MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 12

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

In the matter of the adoption of new rule I on a policy charge; and the amendment of rule 2.55.326.	NOTICE OF PUBLIC HEARING

TO: All Interested Persons:

1. On July 19, 1995, the State Compensation Insurance Fund will hold a public hearing at 2:00 p.m., in Room 303 of the State Compensation Insurance Fund Building, 5 South Last Chance Gulch, Helena, Montana, to consider the adoption of new rule I for a policy charge and amendment of rule 2.55.326, minimum yearly premium.

2. The proposed new rule provides as follows:

RULE I POLICY CHARGE (1) The state fund may assess a policy charge on all policies in effect during a fiscal year. The amount of the charge shall be determined annually by the board for the future fiscal year, and may be in addition to any other charge or premium.

(2) The policy charge is included in the minimum premium if the policy charge plus premium is less than the minimum premium established by the board for the fiscal year.

(3) The policy charge includes, but is not limited to, expense components for issuing, maintaining and servicing policies, which are common to all policies regardless of premium size.

(4) The state fund may cancel the employer's policy for failure to pay a policy charge.

AUTH: Sec. 39-71-2315 and 39-71-2316 MCA
IMP: Sec. 39-71-2311 and 39-71-2316 MCA

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

2.55.326 MINIMUM YEARLY PREMIUM (1) ~~As permitted by 39-71-2316, MCA, t~~The state fund, subject to the approval of the state fund board of directors, may charge a minimum yearly premium to a policy in order to cover ~~its administrative costs the risk of loss~~ for coverage of a small employers.

(2) Minimum yearly premium may be derived by establishing a minimum yearly payroll. The minimum yearly premium shall be determined by multiplying the minimum yearly payroll by the rate of the governing classification of the policy. The board may adopt an amount that the minimum yearly premium may not be below, and may adopt an amount that the minimum yearly premium may not exceed.

(3) Minimum yearly premium may be established as a flat dollar amount.

AUTH: Sec. 39-71-2315 and 39-71-2316 MCA
IMP: Sec. 39-71-2311 and 39-71-2316 MCA

4. The rulemaking is being proposed for the following reasons:

The proposed new rule I is necessary to implement a policy charge. The 1995 Legislature in Senate Bill 374 determined that the State Fund Board of Directors should have the discretion to establish a policy charge for State Fund policyholders. This rule implements the policy charge, which is commonly used by other insurance companies. The policy charge will be assessed on all policyholders and will be used to cover the costs common to all policies, such as expenses related to issuing, maintaining and servicing policies. It is intended that the minimum premium include the policy charge if the premium based on actual payroll plus the policy charge is less than the minimum premium established by the board. The policyholder in this situation would pay the minimum premium amount. The State Fund, in fairness to all policyholders, may cancel a policy for failure to pay the policy charge as its function is to cover the costs common to all policies. If the policy charge were not assessed, premium payments would be utilized to cover such costs.

The proposed changes to ARM 2.55.326 are necessary to implement minimum premium. The 1995 Legislature in Senate Bill 374 determined that the State Fund Board of Directors should have the discretion to establish minimum premium for State Fund policyholders. There is a risk of loss with small policyholders that premium alone does not cover. This rule allows the board to set a minimum premium so as to more appropriately assess small policyholders adequate premium. As the insurer of last resort, the state fund also needs to be sensitive to the needs of small employers while maintaining equity among all policyholders. Two methods are provided. One, which is to set a minimum payroll for each policyholder against which the rate of the governing class code will be assessed, subject to minimum and maximum amounts; or secondly, to establish a flat amount of which premium paid cannot be less than the amount established.

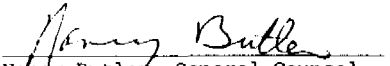
5. The State Compensation Insurance Fund makes reasonable accommodations for persons with disabilities who wish to participate in this public hearing. Persons needing accommodations must contact the State Fund, Attn: Ms. Dwan Ford, P.O. Box 4759, Helena, MT 59604; telephone (406) 444-6480; TDD (406) 444-5971; fax (406) 444-6555, no later than 5:00 p.m., July 10, 1995, to advise as to the nature of the accommodation needed and to allow adequate time to make arrangements.

6. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to state fund attorney Nancy Butler, Legal Department, State Compensation Insurance Fund, 5 South Last Chance Gulch, Helena, Montana 59604-4759. Comments must be received no later than 5:00 p.m. July 27, 1995.

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

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Rick Hill
Chairman of the Board



Nancy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State June 19, 1995.

BEFORE THE BOARD OF INVESTMENTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to definitions, forward commitment fees, investment policy and interest rate reduction for loans to for-profit borrowers funded from the coal tax trust and the proposed adoption of new rules pertaining to infrastructure loans	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF 8.97.1301 DEFINITIONS, 8.97.1303 FORWARD COMMITMENT FEES AND YIELD REQUIREMENTS FOR ALL LOANS, 8.97.1501 INVESTMENT POLICY, CRITERIA, AND PREFERENCES AND 8.97.1502 INTEREST RATE REDUCTION FOR LOANS TO FOR-PROFIT BORROWERS FUNDED FROM THE COAL TAX TRUST, AND THE PROPOSED ADOPTION OF NEW RULES PERTAINING TO INFRASTRUCTURE LOANS

TO: All Interested Persons:

1. On July 19, 1995, at 9:00 a.m., a public hearing will be held in the Board of Investments conference room, 555 Fuller, Helena, Montana, to consider the proposed amendment of the above-stated rules.

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

"8.97.1301 DEFINITIONS In addition to the definitions set forth in 17-5-1503 and 17-6-302, MCA, the following definitions apply in all sub-chapters contained in Title 8, chapter 97, of these rules:

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

(4) "Basic sector of the economy" businesses as envisioned in house bill 602, chapter 477, Montana session laws, 1995 means:

(a) business activity conducted in the state that produces goods and services for which 50 percent or more of the gross revenues are derived from out-of-state sources; or

(b) business activity conducted in-state that produces goods and services, 50 percent or more of which will be purchased by in-state residents in lieu of like or similar goods and services which would otherwise be purchased from out-of-state sources.

(4) through (15) will remain the same, but will be renumbered (5) through (16).

(17) "Infrastructure loan" means a loan for infrastructure projects which may include the acquisition, construction, and improvement of infrastructure or industrial infrastructure, which includes streets, roads, curbs, gutters, sidewalks, pedestrian malls, alleys, parking lots and off-street parking facilities, sewer lines, sewage treatment facilities, storm sewers, waterlines, waterways, water treatment facilities, natural gas lines, electrical lines,

telecommunication lines, rail lines, rail spurs, bridges, publicly owned buildings, and any other public improvements authorized under 7-15-4288(4), MCA.

(16) through (24) will remain the same, but will be renumbered (18) through (26).

(27) "Permanent full-time employee" means an employee who is scheduled to work 40 hours per week for an indefinite period of time. Temporary or part-time employees, and employees on contract or supplied by personnel supply companies, are not to be counted.

(25) through (41) will remain the same, but will be renumbered (28) through (44)."

Auth: The portion of this rule implementing 17-6-201, MCA, is advisory only, but may be a correct interpretation of this section, Sec. 17-5-1503, 17-5-1521, 17-6-324, MCA; IMPLIED, Sec. 17-6-201, 17-6-324, MCA; IMP, Sec. 17-5-1503, 17-6-201, 17-6-211, 17-6-302, MCA

"8.97.1303 FORWARD COMMITMENT FEES AND YIELD REQUIREMENTS FOR ALL LOANS (1) through (2)(b) will remain the same.

(3) the following requirements apply only to commercial, infrastructure, multi-family, economic development linked deposit, and federally guaranteed loans excluding FHA and VA:

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

Auth: Sec. 17-5-1504, 17-5-1521, 17-6-308, 7-6-311, 17-6-315, 17-6-324, MCA; IMP, Sec. 17-5-1504, 17-5-1521, 17-6-304, 17-6-308, 17-6-211, 17-6-315, 17-6-324, MCA

"8.97.1501 INVESTMENT POLICY, CRITERIA, AND PREFERENCES (1) through (4) will remain the same.

(5) The board will not fund loans to any local governmental entity except as provided for under House Bill 602, chapter 477, Montana Session Laws, 1995.

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

Auth: Sec. 17-6-308, 17-6-324, MCA; IMP, Sec. 17-6-304, 17-6-305, 17-6-308, 17-6-314, 17-6-324, MCA

"8.97.1502 INTEREST RATE REDUCTION FOR LOANS ~~TO FOR-PROFIT BORROWERS~~ FUNDED FROM THE COAL TAX TRUST (1) The board will provide an interest rate reduction ~~only~~ to for-profit borrowers, non-profit borrowers, and local government borrowers based on the number of jobs the loan generates over a two-year period. The date of the formal written interim or permanent loan application to the seller/servicer will be used as a beginning date for counting jobs created. Except for local government borrowers, ~~T~~the interest rate reduction shall be limited to a maximum loan size of one percent of the permanent coal trust fund ~~at each fiscal year end~~ as of the month end preceding the application date for the interest rate reduction and calculated as follows:

(a) through (e)(i) will remain the same.

(f) The local government borrower must make application in writing to the board providing satisfactory evidence of the creation of jobs and certify that the interest rate reduction will pass through to the business creating jobs;

(g) The non-profit borrower must make application in writing, through its financial institution, to the board providing satisfactory evidence of the creation of jobs and certify that the interest rate reduction will pass through to the business creating the jobs;

(f) will remain the same, but will be renumbered (h).

(2) will remain the same.

(3) For purposes of calculating the size of the permanent coal tax trust fund, the board shall include all funds listed in 17-5-703(1), MCA."

Auth: Sec. 17-6-308, 17-6-324, MCA; IMP, Sec. 17-6-304, 17-6-308, MCA

3. The proposed new rules will read as follows:

"I LOAN PROGRAM FOR INFRASTRUCTURE LOANS - GENERAL DESCRIPTION (1) The board is authorized to make direct loans to a local government that will create the necessary infrastructure if the loan will result in the creation of a business in the basic sector of the economy estimated to employ at least 50 people in Montana on a permanent, full-time basis or result in the expansion of a business estimated to employ an additional 50 people in Montana on a permanent full-time basis.

(2) A single loan may not be less than $500,000, and loans must be made in $250,000 increments. A loan may not exceed $10,000 per job that is estimated to be created.

(3) A local government must demonstrate to the board's satisfaction that the business entity creating jobs has the ability to repay the loan upon the terms and conditions set by the board."

Auth: Sec. 17-6-308, 17-6-324, MCA; IMP, Sec. 17-6-304, 17-6-308, MCA

"II APPLICATION PROCEDURE FOR INFRASTRUCTURE LOANS

(1) A local government may apply for financing under the infrastructure loan program by submitting an application to the administrator on a form provided by the board. The application must contain:

(a) a complete description of the purpose or purposes for which the loan proceeds are to be used;

(b) evidence that the local government has taken all steps necessary for the authorization and issuance of the obligations;

(c) a description of the proposed loan including principal amount, proposed maturity, proposed repayment schedule, proposed security and any interest rate limitations;

(d) impact information addressing the following:

(i) estimated number of permanent full-time jobs created by the project,

(ii) the impact of the jobs on the state and the community where the project is located,

(iii) the long-term effect of corporate and personal income taxes estimated to be paid by the business and its employees,

(iv) the current and projected ability of the community to provide necessary infrastructure for economic and community development purposes,

(v) the environmental impact of the project and whether any environmental review or permits are required,

(vi) other matters that the board considers necessary;

(e) information about the business creating the jobs addressing the requirements under ARM 8.97.1412(1).

(2) The forward commitment fee indicated under ARM 8.97.1303(3) must be paid.

(3) Forward commitment fees, extension fees, and consultant fees may be financed as part of the larger project but may not be financed on a stand alone basis.

(4) The maximum loan term is twenty years.

(5) An application for the infrastructure loan shall be submitted on an application form provided by the board, shall be properly signed and certified by the local government applicant and by the business creating the jobs on its section of the application.

(6) If the board approves the loan a commitment agreement will be entered into between the board and the local government.

(7) The local government must pass a resolution authorizing the acceptance of the commitment agreement and execute and return the commitment agreement within 30 days of the commitment date or the commitment will expire.

(8) A local government must not be in default on any obligation."

Auth: Sec. 17-6-308, 17-6-324, MCA; IMP, Sec. 17-6-304, 17-6-308, MCA

"III APPLICATION PROCEDURES FOR INFRASTRUCTURE LOAN PROGRAM - LOAN AGREEMENT, CLOSING, FUNDING (1) Each infrastructure loan must be evidenced by:

(a) a note or other evidence of indebtedness;

(b) a loan agreement;

(c) the local government's pledge of infrastructure fees for repayment of the loan;

(d) other security document deemed necessary by the board;

(e) the loan resolution which the local government has adopted authorizing the loan;

(f) an opinion of the attorney to the local government as to the legal and binding nature of the obligation, the security thereof and due amortization thereof;

(g) all necessary state and federal permits must be obtained before loan closing; and

(h) such other items as may be requested by the board or its counsel.

(2) A loan will be funded only after the board receives all required closing documents, including the attorney's opinion."

Auth: Sec. 17-6-308, 17-6-324, MCA; IMP, Sec. 17-6-304, 17-6-308, MCA

REASON: To implement the requirements of House Bill 602 enacted into law by the 1995 Legislature, which allows the Board to make direct loans to local governments for infrastructure purposes.

4. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Board of Investments, 555 Fuller, P.O. Box 200126, Helena, Montana 59620-0126, to be received no later than 5:00 p.m., July 27, 1995.

5. Julie Endner, Program Assistant, has been designated to preside over and conduct the hearing.

BOARD OF INVESTMENTS
WARREN VAUGHAN, CHAIRMAN

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 19, 1995.

BEFORE THE ECONOMIC DEVELOPMENT DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed adoption of new rules pertaining to the implementation of the Job Investment Act	))))	NOTICE OF PROPOSED ADOPTION OF NEW RULES TO IMPLEMENT THE JOB INVESTMENT ACT NO PUBLIC HEARING CONTEMPLATED

To: All Interested Persons:

1. On July 29, 1995, the Department of Commerce proposes to adopt rules to implement the Job Investment Act.

2. The proposed new rules will read as follows:

"I PROCEDURAL RULES (1) The department hereby adopts and incorporates by reference the Attorney General's model procedural rules (ARM 1.3.101 through 1.3.233). A copy of these rules may be obtained from the Economic Development Division, 1424 - 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0501. The review of applications and the granting of job investment loans by the department will not be considered contested cases as contemplated by the model procedural rules for the purposes of 2-4-601 through 2-4-711, MCA, of the Montana Administrative Procedure Act."

Auth: Sec. 2-4-201, 17-6-502, MCA; IMP, Sec. 2-4-201, 17-6-505, MCA

"II CITIZEN PARTICIPATION RULES (1) For purposes of administering this program, the department hereby adopts and incorporates by reference its citizen participation rules as set forth in ARM 8.2.201 through 8.2.206, except that information relating to trade secrets and other proprietary matters and private financial information will be held in confidence as specified in other sections of these rules. A copy of the department's rules regarding citizen participation may be obtained from the Economic Development Division, 1424 - 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0501."

