paid under the previous methodology.

RESPONSE: The department disagrees with this comment, and has responded in detail in previous rule notices. The department believes the current system strikes a reasonable balance in recognizing the costs necessary to provide quality patient care, while discouraging unnecessary spending. The previous methodology indeed may have resulted in lower aggregate reimbursement payments, but in the department's view the previous methodology was neither fair nor reasonable. The current system is much better designed to achieve the goals which the department believes are appropriate for a publicly funded payment system.

COMMENT: The proposed changes are essential to approach legality and are an obvious improvement over the original rules. However, the system still fails to meet legal requirements.

RESPONSE: The department believes that the "original" system, prior to the proposed amendments, met all legal requirements. However, the proposed amendments constitute an improvement over that system. The department believes the system as amended by these proposed amendments also meets all legal requirements.

COMMENT: It is obvious that the bed tax is a cost which must be incurred in its entirety. It is difficult to understand why the department chose to ignore 75% of these costs in the current rules. The department ignored its responsibilities and published rules for July 1, 1992 that it clearly knew in advance (or should have known) were illegal under the Boren Amendment. Only after the expenditure of a substantial sum of money and hundreds of hours of effort on providers' part has the department agreed to minimal improvements in order to avoid legal action.

RESPONSE: The department believed and continues to believe that the system as adopted effective July 1, 1992 met all legal requirements. However, the department recognized that the system was not perfect and that it could be improved. The department believes it is preferable to settle disputes by agreement rather than litigation, and accordingly also spent many hours and devoted substantial resources to resolve this dispute.

COMMENT: The rule proposed fails to address other issues such as the wholly inadequate incentive factor, the improperly computed nursing component and property issues.

RESPONSE: The department does not agree that the incentive factor is "wholly inadequate" or that the nursing component is "improperly computed." The department is in the process of

evaluating the current property reimbursement system and reviewing alternatives for possible adoption at a later date.

3. These amendments as adopted will apply retroactively to medicaid nursing facility services provided on or after July 1, 1992. The amendments will not adversely impact any nursing facility. All nursing facilities participating in the medicaid program will receive a per diem rate either equal to or greater than the per diem rate it is receiving under the current rule. Under the current rule, some providers received decreased per diem rates effective August 1, 1992. In the event these amendments would result in a rate for such facilities for the period July 1, 1992 through July 31, 1992 which is less than the rate in effect on June 30, 1992, then these amendments would apply for such facilities for nursing facility services provided on or after August 1, 1992 and the rules in effect on June 30, 1992 will apply for the month of July 1992. Retroactive application of these amendments is necessary to correct an alleged flaw in the reimbursement methodology which affects the entire 1993 rate year.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State April 19, 1993.

VOLUME NO. 45 OPINION NO. 3

ADMINISTRATIVE LAW AND PROCEDURE - Adoption of rules consistent with legislative goals;
BUILDING CODES - State building codes: application to multiunit condominiums, rental cabins and extended motels, and lodging houses;
BUILDING CODES - State building codes: exclusion of small residential facilities and day-care homes;
COMMERCE, DEPARTMENT OF - Health and safety regulations: inclusion of state building codes;
COMMERCE, DEPARTMENT OF - State building codes: application to multiunit condominiums, rental cabins and extended motels, and lodging houses;
ADMINISTRATIVE RULES OF MONTANA - Sections 8.70.101, 8.70.105;
MONTANA CODE ANNOTATED - Sections 50-60-102, 50-60-201, 50-60-203, 76-2-412.

HELD: 1. MCA § 50-60-102(1) does not require the exclusion from state building code compliance of multiunit condominiums which utilize "area separation walls," rental cabins and extended motel units which contain cooking units, or lodging houses, including bed and breakfast establishments.

2. MCA § 76-2-412(3) excludes from state building code compliance community residential facilities serving eight or fewer persons or day-care homes serving twelve or fewer children.

April 8, 1993

Mr. Jon Noel
Director
Department of Commerce
1424 Ninth Avenue
Helena, MT 59620-0501

Dear Mr. Noel:

Your predecessor as director of the Department of Commerce requested my opinion on the following questions:

1. Does MCA § 50-60-102(1) prohibit the Building Codes Bureau of the Department of Commerce from enforcing the state building codes in the construction of:

   a. condominiums or other such structures which contain five or more dwelling units but which utilize "area separation walls";

b. rental cabins and extended motels which contain cooking units;

c. lodging houses, including bed and breakfast establishments?

2. Does MCA § 76-2-412(3) prohibit the application of state building codes to community residential facilities serving eight or fewer persons or day-care homes serving twelve or fewer children?

MCA § 50-60-102, which defines the application of the state building codes, provides in part:

(1) The state building codes do not apply to:

(a) residential buildings containing less than five dwelling units[.]

The Department of Commerce [hereinafter "Department"] has adopted by rule the Uniform Building Code [UBC] and the Uniform Mechanical Code [UMC]. Mont. Admin. R. 8.70.101 and 8.70.105. By applying certain definitions from the UBC to MCA § 50-60-102(1), the Department has determined that multiunit condominiums which utilize "area separation walls," rental cabins and extended motel units with cooking facilities, and lodging houses, including bed and breakfast establishments, are excluded from the coverage of the state building code by the broad language of MCA § 50-60-102. The request for an opinion has advised me that the Department based its decision on the belief that it is mandated by the broad exclusionary language of MCA § 50-60-102(1). The Department has asked my opinion whether that interpretation is correct.

While the adoption and application of UBC definitions and the resulting interpretation that such buildings are excluded from application of the state building code may be an appropriate discretionary determination pursuant to the authority contained in MCA § 50-60-102(4), I cannot agree that the language of MCA § 50-60-102(1) mandates the exclusion of these buildings.

The plain language of MCA § 50-60-102(1) excludes residential buildings containing less than five dwelling units. The Department, by referring to specific provisions of the UBC, has interpreted the phrase "residential buildings containing less than five dwelling units" to mean a building containing five or more condominium units which utilize "area separation walls," rental cabins and motel units which contain cooking facilities, and lodging houses.

Under UBC § 505, "area separation walls" permit each portion of a building separated by one or more such walls to be considered a separate building. "Dwelling unit," as defined in UBC § 405, is any building or portion thereof which contains living

facilities, including the provisions for sleeping, eating, cooking and sanitation, for not more than one family. A "lodging house" is defined as any building or portion thereof containing not more than five guest rooms where rent is paid in money, goods, labor or otherwise. UBC § 413. By using these definitions adopted from the UBC to construe state law, the Department has concluded that MCA § 50-60-102(1) prohibits the Department from applying the state building codes to these structures.

I conclude that, although the Department's own rules adopting these UBC definitions lead to this interpretation, MCA § 50-60-102, when read in its entirety, does not by itself require such a restrictive interpretation. When the Legislature established the state building construction standards, it pronounced:

> It is essential that building codes be adopted and enforced to protect the health and safety of the residents of this state[.]

1969 Mont. Laws, ch. 366, § 4. Additionally, the appropriate state agency is to administer the act so as to "effectuate the purposes of this act and enforce the orders by all appropriate administrative and judicial proceedings." See 1969 Mont. Laws, ch. 366, § 6.

In order to determine the proper scope of the exclusionary language found in MCA § 50-60-102(1) it is necessary to read the statute as a whole. Sutherland Statutory Construction § 46.05 (5th ed. 1992). Subsection (4) of MCA § 50-60-102 provides:

> The department may limit the application of any rule or portion of the state building code to include or exclude:
>
> (a) specified classes or types of buildings according to use or other distinctions as may make differentiation or separate classification or regulation necessary, proper, or desirable[.]

This broad discretionary authority was granted to the Department to carry out the legislative goals enunciated in MCA § 50-60-201.

Prior to amendment in 1981 of MCA § 50-60-102 the state building codes applied only to buildings which were considered public places. Some confusion arose over whether apartment buildings should be considered public places. The Department of Administration, which enforced the state building codes at that time, sought legislative reform to clarify the definition of "public places." That reform resulted in the present language of MCA § 50-60-102.

The request for an opinion indicates that the Department's present interpretation of MCA § 50-60-102, which derives from application of the UBC definitions, can produce absurd enforcement situations and/or dangerous circumstances. For example, motel cabins which normally fall within the enforcement provisions of the state building code are exempted from enforcement when they are equipped with cooking facilities. Although this circumstance should call for greater regulation, these motel units are excluded from regulation altogether under the Department's current interpretation.

Nothing in the plain language of MCA § 50-60-102 or its legislative history requires adoption of a construction which leads to absurd results. There may be a number of reasonable interpretations, one of which is that the Legislature intended by the enactment of MCA § 50-60-102(1) to exempt from building code compliance only those buildings intended for noncommercial purposes. If, in the Department's opinion, a restrictive reading of MCA § 50-60-102(1) does not further the legislative goals but effectively advances the very evils sought to be remedied by the building construction standards, then such an interpretation should be avoided. See Sutherland Statutory Construction § 65.03 (5th ed. 1992). The fact that one of several alternative interpretations produces unreasonable results is sufficient basis for rejecting that alternative. Johnson v. Marias River Elec. Coop., Inc., 211 Mont. 518, 524, 687 P.2d 668, 671 (1984); Sutherland Statutory Construction § 45.12 (5th ed. 1992). The Department may thus adopt other definitions by its rulemaking authority which would more reasonably satisfy and promote the purposes of the state building codes. See also MCA § 50-60-203 (authority of Department to make rules, to adopt nationally recognized building codes, such as UBC, in whole or in part and to adopt rules more stringent than those in the UBC).

Therefore, I believe the Department is not bound by the language of MCA § 50-60-102 to exclude such buildings from code compliance. The Department could, by rulemaking, clarify that its adoption of certain UBC provisions does not exclude application of the state building code to these structures.

The second question posed by the Department's opinion request concerns the proper interpretation of MCA § 76-2-412(3) which provides in relevant part:

> Any safety or sanitary regulation of the department or any other agency of the state or a political subdivision thereof which is not applicable to residential occupancies in general may not be applied to a community residential facility serving eight or fewer persons or to a day-care home serving 12 or fewer children.

The Department has concluded that because the state building codes do not apply to residential buildings containing less than five dwelling units under MCA § 50-60-102(1) they are not applicable to small community residential and day-care facilities.

In 1974, the Legislature enacted House Bill 686 which supplied the pertinent exclusionary language in MCA § 76-2-412(3). The legislative history discloses that the imposition of health and safety regulations on smaller home-care facilities was inconsistent with the intent to retain an atmosphere of traditional family homes. The statute was amended in 1974 with the clear purpose of having these facilities treated simply as residential occupancies and excluding them from all safety or sanitary regulations which did not apply to residential occupancies. The statutory language is clear in expressly exempting these facilities from health and safety regulations, which include state building codes. Thus, any attempt to apply the state building codes to such facilities would be contrary to the plain language of the statute.

Based on the clear language of the statute, I conclude that the Legislature intended by this enactment to exclude smaller home-care and day-care facilities from compliance with all state building regulations which are not applicable to residential occupancies.

THEREFORE, IT IS MY OPINION:

1. MCA § 50-60-102(1) does not require the exclusion from state building code compliance of multiunit condominiums which utilize "area separation walls," rental cabins and extended motel units which contain cooking units, or lodging houses, including bed and breakfast establishments.

2. MCA 76-2-412(3) excludes from state building code compliance community residential facilities serving eight or fewer persons or day-care homes serving twelve or fewer children.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/dh

VOLUME NO. 45 OPINION NO. 4

CITIES AND TOWNS - Authority to assess fee for fire hydrant water service provided to rural improvement district;
COSTS - Authority of municipality to assess fee for fire hydrant water service provided to rural improvement district;
COUNTIES - Authority of municipality to assess fee for fire hydrant water service provided to rural improvement district;
COUNTIES - Authority to charge rural improvement district maintenance fund with fee assessed by municipality for fire hydrant water service;
FEES - Authority of county to charge rural improvement district maintenance fund with fee assessed by municipality for fire hydrant water service;
RURAL SPECIAL IMPROVEMENT DISTRICT - Authority of municipality to assess fee for fire hydrant water service provided to;
RURAL SPECIAL IMPROVEMENT DISTRICT - Authority to charge maintenance fund with fee assessed by municipality for fire hydrant water service;
MONTANA CODE ANNOTATED - Sections 7-12-2102(1), 7-12-2161(2), 7-12-2162, 7-12-4102(d)(iii)-(iv), 7-13-4305, 7-13-4311, 7-13-4312, 69-7-201.

HELD: 1. When a rural improvement district requests that a municipal water utility provide water service to fire hydrants owned by the district, the municipality is authorized to provide that service and assess a charge for it.

2. Payment of a fire hydrant fee charged to a rural improvement district for provision of water to hydrants owned by the rural improvement district may be made from the district's maintenance fund.

April 12, 1993

Mr. Dennis Paxinos
Yellowstone County Attorney
P.O. Box 35025
Billings, MT 59107-5025

Dear Mr. Paxinos:

You have requested my opinion concerning two questions which I have rephrased as follows:

1. May a municipal water utility assess an annual fire hydrant fee for supplying water to fire hydrants outside the city limits which are owned by a rural improvement district?

2. If the city may assess such a charge, may the payment be made from the rural improvement district's maintenance fund?

A number of rural improvement districts [RID's] have been formed in Yellowstone County [the County] which obtain water for fire hydrants from the City of Billings Public Utility Department [the City]. The RID's, which own the hydrants, have requested the water service from the City, for which the City assesses a fixed, annual "fire hydrant water service fee" in accordance with a fee schedule set by the Billings City Council. You have also mentioned that the County's board of commissioners has established a fire service area denoted the Billings Urban Fire Service Area (BUFSA), which has contracted with the City to provide various fire protection services. All of the RID's lie within the BUFSA boundary and outside the Billings city limits. Although the BUFSA contract particularly denotes the services to be provided by the City, water service to fire hydrants owned by the RID's is not specifically mentioned.

The County's position is that the City may not assess a fire hydrant water service fee in addition to the annual fee paid the City under the BUFSA contract, and the City maintains that there was never any intention that it would provide a fire hydrant water service under the BUFSA contract.

I cannot address the issue of whether the contract allows the City to assess this fee, because it would require me to resolve disputed issues of fact relating to the intention of the parties to the contract. However, in the interest of providing some guidance regarding the issues raised, I have addressed your remaining questions as rephrased above.