Auth: Sec. 2-3-103, 17-6-505, MCA; IMP, Sec. 2-3-103, 17-6-505, MCA

"III DEFINITIONS (1) In addition to the definitions set forth in 17-6-505, MCA, the following definitions shall apply for purposes of these rules:

(a) "Act" means the Job Investment Act;

(b) "Department" means the Montana department of commerce established in 2-15-801, MCA;

(c) "Local government body" means a body of the city or county government;

(d) "Economic development organization" means a certified community recognized by the department of commerce or designated by city/county government as the lead economic development organization;

(e) "Qualified business" means a business enterprise that either is or will be located in the state and produces goods or provides services that will, as a result of receiving a job investment loan, create and/or retain jobs for Montana workers;

(f) "Loan review committee" means the committee that is established by the department to consider economic development loan applications for funding by the community development block grant program and is responsible for reviewing and recommending to the Montana board of science and technology development (MBSTD) the approval or denial of job investment loans.

(2) Notice is hereby given that (1)(a)(e)(f) above repeat in substantial part the definitions set forth in 17-6-503, MCA, and are included to provide full notice to the public of the definitions under which the job investment rules are adopted."

Auth: Sec. 12-6-502, 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"IV APPLICATION PROCEDURES (1) Qualified businesses shall submit an application to the department of commerce economic development division.

(2) Applications must include a letter of support from the local governing body, which includes:

(a) county commission,

(b) city commission, and/or

(c) lead economic development organization.

(3) All applications including business plans and financial information will become the property of the state of Montana."

Auth: Sec. 17-6-504, MCA; IMP, Sec. 17-6-505, MCA

"V LOAN REVIEW COMMITTEE (1) In the event that the Montana board of science and technology development does not concur with the recommendation by the loan review committee, the board will prepare a written finding, consistent with the criteria set forth in the administrative rules herein, describing the rationale upon which the alternative selection was made.

(2) The loan review committee will consist of the following:

(a) five department of commerce regional development officers;

(b) director and deputy director of the department of commerce;

(c) senior economic development policy advisor to the governor;

(d) executive director of the Montana board of science and technology development.

(3) The loan review committee may make funding decisions with five members present and members may participate by telephone during the meeting. A majority of the committee members present may make the final decision. Members may not vote by proxy."

Auth: Sec. 17-6-510, MCA; IMP, Sec. 17-6-505, MCA

"VI CONFIDENTIALITY AND OPEN MEETINGS (1) Unless otherwise required by law, information including business plan information and financial exhibits submitted by an applicant will be treated as confidential by the Department, its staff and technical reviewers, except the following:

(a) name and address of applicant;

(b) short description of proposed project;

(c) amount of loan;

(d) the program under which the applicant is applying;

(e) any other information in which the demand of individual privacy does not clearly exceed the merits of public disclosure; and

(f) any information in which the demand of individual privacy clearly exceeds the merits of public disclosure, but the applicant has expressly waived his right to privacy.

(2) The department shall maintain public files on each completed application received that will contain the following information:

(a) items (1)(a) through (f) of this rule;

(b) all written documents received or prepared concerning items (1)(a) through (f) of this rule;

(c) the loan review committee's action regarding the application, including the committee's approval or disapproval of the application, the terms and interest rate of financing, and the loan repayment schedule and record.

(3) The department shall open all committee meetings when the discussion addresses issues enumerated in (1)(a) through (f) or when the demand of individual privacy does not exceed the merits of public disclosure or when the applicant has expressly waived his right to privacy.

(4) This rule is based on the department's finding that, except for the information described in (1)(a) through (f), the demands of individual privacy clearly exceed the merits of public disclosure of the personal, financial and business information that is contained in applications and supporting documentation submitted to the loan review committee."

Auth: Sec. 17-6-502, MCA; IMP, Sec. 17-6-505, MCA

"VII BUSINESS APPLICATION REQUIREMENTS (1) Each applicant must submit the following:

(a) a current business plan and copies of all documentation submitted to and reviewed by the private lender(s) involved in the project. Each business plan must contain sufficient information for the department to obtain an adequate understanding of the business to be assisted, including:

(i) the products or services offered,

(ii) estimated market potential,

(iii) management experience of principals,

(iv) current financial position,

(v) collateral available,

(vi) details of the proposed venture, and

(vii) a copy of a commitment letter from the participating private lender(s) subject to job investment loan funding.

(A) Job investment loan funds may not exceed the funding provided by private lenders and at least one private lender must be a financial institution.

(B) Financial institutions must complete their review and provide contingent approval of a project before job investment loan funds are committed by the department."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"VIII INTEREST RATES (1) The rate of interest charged may not be less than the prevailing market rate for a similar loan. The interest rate will be adjusted to account for the level of risk."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"IX LOAN LOSS RESERVE FUND (1) The department will create a loan loss reserve based on loan portfolio performance."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"X TERMS OF JOB INVESTMENT LOAN AGREEMENT (1) The department will consider the proposed use(s) of job investment loan funds and cash flow analysis when determining the term of the loan.

(2) A loan that is over 30 days delinquent will be considered in default by the department. A loan that is 90 days delinquent is a nonperforming loan subject to possible liquidation."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"XI COLLATERAL (1) The Montana board of science and technology development will secure the most favorable collateral position possible on any job investment loan."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"XII FUNDING CRITERIA (1) The applicant is required to demonstrate that:

(a) the loan amount is justified based on consideration of the following factors:

(i) the project results in the creation and/or retention of direct and indirect jobs in Montana;

(ii) no job displacement in Montana is identified as a potential result of the loan;

(iii) the level of assistance is appropriate in relation to the public benefit expected to result from the project. Emphasis will be given to projects in areas that are economically depressed if they meet acceptable levels of financial risk as determined by the loan committee;

(iv) a financing gap exists and the project needs job investment loan funds to proceed;

(v) proposed management is experienced in the type of business activities proposed and has demonstrated the capacity to successfully manage the entity to be assisted;

(vi) the application is complete as submitted, and contains accurate information;

(vii) the earning projections submitted with the application are realistic and attainable, supported by historical trends and industry norms and indicated that projected cash flow is sufficient to support increased debt;

(viii) the application documents a sound, well-reasoned proposal with a perceived strong chance for success if funds are received;

(ix) the project is ready to proceed immediately upon approval of job investment loan funding.

(2) Applications where viability may be questionable, or where the overall business plan or need for assistance is inadequately documented, may be either restructured, renegotiated or not funded depending on the severity and nature of the problems identified."

Auth: Sec. 17-6-505, MCA; IMP, Sec. 17-6-505, MCA

"XIII LOAN DOCUMENTATION (1) Loan documents containing terms and conditions similar to banking industry norms will be used for job investment loan projects. The department and the Montana board of science and technology development will establish procedures to ensure the proper filing of Uniform Commercial Code (UCC) forms, recordation of trust indentures, preparation of promissory notes, security documents and loan agreements, and monitoring of loan conditions."

Auth: Sec. 17-6-505, 17-6-510, MCA; IMP, Sec. 17-6-505, MCA

REASON: These new rules are proposed to implement Senate Bill 38, the Job Investment Act, enacted by the 54th Montana Legislature. The Montana Job Investment Loan program will provide funding for loans to Montana businesses as part of a financing package to permit business expansion, job creation and job retention.

3. Interested persons may submit their data, views or arguments concerning the proposed adoptions in writing to the Economic Development Division, 1424 - 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0501, to be received no later than 5:00 p.m., July 27, 1995.

4. If a person who is directly affected by the proposed adoptions wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Economic Development Division, 1424 - 9th Avenue, P.O. Box 200501, Helena, Montana 59620-0501, to be received no later than 5:00 p.m., July 27, 1995.

5. If the Department receives requests for a public hearing on the proposed adoptions from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed adoptions, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those businesses/persons directly affected has been determined to be

2300, based on the 23,000 businesses who have unemployment insurance in the State of Montana.

DEPARTMENT OF COMMERCE
JON NOEL, DIRECTOR

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 19, 1995.

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA
(As of July 1, 1995, the Department of Environmental Quality)

In the matter of the amendment of rule 16.45.402 and new rule I establishing minimum standards for underground piping	))))	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE AND ADOPTION OF NEW RULE I

(Underground Storage Tanks)

To: All Interested Persons

1. On July 20, 1995, at 1:30 p.m., the department will hold a public hearing in Room C209, side 2, of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the amendment and adoption of the above-captioned rules.

2. The rules, as proposed to be amended and adopted, appear as follows (new material in the existing rule is underlined; material to be deleted is interlined):

16.45.402 REQUIREMENTS FOR PETROLEUM UST SYSTEMS (1) Owners and operators of petroleum UST systems shall provide release detection for tanks and piping as follows:

(1)(a)-(d) Remain the same but are renumbered (a)(i)-(iv).

~~(2)~~(b) ~~Piping.~~ Underground piping that routinely contains regulated substances must be monitored for releases in a manner that meets one of the following requirements:

~~(a)~~(i) ~~Pressurized piping.~~ Underground piping that conveys regulated substances under pressure must:

~~(i)~~(A) be equipped with an automatic line leak detector conducted in accordance with ARM 16.45.405(1); and

~~(ii)~~(B) have an annual line tightness test conducted in accordance with ARM 16.45.405(2) or have monthly monitoring conducted in accordance with ARM 16.45.405(3).

~~(b)~~(ii) ~~Suction piping.~~ Underground piping that conveys regulated substances under suction must either have a line tightness test conducted at least every 3 years and in accordance with ARM 16.45.405(2), or use a monthly monitoring method conducted in accordance with ARM 16.45.405(3). No release detection is required for suction piping that is designed and constructed to meet the following standards:

~~(i)~~(A) the below-grade piping operates at less than atmospheric pressure;

~~(ii)~~(B) the below-grade piping is closed so that the contents of the pipe will drain back into the storage tank if the suction is released;

~~(iii)~~(C) only one check valve is included in each suction line;

~~(iv)~~(D) the check valve is located directly below and as close as practical to the suction pump; and

~~(v)~~(E) a method is provided that allows compliance with ~~(2)(b)(ii)-(iv)~~ (b)(ii)(B)-(D) of this rule to be readily determined.

(iii) Underground piping connected to heating oil tanks with a capacity of 660 gallons or less is exempt from the requirements of (b)(i) and (ii) of this rule provided that:

(A) the new primary underground piping has secondary containment;

(B) liquid released into the interstitial space will move not more than 20 feet before being detected in a standpipe or sump;

(C) the interstice is visually monitored for released liquid once every 30 days; and

(D) the test results are maintained for at least 1 year.

(iv) New underground piping connected to underground heating oil tanks with a capacity of 660 gallons or less shall slope back towards tanks that do not have foot valves.

AUTH: 75-10-405, 75-11-302, MCA; IMP: 75-10-405, 75-11-302, MCA

RULE I ADDITIONAL PERFORMANCE STANDARDS FOR NEW UNDERGROUND PIPING CONNECTED TO ABOVE GROUND TANKS OR TO UNDERGROUND TANKS NOT LOCATED AT A FARM OR RESIDENCE WITH A CAPACITY OF 1100 GALLONS OR LESS USED TO STORE HEATING OIL (1) Primary underground piping connected to above ground tanks or to underground tanks with a capacity of 660 gallons or less used exclusively to store heating oil for consumptive use on the premises where stored may be constructed of copper provided that the piping is enclosed in secondary containment consistent with these rules.

(2) In addition to cathodically protected steel or non-metallic pipe listed for use with petroleum products and/or motor fuels, schedule 40 or greater PVC pipe and fittings may be used to provide secondary containment for heating oil tank systems subject to this rule provided that only adhesives resistant to petroleum products are used to bond PVC joints.

(3) If liquid or vapor sensors are not used to monitor the interstitial space for a release, the piping system must be installed so that any liquid released into the interstitial space will not move more than 20 feet before being visually detected in a sump or standpipe.

AUTH: 75-10-405, 75-11-302, MCA; IMP: 75-10-405, 75-11-302, MCA

3. The department proposes this amendment of ARM 16.45.402 and adoption of new rules as necessary to establish standards for the inspection, prevention, and release detection of regulated substances in underground piping as mandated by Ch. 339 of the 1993 Laws of Montana.

4. Interested persons may submit their data, views, or arguments concerning the proposed amendment and adoption, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Marty Tuttle, Department of Health and Environmental Sciences (Department of Environmental Quality after June 30, 1995), Cogswell Building, PO Box 200901, Helena, MT 59620-0901, no later than 5:00 p.m., July 27, 1995.

5. Marty Tuttle has been designated to preside over and conduct the hearing.

/s ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA
(As of July 1, 1995, the Department of Environmental Quality)

In the matter of the amendment of rule 16.45.1101 and adoption of new rule I establishing minimum standards for double-walled UST systems.	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT AND ADOPTION OF RULES (Underground Storage Tanks)

To: All Interested Persons

1. On July 20, 1995, at 1:30 p.m., the department will hold a public hearing in Room C209, side 2, of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the amendment and adoption of the above-captioned rules.

2. The rules, as proposed to be amended, appear as follows (new material in the existing rule is underlined; material to be deleted is interlined):

16.45.1101 DEFINITIONS In addition to the definitions contained in 75-11-302, MCA, for ~~For~~ the purposes of this subchapter, the following terms have the meanings given in this section:

(1)-(2) Remain the same.

(3) "Compatible with" means certified as adequate and safe for the storage and delivery of petroleum products by a nationally recognized independent laboratory or organization competent to provide such certification.

(3)-(8) Remain the same but are renumbered (4)-(9).

(10) "Liner" means an impervious material used as a method of secondary containment to prevent a release of any petroleum or petroleum products from a petroleum storage tank system.

(9)-(14) Remain the same but are renumbered (11)-(16).

(17) "Rigid" means an intrinsic characteristic which allows a material to maintain a pre-formed shape or configuration without internal or external support.

(18) "Secondary containment" means any system used to provide release detection and release prevention. Examples of secondary containment include a double-walled tank or a double-walled integral piping system.

AUTH: 75-11-319, MCA; IMP: 75-11-302, 75-11-309, MCA

RULE I DESIGN, CONSTRUCTION, AND INSTALLATION STANDARDS FOR ALL DOUBLE-WALLED PETROLEUM STORAGE TANK SYSTEMS (1) All double-walled underground petroleum storage tank systems must be designed and constructed in accordance with the following standards:

(a) All components of the petroleum storage tank system, including product and vent piping located below grade, shall include secondary containment that consists of rigid inner and outer walls separated by an interstitial space that is monitored for a release of petroleum or petroleum products;

(b) A petroleum storage tank must be designed and fabricated to meet or exceed the new UST system performance standards promulgated in ARM 16.45.201(1);

(c) All underground piping associated with a petroleum storage tank system must be designed and fabricated to meet or exceed the new UST system performance standards promulgated in ARM 16.45.201(2);

(d) All elements of the petroleum storage tank system must be compatible with the storage and delivery of petroleum products;

(e) A non-metallic double-walled piping system must be compatible with the storage and delivery of petroleum products;

(f) Metallic and non-metallic petroleum storage tank system components, including but not limited to flexible connectors, fill risers, and nylon bushings, must be compatible with the storage and delivery of petroleum products;

(g) Fill risers, spill containment equipment, gauging ports, ball float vent valve extractors, automatic tank gauging systems, ports and other openings to the tank must be located and installed within approved tank sumps;

(h) Pumps, flexible connectors, valves, and other threaded pipe components must be installed within approved dispenser pans or sumps; and

(i) Petroleum storage tank and piping sumps must be equipped with liquid-tight penetration fittings.

(2) Double-walled petroleum storage tank systems and associated piping must be managed and operated in compliance with all rules promulgated in this chapter, including but not limited to being installed in compliance with ARM 16.45.1201 et seq.

(3) For purposes of this rule, clay-based composite products, off-site natural clays, concrete, and synthetic liners do not meet the definitions of "double-walled tank system" or "secondary containment" and these products are strictly prohibited from being used for such purposes.

AUTH: 75-11-319, MCA; IMP: 75-11-302, 75-11-309, 75-11-319, MCA

3. The department proposes these amendments to ARM 16.45.1101 and adoption of new rule as necessary to establish the criteria for the design, construction, and installation of double-walled petroleum storage tank systems mandated by Ch. 339 of the 1993 Laws of Montana and which tank owners must meet in order to qualify for a reduced deductible when applying to the petroleum tank release cleanup fund.

4. Interested persons may submit their data, views, or arguments concerning the proposed rules, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Marty Tuttle, Department of Health and Environmental Sciences (Department of Environmental Quality

after June 30, 1995), Cogswell Building, PO Box 200901, Helena, MT 59620-0901, no later than 5:00 p.m., July 27, 1995.

5. Marty Tuttle has been designated to preside over and conduct the hearing.

/s/ ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA
(As of July 1, 1995, the Department of Environmental Quality)

In the matter of the adoption of new rules I-VII establishing minimum standards for aboveground double-walled petroleum storage tank systems.	)))))	NOTICE OF PUBLIC HEARING FOR PROPOSED ADOPTION OF NEW RULES I-VII (Aboveground Tanks)

To: All Interested Persons

1. On July 20, 1995, at 1:30 p.m., the department will hold a public hearing in Room C209, side 2, of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the adoption of the above-captioned rules.

2. The rules, as proposed, appear as follows:

RULE I PURPOSE (1) The purpose of these rules is to establish minimum design, construction, and installation standards for aboveground double-walled petroleum storage tank systems, other similarly constructed and equally protected aboveground petroleum storage tank systems, and all associated on-site double-walled integral piping systems owned or operated by persons that want to qualify for a reduced deductible under the statutes and rules governing the Montana petroleum tank release cleanup fund.

(2) These standards will provide the petroleum tank release compensation board with criteria to evaluate eligibility for 100% reimbursement of expenses associated with accidental releases of petroleum product from aboveground double-walled or equally protected aboveground petroleum storage tank systems.

(3) These rules are not intended to supersede or to replace any fire or life-safety rules duly adopted by the department of justice fire prevention and investigation bureau which regulate the installation, operation, or management of aboveground petroleum storage tank systems.

(4) The department does not intend to use these rules for regulatory purposes.

AUTH: 75-11-319, MCA; IMP: 75-11-319, MCA

RULE II APPLICABILITY (1) This chapter applies to all aboveground double-walled petroleum storage tank systems with maximum storage capacities of less than 30,000 gallons that are used to store petroleum or petroleum product and are owned or operated by persons seeking 100% reimbursement of eligible expenses from the petroleum tank release compensation fund pursuant to Title 75, chapter 11, part 3, MCA, "Petroleum Storage Tank Cleanup".

AUTH: 75-11-319, MCA IMP: 75-11-319, MCA

RULE III DEFINITIONS In addition to the definitions contained in 75-11-302, MCA, the following words, phrases, or terms shall have the following meaning in this chapter, unless the context indicates otherwise:

(1) "Aboveground storage tank system" or "AST" means any one or a combination of tanks used to contain an accumulation of petroleum or petroleum product that is 90% or more above the soil surface. AST includes integral piping located aboveground and petroleum storage tanks located in an enclosed liquid-tight and vapor-tight vault or special enclosure designed and constructed in accordance with the uniform fire code.

(2) "Cathodic protection" means the prevention of corrosion of a metallic surface by making that surface the cathode of an electrochemical cell through the use of galvanic anodes, impressed currents, or other similar methods.

(3) "Compatible", in the case of a substance in a petroleum storage tank system, means capable of maintaining that substance's physical and chemical properties upon contact with one or more other substances for the design life of the petroleum storage tank system under conditions likely to be encountered by the petroleum storage tank system.

(4) "Corrosion expert" means a person with knowledge of physical sciences and principles of engineering and mathematics acquired through education and related practical experience who is qualified to engage in the control of corrosion on buried or submerged metal piping systems and metal tanks and is either accredited or certified by the national association of corrosion engineers or a registered professional engineer certified or licensed to conduct corrosion control of buried or submerged metal piping systems and metal tanks.

(5) "Department" means the department of environmental quality.

(6) "Double-walled tank system" means a petroleum storage tank and associated piping designed and constructed with rigid inner and outer walls separated by an interstitial space that is monitored for a release.

(7) "In contact with the soil" means a portion of a tank or integral piping physically touched by soil or separated from the soil by only a casing, wrapping, or a pervious structure.

(8) "Integral piping" means all continuous, on-site piping until the union of the piping and dispensing equipment and all other valves, elbows, joints, flanges, and flexible connectors attached to a petroleum storage tank system through which petroleum or petroleum product flows.

(9) "Liner" means an impervious material used as a method of secondary containment to prevent a release of any petroleum or petroleum product from a petroleum storage tank system. The defined term does not include interior tank linings or exterior tank coatings.

(10) "Overfill" means a release of petroleum or petroleum product that occurs when an aboveground tank is filled beyond

maximum capacity.

(11) "Petroleum storage tank" means a tank that contains or contained petroleum or petroleum product and that is:

(a) an aboveground storage tank situated in an underground area such as a basement, cellar, mine, drift, shaft, or tunnel;

(b) an aboveground storage tank situated inside a vault or special enclosure as set forth in section 79.902(c) and Appendix II-F of the uniform fire code;

(c) an aboveground storage tank with a capacity of less than 30,000 gallons; or

(d) aboveground pipes associated with tanks under (a)-(c) of this definition, except pipelines regulated under the following laws:

(i) the Natural Gas Pipeline Safety Act of 1968 (49 USC 1671, et seq.);

(ii) the Hazardous Liquid Pipeline Safety Act of 1979 (49 USC 2001, et seq.); and

(iii) state law comparable to the provisions of law referred to in (i) and (ii) above.

(12) "Pipe" means any hollow cylindrical or tubular conveyance constructed of approved non-earthen materials (e.g., cathodically protected metal, plastic or fiberglass) through which petroleum and petroleum product is designed to flow.

(13) "Release detection" means a method of detecting whether a release of petroleum or petroleum product occurred from the petroleum storage tank system into the environment or into the secondary containment.

(14) "Rigid" means an intrinsic characteristic which allows a material to maintain a pre-formed shape or configuration without internal or external support.

(15) "Secondary containment" means any approved system used to provide release detection and release prevention. Examples of secondary containment include an approved double-walled tank, an approved double-walled integral piping system, or an approved single-walled tank or integral piping system that is protected by an enclosed concrete vault or special enclosure as required by the uniform fire code.

(16) "Shop-fabricated storage tank" means a storage tank constructed at the tank manufacturer's plant according to approved standards and accepted engineering principles and transported to the facility for installation.

(17) "Storage tank system" means an approved aboveground petroleum storage tank and all associated integral piping and release detection components.

(18) "Tank" means an enclosed aboveground stationary device, no more than 10% of which is located beneath the surface of the ground, constructed of approved non-earthen materials that provide structural support and designed to store petroleum or petroleum product.

AUTH: 75-11-319, MCA; IMP: 75-11-319, MCA

RULE IV STANDARDS INCORPORATED BY REFERENCE (1) Referenced standards are available for inspection at the department

of justice fire prevention and investigation bureau, Scott Hart building, the Montana department of environmental quality, Cogswell building, Helena, Montana, and from the following sources:

(a) American Petroleum Institute (API), 1220 L Street, N.W., Washington, D.C. 20037, (202) 682-8372;

(b) National Association of Corrosion Engineers (NACE), 1440 South Creek Drive, P.O. Box 218340, Houston, Texas 77218, (713) 492-0525;

(c) National Fire Protection Association (NFPA), 1 Batterymarch Park, Quincey, Massachusetts 02269, (800) 344-3555;

(d) Steel Tank Institute (STI), 570 Oakwood Road, Lake Zurich, Illinois 60047, (708) 438-8265;

(e) Underwriters Laboratories (UL), 333 Pfingsten Road, Northbrook, Illinois 60062, (708) 272-8800;

(f) Western Fire Chiefs Association (WFCA), 5360 South Workman Mill Road, Whittier, California 90601, (301) 699-0124;

(g) Petroleum Equipment Institute (PEI), P.O. Box 2380, Tulsa, Oklahoma 74101-2380, (918) 494-9696; and

(h) International Conference of Building Officials (ICBO), 5360 South Workman Mill Road, Whittier, California 90601, (301) 699-0541.

(2) For purposes of this chapter, the department hereby adopts and incorporates by reference each of the following:

(a) The following published by the American Petroleum Institute:

(i) Specification No. 12B, "Specification for Bolted Tanks for Storage of Production Liquids" 1977, 12th edition, as supplemented January, 1982;

(ii) Specification No. 12D, 1982, as supplemented in 1985, "Specification for Field Welded Tanks for Storage of Production Liquids", ninth edition;

(iii) Specification No. 12F, 1982 as supplemented in 1988, "Specification for Shop Welded Tanks for Storage of Production Liquids", tenth edition;

(iv) Specification No. 12P, September 1, 1986, "Specification for Fiberglass Reinforced Plastic Tanks", first edition;

(v) Standard No. 620, 1985, "Recommended Rules for Design and Construction of Large Welded Low-Pressure Storage Tanks", eighth edition;

(vi) Standard No. 650, 1988, "Welded Steel Tanks for Oil Storage", eighth edition;

(vii) RP 651, (Draft-October 1990), "Cathodic Protection of Aboveground Petroleum Storage Tanks";

(viii) RP 652, (Draft-October 1990), "Lining of Aboveground Petroleum Storage Tanks";

(ix) Standard No. 653, (Draft-October 1990), "Tank Inspection, Repair, Alteration and Reconstruction", first edition;

(x) Publication No. 1110, 1981, "Recommended Practice for the Pressure Testing of Liquid Petroleum Pipelines";

(xi) RP 1615, 1987, "Installation of Underground Petroleum Storage Systems";

(xii) RP 1632, 1987, as supplemented in March 6, 1989,

"Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems"; and

(xiii) RP 2350, March, 1987, "Overfill Protection for Petroleum Storage Tanks".

(b) The following published by the national association of corrosion engineers:

(i) Standard No. RP-0169-83 "Control of External Corrosion on Underground or Submerged Metallic Piping Systems" (1983); and

(ii) Standard No. RP-0285-95 "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems" (1985).

(c) The national fire protection association's: Standard No. 31, "Installation of Oil-Burning Equipment", 1987 Edition.

(d) The Steel Tank Institute's R892-89, "Recommended Practice for Corrosion Protection of Underground Piping Networks Associated with Liquid Storage and Dispensing Systems".

(e) The following published by Underwriters Laboratories:

(i) Specification 142 "Steel Aboveground Tanks for Flammable and Combustible Liquids", 7th edition (April 1, 1993);

(ii) Standard 567, "Pipe Connectors for Flammable, Combustible and LP Gas";

(iii) UL Subject 971, "UL Listed Non-metal Pipe"; and

(iv) UL 2085, 1994, "Insulated Aboveground tanks for Flammable and Combustible Liquid".

(f) Uniform fire code (UFC), 1991 edition, adopted by the fire prevention and investigation bureau.

(g) The Petroleum Equipment Institute's standard RP200-92, "Recommended Practice for the Installation of Aboveground Storage Systems for Motor Vehicle Fueling".

(h) Uniform mechanical code, 1991 edition, adopted by the department of commerce, building codes bureau.

(3) The documents incorporated by reference in (2) above may be obtained at the department of justice fire prevention and investigation bureau, Scott Hart building, and the Montana department of environmental quality, Cogswell building, PO Box 200901, Helena, MT 59620-0901.

AUTH: 75-11-319, MCA IMP: 75-11-319, MCA

RULE V DESIGN, CONSTRUCTION AND INSTALLATION STANDARDS FOR ALL ABOVEGROUND DOUBLE-WALLED PETROLEUM STORAGE TANK SYSTEMS (1) All aboveground double-walled petroleum storage tank systems owned or operated by persons that want to qualify for a reduced deductible allowed by the statutes and rules governing the Montana petroleum tank release cleanup fund must be designed and constructed in accordance with the following standards:

(a) Aboveground petroleum storage tank systems shall consist of either shop-fabricated double-walled storage tanks or petroleum storage tanks installed in a vault or special enclosure as required by UFC Sec. 79.902(c) and Appendix II-F (these assemblies may be referred to in this rule as "protected systems"), and any integral double-walled piping shall meet the requirements of this section at the time of construction and

installation.

(b) Storage tank systems must be constructed of materials that are compatible with the petroleum product stored in the system.

(c) In addition to secondary containment as required by (1)(i) of this rule, petroleum storage tanks must be designed and constructed to meet any of the following standards:

(i) aboveground storage tanks constructed of steel shall meet or exceed the requirements of UL No. 142, API Standard No. 620, API Standard No. 650, API Standard No. 12D or API Standard No. 12F;

(ii) aboveground storage tanks constructed of materials other than steel may not be installed unless such materials have received the written approval of the department of justice fire prevention and investigation bureau. Where required (e.g., "Motor Vehicle Fuel-Dispensing Stations"), protected systems must be listed in UL 2085, UFC Standard 79-7, the Southwest Research Institute (SwRI), or any other testing agency approved by the state fire marshal.

(d) Tanks must be located and supported in accordance with the requirements of uniform fire code Article 79.

(e) The bottom of metal tanks that rest on or within the soil must be cathodically protected with sacrificial anodes or an impressed current system designed, constructed and installed in accordance with API RP 651 and NACE Standard Number RP-0285-95, and:

(i) a corrosion expert must design and supervise the installation of impressed current cathodic protection systems;

(ii) each cathodic protection system must have a test station or a monitoring method that enables the owner or operator to ensure cathodic protection.

(f) Exterior coatings must be designed and applied to storage tank systems to prevent corrosion and deterioration and to protect against degradation by ultraviolet light.

(g) All integral piping, including bulk product piping and hydrant piping, must be constructed with secondary containment as provided in (1)(i) of this rule. All integral piping systems must be constructed in accordance with accepted engineering principles and uniform fire code Article 79, division VII. Integral piping must be constructed of one or more of the following materials and in accordance with the following standards:

(i) cathodically protected coated steel in accordance with UFC Article 79, API RP 1615, API RP 1632, NACE RP-0169-83 and NACE RP-0285-85 or STI R892-89;

(ii) non-metallic pipe (e.g., approved PVC and/or fiberglass) must not be installed as primary aboveground piping unless it satisfies the 2-hour fire protection requirement for tank assemblies in accordance with uniform fire code Article 79 and Appendix II-F.