A city that operates a municipal water system is empowered to furnish water to "any person, factory, or other industry located outside the corporate limits of such city or town." MCA § 7-13-4311. MCA § 7-13-4312 further provides:

> The city council of any city within Montana that owns and operates a municipal water system and/or a municipal sewer system to furnish water and sewer services to the inhabitants of such city as a public utility shall, in addition to all other powers, have power to furnish water from such water system and sewage services from such sewer system to the inhabitants or to any person, factory, industry, or producer of farm or other products located outside of the corporate limits of such city at reasonable rates filed by the city or town council and approved, when otherwise required by statute, by the public service commission. Such city council is further empowered to make collections for furnishing water and sewer services in the same manner as collections are made within the corporate limits.

MCA § 7-13-4305 provides that no person, firm, or corporation may use a municipal water system "unless they pay the full and established rate for said service." Finally, MCA § 69-7-201 requires a municipal utility to adopt rules governing the rates for utility service, and the extension of service to users "outside the municipal boundaries." I conclude that when an RID requests that a municipal water utility provide water service to fire hydrants owned by the RID, the municipality is authorized to provide that service and to assess a charge for it.

Your second question is whether the RID may pay out of its maintenance fund a fire hydrant fee assessed when it uses a municipal water service to supply water to its fire hydrants. The Legislature has provided that an RID may be created for the purpose of constructing water mains and hydrants. MCA §§ 7-12-2102(1) and -4102(d)(iii)-(iv). The board of commissioners must levy an assessment against property holders in the RID "equal to the whole cost of maintaining, preserving, or repairing ... improvements within the district." MCA § 7-12-2161(2). Money collected from the assessment must be deposited in the RID's maintenance fund, and may be used "to defray the expense of maintenance, preservation, or repair of said improvements and for no other purpose." MCA § 7-12-2162. You have suggested that a fee for supplying the RID hydrants with water could not be paid out of the RID's maintenance fund because such a fee does not constitute "maintenance, preservation, or repair" of the fire hydrant improvements.

I have been unable to locate any Montana cases or Attorney General's Opinions which construe the phrase "maintenance, preservation, or repair" as used in this statute. However, while the statute does not define the term "maintenance," rules of statutory construction dictate that the term must not be construed in isolation, particularly when to do so would lead to an absurd result.

> "[T]he cardinal principle of statutory construction is that the intent of the legislature is controlling." In construing legislative intent, statutes must be read and considered in their entirety and legislative intent may not be gained from the wording of any one particular section or sentence, but only from a consideration of the whole. It is out [sic] duty to interpret individual sections of an act in such a manner as to insure coordination with the other sections of the act.

State v. Meader, 184 Mont. 32, 36-37, 601 P.2d 386, 388-89 (1979) (citations omitted); accord State v. Magnuson, 210 Mont. 401, 408, 682 P.2d 1365, 1369 (1984) (legislation must be read as whole in ascertaining legislative intent). In applying this rule of construction, every effort should be made to secure a

reasonable construction and to avoid absurd results. McClanahan v. Smith, 186 Mont. 56, 61, 606 P.2d 507, 510 (1980) (when there is doubt about meaning of phrase in statute, phrase must be given reasonable construction in harmony with entire statute); Dover Ranch v. County of Yellowstone, 187 Mont. 276, 283, 609 P.2d 711, 715 (1980) (statute must be read as whole and construed to avoid absurd results). Thus, "[a] statute will not be interpreted to defeat its object or purpose, and the objects sought to be achieved by the legislature are of prime consideration in interpreting it." Dover Ranch, 187 Mont. at 284, 609 P.2d at 715.

As noted above, the Legislature has granted counties the power to create RID's outside of incorporated cities and towns for the purpose of acquiring and constructing certain improvements "in the public interest," including the construction of water mains and hydrants. MCA §§ 7-12-2102(1) and -4102(d)(iii)-(iv). Maintenance, preservation and repair of such improvements are paid for from the RID maintenance fund. Construing the term "maintenance" in MCA § 7-12-2162 as precluding payment for the cost of providing water to hydrants constructed under authority of these statutes would lead to an absurd result: fire hydrants without a supply of water.

The Supreme Court of California reached a similar conclusion in Roberts v. City of Los Angeles, 61 P.2d 323, 324 (Cal. 1936), an analogous case that involved construction of the title of a bill permitting municipalities to establish and maintain an electric street lighting system, and to assess a tax on the property benefited. The bill title provided in pertinent part:

> An act to provide for the acquisition, installation, construction, reconstruction, extension, repair and maintenance by municipalities of waterworks, electric power works, gas works, lighting works, and other public works and utilities; for the assessment of the cost and expenses thereof upon the property benefited; and for the issue of improvement bonds[.]

61 P.2d at 324. Since the bill title did not refer to furnishing power to the electric lighting system, the issue before the court was whether the bill title contemplated the provision of electric current to the system. In concluding that the provision of electricity was within the bill's scope, the court stated:

> The only logical inference that can flow from the language of the title is that the production and furnishing of electric current was one of the main objects and purposes conferred on cities by the Legislature. The construction of an electric power works with no purpose or means of furnishing light would be as void of rationality as would the building of a reservoir storage system without providing any

> means of supplying it with water, or a locomotive without providing any means of generating steam. Reading the words "acquisition," "installation," "construction," "extension," "repair," and "maintenance," with the context of the title itself, it would seem that there can be no doubt but that the title of the act contemplated the operation of lighting works and the furnishing of electric current by that means. If this is not so, there would be no occasion to repair anything and there would be nothing of a useful character to maintain.

61 P.2d at 327.

When the applicable Montana statutes are read together, a reasonable construction is that the Legislature intended the term "maintenance" in MCA § 7-12-2162 to include provision of a supply of water to the hydrants so that they would actually constitute improvements in the public interest. I therefore conclude that the payment of a fire hydrant fee charged to an RID for provision of water to hydrants owned by the RID may be made from the rural improvement district's maintenance fund.

THEREFORE, IT IS MY OPINION:

1. When a rural improvement district requests that a municipal water utility provide water service to fire hydrants owned by the district, the municipality is authorized to provide that service and assess a charge for it.

2. Payment of a fire hydrant fee charged to a rural improvement district for provision of water to hydrants owned by the rural improvement district may be made from the district's maintenance fund.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/mlr

## 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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## BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, directs that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 2-15-108, MCA is that the Secretary of State publish monthly in the *Montana Administrative Register* a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments made in March, 1993, are published. Vacancies scheduled to appear from May 1, 1993, through July 31, 1993, are also listed, as are current recent vacancies due to resignations or other reasons.