(h) Storage tank systems with a capacity of 660 gallons or less used to store heating oil for consumptive use on the premises where stored must be designed, constructed, and installed in accordance with the secondary containment require-

ments of Sec. 79.115(d) of the uniform fire code, the uniform mechanical code, NFPA 31, and (1)(i) of this rule. In addition, installation of such storage tank systems must be completed in accordance with the requirements of all local fire code and building code ordinances.

(i) For the purposes of this chapter, secondary containment of petroleum storage tank systems must be designed and constructed as follows:

(i) Shop-fabricated storage tanks must be designed and constructed with rigid inner and outer walls separated by an interstitial space that is capable of being monitored for a release. The interstice must be designed to direct any release to a monitoring point or points and must be provided with an emergency vent equal in size to the emergency vent on the primary tank;

(ii) Piping must be designed and constructed with a rigid inner and outer wall separated by an interstitial space that is capable of being monitored for a release. Primary (i.e., product conveying) piping must be constructed only of approved metallic material;

(iii) Vaults and special enclosures must be designed and constructed in accordance with UFC Sec. 79.902(c) and Appendix II-F, and the owner or operator must receive written approval of the design and construction from the department of justice fire prevention and investigation bureau prior to installation; and

(iv) For the purposes of this rule, the use of clay-based composite products, off-site natural clays or synthetic liners does not satisfy the definition of double-walled or secondary containment construction and is strictly prohibited. Concrete and/or concrete composite material constructed in accordance with accepted engineering principles and listed as a system that provide 2-hour fire protection in accordance with requirements of the uniform fire code, such as vaulted or special enclosure systems, shall satisfy the definition of "double-walled" and "secondary-containment".

(2) Catchment pans and sumps must be installed under dispensers.

(3) Tanks, piping and ancillary equipment must be protected from tampering and damage by fences and barriers.

(4) Tanks with a capacity greater than 1,100 gallons must be equipped with equipment which prevents the tank from being overfilled or a high-level alarm which alerts the transport operator to stop product flow in time to prevent the tank from being overfilled.

AUTH: 75-11-319, MCA; IMP: 75-11-319, MCA

RULE VI INSTALLATION OF ABOVEGROUND DOUBLE-WALLED PETROLEUM STORAGE SYSTEMS (1) All aboveground double-walled petroleum storage tank systems must be properly installed in accordance with:

(a) the manufacturer's specifications and/or recommendations;

(b) the appropriate recommended practices adopted by

reference in [Rule IV]; and

(c) uniform fire code Article 79 and Appendix II-F, or when applicable, the uniform mechanical code and NFPA 31, and all local fire code and building code ordinances.

(2) Vaults and special enclosures must be installed in accordance with uniform fire code Article 79 and Appendix II-F, and the conditions set forth in the written approval provided by the department of justice fire prevention and investigation bureau or the local fire official with uniform fire code jurisdiction.

AUTH: 75-11-319, MCA; IMP: 75-11-319, MCA

RULE VII GENERAL RELEASE DETECTION STANDARDS (1) As part of an aboveground double-walled petroleum storage tank system's design covered under this chapter, an owner and an operator shall provide a method, or a combination of methods, of release detection that monitors the storage tank system's interstitial space at intervals of not less than every 30 days.

AUTH: 75-11-319, MCA; IMP: 75-11-319, MCA

3. The department proposes these rules to establish design, construction, and installation criteria for aboveground double-walled petroleum storage tank systems in order to meet the mandate of Ch. 339 of the 1993 Laws of Montana to promulgate such rules to encourage aboveground double-walled petroleum storage tank systems because of the reduced risk to the environment posed by such systems.

4. Interested persons may submit their data, views, or arguments concerning the proposed rules, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Marty Tuttle, Department of Health and Environmental Sciences (Department of Environmental Quality after June 30, 1995), Cogswell Building, PO Box 200901, Helena, MT 59620-0901, no later than 5 p.m., July 27, 1995.

5. Marty Tuttle has been designated to preside over and conduct the hearing.

for ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA
(As of July 1, 1995, Department of Environmental Quality)

In the matter of the amendment of rule 16.42.402 and 16.42.405 concerning accreditation of asbestos-related occupations and penalties for violations of asbestos laws and rules	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED (Asbestos)

To: All Interested Persons

1. On July 31, 1995, the department proposes to amend ARM 16.42.402 concerning accreditation of asbestos-related occupations, and 16.42.405 concerning penalties for violations of asbestos laws and rules.

2. The rules, as proposed to be amended, appear as follows (new material is underlined; material to be deleted is interlined):

16.42.402 ACCREDITATION & ACCREDITATION RENEWAL APPLICATIONS (1) All persons seeking accreditation in an asbestos-type occupation or renewal of accreditation in an asbestos-type occupation must pay a fee for accreditation or renewal for each accreditation or renewal as follows:

(a) asbestos inspector $125
(b) asbestos management planner $125
(c) asbestos abatement project designer $125
(d) asbestos contractor/asbestos abatement supervisor $125
(e) asbestos worker ..... $ 30

(2) The surcharge for individuals seeking accreditation or accreditation renewal based on attendance of a training course or refresher course that is not Montana approved shall be, as applicable, $25 plus the accreditation or accreditation renewal fee for (1)(a)-(d) of this rule, and, $10 plus the accreditation or accreditation renewal fee for (1)(e) of this rule.

(3) For accreditation and renewal in more than one discipline with an application for each simultaneously submitted to the department, the fee is $250 ~~including~~ plus the surcharges, if applicable, or the total of the two highest fees ~~including~~ plus the surcharges, if applicable, whichever is less.

AUTH: 75-2-503, MCA; IMP: 75-2-503, MCA

16.42.405 PENALTY (1) In addition to all statutory remedies available upon discovering a violation of this subchapter or of 75-2-501 through 75-2-514, MCA, the department may initiate a compliance action in the form of a written

administrative order, which order shall cite the violation committed, including the provisions violated and the facts alleged to constitute a violation. The order shall state the required corrective action to end the violation.

(2) The department, may suspend, deny, or revoke a person's accreditation if the person has violated all or a portion of Title 75, chapter 2, part 5, a rule promulgated thereunder, a permit provision, or an order.

(3) The accreditation of a person accredited as a worker, contractor/supervisor, inspector, management planner, or project designer, will be revoked for reasons including, but not limited to, any of the following:

(a) performing work requiring accreditation at a job site without being in physical possession of initial and current accreditation certificates;

(b) permitting the duplication or use of one's own accreditation certificate by another;

(c) performing work for which accreditation has not been received; or

(d) obtaining accreditation from a training provider that does not have approval to offer training for the particular discipline from either the US environmental protection agency or the state.

(4) The department may suspend, revoke or withdraw approval of training course accreditation for reasons including, but not limited to, the following:

(a) misrepresentation of the extent of a training course's approval by the state;

(b) failure to submit required information or notifications in a timely manner;

(c) failure to maintain requisite records;

(d) falsification of accreditation records, instructor qualifications, or other accreditation information; or

(e) failure to adhere to training standards and requirements of the state accreditation program.

AUTH: 75-2-503, MCA; IMP: 75-2-503, 75-2-514, MCA

3. The department is proposing the amendments to ARM 16.42.402 because they are necessary to clarify that surcharges are added to the base charge, not included within it and, thereby, conform to what has in fact been the meaning of the rule, both understood and applied, to both the department and the regulated industry. The amendments to ARM 16.44.405 are proposed because they are necessary to conform existing state asbestos abatement regulations to federal requirements and allow Montana to operate an asbestos program to which the EPA will defer. These proposed amendments bring the state rules into conformance with the Model Accreditation Plan revisions required by the federal Asbestos School Hazard Abatement Reauthorization Act of 1990.

4. Interested persons may submit their data, views, or arguments concerning the proposed amendments, in writing, to Jim Madden, Department of Health and Environmental Sciences (after June 30, 1995, Department of Environmental Quality),

Cogswell Building, PO Box 200901, Helena, MT 59620-0901, no later than July 27, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express his/her data, views, and arguments orally or in writing at a public hearing, he/she must make written request for a hearing and submit this request along with any written comments he/she has to Jim Madden, Department of Health and Environmental Sciences (Department of Environmental Quality after June 30, 1995), Cogswell Building, PO Box 200901, Helena, MT 59620-0901. A written request for a hearing must be received no later than July 27, 1995.

6. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed 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, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be in excess of 25 persons, based on the number of persons in asbestos-related occupations.

/s/ ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA
(As of July 1, 1995, the Board of Environmental Review)

In the matter of the amendment of rules 16.20.603, 617, 618, 619, 620, 621, 622, 623, 624, 641, 707, 712, 1003, 1802 concerning surface and groundwater water quality standards, mixing zones, and nondegradation of water quality.	)	NOTICE OF PUBLIC HEARING (Water Quality)

To: All Interested Persons

On May 11, 1995, the board published a notice at page 743 of the Montana Administrative Register, Issue No. 9, of the proposed amendment of the above-captioned rules. The notice of proposed board action is amended as follows because the Montana Environmental Information Center and the Greater Yellowstone Coalition requested a public hearing.

1. On August 4, 1995, at 8:00 a.m., a public hearing will be held in Room C209 of the Cogswell Building to consider the amendment of the above-captioned rules.

2. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to Yolanda Fitzsimmons, Department of Health and Environmental Sciences (after June 30, 1995, the Department of Environmental Quality), PO Box 200901, Helena, MT 59620-0901, and must be received no later than August 4, 1995.

3. Will Hutchison has been designated to preside over and conduct the hearing.

RAYMOND W. GUSTAFSON, Chairman
BOARD OF HEALTH AND
ENVIRONMENTAL SCIENCES

by William L. Hutchison
ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:
Eleanor L. Parker
Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the proposed adoption of one new rule related to the operation of the uninsured employers' fund and the underinsured employers' fund, and the amendment of ARM 24.29.2831 and 24.29.2837	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULE I AND AMENDMENT OF EXISTING RULES

TO ALL INTERESTED PERSONS:

1. On July 21, 1995, at 10:00 a.m., a public hearing will be held in the first floor conference room at the Walt Sullivan Building (Dept. of Labor Building), 1327 Lockey Street, Helena, Montana, to consider the adoption of one new rule related to the operation of the uninsured employers' fund and the underinsured employers' fund, and the amendment of ARM 24.29.2831 and 24.29.2837.

The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 5:00 p.m., July 17, 1995, to advise us of the nature of the accommodation that you need. Please contact the Employment Relations Division, Attn: Ms. Linda Wilson, P.O. Box 8011, Helena, MT 59604-8011; telephone (406) 444-6531; TDD (406) 444-5549; fax (406) 444-4140. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Ms. Wilson.

2. The Department of Labor and Industry proposes to adopt one new rule as follows:

RULE I COMPROMISE OF PENALTIES ASSESSED (1) The UEF, in its sole discretion, may enter into a compromise settlement with an uninsured employer of the amount assessed pursuant to ARM 24.29.2831, upon such terms and conditions that the UEF deems expedient and appropriate.

(2) The UIEF, in its sole discretion, may enter into a compromise settlement with an uninsured employer of the amount assessed pursuant to ARM 24.29.2837, upon such terms and conditions that the UIEF deems expedient and appropriate.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-506, 39-71-533 MCA

REASON: There is reasonable necessity for the adoption of proposed RULE I in order to make clear that recently adopted rules (24.29.2831 and 24.29.2837, effective May 1, 1995) do not limit the ability of the UEF and the UIEF to enter into compromise settlements. Staff, in implementing the new rules,

had questioned whether their ability to compromise amounts due had been eliminated due to the rules. In order to eliminate any ambiguity and to reassure employers that such compromises are still possible, the rule is being proposed.

3. The Department of Labor and Industry proposes to amend the rules as follows: (new matter underlined, deleted matter interlined)

24.29.2831 COLLECTION OF PENALTIES AND OTHER PAYMENTS FROM UNINSURED EMPLOYERS (1) Remains the same.

(2) The amount of the penalty assessed is $200.00, or twice the amount of the premium that the uninsured employer should have paid on the past 3 year payroll while the employer was uninsured, whichever is greater.

(3) and (4) Remain the same.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-504 MCA

24.29.2837 CALCULATION OF PENALTY ON UNDERINSURED EMPLOYERS (1) Remains the same.

(2) Subject to the minimum amount of penalty, the amount of penalty assessed ranges from 100% of the amount of the proper premium to 200% of the proper premium, for each employee not properly classified. In deciding what is the amount of the penalty to be assessed, the department will consider the following factors:

(a) and (b) Remain the same.

(3) through (5) Remain the same.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-532 MCA

REASON: There is reasonable necessity to amend the rules as proposed in order to clarify that rules only address the amount of penalty that is assessed by the UEF and the UIEF, as opposed to the amount that must be accepted in satisfaction of the debt. (See proposed RULE I, above.) The proposed language uses the term "assessed" as a term of art to describe the imposition of an amount due as a tax or penalty, which also serves to clarify the amount that is due in the case of an employer's bankruptcy.

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

Dennis Zeiler, Bureau Chief
Workers' Compensation Regulations Bureau
Employment Relations Division
Department of Labor and Industry
P.O. Box 8011
Helena, Montana 59604-8011

and must be received by no later than 5:00 p.m., July 28, 1995.

5. The Department proposes to make the new rule and amendments effective August 15, 1995. The Department reserves the right to adopt only portions of the proposed rule or amendments, or to adopt some or all of the proposals at a later date.

6. The Hearing Bureau of the Legal/Centralized Services Division of the Department has been designated to preside over and conduct the hearing.

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

David A. Scott
Rule Reviewer

By: David A. Scott, Chief Counsel
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 19, 1995.

BEFORE THE BOARD OF LAND COMMISSIONERS
AND THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 26.4.161, to require an operating permit for hard rock mills that are not located at a mine site and that use cyanide.	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 29, 1995, or as soon thereafter as the boards may meet, the Board of Land Commissioners and the Board of Environmental Review propose to amend ARM 26.4.161, pertaining to the application of the operating permit requirement to hard rock mills that are not located at a mine site and that use cyanide.

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

26.4.161 MILLS: APPLICABILITY OF RULES TO MILLS (1) ARM 26.4.160 through 26.4.167 apply to all mills under permit pursuant to Title 82, chapter 4, part 3, MCA, on June 1, 1990, to all mills constructed or beginning operation after June 1, 1990, and to the expansion of any mill facility or complex concluded after June 1, 1990. In addition, ARM 26.4.160 through 26.4.167 apply to mills that were constructed and operated prior to June 1, 1990, and that use cyanide ore processing reagent after [the date that is 6 months after the effective date of this rule amendment].

(2) remains the same.

(3) Mills constructed as a part of a new mining operation must be permitted under the mine operating permit using the information required in ARM 26.4.162- through 26.4.167.

(AUTH: Sec. 82-4-321, MCA; IMP, Sec. 82-4-304, MCA.)

3. The third sentence in section 82-4-304, MCA, is a grandfather clause that exempts from the operating permit requirement of 82-4-335 custom mills that were constructed and operating prior to the effective date of the Board's hard rock mill rules. Those rules were effective on June 1, 1990.