Individuals interested in serving on a new board should refer to the bill that created the board for details about the number of members to be appointed and qualifications necessary.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

**IMPORTANT**

Membership on boards and commissions changes constantly. The following lists are current as of April 6, 1993.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Board of Aeronautics** (Transportation) | | | |
| Mr. Byron Bayers | Governor | Gipe | 3/9/1993 |
| Twin Bridges | | | 1/1/1997 |
| Qualifications (if required): represents County Commissioners Association | | | |
| Mr. Fred Booth | Governor | Pederson | 3/9/1993 |
| Highwood | | | 1/1/1997 |
| Qualifications (if required): represents Montana Pilots' Association | | | |
| Mr. Ronald S. Mercer | Governor | Attwood | 3/9/1993 |
| Helena | | | 1/1/1997 |
| Qualifications (if required): represents Montana Airport Management Association | | | |
| **Board of Dentistry** (Commerce) | | | |
| Ms. Lisa Hinebaugh | Governor | Amsberry | 3/29/1993 |
| Chinook | | | 3/29/1997 |
| Qualifications (if required): public member | | | |
| Dr. Donald O. Nordstrom | Governor | Noonan | 3/29/1993 |
| Missoula | | | 3/29/1998 |
| Qualifications (if required): dentist | | | |
| Mr. Jack Traxler | Governor | Amsberry | 3/29/1993 |
| Missoula | | | 3/29/1997 |
| Qualifications (if required): senior citizen slot as public member | | | |
| **Board of Health and Environmental Sciences** (Health and Environmental Sciences) | | | |
| Dr. Lorette I. Meske | Governor | Reynolds | 3/11/1993 |
| Helena | | | 1/1/1997 |
| Qualifications (if required): doctor licensed by board of medical examiners | | | |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Board of Livestock** (Livestock) | | | |
| Mr. Leonard Grove | Governor | reappointed | 3/1/1993 |
| Judith Gap | | | 3/1/1997 |
| Qualifications (if required): sheep producer | | | |
| Mr. Jerry E. Leep | Governor | reappointed | 3/1/1993 |
| Amsterdam | | | 3/1/1997 |
| Qualifications (if required): represents dairy and poultry producers | | | |
| Mr. Jack Salmond | Governor | reappointed | 3/1/1993 |
| Choteau | | | 0/0/0 |
| Qualifications (if required): none specified | | | |
| **Board of Passenger Tramway Safety** (Commerce) | | | |
| Mr. Merv Ericksson | Governor | Muchmore | 3/24/1993 |
| Missoula | | | 1/1/1995 |
| Qualifications (if required): employee from U.S. Forest Service working in field | | | |
| **Board of Personnel Appeals** (Labor and Industry) | | | |
| Mr. Steven R. Henry | Governor | Kapinos | 3/26/1993 |
| Billings | | | 1/1/1997 |
| Qualifications (if required): represents labor | | | |
| Ms. Doris M. Poppler | Governor | O'Neil | 3/26/1993 |
| Billings | | | 1/1/1997 |
| Qualifications (if required): represents management | | | |
| Mr. Thomas Schneider | Governor | Schneckloth | 3/26/1993 |
| Helena | | | 1/1/1997 |
| Qualifications (if required): represents labor | | | |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Board of Personnel Appeals** (Labor and Industry) cont. | | | |
| Mr. Brad Talcott | Governor | Poore | 3/26/1993 |
| Great Falls | | | 1/1/1997 |
| Qualifications (if required): represents general labor-management | | | |
| **Board of Social Work Examiners and Professional Counselors** (Commerce) | | | |
| Mr. C. James Armstrong | Governor | reappointed | 3/3/1993 |
| Fort Harrison | | | 1/1/1997 |
| Qualifications (if required): licensed professional social worker | | | |
| Mr. Ervin Booth | Governor | reappointed | 3/3/1993 |
| Roundup | | | 1/1/1997 |
| Qualifications (if required): licensed professional counselor | | | |
| Ms. Mary Meis | Governor | reappointed | 3/3/1993 |
| Conrad | | | 1/1/1997 |
| Qualifications (if required): licensed professional social worker | | | |
| Mr. Patrick Wolberd | Governor | reappointed | 3/3/1993 |
| Billings | | | 1/1/1997 |
| Qualifications (if required): licensed professional social worker | | | |
| **Children's Trust Fund Board** (Family Services) | | | |
| Mr. Kirk Astroth | Governor | Males | 3/30/1993 |
| Belgrade | | | 1/1/1995 |
| Qualifications (if required): state gov. agency involved in educat. & social work w/kids | | | |
| **Coal Board** (Commerce) | | | |
| Mr. Roger Knapp | Governor | Fletcher | 3/12/1993 |
| Hysham | | | 1/1/1997 |
| Qualifications (if required): resides in impact area | | | |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Developmental Disabilities Planning and Advisory Council** (Social and Rehabilitation Services) | | | |
| Dr. Richard Offner<br>Missoula<br>Qualifications (if required): represents university program | Governor | reappointed | 3/1/1993<br>1/1/1996 |
| Mr. Bob Anderson<br>Helena<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Mr. Steve Clincher<br>Poplar<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Mr. Randy Cochran<br>Billings<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Ms. Mary Lynn Donnelly<br>Helena<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Mr. Al Donohue<br>Great Falls<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Mr. Cary Lund<br>Helena<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| Ms. Florence Massey<br>Billings<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Developmental Disablilites Planning and Advisory Council** (Social and Rehabilitation Services) cont. | | | |
| Mr. James W. Royan<br>Missoula<br>Qualifications (if required): represents Region III and a consumer | Governor | Bradford | 3/3/1993<br>1/1/1997 |
| **Family Support Services Advisory Council** (Social and Rehabilitation Services) | | | |
| Ms. Laurie DeLong<br>Helena<br>Qualifications (if required): public member | Governor | Freeman | 3/11/1993<br>9/9/1994 |
| Mr. John Holbrook<br>Helena<br>Qualifications (if required): public member | Governor | Bandy | 3/11/1993<br>9/9/1994 |
| Mr. Bill Prickett<br>Great Falls<br>Qualifications (if required): public member | Governor | new position | 3/11/1993<br>9/9/1994 |
| Ms. Barbara Stefanic<br>Laurel<br>Qualifications (if required): public member | Governor | new position | 3/11/1993<br>9/9/1994 |
| **Hard-rock Mining Impact Board** (Commerce) | | | |
| Mr. Dick Heineman<br>Wibaux<br>Qualifications (if required): county commissioner | Governor | McCauley | 3/30/1993<br>1/1/1997 |
| Ms. Carol Kienenberger<br>Malta<br>Qualifications (if required): represents major financial institution in Montana | Governor | Calahan | 3/30/1993<br>1/1/1997 |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Hard-rock Mining Impact Board** (Commerce) cont. | | | |
| Mr. Roger W. Korndor | Governor | Calahan | 3/30/1993 |
| Lincoln | | | 1/1/1997 |
| Qualifications (if required): represents major financial instituion in Montana | | | |
| Mr. James McCauley | Governor | Young | 3/30/1993 |
| Boulder | | | 1/1/1997 |
| Qualifications (if required): public member residing in an impact area | | | |
| **Petroleum Tank Release Compensation Board** (Health and Environmental Sciences) | | | |
| Mr. Richard Levandowski | Governor | Blehm | 3/12/1993 |
| Helena | | | 3/12/1996 |
| Qualifications (if required): represents Fire Prevention and Investigation Bureau | | | |
| Mr. Robert J. Robinson | Governor | Iverson | 3/12/1993 |
| Helena | | | 3/12/1996 |
| Qualifications (if required): Director of Department of Health and Environmental Sciences | | | |
| Mr. Dean South | Governor | Audit | 3/12/1993 |
| Helena | | | 3/12/1996 |
| Qualifications (if required): represents petroleum services industry | | | |
| **Social and Rehabilitation Appeals Board** (Social and Rehabilitation Services) | | | |
| Ms. Gloria Paladichuk | Governor | Frey | 3/30/1993 |
| Sidney | | | 1/1/1997 |
| Qualifications (if required): public member | | | |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **State Advisory Council of Food and Nutrition** (Health and Environmental Sciences) | | | |
| Ms. Freida Hicks | Governor | Thompson | 3/16/1993 |
| Helena | | | 8/30/1993 |
| Qualifications (if required): represents Montana Food Stamp Program | | | |
| Ms. Annette Sutherland | Governor | Templer | 3/16/1993 |
| Box Elder | | | 8/30/1993 |
| Qualifications (if required): represents Elder Nutrition Program | | | |
| **State Tax Appeal Board** (Administration) | | | |
| Mr. Patrick E. McKelvey | Governor | reappointed | 3/1/1993 |
| Helena | | | 3/1/1999 |
| Qualifications (if required): none specified | | | |
| **Youth Justice Advisory Council** (Justice) | | | |
| Mr. Craig Anderson | Governor | not listed | 3/1/1993 |
| Glendive | | | 3/1/1995 |
| Qualifications (if required): none specified | | | |
| Ms. Diane G. Barz | Governor | not listed | 3/1/1993 |
| Billings | | | 3/1/1995 |
| Qualifications (if required): none specified | | | |
| Mr. Randy H. Bellingham | Governor | not listed | 3/1/1993 |
| Billings | | | 3/1/1995 |
| Qualifications (if required): none specified | | | |
| Mr. Al Davis | Governor | not listed | 3/1/1993 |
| Helena | | | 3/1/1995 |
| Qualifications (if required): none specified | | | |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Youth Justice Advisory Council** (Justice) cont. | | | |
| Mr. Rick Day<br>Helena<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Ms. Gail Gray<br>Helena<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. Allen Horsfall<br>Hamilton<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. Henry Hudson<br>Clancy<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Rep. Royal Johnson<br>Billings<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. Ted O. Lympus<br>Kalispell<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Ms. Jeannette Manning<br>Helena<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Ms. Kate Mrgudic<br>Missoula<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |

## BOARD AND COUNCIL APPOINTEES: MARCH, 1993

| Appointee | Appointed by | Succeeds | Appointment/End Date |
|---|---|---|---|
| **Youth Justice Advisory Council** (Justice) cont. | | | |
| Mr. Steve P. Nelson<br>Bozeman<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. Kim Olson<br>Bozeman<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. David Pope<br>Bozeman<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Mr. Gary Racine<br>Browning<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |
| Ms. Sally Stansberry<br>Missoula<br>Qualifications (if required): none specified | Governor | not listed | 3/1/1993<br>3/1/1995 |

## VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Aging Advisory Council** (Governor) | | |
| Ms. Dorothea C. Neath, Helena | Governor | 7/18/1993 |
| Qualifications (if required): member from Region IV | | |
| Ms. Pauline Nikolaisen, Kalispell | Governor | 7/18/1993 |
| Qualifications (if required): member from Region IV | | |
| Ms. Mary Alice Rehbein, Lambert | Governor | 7/18/1993 |
| Qualifications (if required): member from Region I | | |
| **Agriculture Development Council** (Agriculture) | | |
| Ms. Julie Burke, Glasgow | Governor | 7/1/1993 |
| Qualifications (if required): active in agriculture | | |
| Mr. John W. Morse Jr., Dillon | Governor | 7/1/1993 |
| Qualifications (if required): active in agriculture | | |
| Mr. John Swanz, Judith Gap | Governor | 7/1/1993 |
| Qualifications (if required): active in agriculture | | |
| **Alfalfa Leaf Cutting Bee Advisory Council** (Agriculture) | | |
| Mr. Tim Wetstein, Joliet | Governor | 7/1/1993 |
| Qualifications (if required): member of alfalfa seed growers | | |
| **American Indian Monument and Tribal Circle of Flags** (Commerce) | | |
| Mr. Deane Blanton, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represents Department of Administration, Architecture & Engineering Division | | |
| Rep. Floyd "Bob" Gervais, Browning | Governor | 6/30/1993 |
| Qualifications (if required): represents Blackfeet Tribe | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **American Indian Monument and Tribal Circle of Flags** (Commerce) cont. | | |
| Mr. James King, Sr., Lame Deer | Governor | 6/30/1993 |
| Qualifications (if required): represents Northern Cheyenne Tribe | | |
| Mr. Warren Matte, Harlem | Governor | 6/30/1993 |
| Qualifications (if required): represents Gros Ventre & Assiniboine Tribes | | |
| Mr. Dave Schwab, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represents Montana Historical Society | | |
| Mr. Caleb Shields, Poplar | Governor | 6/30/1993 |
| Qualifications (if required): represents Assiniboine and Sioux Tribes | | |
| Ms. Nelvette Siemion, Crow Agency | Governor | 6/30/1993 |
| Qualifications (if required): represents Crow Tribe | | |
| Mr. Duncan Standing Rock, Sr., Box Elder | Governor | 6/30/1993 |
| Qualifications (if required): represents Chippewa-Cree Tribe | | |
| Mr. Nicholas Peterson Vrooman, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represents Montana Arts Council | | |
| Mr. Tim Zimmerman, Havre | Governor | 6/30/1993 |
| Qualifications (if required): represents Little Shell Tribe | | |
| **Board of Banking** (Commerce) | | |
| Mr. C. David Bliss, Conrad | Governor | 7/1/1993 |
| Qualifications (if required): public member | | |
| Mr. Jack Hensley, Kalispell | Governor | 7/1/1993 |
| Qualifications (if required): officer of state bank | | |

## VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Board of Barbers** (Commerce) | | |
| Sergeant James Thul, Great Falls<br>Qualifications (if required): barber | Governor | 7/1/1993 |
| Mr. Robert L. "Lanny" White, Townsend<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| **Board of Cosmetologists** (Commerce) | | |
| Ms. Janet Markle, Glasgow<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| Mr. Scott Stekly, Great Falls<br>Qualifications (if required): 1 of 3 licensed cosmetologists | Governor | 7/1/1993 |
| **Board of Directors, Montana Self Insurers Guaranty Fund** (Administration) | | |
| Mr. Charles J. Gilder, Butte<br>Qualifications (if required): none specified | Governor | 7/1/1993 |
| Mr. Donald E. Jenkins, Great Falls<br>Qualifications (if required): none specified | Governor | 7/1/1993 |
| Mr. Donald Mizner, Missoula<br>Qualifications (if required): none specified | Governor | 7/1/1993 |
| **Board of Hearing Aid Dispensers** (Commerce) | | |
| Mr. Ben Havdahl, Helena<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| Mr. Walter Hopkins, Great Falls<br>Qualifications (if required): hearing aid dispenser | Governor | 7/1/1993 |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Board of Landscape Architects** (Commerce) | | |
| Mr. Bruce F. Lutz, Kalispell | Governor | 7/1/1993 |
| Qualifications (if required): licensed landscape architect | | |
| Mr. Tom Selstad, Great Falls | Governor | 7/1/1993 |
| Qualifications (if required): public member | | |
| **Board of Morticians** (Commerce) | | |
| Mr. John Patrick Hoffman, Havre | Governor | 7/1/1993 |
| Qualifications (if required): licensed mortician | | |
| **Board of Nursing** (Commerce) | | |
| Ms. Elizabeth Campo, Great Falls | Governor | 7/1/1993 |
| Qualifications (if required): 1 of 4 registered professional nurses | | |
| **Board of Nursing Home Administrators** (Commerce) | | |
| Mr. Ronald Borgman, Columbus | Governor | 5/28/1993 |
| Qualifications (if required): nursing home administrator | | |
| **Board of Pharmacy** (Commerce) | | |
| Ms. Diana M. Pennell, Lewistown | Governor | 7/1/1993 |
| Qualifications (if required): public member | | |
| **Board of Physical Therapy Examiners** (Commerce) | | |
| Ms. Joyce Dougan, Missoula | Governor | 7/1/1993 |
| Qualifications (if required): physical therapist | | |
| **Board of Public Accountants** (Commerce) | | |
| Mr. Marvin Stephens, Lewistown | Governor | 7/1/1993 |
| Qualifications (if required): certified public accountant | | |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Board of Radiologic Technologists** (Commerce) | | |
| Ms. Robin Anderson, Bozeman | Governor | 7/1/1993 |
| Qualifications (if required): radiologic technologist | | |
| Ms. Debra Metz, Big Arm | Governor | 7/1/1993 |
| Qualifications (if required): public member | | |
| Ms. Debbie Sanford, Lewistown | Governor | 7/1/1993 |
| Qualifications (if required): limited permit radiologic technologist | | |
| Dr. J.D. "Jerry" Wolf, Billings | Governor | 7/1/1993 |
| Qualifications (if required): medical doctor | | |
| **Board of Real Estate Appraisers** (Commerce) | | |
| Mr. Patrick Asay, Cardwell | Governor | 5/1/1993 |
| Qualifications (if required): appraiser represent Internat'l Right-of-Way Association | | |
| **Board of Realty Regulation** (Commerce) | | |
| Ms. B. Helen Garrick, Missoula | Governor | 5/9/1993 |
| Qualifications (if required): affiliated with the Republican Party | | |
| **Board of Regents** (Education) | | |
| Mr. Travis M. Belcher, Helena | Governor | 6/1/1993 |
| Qualifications (if required): student at unit of higher education jurisdiction of Board of Regents | | |
| **Board of Sanitarians** (Commerce) | | |
| Mr. Danny Corti, Missoula | Governor | 7/1/1993 |
| Qualifications (if required): licensed sanitarian and not a public member | | |
| Mr. Donald E. Sampson, Missoula | Governor | 7/1/1993 |
| Qualifications (if required): public member | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Board of Veterans Affairs** (Military Affairs) | | |
| Ms. Bernadette A. Opp, Missoula | Governor | 5/18/1993 |
| Qualifications (if required): none specified | | |
| **Chemical Dependency Advisory Council** (Corrections & Human Services) | | |
| Rep. Steve Benedict, Hamilton | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Ms. Carole Carey, Ekalaka | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Ms. Dana L. Christensen, Kalispell | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Mr. Terry Dennis, Billings | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Mr. Jim Gamell, Great Falls | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Ms. Carol Judge, Helena | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Ms. Sandra Lambert, Miles City | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Mr. Marko Lucich, Butte | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Mr. Curtis C. Moxley, Chinook | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Chemical Dependency Advisory Council** (Corrections & Human Services) cont. | | |
| Mr. Patrick Wolberd, Billings | Director | 7/1/1993 |
| Qualifications (if required): none specified | | |
| **Child Care Advisory Council** (Social and Rehabilitation Services) | | |
| Ms. Peggy Baraby, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represent state agency | | |
| Mr. Hugh Brown, Chester | Governor | 6/30/1993 |
| Qualifications (if required): parent representative | | |
| Ms. Gayle Carpenter, Helena | Governor | 6/30/1993 |
| Qualifications (if required): public member | | |
| Ms. Colleen McGuire, Deer Lodge | Governor | 6/30/1993 |
| Qualifications (if required): public member | | |
| Ms. Linda Patrick, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represents state agency | | |
| Ms. Mary Jo Simpkins, Great Falls | Governor | 6/30/1993 |
| Qualifications (if required): parent representative | | |
| Ms. Susan Skinner, Helena | Governor | 6/30/1993 |
| Qualifications (if required): represents state agency | | |
| **Clark Fork Rehabilitation Advisory Council** (Governor) | | |
| Mr. Vic Andersen, Helena | Governor | 5/23/1993 |
| Qualifications (if required): none specified | | |
| Sen. Thomas Beck, Deer Lodge | Governor | 5/23/1993 |
| Qualifications (if required): none specified | | |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Clark Fork Rehabilitation Advisory Council** (Governor) cont. | | |
| Mr. Frank Bennett, Anaconda<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Cal Christian, Anaconda<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Bob Fox, Helena<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Pat Graham, Helena<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Glen Green, Deer Lodge<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Frank Munshower, Bozeman<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Peter Nielson, Missoula<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Steve Pilcher, Helena<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Ms. Sandy Stash, Anaconda<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Tim Sullivan, Butte<br>Qualifications (if required): none specified | Governor | 5/23/1993 |
| Mr. Ray Tillman, Butte<br>Qualifications (if required): none specified | Governor | 5/23/1993 |

## VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Commission on Uniform State Laws** (Governor) | | |
| Mr. Ed Eck, Missoula | Governor | 7/1/1993 |
| Qualifications (if required): recog. bar member or faculty of state university law school | | |
| Joseph P. Mazurek, Helena | Governor | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Mr. James E. Vidal, Kalispell | Governor | 7/1/1993 |
| Qualifications (if required): recog. bar member or faculty of state university law school | | |
| **Committee on Telecommunication Services for the Handicapped** (Social and Rehabilitation Services) | | |
| Mr. Ralph Foster, Joplin | Governor | 7/1/1993 |
| Qualifications (if required): member who is handicapped | | |
| Ms. Joan Mandeville, Helena | Governor | 7/1/1993 |
| Qualifications (if required): member of independent local exchange | | |
| Ms. Rebecca Plaggemeyer, Helena | Governor | 7/1/1993 |
| Qualifications (if required): member of an InterLATA carrier | | |
| Mr. Edward G. VanTighem, Great Falls | Governor | 7/1/1993 |
| Qualifications (if required): handicapped-deaf or hard of hearing | | |
| **Education Advisory Council** (Governor) | | |
| Sen. Robert Brown, Whitefish | Governor | 5/1/1993 |
| Qualifications (if required): legislator and teacher | | |
| Dr. Peter Carparelli, Billings | Governor | 5/1/1993 |
| Qualifications (if required): regional superintendent | | |
| Mr. John Dallum, Cascade | Governor | 5/1/1993 |
| Qualifications (if required): parent of elementary student | | |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Education Advisory Council** (Governor) cont. | | |
| Mr. Bob Deming, Great Falls | Governor | 5/1/1993 |
| Qualifications (if required): serves on Board of Higher Education | | |
| Mr. LeRoy Ensign, Bozeman | Governor | 5/1/1993 |
| Qualifications (if required): represents private schools | | |
| Ms. Martha H. Parrish, Rexford | Governor | 5/1/1993 |
| Qualifications (if required): elementary school librarian | | |
| Mr. Sidney Sutherland, Fairfield | Governor | 5/1/1993 |
| Qualifications (if required): guidance counselor | | |
| Ms. Linda Vaughey, Havre | Governor | 5/1/1993 |
| Qualifications (if required): school board member | | |
| **Electrical Board** (Commerce) | | |
| Mr. Kenneth Olsen, Billings | Governor | 7/1/1993 |
| Qualifications (if required): none specified | | |
| **Family Support Services Advisory Council** (Social and Rehabilitation Services) | | |
| Ms. Linda Botten, Bozeman | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Ms. Sylvia Danforth, Miles City | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Dr. Rowena Foos, Billings | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Ms. Sue Forest, Missoula | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Family Support Services Advisory Council** (Social and Rehabilitation Services) cont. | | |
| Ms. Margaret Grogan, Great Falls<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Sen. Ethel M. Harding, Polson<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Beth Kenny, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. John Madsen, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Ted Maloney, Missoula<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Sandi Marisdotter, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Dan McCarthy, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Jeanette McCormick, Choteau<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Pete Surdock, Jr., Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Judy Wright, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |

## VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Historical Society Board of Trustees** (Education) | | |
| Mr. John Burke, Butte<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| Mr. Stuart W. Conner, Billings<br>Qualifications (if required): none specified | Governor | 7/1/1993 |
| Mr. William M. Holt, Lolo<br>Qualifications (if required): recognized archeologist | Governor | 7/1/1993 |
| Ms. Helen L. Hornby, Livingston<br>Qualifications (if required): none specified | Governor | 7/1/1993 |
| **Incentive Awards Advisory Council** (Administration) | | |
| Mr. Jim Adams, Helena<br>Qualifications (if required): general public member | Director | 7/1/1993 |
| Ms. Laurie Ekanger, Clancy<br>Qualifications (if required): ex-officio non-voting member | Director | 7/1/1993 |
| Mr. Jack Ellery, Helena<br>Qualifications (if required): state employee | Director | 7/1/1993 |
| Ms. Renee Erdmann, Helena<br>Qualifications (if required): state employee | Director | 7/1/1993 |
| Mr. Russell G. McDonald, Helena<br>Qualifications (if required): state employee | Director | 7/1/1993 |
| Ms. Lois A. Menzies, Helena<br>Qualifications (if required): state employee | Director | 7/1/1993 |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Incentive Awards Advisory Council** (Administration) cont. | | |
| Ms. Janet Myren, Helena | Director | 7/1/1993 |
| Qualifications (if required): state employee | | |
| Mr. John H. Noble, Helena | Director | 7/1/1993 |
| Qualifications (if required): state employee | | |
| **Joint Committee on Postsecondary Education Policy & Budget** (Education) | | |
| Ms. Marilyn Miller, Helena | Governor | 7/1/1993 |
| Qualifications (if required): member of executive branch | | |
| **Judicial Standards Commission** (Judicial) | | |
| Mr. Marvin Cowdrey, Bozeman | Governor | 7/1/1993 |
| Qualifications (if required): none specified | | |
| Judge Mark P. Sullivan, Butte | elected | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. Victor F. Valgenti, | Supreme Court | 6/30/1993 |
| Qualifications (if required): none specified | | |
| **Library Services Advisory Council** (Education) | | |
| Ms. Jean R. Anderson, Billings | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. user of public library service in South Central Fed. | | |
| Mr. Dave Beatty, Deer Lodge | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. state agency employees and the institutionalized | | |
| Ms. Evelyn Casterline, Culbertson | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. user of public library service in Golden Plains Fed. | | |
| Ms. Greta Chapman, Libby | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. public libraries | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Library Services Advisory Council** (Education) cont. | | |
| Mr. Bill Cochran, Billings | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. federation coordinators | | |
| Ms. Connie Heckathorn, Whitefish | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. user of public library service in Tamarack Federation | | |
| Ms. Beverly Knapp, Bozeman | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. user of public library service in Broad Valleys Fed. | | |
| Ms. Susan Long, Kalispell | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. special libraries | | |
| Ms. Anita Nelson, Missoula | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. disabled | | |
| Mr. Al Randall, Libby | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. school libraries | | |
| Mr. Jim Reno, Billings | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. disadvantaged | | |
| Rep. Bill Strizich, Great Falls | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. legislature | | |
| Ms. Elise Thomas, Chinook | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. user of public library service in Pathfinder Federation | | |
| Mr. John Thomas, Helena | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. academic libraries | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Library Services Advisory Council** (Education) cont. | | |
| Ms. Diane VanGorden, Baker | Chairperson | 5/31/1993 |
| Qualifications (if required): rep. Montana Library Association | | |
| **MIAMI Project Advisory Council** (Health and Environmental Sciences) | | |
| Ms. Lil Anderson, Billings | Governor | 6/30/1993 |
| Qualifications (if required): local service provider | | |
| Ms. Nancy Colton, Bozeman | Governor | 6/30/1993 |
| Qualifications (if required): representative of parent organization | | |
| Ms. Marietta Cross, Missoula | Governor | 6/30/1993 |
| Qualifications (if required): representative non profit child health organization | | |
| Mr. Dan Dennehy, Butte | Governor | 6/30/1993 |
| Qualifications (if required): rep. of local health department | | |
| Ms. Nancy Ellery, Helena | Governor | 6/30/1993 |
| Qualifications (if required): representative from SRS supervise services MT Medicaid | | |
| Dr. Jeffrey P. Hinz, Great Falls | Governor | 6/30/1993 |
| Qualifications (if required): obstetrician/pediatrician | | |
| Rep. Angela Russell, Lodge Grass | Governor | 6/30/1993 |
| Qualifications (if required): American Indian | | |
| Mr. Dale Taliaferro, Helena | Governor | 6/30/1993 |
| Qualifications (if required): from dept. provides preventive health services for women & child | | |
| **Montana Health Facility Authority Board** (Commerce) | | |
| Dr. Amos Little, Helena | Governor | 7/29/1993 |
| Qualifications (if required): none specified | | |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Montana Mint Committee** (Agriculture) | | |
| Mr. Brian Schweitzer, Whitefish | Governor | 7/1/1993 |
| Qualifications (if required): active mint grower | | |
| **Motorcycle Safety Advisory Committee** (Office of Public Instruction) | | |
| Ms. Anita Drews, East Helena | Governor | 7/1/1993 |
| Qualifications (if required): represents Department of Justice | | |
| Mr. Guy Ronald Smith, Sunburst | Governor | 7/1/1993 |
| Qualifications (if required): certified motorcycle safety instructor | | |
| Ms. Pat Wherley, Three Forks | Governor | 7/1/1993 |
| Qualifications (if required): motorcycle rider representing motorcycle riding groups | | |
| **Noxious Weed Advisory Council** (Agriculture) | | |
| Mr. P.L. "Joe" Boyd, Billings | Director | 6/30/1993 |
| Qualifications (if required): consumer group | | |
| Mr. Dane Castleberry, Ekalaka | Director | 6/30/1993 |
| Qualifications (if required): livestock production | | |
| Rep. Fred "Fritz" Daily, Butte | Director | 6/30/1993 |
| Qualifications (if required): council Chairman | | |
| Ms. Candace Durran, Helena | Director | 6/30/1993 |
| Qualifications (if required): sportsman/wildlife group | | |
| Ms. Mercy Knowlton, Poplar | Director | 6/30/1993 |
| Qualifications (if required): Agriculture Crop Production | | |
| Mr. Lonnie McCurdie, Conrad | Director | 6/30/1993 |
| Qualifications (if required): At-Large Member | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Noxious Weed Advisory Council** (Agriculture) cont. | | |
| Mr. Wayne Pearson, Absarokee | Director | 6/30/1993 |
| Qualifications (if required): Montana Weed Control Association | | |
| Rep. Bob Thoft, Stevensville | Director | 6/30/1993 |
| Qualifications (if required): Biological Research & Control | | |
| Mr. Thomas A. Wood, Joplin | Director | 6/30/1993 |
| Qualifications (if required): Herbicide Dealer & Applicator | | |
| **Petroleum Tank Release Compensation Board** (Health and Environmental Sciences) | | |
| Mr. Ray Blehm, Helena | Governor | 6/30/1993 |
| Qualifications (if required): State Fire Marshall | | |
| Mr. Donald E. Pizzini, Great Falls | Governor | 6/30/1993 |
| Qualifications (if required): Director of Department of Health & Environmental Sciences | | |
| **Public Vehicle Fueling Advisory Council** (Administration) | | |
| Ms. Ronna Alexander, Bozeman | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. Bob Anderson, Helena | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. Bill Ballard, Butte | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. Bruce Barrett, Helena | Governor | 6/30/1993 |
| Qualifications (if required): representative of Department of Transportation | | |
| Mr. Larry Blades, Joliet | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Public Vehicle Fueling Advisory Council** (Administration) cont. | | |
| Mr. Bob Blyth, Butte<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Donna Campbell, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Russ Fillner, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. John Geach, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Beverly Gibson, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Gail Gray, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Ms. Donna Hall, Great Falls<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Alec Hansen, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Kurt Hilyard, Fort Benton<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Bob Marks, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |
| Mr. Randy Mosely, Helena<br>Qualifications (if required): none specified | Governor | 6/30/1993 |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Public Vehicle Fueling Advisory Council** (Administration) cont. | | |
| Mr. Ed Robinson, Helena | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. William S. Rose, Bozeman | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| Mr. Howard Wheatley, Great Falls | Governor | 6/30/1993 |
| Qualifications (if required): none specified | | |
| **Special Education Advisory Council** (Office of Public Instruction) | | |
| Rep. Bob Bachini, Havre | Superintendent of Schools | 7/1/1993 |
| Qualifications (if required): legislator | | |
| Ms. Sherry Bock, Great Falls | Superintendent of Schools | 7/1/1993 |
| Qualifications (if required): teacher of children with handicapping conditions | | |
| Mr. James F. Canan, Billings | Superintendent of Schools | 7/1/1993 |
| Qualifications (if required): parent of child with handicapping condition | | |
| Mr. Mike Hanshew, Helena | Superintendent of Schools | 7/1/1993 |
| Qualifications (if required): state agency | | |
| Ms. Betty Jo Vance, Helena | Superintendent of Schools | 7/1/1993 |
| Qualifications (if required): deaf/blind representative | | |
| **State Library Commission** (Education) | | |
| Ms. Anne Hauptman, Billings | Governor | 5/22/1993 |
| Qualifications (if required): public member | | |
| Mr. Lloyd Wallin, Deer Lodge | Governor | 5/22/1993 |
| Qualifications (if required): public member | | |

## VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Teachers' Retirement Board** (Administration) | | |
| Ms. Verna Green, Helena<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| Ms. Nancy Keenan, Helena<br>Qualifications (if required): Superintendent of Public Instruction | Governor | 7/1/1993 |
| Mr. John Kranick, Great Fall<br>Qualifications (if required): retired teacher | Governor | 7/1/1993 |
| Ms. Nancy B. Trackwell, Great Falls<br>Qualifications (if required): public member | Governor | 7/1/1993 |
| **Tourism Advisory Council** (Commerce) | | |
| Mr. Arnold D. "Smoke" Elser, Missoula<br>Qualifications (if required): from Glacier Country | Governor | 7/1/1993 |
| Mr. Ken Hoovestol, Great Falls<br>Qualifications (if required): from Russell Country | Governor | 7/1/1993 |
| Mr. Richard D. Krott, Helena<br>Qualifications (if required): from Gold West Country | Governor | 7/1/1993 |
| Mr. Larry McRae, Kalispell<br>Qualifications (if required): from Glacier Country | Governor | 7/1/1993 |
| **Vocational Education Advisory Council** (Governor) | | |
| Mr. Fred "Rocky" Clark, Butte<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Mr. Jeff Dietz, Billings<br>Qualifications (if required): none specified | Governor | 5/1/1993 |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Vocational Education Advisory Council (Governor) cont.** | | |
| Ms. Ann Haagenstad, Clancy<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Dr. Jon Jourdonnais, Great Falls<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Dr. August "Gus" Korb, Havre<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Dr. Dennis Lerum, Missoula<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Mr. Jesse O'Hara, Great Falls<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Dr. Robert Schaal, Kalispell<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Mr. James Schultz, Lewistown<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Colonel Gordon Simmons, Missoula<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Rep. Charles "Chuck" Swysgood, Dillon<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Ms. Avis Ann "Sanny" Tobin, Helena<br>Qualifications (if required): none specified | Governor | 5/1/1993 |
| Mr. Howard Williams, Helena<br>Qualifications (if required): none specified | Governor | 5/1/1993 |

VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Water Plan Advisory Council** (Natural Resources and Conservation) | | |
| Mr. Joe Aldegarie, Missoula<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Sen. Esther Bengtson, Shepherd<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Stan Bradshaw, Helena<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Ms. Ana Brenden, Scobey<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Jay Chamberlain, Dillon<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Ms. Connie Cole, Helena<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Jack Galt, Martinsdale<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Dennis Iverson, Helena<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Rep. Tom Lee, Bigfork<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Glenn Marx, Helena<br>Qualifications (if required): none specified | Governor | 7/25/1993 |
| Mr. Don Pfau, Lewistown<br>Qualifications (if required): none specified | Governor | 7/25/1993 |

**VACANCIES ON BOARDS AND COUNCILS -- May 1, 1993 through July 31, 1993**

| Board/current position holder | Appointed by | Term end |
|---|---|---|
| **Water Plan Advisory Council** (Natural Resources and Conservation) cont. | | |
| Mr. Jerald Sorensen, Polson | Governor | 7/25/1993 |
| Qualifications (if required): none specified | | |
| Mr. John Wardell, Helena | Governor | 7/25/1993 |
| Qualifications (if required): none specified | | |
| Mr. Jim Wedeward, Billings | Governor | 7/25/1993 |
| Qualifications (if required): none specified | | |
| **Western Interstate Commission for Higher Education** (Governor) | | |
| Dr. John Hutchinson, Helena | Governor | 6/19/1993 |
| Qualifications (if required): commissioner of higher education | | |