In Section 11 of Chapter 204, Laws of 1990, the Legislature amended § 82-4-335 to remove from the grandfather clause custom mills that use cyanide. However, this amendment does not take effect until the Board implements it by modifying ARM 26.4.161. The rule amendment is proposed to implement the legislation by requiring that mills using cyanide have an operating permit six months after the date of publication of the final rule. This delayed effective date would allow a mill currently in operation to continue operating while the permit application is being processed.

The amendment to section (3) of the rule is for style and makes no substantive change.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment, in writing, to Sandra J. Olsen, Chief, Hard Rock Bureau, Department of Environmental Quality, 1625 11th Avenue, PO Box 201601, Helena, MT 59620-1601. To guarantee consideration, comments must be received or postmarked no later than August 1, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express his or her data, views, or arguments orally or in writing at a public hearing, he or she must make written request for hearing and submit this request along with any written comments to Sandra J. Olsen, Chief, Hard Rock Bureau, Department of Environmental Quality, 1625 11th Avenue, PO Box 201601, Helena, MT 59620-1601. A written request for hearing must be received no later than August 1, 1995.

6. If the agency receives request for public hearing on the proposed amendment, from either 10 percent 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. Ten percent of those persons directly affected has been determined to be one person based on two active off-site mills currently using cyanide in Montana.

Reviewed by:

John F. North
Chief Legal Counsel

Arthur R. Clinch
Commissioner

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of ARM 26.6.411, pertaining to nonexport agreement for timber sales from state lands.	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On September 18, 1995, the Board of Land Commissioners and Department of State Lands propose to amend ARM 26.6.411, pertaining to nonexport agreement for timber sales from state lands.

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

26.6.411 AGREEMENT NOT TO EXPORT STATE LOGS

(1) remains the same.

(2) Any person purchasing timber from the state of Montana must have first entered into an agreement with the department (referred to hereinafter as a nonexport agreement) containing the following commitments on behalf of the purchaser:

(a) Unprocessed timber, as defined in the Act, originating from lands owned by the state of Montana shall not:

(i) be exported from the United States; ~~or~~

(ii) be sold, traded, exchanged, or otherwise given to any person unless that person agrees not to export such unprocessed timber from the United States and agrees to require such a prohibition in any subsequent resale or other transaction involving such unprocessed timber~~.~~; or

(iii) be used in substitution for exported unprocessed timber originating from private lands in Montana;

(b) remains the same.

(c) For purposes of such nonexport agreement, the ~~term "export"~~ following definitions apply:

(i) "Export" ~~shall mean~~ means either direct or indirect export to a foreign country and occurs on the date that a person enters into a contract or other binding transaction for the export of unprocessed timber or, if that date cannot be established, when unprocessed timber is found in an export yard or pond, bundled or otherwise prepared for shipment, or aboard an ocean-going vessel. An export yard or pond is an area where sorting and/or bundling of logs for shipment outside the United States is accomplished. Timber is exported indirectly when export occurs as a result of a sale to another person or as a result of any subsequent transaction.

(ii) "Substitution" means the purchase of unprocessed timber originating from state forests as provided in 77-5-101, MCA, to be used as replacement for unprocessed timber from

private lands in Montana that is exported by the purchaser. Substitution occurs when a person purchasing timber from the state of Montana has exported unprocessed timber from private lands in the state during the period of one (1) year prior to the purchase date.

(d) remains the same.

(3) through (5) remain the same.

(AUTH: Sec. 77-4-201, MCA; IMP, Sec. 77-4-201, MCA.)

3. This rulemaking is being proposed because Chapter 372, Laws of 1991, directs the Department to amend ARM 26.6.411 in the manner proposed.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment, in writing, to Pat Flowers, Chief, Forest Management Bureau, Department of Natural Resources and Conservation, 2705 Spurgin Road, Missoula, MT 59801. To guarantee consideration, comments must be received or postmarked no later than August 1, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express his or her data, views, or arguments orally or in writing at a public hearing, he or she must make written request for hearing and submit this request along with any written comments to Pat Flowers, Chief, Forest Management Bureau, Department of Natural Resources and Conservation, 2705 Spurgin Road, Missoula, MT 59801. A written request for hearing must be received no later than August 1, 1995.

6. If the agency receives request for public hearing on the proposed amendment, from either 10 percent 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. Ten percent of those persons directly affected has been determined to be one person based on the fact that at any one time approximately 15 persons have timber sale contracts with the Department.

Reviewed by:

John F. North
Chief Legal Counsel

Arthur R. Clinch
Commissioner

Certified to the Secretary of State June 19, 1995.

BEFORE THE BOARD OF LAND COMMISSIONERS
AND THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 26.4.410, 26.4.1001, and 26.4.1001A, pertaining to renewal of strip mine operating permits and to regulation of coal and uranium prospecting.	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 29, 1995, or as soon thereafter as the boards may meet, the Board of Land Commissioners and the Board of Environmental Review propose to amend ARM 26.4.410, 26.4.1001, and 26.4.1001A, pertaining to renewal of strip mine operating permits and to regulation of coal and uranium prospecting.

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

26.4.410 PERMIT RENEWAL (1) Applications for renewals of a permit must be made at least ~~120~~ 240, but not more than ~~150~~ 300 days prior to the expiration date. Renewal applications must be on a form provided by the department, including, at a minimum, the following:

(a) through (c) remain the same.

(2) through (5) remain the same.

(AUTH: Sec. 82-4-204, 205, MCA; IMP, Sec. 82-4-221, 226, MCA.)

26.4.1001 PERMIT REQUIREMENT (1) A person who intends to prospect for coal or uranium on land not included in a valid strip or underground mining permit must obtain a prospecting permit from the department if the prospecting will:

(a) be conducted to determine the location, quality or quantity of a natural mineral deposit and will substantially disturb, as defined in ARM 26.4.301, the natural land surface; or

(b) will be conducted on an area designated unsuitable for strip or underground coal mining pursuant to 82-4-227 or 82-4-228, MCA.

(2) through (5) remain the same.

(AUTH: Sec. 82-4-204, 205, MCA; IMP, Sec. 82-4-226, MCA.)

26.4.1001A NOTICE OF INTENT TO PROSPECT (1) ~~A person who conducts~~ This rule applies to a prospecting operation that is:

(a) outside an area designated unsuitable for coal mining pursuant to 82-4-227 or 82-4-228, MCA~~,~~ and

(b) that is:

(i) not conducted for the purpose of determining the location, quality or quantity of a natural mineral deposit~~,~~; or

(ii) conducted for the purpose of determining the location, quality, or quantity of a natural mineral deposit but does not substantially disturb, as defined in ARM 26.4.301, the natural land surface.

(2) A person who conducts a prospecting operation must, before conducting the prospecting operations, file with the department a notice of intent to prospect that meets the requirements of ~~(2) or~~ (3) or (4). A notice of intent to prospect is effective for one year after it is filed. If prospecting activities described in a notice are not conducted within the year, they may be incorporated by reference in a subsequent notice of intent to prospect.

~~(2)~~ (3) A notice of intent for prospecting activities that will not substantially disturb, as defined in ARM 26.4.301, the natural land surface must contain the following:

(a) and (b) remain the same.

~~(3)~~ (4) A notice of intent to prospect for prospecting operations that will substantially disturb, as defined in ARM 26.4.301, the natural land surface, must contain the following:

(a) through (c) remain the same.

~~(4)~~ (5) Within 30 days of receipt of a notice of intent to prospect pursuant to ~~(2) or~~ (3) or (4), the department shall notify the person who filed the notice whether the notice meets the requirements of ~~(2) or~~ (3) or (4).

~~(5)~~ (6) Each person who conducts prospecting which substantially disturbs the natural land surface shall, while in the exploration area, have available to the department for review upon request a copy of the notice of intent to prospect.

~~(6)~~ (7) All provisions of this subchapter, except ARM 26.4.1001(1), (2)(i) and (j), (3), (4), and (5), 26.4.1003, 26.4.1014, 26.4.1016, and 26.4.1017, apply to a prospecting operation for which a permit is not required pursuant to ARM 26.4.1001.

(AUTH: Sec. 82-4-205, 226, MCA; IMP, Sec. 82-4-226, MCA.)

3. In Chapter 159, Laws of 1995, the Legislature, at the request of the Department, amended the Montana Strip and Underground Mine Reclamation Act in two respects. First, it amended §§ 82-4-203(26) and 82-4-226(8) by expanding the definition of "prospecting" and adjusting the permitting requirements to reflect this amendment. These changes were made to comply with a directive of the Office of Surface Mining made pursuant to 30 CFR, Part 732. Second, the Legislature amended § 82-4-221(1) by changing the window of time during which an application to renew an operating permit must be submitted from 120-150 days prior to the renewal date to 240-300 days prior to the renewal date. These rule amendments are proposed to implement Chapter 159, Laws of 1995.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment, in writing, to Bonnie Lovelace, Chief, Coal and Uranium Bureau, Department of Environmental Quality, 1625 11th Avenue, PO Box 201601, Helena, MT 59620-1601. To guarantee consideration,

comments must be received or postmarked no later than August 1, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express his or her data, views, or arguments orally or in writing at a public hearing, he or she must make written request for hearing and submit this request along with any written comments to Bonnie Lovelace, Chief, Coal and Uranium Bureau, Department of Environmental Quality, 1625 11th Avenue, PO Box 201601, Helena, MT 59620-1601. A written request for hearing must be received no later than August 1, 1995.

6. If the agency receives request for public hearing on the proposed amendment, from either 10 percent 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. Ten percent of those persons directly affected has been determined to be one person based on fewer than 10 active coal or uranium operating permittees in Montana.

Reviewed by:

John F. North
Chief Legal Counsel

Arthur R. Clinch
Commissioner

Certified to the Secretary of State June 19, 1995.

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

In the matter of the adoption of Rules I through V pertaining to medicaid estate recoveries and liens	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES I THROUGH V PERTAINING TO MEDICAID ESTATE RECOVERIES AND LIENS

TO: All Interested Persons

1. On July 20, 1995, at 1:30 p.m., a public hearing will be held in Room 306 of the Public Health and Human Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of Rules I through V pertaining to medicaid estate recoveries and liens.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on July 10, 1995, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] MEDICAID ESTATE RECOVERIES, WAIVER OF RECOVERY BASED UPON UNDUE HARDSHIP (1) The department shall waive, in whole or in part, its claim under [section 5, ch. 492, L. 1995], if the applicant demonstrates that recovery would result in an undue hardship to the applicant as provided in this rule.

(2) An applicant may request an undue hardship waiver of estate recovery by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59604-4210.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses and other matters relevant and necessary to determine whether an undue hardship would result from recovery.

(3) The persons entitled to apply for an undue hardship waiver as provided in this rule are:

(a) a person that has succeeded to part or all of the decedent's assets or that would succeed to all or part of the decedent's assets but for recovery by the department, including a person that received or would have received a beneficial interest in the assets but not legal title; or

(b) a person who was during the decedent's lifetime and after the decedent's death remains dependent upon the decedent's assets for food, shelter or clothing.

(4) In determining whether an undue hardship would result from recovery, the department shall consider the following factors:

(a) Whether the applicant would become eligible for public assistance without receipt of all or part of the proceeds of the estate or retention of all or part of the value of property received by survival or distribution;

(b) Whether the applicant would be able to discontinue eligibility for public assistance if the applicant were permitted to receive all or part of the proceeds of the estate or to retain all or part of the value of property received by survival or distribution;

(c) When the estate assets or property received by survival or distribution are part of a business that existed during the decedent's lifetime, including a working farm or ranch, whether recovery by the department would deprive the applicant of their sole means of livelihood and the applicant has no other means of satisfying the department's claim;

(d) The applicant is an aged, blind or disabled relative of the decedent who for one year or more before the decedent's death had been continuously and lawfully living in a residence owned by the decedent and continues to reside there, and who would have significant difficulty establishing an alternative living arrangement, obtaining financing (such as a home equity loan) to repay the department or arranging other means to repay the department;

(e) The applicant is a relative of the decedent who for one year or more before the decedent's death had been continuously and lawfully living in a residence owned by the decedent and continues to reside there, and who would have no means of providing or obtaining alternative shelter and there is no person legally responsible or assets otherwise available to provide the person shelter;

(f) Without recovery by the department, the applicant would receive or be permitted to retain property that the applicant transferred to the decedent for no consideration; or

(g) Whether the property that applicant would receive or be permitted to retain without recovery by the department is needed by the applicant to acquire necessities of life, such as food, shelter, clothing or medical care and whether there are any other assets or means available to the applicant to satisfy in full or in part the department's claim.

(5) An undue hardship does not exist if the decedent or applicant created the hardship by using estate planning methods to divert or shelter assets to avoid estate recovery.

(6) The department may limit an undue hardship waiver to a partial or temporary waiver of recovery and/or may condition a waiver upon the applicant's agreement and provision of security for repayment in appropriate cases if the limited waiver would address reasonably the applicant's hardship.

(7) To the extent that there currently is, or later comes into existence, a conflict between the provisions of this rule and standards promulgated by the secretary of the U.S. department of health and human services, the federal standards shall control.

(8) The department shall provide the applicant written notice of its determination on an application for an undue hardship waiver of estate recovery.

(9) An applicant aggrieved by an adverse determination on an application for an undue hardship waiver of estate recovery may assert a claim of entitlement to an undue hardship waiver as provided in [section 5(7)(c), ch. 492, L. 1995]. An aggrieved applicant is not entitled to an administrative review, fair hearing or contested case hearing regarding the determination.

AUTH: Sections 5 and 26, ch. 492, L. 1995
IMP: Section 5, ch. 492, L. 1995

[RULE II] MEDICAID REAL PROPERTY LIEN, NOTICE AND RIGHT TO HEARING (1) At least 45 days prior to filing a lien under [sections 8, ch. 492, L. 1995] upon real property of a medicaid applicant or recipient, the department must provide the applicant or recipient notice of its determination that applicant or recipient is permanently institutionalized and that none of the exceptions provided by [sections 8, ch. 492, L. 1995] or federal law apply. The notice must inform the applicant or recipient of the right to a fair hearing as provided in subsection (2).

(2) The applicant or recipient upon whose property the department proposes to impose a lien under [sections 8, ch. 492, L. 1995] is entitled to a fair hearing according to the provisions of ARM 46.2.201, et seq. The applicant or recipient must request the hearing within 30 days of receipt of the notice required under subsection (1).

(3) If a hearing is requested, the department may not file the lien until permitted to do so by order of the hearing officer or a court of law, which may be granted after a determination on the merits or before a determination on the merits upon a demonstration by the department that the lien is necessary to prevent the applicant, recipient or other person from disposing of the property to avoid the lien.

AUTH: Section 26, ch. 492, L. 1995 and 2-4-201 MCA
IMP: Sections 8 and 9, ch. 492, L. 1995 and 2-4-201 MCA

[RULE III] MEDICAID REAL PROPERTY LIEN, WAIVER OF LIEN RECOVERY BASED UPON UNDUE HARDSHIP (1) The department shall waive, in whole or in part, its recovery upon a lien under [sections 8 through 25, ch. 492, L. 1995], if the applicant demonstrates that recovery would result in an undue hardship to the applicant.

(2) An applicant may request an undue hardship waiver of lien recovery by filing an application on the form prescribed by the department. Application forms may be obtained from and must

be filed with the Department of Public Health and Human Services, Medicaid Services Division, Lien Recoveries, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses and other matters relevant and necessary to determine whether an undue hardship would result from recovery.

(3) The persons entitled to apply for an undue hardship waiver as provided in this rule are:

(a) a person that has succeeded to part or all of the recipient's interest in the liened property or that would succeed to all or part of the recipient's interest but for recovery by the department, including a person that received or would have received a beneficial interest in the liened property but not legal title; or

(b) a person who is dependent upon the liened property for shelter or if the recipient is deceased, was during the recipient's lifetime and after the decedent's death remains dependent upon the liened property for shelter.

(4) In determining whether an undue hardship would result from recovery, the department shall consider the following factors:

(a) Whether the applicant would become eligible for public assistance as a result of lien recovery by the department;

(b) Whether the applicant would be able to discontinue eligibility for public assistance if the department were to waive lien recovery;

(c) When the liened property is part of a business that exists or existed during the recipient's lifetime, including a working farm or ranch, whether lien recovery by the department would deprive the applicant of their sole means of livelihood and the applicant has no other means of satisfying the department's claim;

(d) The applicant is an aged, blind or disabled relative of the recipient who for one year or more before the recipient's death had been continuously and lawfully living in the liened property and continues to reside there, and who would have significant difficulty establishing an alternative living arrangement, obtaining financing (such as a home equity loan) to repay the department or arranging other means to repay the department;

(e) The applicant is a relative of the recipient who for one year or more before the recipient's death had been continuously and lawfully living in the liened property and continues to reside there, and who would have no means of providing or obtaining alternative shelter and there is no person legally responsible or assets otherwise available to provide the person shelter;

(f) Without lien recovery by the department, the applicant would receive or be permitted to retain liened property that the applicant transferred to the decedent for no consideration; or

(g) Whether the liened property is needed by the applicant for shelter and whether there are any other assets or means

available to the applicant to satisfy in full or in part the department's claim.

(5) An undue hardship does not exist if the recipient or applicant created the hardship by using estate planning methods to divert or shelter assets to avoid estate recovery.

(6) The department may limit an undue hardship waiver to a partial or temporary waiver of lien recovery and/or may condition a waiver upon the applicant's agreement and provision of security for repayment in appropriate cases if the limited waiver would address reasonably the applicant's hardship.

(7) To the extent that there currently is, or later comes into existence, a conflict between the provisions of this rule and standards promulgated by the secretary of the U.S. department of health and human services, the federal standards shall control.

(8) The department shall provide the applicant written notice of its determination on an application for an undue hardship waiver of lien recovery.

(9) An applicant aggrieved by an adverse determination on an application for an undue hardship waiver of lien recovery may assert a claim of entitlement to an undue hardship waiver as provided in [section 17(1)(c), ch. 492, L. 1995]. An aggrieved applicant is not entitled to an administrative review, fair hearing or contested case hearing regarding the determination.

AUTH: Sections 17 and 26, ch. 492, L. 1995
IMP: Section 17, ch. 492, L. 1995

[RULE IV] MEDICAID REAL PROPERTY LIEN, SPOUSE'S LIMITED RECOVERY EXEMPTION (1) The department shall provide to the recipient's surviving spouse an exemption from recovery on a lien under [section 8, ch. 492, L.1995] to the extent and under the conditions specified in [section 19, ch. 492, L.1995], according to the procedures and requirements specified in this rule.

(2) A recipient's spouse may request the exemption by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, Medicaid Services Division, Lien Recoveries, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) The department may require the applicant to submit any information and documentation regarding the applicant's finances, property, employment, liabilities, expenses, fair market value of assets, and other matters relevant and necessary to determine entitlement to and the amount of any exemption under this rule.

(3) The department must provide the applicant notice of its determination on an application for the spousal exemption. The notice must inform the applicant or recipient of the right to a fair hearing as provided in subsection (2).

(4) An applicant aggrieved by the department's determination on an application for a spousal exemption under this rule is entitled to a fair hearing according to the

provisions of ARM 46.2.201, et seq. The applicant or recipient must request the hearing within 30 days of receipt of the notice required under subsection (1).

(5) If a hearing is requested, the department may, subject to order of the hearing officer or a court having jurisdiction of the matter, take action to preserve the security of the lien but may not take further action to recover upon the lien until permitted to do so by order of the hearing officer or a court of law, which may be granted after a determination on the merits or before a determination on the merits upon a demonstration by the department that the lien is necessary to prevent the applicant or another party from disposing of the property to avoid the lien.

AUTH: Sections 19 and 26, ch. 492, L. 1995 and 2-4-201 MCA
IMP: Section 19, ch. 492, L. 1995 and 2-4-201 MCA

[RULE V] MEDICAID REAL PROPERTY LIEN, RELEASE OF LIEN AFTER RECIPIENT'S RETURN HOME (1) If a recipient upon whose real property the department has imposed a lien under [section 8, ch. 492, L.1995] has been discharged from the facility and has returned home, the department shall upon written request file a release of the lien in the clerk and recorder's office.

(2) The written request must contain the name and social security number of the recipient and must be accompanied by a copy of the legal description of the property subject to the lien.

(3) The department may require reasonable documentation or verification that the recipient has been discharged from the facility and returned home.

AUTH: Section 26, ch. 492, L. 1995
IMP: Section 11, ch. 492, L. 1995

3. The proposed rules are necessary to implement provisions of Senate Bill 236, enacted by the 1995 Montana legislature, (Chapter 492, Law of Montana, 1995) relating to medicaid estate recoveries and real property liens.

Proposed [Rule I] is necessary to comply with Section 5 of Senate Bill 236, which requires the department to adopt rules establishing procedures and criteria for undue hardship exceptions to department estate recoveries. Section 5 of SB 236 authorizes recovery of medicaid expenditures from estates of deceased recipients and individuals that have received the recipient's property by distribution or survival. The proposed rules have been developed consistent with federal guidelines for implementation of federal statute requiring the undue hardship waiver.

Proposed [Rule II] is necessary to comply with Sections 8 and 9 of Senate Bill 236, which requires the department to provide notice and an opportunity for a hearing when the department

determines that an applicant or recipient is permanently institutionalized and that the department intends to impose a lien.

Proposed [Rule III] is necessary to comply with Section 17 of Senate Bill 236, which requires the department to adopt rules establishing procedures and criteria for undue hardship exceptions to department lien recoveries. Section 8 of SB 236 authorizes imposition of liens upon real property of certain medicaid applicants and recipients to secure property for later recovery of medicaid expenditures. The bill specifies the conditions under which recovery may be undertaken by the department, and requires the department to provide by rule for an undue hardship exception to lien recovery. The proposed rules have been developed consistent with federal guidelines for implementation of federal statute requiring the undue hardship waiver.

Proposed [Rule IV] is necessary to implement section 19 of SB 236, which allows for a limited exemption from the real property lien for spouses of recipients. The bill authorizes the department to by rule require applying spouses to file an application for the exemption and to provide information, documentation, verification of assets and fair market value of assets. The proposed rules are necessary to establish the application process, inform potential applicants of the procedures for applying for and obtaining the exemption and specify notice and hearing requirements.

Proposed [Rule V] is necessary to implement section 11(5) of SB 236. That section provides that the department's lien dissolves if the recipient is discharged from the facility and returns home, and that under these circumstances the department is required to file a release of the lien upon written request. The proposed rule is necessary to establish and inform potential requestors of a procedure for written requests for releases in such cases.

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 Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than July 27, 1995.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services are changed to the Department of Public Health and Human Services.

6. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.5.1002 pertaining day care rates for state paid day care	NOTICE OF AMENDMENT OF RULE 11.5.1002 PERTAINING TO DAY CARE RATES FOR STATE PAID DAY CARE

TO: All Interested Persons

1. On May 11, 1995, the Department of Family Services published notice of the proposed amendment of Rule 11.5.1002 pertaining to day care rates for state paid day care, at page 740 of the 1995 Montana Administrative Register, issue number 9.

2. The department has amended the rule as proposed, and also as proposed, the amendment is effective July 1, 1995.

3. No comments were received.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson

Hank Hudson, Director

John Melcher

John Melcher, Rule Reviewer

Certified to the Secretary of State, June 19, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.7.313 pertaining the model rate matrix used to determine payment to youth care facilities	))))	NOTICE OF AMENDMENT OF RULE 11.7.313 PERTAINING TO THE MODEL RATE MATRIX USED TO DETERMINE PAYMENT TO YOUTH CARE FACILITIES

TO: All Interested Persons

1. On May 11, 1995, the Department of Family Services published notice of the proposed amendment of Rule 11.7.313 pertaining to the model rate matrix used to determine payment to youth care facilities, at page 736 of the 1995 Montana Administrative Register, issue number 9.

2. The department has amended the rule as proposed, and also as proposed, the rule amendment is effective July 1, 1995.

3. No comments were received.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretaty of State, June 19, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.13.101 pertaining to the application of the model rate matrix to basic level therapeutic youth group homes	NOTICE OF AMENDMENT OF RULE 11.13.101 PERTAINING TO THE APPLICATION OF THE MODEL RATE MATRIX TO BASIC LEVEL THERAPEUTIC YOUTH GROUP HOMES

TO: All Interested Persons

1. On May 11, 1995, the Department of Family Services published notice of the proposed amendment of Rule 11.13.101 pertaining to the application of the model rate matrix to basic level therapeutic youth group homes at page 738 of the 1995 Montana Administrative Register, issue number 9.

2. The department has amended the rule as proposed.

3. No comments were received.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, June 19, 1995.

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

In the matter of proposed amendment of ARM 12.6.901 relating to the restriction of motor-propelled water craft on the Blackfoot, Clark Fork, and the Bitterroot Rivers.	NOTICE OF THE AMENDMENT OF RULE 12.6.901

To: All Interested Persons

1. On April 27, 1995, the Fish, Wildlife & Parks Commission (commission) published notice of the proposed amendment of the above-captioned rule at page 557, 1995 Montana Administrative Register, issue number 8.

2. The commission amends the rule with the following changes from the rule amendment as proposed (new material is in uppercase; material to be deleted is interlined):

12.6.901 WATER SAFETY REGULATIONS (1) In the interest of public health, safety, or protection of property, the following regulations concerning the public use of certain waters of the state of Montana are hereby adopted and promulgated by the Montana fish, wildlife and parks commission.

(a) The following waters are closed to use for any motor-propelled water craft except in case of use for official patrol, search and rescue, maintenance of hydroelectric projects and related facilities with prior notification by the utility, or for scientific purposes, or for special events such as testing motorized watercraft by prior written approval of the director;

Beaverhead County through Meagher County same as proposed.

Mineral County:	(A) The Clark Fork River from St. John's fishing access site to ~~Tarkio fishing access site~~ THE MOUTH OF FISH CREEK, also known as the Alberton Gorge Whitewater section.
Missoula County:	(A) Frenchtown Pond (B) Harpers Lake (C) Bitterroot River from the Ravalli county line to its confluence with the Clark Fork River. ExceptionS: ~~Motorized craft may be used from March 1 through June 15 on the portion of the Bitterroot River from the mouth of Lolo Creek downstream to the Clark Fork River.~~ (1) ANY MOTORIZED CRAFT MAY BE USED FROM MAY 1 THROUGH JUNE 30 ON THE

PORTION OF THE BITTERROOT RIVER FROM THE FLORENCE BRIDGE IN RAVALLI COUNTY DOWNSTREAM TO THE CLARK FORK RIVER. (2) MOTORIZED CRAFT POWERED BY 15 HORSEPOWER OR LESS MAY OPERATE ANYWHERE ON THE BITTERROOT RIVER FROM OCTOBER 1 THROUGH JANUARY 31.
(D) The Blackfoot River and its tributaries from Missoula county line to the Stimson Lumber Mill Dam at Bonner.
(E) The Clark Fork River and tributaries from the Granite county line to the Milwaukee Bridge abutments on Milltown Reservoir.

Powell County same as proposed.

Ravalli County:

~~(A) Twin Lakes~~
~~(B) The Bitterroot River from its headwaters to the Missoula county line.~~
(A) THE BITTERROOT RIVER FROM ITS HEADWATERS TO THE MISSOULA COUNTY LINE. EXCEPTIONS: (1) ANY MOTORIZED CRAFT MAY BE USED FROM MAY 1 THROUGH JUNE 30 ON THE PORTION OF THE BITTERROOT RIVER FROM THE FLORENCE BRIDGE DOWNSTREAM TO THE CLARK FORK RIVER. (2) MOTORIZED CRAFT POWERED BY 15 HORSEPOWER OR LESS MAY OPERATE ANYWHERE ON THE BITTERROOT RIVER FROM OCTOBER 1 THROUGH JANUARY 31.

Richland County through (b) same as proposed.

(c) The following waters are limited to a controlled no wake speed. No wake speed is defined as a speed whereby there is no "white" water in the track or path of the vessel or in created waves immediate to the vessel:

Big Horn County through Madison County same as proposed.

~~Mineral County: (A) Clark Fork River from Tarkio fishing access site to Forest Grove fishing access site. (This portion of the river is the lower end of the Alberton Gorge Whitewater section.)~~

Missoula County same as proposed.

AUTH: 87-1-303, 23-1-106(1) MCA
IMP: 87-1-303, 23-1-106(1) MCA

3. The following is a summary of changes made to the river use rules as originally proposed. These changes are based on public input and further analysis by the commission and staff of the Department of Fish, Wildlife & Parks (department). Four modifications to the proposed rule were adopted by the commission during final adoption. These changes include:

The original dates proposed for motorized use on the lower Bitterroot River, March 1 through June 15, were changed to May 1 through June 30, to reflect the forty year average for high flows on the river. This change also addressed concerns relating to early waterfowl and bird nesting and early spring recreational use prior to high water.

The portion of the Bitterroot River available for motorized use in May and June was moved further upstream from the mouth of Lolo Creek to the Florence Bridge. Based on public comment, the commission has decided that public safety would not be compromised by this extension.

The use of motorized watercraft of 15 horsepower or less from October 1 through January 31 was added to recognize traditional waterfowl and deer hunting use.

The restrictions proposed on the lower Clark Fork River from Fish Creek to Forest Grove on motorized use were dropped from the final rule, because the commission had determined, based on public input and analysis by departmental staff, that public safety would not be compromised if these proposed restrictions were dropped.

4. Approximately 225 individuals attended the three public hearings conducted to receive comments on the commission's proposed rule. Individuals testifying also provided written comments to add to the record. A total of 329 comments were received during the formal comment period ending May 31, 1995, with 308 written and oral and 21 telephone responses.

Of the 329 comments, 230, or 70%, favored the rules as proposed or favored more restrictions, and 99, or 30% were opposed to some or all restrictions. Of those opposing the proposed rules, 22 specifically were against any restrictions on the Clark Fork River below Fish Creek. The final rule addressed the concerns of these opponents, which changed the total of those opposed to 77, or 23% of the commentors.

Several commentors suggested changes to the proposed rule, and a summary of these, with a commission response, follows:

COMMENT 1: Regulations would not be needed if individuals respected the rights of others, showed courtesy for others and used common sense.

RESPONSE 1: While in principle the commission agrees, the increasing amount of recreational use requires the implementation of enforceable rules to address safety issues.

COMMENT 2: Implement a no wake zone on Blackfoot River below Stimson Lumber Company Dam.

RESPONSE 2: Rules were adopted in July 1994 to address safety issues in this area, and an evaluation of their effectiveness will continue through 1995 before additional restrictions are considered. These rules restrict motorized craft to a no wake restriction in some sections of the river while allowing unrestricted use in other sections.

COMMENT 3: The Flathead and Clearwater Rivers, as well as some lakes, should be designated non-motorized.

RESPONSE 3: These rivers and lakes were not included in this rule-making process and would require public notice of any such proposed restrictions to assure adequate public involvement and participation. A no wake designation already exists on the Clearwater River north of Seeley Lake. The issue of safety on the Flathead River has been forwarded to department administrative region 1 in Kalispell for consideration.

COMMENT 4: Restricting the use of public waters for special interest groups, such as floaters and outfitters, is not fair to rest of public.

RESPONSE 4: The rules were not proposed to favor any particular user group, and are intended to address safety concerns as more and more people use the river resources.

COMMENT 5: No real safety issue exists and no injuries or deaths have been documented.

RESPONSE 5: The department has received several calls relating experiences that can only be categorized as dangerous situations, although it is true no injuries or deaths have been documented. The commission has a responsibility to address the potential for accidents if dangerous situations exist, or are likely to exist.

COMMENT 6: The Clark Fork River, running through the city of Missoula, should be designated non-motorized.

RESPONSE 6: This portion of the river was not addressed in the proposed rule, and no safety issues have been brought to the attention of the commission at this time. Any action would require a new rule-making process.

COMMENT 7: The Clark Fork River from Missoula to Petty Creek should be designated a no wake zone.

RESPONSE 7: This portion of the Clark Fork is wide with good visibility. Dangerous situations have not been recorded for this area, and, given the size of the river, no action is proposed at this time by the commission.

COMMENT 8: I pay taxes and registration for a motorized craft, therefore, these waterways are as much for my personal enjoyment as they are for fishermen and rafters.

RESPONSE 8: The commission recognizes the contributions of motorized users to providing funds for access site development,

but safety considerations require restrictions which may limit or exclude certain types of recreational watercraft on certain waters.

COMMENT 9: Too many rules already exist on our rivers.

RESPONSE 9: The rules pertaining to recreational use of rivers are intended to provide for the safety and welfare of all recreationalists, and may be more restrictive for one user group than another. With more people vying for use of these limited resources, additional rules will likely occur in the future if necessary for the safety of the users of a stream, river or lake.

COMMENT 10: Motorized craft are an effective tool for search and rescue, and are often used to assist non-motorized users who get in trouble.

RESPONSE 10: The rules allow for the use of motorized craft for "official patrol, search and rescue, maintenance of hydroelectric projects and related facilities with prior notification by the utility, or for scientific purposes, or for special events such as testing motorized watercraft by prior written approval of the director; . . ."

COMMENT 11: Restrictions on the lower Clark Fork River would hinder economic development efforts, since motorized use is a part of the recreational opportunity advertized.

RESPONSE 11: The proposed rule was amended to exclude restrictions below Fish Creek, which addresses this concern.

COMMENT 12: Noise created by motorized craft is an issue that needs addressing and perhaps a decibel level needs to be established.

RESPONSE 12: Most individual watercraft meet noise standards imposed by current law (23-2-526(3), MCA) of 86 decibels when measured at a distance of 50 feet, and manufacturers have been reducing noise levels on new craft as technology allows.

COMMENT 13: Use of the access to the Bitterroot River at the Lolo sewage treatment plant is creating problems for area homeowners, and motorized use is increasing.

RESPONSE 13: The problems associated with this county-owned property are currently being discussed with county planners and the department. Landowners will also be asked to participate in any remedies or development of this site. The rule restricts motorized use of this section of river to May and June, which should alleviate some of the concerns expressed.

COMMENT 14: Can the commission impose restrictions on a navigable river or impose restrictions on motorized use?

RESPONSE 14: The commission is granted authority to "adopt and enforce rules governing recreational uses of all public fishing reservoirs, public lakes, rivers and streams. . ." under 87-1-303, MCA. This authority applies to all public lakes, streams, and rivers including both navigable and nonnavigable water bodies.

COMMENT 15: No real safety issues exist below Fish Creek on the lower Clark Fork River.

RESPONSE 15: The commission concurs, and the adopted rule has been amended so there are no restrictions below Fish Creek.

COMMENT 16: Small motorized craft should be allowed for waterfowl and deer hunting on the Bitterroot River.

RESPONSE 16: The commission agrees that this traditional use can continue without creating a safety concern. The rule was amended to allow motorized craft of 15 horsepower or less to operate on the Bitterroot River from October 1 through January 31 each year.

COMMENT 17: Small motorized craft should be allowed on all rivers since they don't present a safety issue.

RESPONSE 17: This comment is true if the craft is operated during times when other uses are not occurring on a river. However, with the increasing number of recreationalists, the commission feels that rules covering all situations allow for safer recreation at all times, because everyone knows what type of use to expect when they enter a section of a river associated with this rule.

COMMENT 18: A person should have the right to use the river for recreation or irrigation.

RESPONSE 18: Certain types of uses are restricted under this rule, but the rules do not prohibit most activities. No water right for irrigation is affected by this rule.

COMMENT 19: Allow motorized water craft to use entire Bitterroot River during high water.

RESPONSE 19: The rule was modified to allow use on the lower Bitterroot River from Florence Bridge downstream to the Clark Fork River during May and June. These two months represent the 40 year average for high flows. With increasing use of the river during all times of the year, including high water, this restriction was warranted for safety reasons. The use of the river by motorized craft during high water does not create the safety concerns that the same use during low water creates.

COMMENT 20: Allow motorized use during high water based on actual flows by marking bridge abutments or having a phone line that would give current river flows.

RESPONSE 20: The commission agreed to investigate this recommendation, and, if feasible, look at amending the rules in the future to possibly accommodate this suggestion on areas identified for motorized recreation.

COMMENT 21: Establish every other day as motorized use or non-motorized use, or establish times of day when particular activities can occur.

RESPONSE 21: Non-motorized use of rivers is estimated to represent 90 to 95% of the existing recreational use. Every other day would give 50% of the use to a group that proportionately represents far less use. The time of day restrictions has more merit, and will be considered in the future. Other combinations of use days and times may be solutions to future issues that develop. However, it is important to recognize that in constricted areas there is a danger of collisions between motorized craft in addition to the danger of collisions between motorized craft and other recreational users.

COMMENT 22: Motorized use disturbs and disrupts nesting

waterfowl and other wildlife, especially in early spring.

RESPONSE 22: The rules restrict use on the Bitterroot River to the high water periods of May and June, which reduces impacts to nesting waterfowl and other bird life. The upper Clark Fork is designated non-motorized, which addresses concerns on that portion of the river. Any disturbance, whether motorized or non-motorized, can have an affect on nesting birds.

COMMENT 23: Wakes from motorized craft create sedimentation problems and cause bank erosion, and should be sufficient reason for banning all motorized use on rivers.

RESPONSE 23: Additional studies of this contention are necessary before conclusions are drawn. Natural spring run-off produces the same actions at a much higher level than boat wakes. However, during low flows, this activity may be detrimental to fish roe and aquatic life by depositing fine sediments over them. This issue will be researched.

COMMENT 24: Restrictions need to be placed on floaters, since there are getting to be too many using certain areas.

RESPONSE 24: This is a valid observation, and one can anticipate that such restrictions will have to occur at some point in the future, especially on areas like the Alberton Gorge. The Smith River has such restrictions, but legislation is needed to establish them on any other body of water.

COMMENT 25: Floaters should pay costs associated with access site maintenance through registration of all craft.

RESPONSE 25: Legislation would be required to implement a registration requirement for non-motorized craft.

COMMENT 26: Rafts, canoes, kayaks and personal water craft should have identifying numbers on them so a person could report violations or misconduct.

RESPONSE 26: Again, legislation would be necessary to implement this suggestion.

COMMENT 27: A study is needed of motorized use impacts from oil, gas and noise pollution.

RESPONSE 27: Current water quality monitoring has not detected a problem with motorized use on rivers. Noise pollution represents more of a social issue, which the commission has no authority over.

5. The rule has been reviewed and approved by the Department of Health and Environmental Sciences as required by 87-1-303(2), MCA, with a determination that the rule would not have an adverse impact on public health or sanitation.

FISH, WILDLIFE & PARKS COMMISSION

Robert N. Lane
Rule Reviewer

Patrick J. Graham
Secretary

Certified to the Secretary of State on June 19, 1995.

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

In the matter of the amendment of rules 16.28.101, 201, 202, 203, 204, 305, 605D, 609A, the adoption of new rules I-III, and the repeal of rules 16.28.605C, 606B, 612B, 632, 632A, 632B, and 637 concerning control measures for communicable diseases.	NOTICE OF AMENDMENT OF RULES, ADOPTION OF NEW RULES, I - 16.28.606D, II - 16.28.610E, III - 16.28.632D AND REPEAL OF RULES (Communicable Diseases)

1. On May 11, 1995, the department published notice of the proposed amendment of ARM 16.28.101, 201, 202, 203, 204, 305, 605D, and 609A, the adoption of new rules I-III, and the repeal of ARM 16.28.605C, 606B, 612B, 632, 632A, 632B, and 637 pertaining to control measures for communicable diseases, at page 751 of the 1995 Montana Administrative Register, issue No. 9.

2. The department has adopted new rules I-III and repealed the above-referenced rules as proposed. The department has amended the rules as proposed with the following changes noted (added language is underlined and deleted language is interlined).

16.28.305 CONFIRMATION OF DISEASE (1)(a) Subject to the limitation in (b) below, if a local health officer receives information about a case of any of the following diseases, the officer or the officer's authorized representative must ensure that a specimen from the case is submitted to the department, which specimen will be analyzed to confirm the existence or absence of the disease in question:

(i)-(vii) Same as proposed.

(viii) Human immunodeficiency virus (HIV)

(viii)-(xxviii) Same as proposed but renumbered (ix)-(xxix).

(b) Same as proposed.

(2)-(3) Same as proposed.

16.28.605D CHLAMYDIAL GENITAL INFECTION (1) An individual with a chlamydial genital infection must be directed to undergo appropriate antibiotic therapy and to avoid sexual contact until 24 hours have passed after completion of the treatment regimen.

(2) ~~It is recommended that an~~ An individual who contracts the infection must be interviewed to determine the person's sexual contacts, and ~~that~~ those contacts must be examined and must receive the medical treatment indicated by clinical and laboratory findings.

16.28.609A GONOCOCCAL INFECTION (1) A person who contracts genital gonococcal infection must be directed to undergo appropriate antibiotic therapy and to avoid sexual contact until 24 hours have passed after completion of the treatment regimen.

(2) An individual who contracts the infection must be interviewed to determine the person's sexual contacts, and ~~it is~~

~~recommended that~~ those contacts must be examined and must receive the medical treatment indicated by clinical and laboratory findings.

3. The only comments received were from department staff. A summary of those comments and the department's response follow:

Comment concerning ARM 16.28.305: HIV should be included in the list under (1)(a). Samples submitted for confirmation are routinely investigated by epidemiology program staff. The information facilitates timely investigation and assists with data tracking, partner notification efforts, and disease reporting.

Response: The department agrees that HIV should be included in the list and the rule has been amended accordingly.

Comment concerning ARM 16.28.605D: The language "it is recommended that" should be removed, consistent with the intention to strengthen the control measures for these conditions. Interviewing and treating partners is an important part of disease intervention and must be performed.

Response: The department agrees that the stated language should be removed and the rule has been amended accordingly.

Comment concerning ARM 16.28.609A: The language "it is recommended that" should be removed, consistent with the intention to strengthen the control measures for these conditions. Interviewing and treating partners is an important part of disease intervention and must be performed.

Response: The department agrees that the stated language should be removed and the rule has been amended accordingly.

for ROBERT J. ROBINSON, Director

Certified to the Secretary of State June 19, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of Montana's prevailing wage rates, ARM 24.16.9007	)))	NOTICE OF AMENDMENT OF PREVAILING WAGE RATES-SERVICE OCCUPATIONS

TO ALL INTERESTED PERSONS:

1. On March 30, 1995, the Department published notice at pages 442 to 443 of the Montana Administrative Register, Issue No. 6, to consider the amendment of the above-captioned rule.

2. On April 21, 1995, a public hearing was held in Helena concerning the proposed amendments at which oral and written comments were received. Additional written comments were received prior to the closing date of May 5, 1995.

3. The Department has thoroughly considered the comments and testimony received on the proposed prevailing wage rates. The following is a summary of the comments received, along with the Department's response to those comments:

Comment 1: Mr. Gary E. Gray, General Manager, Burns International Security Services, commented that wage rates for security guards were low in District 3. He submitted data for employees in Districts 3 and 4.
Response 1: The Department added this information to the calculation of the prevailing rate for security guards. As a result, the wage rate for this occupation increased in Districts 3 and 4.

Comment 2: Mr. Gray also commented that wage rates for security guards were high in District 1.
Response 2: The Department believes that the wage rate for security guards in District 1 reflects the labor market in that particular district. The number of hours submitted for work done in this district was sufficient to set a district rate.

Comment 3: Mr. Gene Fenderson, President/Business Manager, Montana District Council of Laborers, commented that wage rates for garbage collectors were low in Districts 3, 4, and 5.
Response 3: The Department received additional information from employers in District 5. As a result, the rate for this occupation increased in both Districts 3 and 5.

Comment 4: Mr. Fenderson, also speaking on behalf of teamsters, operators, laborers, and carpenters on heavy and highway projects, commented on statewide heavy and highway construction rates that were being submitted to the U.S. Department of Labor and urged the adoption of the new rates by the state.
Response 4: The Department will adopt the most current heavy and highway rates published by the U.S. Department of Labor during the first week of June.

Comment 5: Mr. Fenderson also commented on public employer bid letting that affects service occupations with no currently published prevailing wage rate. He would like to see a mechanism set up to survey and publish rates for those occupations in a punctual manner.
Response 5: The Department has an informal process to establish interim advisory rates for occupations that are not included in the published rates. The Department believes that the biennial survey and hearing process appropriately balances the need for up-to-date rates with the budgetary constraints the Department faces.

Comment 6: Additional data were submitted to the Department by employers during the comment period.
Response 6: As a result of the additional data received, prevailing wage rates and fringe benefits for certain occupations were raised and others were lowered.

4. After consideration of the comments received on the proposed amendments, the Department adopts and incorporates by reference the prevailing rates of wages entitled "State of Montana Prevailing Wage Rates" for service occupations and for heavy and highway construction, dated July 1, 1995. The service occupations rates are as proposed, but with changes in the standard prevailing rate of wages for the following occupations:

Wage increases due to additional data:

Auto Accessories Installer: Districts 1, 2, 5, 6, 7, 8, 10
Cleaner/Janitor: Districts 7, 9
Electronics Mechanic, Computer: District 1
Garbage Collector: Districts 3, 5, 8, 9, 10
Janitor-Building Maintenance: Districts 1, 7, 8, 9
Janitorial Services Supervisor: Districts 6, 7, 8, 9
Mechanic, Automotive: Districts 3, 5
Office Machine Servicer: Districts 1, 2, 3, 4, 6, 7, 8, 9, 10
Security Guard: Districts 3, 4
Snow-plow Operator, Truck: Districts 2, 5, 6, 7

Wage decreases due to additional data:

Cleaner/Janitor: District 1
Electronics Mechanic, Computer: Districts 2, 7, 8, 9, 10
Groundskeeper: Districts 2, 3, 7, 9, 10
Janitor-Building Maintenance: District 5
Mechanic, Automotive: Districts 1, 6, 7
Mechanic, Construction Equipment: Districts 2, 3, 5, 6, 7, 9, 10
Radio Mechanic: Districts 1 through 10
Security Guard: Districts 2, 5, 6, 7, 8, 9, 10

Fringe benefit increases due to additional data:

Auto Accessories Installer: District 2
Cleaner/Janitor: District 7

Forest Worker: Districts 2, 3, 4, 5, 6, 7, 8, 9, 10
Garbage Collector: Districts 3, 9
Janitor-Building Maintenance: Districts 7, 8
Mechanic, Automotive: Districts 3, 5, 7
Radio Mechanic: Districts 1 through 10
Snow-plow Operator, Truck: District 6

Fringe benefit decreases due to additional data:

Cleaner/Janitor: Districts 9, 10
Electronics Mechanic, Computer: Districts 1, 2, 7, 8, 9, 10
Garbage Collector: Districts 5, 8, 10
Janitor-Building Maintenance: Districts 5, 9
Janitorial Services Supervisor: District 9
Mechanic, Automotive: Districts 1, 6
Mechanic, Construction Equipment: Districts 2, 3, 5, 6, 7, 9, 10
Office Machine Servicer: Districts 1, 2, 3, 4, 6, 7, 8, 9, 10
Security Guard: Districts 2, 3, 5, 6, 7, 8, 9, 10

AUTH: 18-2-431 and 2-4-307 MCA;
IMP: 18-2-401 through 18-2-432 MCA.

5. The amendments, including the standard prevailing rate of wages, are effective July 1, 1995.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 19, 1995.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the transfer of ARM 24.30.701 through 24.30.749, inclusive, to the Department of Commerce	) NOTICE OF TRANSFER OF RULES (Boilers)	

TO ALL INTERESTED PERSONS:

1. Pursuant to Chapter 514, Laws of 1995, effective July 1, 1995, responsibility for operation of the boiler inspection program is transferred from the Department of Labor and Industry to the Department of Commerce. In order to implement that legislation, ARM 24.30.701 through 24.30.749, inclusive, are transferred to the administrative rules of the Department of Commerce, effective July 1, 1995.

2. The Department of Commerce has determined that the transferred rules will be numbered as follows:

OLD	NEW
24.30.701 through 24.30.749, inclusive	8.70.801 through 8.70.849, inclusive

3. The history of each rule will remain the same insofar as the authority and implementation.

4. The transfer is effective July 1, 1995.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 19, 1995.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the transfer of ARM 24.30.1201 through 24.30.1207, inclusive, to the Department of Commerce	) NOTICE OF TRANSFER OF RULES) (Hoisting and Crane Operators))

TO ALL INTERESTED PERSONS:

1. Pursuant to Chapter 514, Laws of 1995, effective July 1, 1995, responsibility for operation of the hoisting and crane operator licensing program is transferred from the Department of Labor and Industry to the Department of Commerce. In order to implement that legislation, ARM 24.30.1201 through 24.30.1207, inclusive, are transferred to the administrative rules of the Department of Commerce, effective July 1, 1995.

2. The Department of Commerce has determined that the transferred rules will be numbered as follows:

OLD	NEW	
24.30.1201	8.15.201	Purpose
24.30.1202	8.15.202	Definitions
24.30.1203	8.15.203	Hoisting Operators License Requirements
24.30.1204	8.15.204	Mine Hoisting Operators License Requirements
24.30.1205	8.15.205	Crane Hoisting Operators License Requirements
24.30.1206	8.15.206	Procedure to Prohibit Use of Equipment in Violation of Title 50 Chapter 76 Concerning Hoisting Engines and Crane Operators
24.30.1207	8.15.207	Standard Forms

3. The history of each rule will remain the same insofar as the authority and implementation.

4. The transfer is effective July 1, 1995.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 19, 1995.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the transfer of ARM 24.30.1701 through 24.30.1707, inclusive, to the Department of Commerce	) NOTICE OF TRANSFER OF RULES) (Construction Blasters))

TO ALL INTERESTED PERSONS:

1. Pursuant to Chapter 514, Laws of 1995, effective July 1, 1995, responsibility for operation of the construction blaster licensing program is transferred from the Department of Labor and Industry to the Department of Commerce. In order to implement that legislation, ARM 24.30.1701 through 24.30.1707, inclusive, are transferred to the administrative rules of the Department of Commerce, effective July 1, 1995.

2. The Department of Commerce has determined that the transferred rules will be numbered as follows:

OLD	NEW	
24.30.1701	8.15.101	Purpose
24.30.1702	8.15.102	Definitions
24.30.1703	8.15.103	Construction Blaster License Requirements
24.30.1704	8.15.104	Use of Explosives--Incorporation of Standards of National Organizations and Federal Agencies
24.30.1705	8.15.105	Variances
24.30.1706	8.15.106	Training Programs
24.30.1707	8.15.107	Suspension, Revocation, or Refusal to Renew Construction Blaster's License

3. The history of each rule will remain the same insofar as the authority and implementation.

4. The transfer is effective July 1, 1995.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 19, 1995.

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

In the matter of the adoption of Rules I through IX pertaining to self-sufficiency trusts	))))	CORRECTED NOTICE OF ADOPTION

TO: All Interested Persons

1. On March 30, 1995, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rules I through IX pertaining to self-sufficiency trusts at page 446 of the 1995 Montana Administrative Register, issue no. 6, and on May 25, 1995, the Department published the notice of adoption of the proposed rules at page 935 of the 1995 Montana Administrative Register, issue number 10.

2. The notice of adoption incorrectly specified the program title to be "SELF-SUFFICIENCY TRUST:" on [RULE V] 46.2.508 through [RULE IX] 46.2.513 when it should have read "SELF-SUFFICIENCY TRUSTS:".

3. All portions of the May 25, 1995 notice of adoption not specifically changed by this amended notice remain the same.

Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State June 19, 1995.

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

In the matter of the of the adoption of Rules I through XLIV and the amendment of rules 46.8.102, 46.8.106, 46.8.2002, 46.8.2005, 46.8.2006, 46.8.2008, 46.8.2009, 46.8.2014, 46.8.2020, 46.8.2021, 46.8.2026, 46.8.2027, 46.8.2028, 46.8.2029, 46.8.2031, 46.8.2039, 46.8.2041, 46.8.2044, 46.8.2045, 46.8.2047 pertaining to developmental disabilities eligibility, adult and family services and staffing	)	NOTICE OF THE ADOPTION OF RULES I THROUGH XLIV AND THE AMENDMENT OF RULES 46.8.102, 46.8.106, 46.8.2002, 46.8.2005, 46.8.2006, 46.8.2008, 46.8.2009, 46.8.2014, 46.8.2020, 46.8.2021, 46.8.2026, 46.8.2027, 46.8.2028, 46.8.2029, 46.8.2031, 46.8.2039, 46.8.2041, 46.8.2044, 46.8.2045, 46.8.2047 AND REPEAL OF 46.8.103 PERTAINING TO DEVELOPMENTAL DISABILITIES ELIGIBILITY, ADULT AND FAMILY SERVICES AND STAFFING

TO: All Interested Persons

1. On April 27, 1995, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rules I through XLIV and the amendment of rules 46.8.102, 46.8.106, 46.8.2002, 46.8.2005, 46.8.2006, 46.8.2008, 46.8.2009, 46.8.2014, 46.8.2020, 46.8.2021, 46.8.2026, 46.8.2027, 46.8.2028, 46.8.2029, 46.8.2031, 46.8.2039, 46.8.2041, 46.8.2044, 46.8.2045, 46.8.2047 pertaining to developmental disabilities eligibility, adult and family services and staffing at page 568 of the 1995 Montana Administrative Register, issue number 8.

2. The Department has amended rules 46.8.2002, 46.8.2005, 46.8.2006, 46.8.2008, 46.8.2009, 46.8.2014, 46.8.2020, 46.8.2021, 46.8.2026, 46.8.2027, 46.8.2028, 46.8.2029, 46.8.2031, 46.8.2039, 46.8.2041, 46.8.2044, 46.8.2045 and 46.8.2047 as proposed.

3. The Department has adopted [RULE I] 46.8.301, ELIGIBILITY: GENERAL ELIGIBILITY REQUIREMENTS; [RULE III] 46.8.305, ELIGIBILITY: STATE FUNDED FAMILY EDUCATION AND SUPPORT SERVICES; [RULE IV] 46.8.306, ELIGIBILITY: FEDERALLY FUNDED PART H FAMILY EDUCATION AND SUPPORT SERVICES; [RULE VII] 46.8.311, ELIGIBILITY: CHILDRENS' SUMMER DAY SERVICES; [RULE VIII] 46.8.315, ELIGIBILITY: STATE FUNDED ADULT SERVICES; [RULE X] 46.8.320, ELIGIBILITY: STATE FUNDED SENIOR SERVICES; [RULE XIII] 46.8.1901, STAFFING: APPLICABILITY; [RULE XIV] 46.8.1902, STAFFING: STAFF COMPETENCIES GENERALLY; [RULE XV] 46.8.1905, STAFFING: STAFF COMPETENCIES FOR FAMILY EDUCATION AND SUPPORT SERVICES; [RULE XVII] 46.8.1909, STAFFING: CONTRACTOR STAFFING FOR SERVICES; [RULE XVIII] 46.8.1910, STAFFING: CONTRACTOR

STAFFING FOR SUPPORTED LIVING SERVICES; [RULE XX] 46.8.1104 ADULT AND FAMILY SERVICES: LEISURE AND COMMUNITY ACTIVITIES; [RULE XXI] 46.8.1601 ADULT SERVICES: PURPOSE; [RULE XXII] 46.8.1602, ADULT SERVICES: PERFORMANCE REQUIREMENTS; [RULE XXIII] 46.8.1605, ADULT SERVICES: COMMUNITY HOME SERVICES REQUIREMENTS; [RULE XXIV] 46.8.1608, ADULT SERVICES: WORK OR DAY SERVICES REQUIREMENTS; [RULE XXV] 46.8.1609, ADULT SERVICES: SUPPORTED LIVING SERVICES REQUIREMENTS; [RULE XXVI] 46.8.1610, ADULT SERVICES: SUPPORTED LIVING SERVICES SAFETY REQUIREMENTS; [RULE XXVII] 46.8.1701, FAMILY SERVICES: PURPOSE; [RULE XXVIII] 46.8.1702, FAMILY SERVICES: GENERAL DEFINITIONS; [RULE XXX] 46.8.1704, FAMILY SERVICES: DEFINITIONS FOR STATE FUNDED FAMILY EDUCATION AND SUPPORT SERVICES; [RULE XXXI] 46.8.1706, FAMILY SERVICES: GENERAL REQUIREMENTS; [RULE XXXIII] 46.8.1709, FAMILY SERVICES: STATE FUNDED FAMILY EDUCATION AND SUPPORT SERVICES REQUIREMENTS; [RULE XXXIV] 46.8.1710, FAMILY SERVICES: FEDERALLY FUNDED PART H FAMILY EDUCATION AND SUPPORT SERVICES REQUIREMENTS; [RULE XXXV] 46.8.1711, FAMILY SERVICES: FAMILY EDUCATION AND SUPPORT SERVICES RESOURCE AND SUPPORT WRAP-AROUND SERVICES REQUIREMENTS; [RULE XXXVI] 46.8.1712, FAMILY SERVICES: FEDERALLY FUNDED INTENSIVE FAMILY EDUCATION AND SUPPORT SERVICES REQUIREMENTS; [RULE XXXVII] 46.8.1715, FAMILY SERVICES: CHILDREN'S COMMUNITY HOME SERVICES REQUIREMENTS; [RULE XXXVIII] 46.8.1716, FAMILY SERVICES: CHILDREN'S SUMMER DAY SERVICES REQUIREMENTS; [RULE XXXIX] 46.8.2050, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: SUPPORTED LIVING COORDINATION, DEFINITION; [RULE XL] 46.8.2051, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: SUPPORTED LIVING COORDINATION, REQUIREMENTS; [RULE XLI] 46.8.2052, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: MEAL SERVICES, DEFINITIONS; [RULE XLII] 46.8.2053, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: MEAL SERVICES, REQUIREMENTS; [RULE XLIII] 46.8.2054, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: RESPIRATORY SERVICES, DEFINITION; and [RULE XLIV] 46.8.2055, MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: RESPIRATORY SERVICES, REQUIREMENTS as proposed.

4. The Department has adopted the following rules as proposed with the following changes:

[RULE II] 46.8.302 ELIGIBILITY: EVALUATION (1) Diagnostic and evaluation services to determine whether a person has a developmental disability, if not otherwise available to the person from other programs of services, are available to any person believed to have a developmental disability and to be in need of developmental disabilities services.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-209 MCA

[RULE V] 46.8.307 ELIGIBILITY: FEDERALLY FUNDED INTENSIVE FAMILY EDUCATION AND SUPPORT SERVICES Subsections (1) through (3) remain as proposed.

(4) The person must be determined by the field services specialist or the intensive SERVICES review committee to meet the eligibility requirements for intensive services.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-209 MCA

[RULE VI] 46.8.310 ELIGIBILITY: CHILDRENS' COMMUNITY HOME SERVICES Subsection (1) remains as proposed.

(2) The person must be determined by the field services specialist or the intensive SERVICES review committee to meet the eligibility requirements for intensive services.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-209 MCA

[RULE IX] 46.8.317 ELIGIBILITY: FEDERALLY FUNDED INTENSIVE ADULT SERVICES Subsections (1) through (3) remain as proposed.

(4) The person must be determined by the field services specialist or intensive SERVICES review committee to meet the eligibility requirements for intensive services.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-209 MCA

[RULE XI] 46.8.321 ELIGIBILITY: FEDERALLY FUNDED SENIOR SERVICES Subsections (1) and (2) remain as proposed.

(3) The person must be determined by the field services specialist or intensive SERVICES review committee to meet the eligibility requirements for intensive services established by the department.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-209 MCA

[RULE XII] 46.8.325 ELIGIBILITY: APPEAL PROCEDURES Subsections (1) and (2) remain as proposed.

(3) An adverse decision regarding eligibility for federally funded Part H family education and support services is appealable through the internal grievance procedure provided by the contractor. ~~If a resolution to the adverse decision regarding eligibility cannot be reached through the internal grievance procedure, the~~ PARENTS MAY CHOOSE EITHER TO USE OR NOT TO USE THE INTERNAL GRIEVANCE PROCEDURE. THE adverse decision is ALSO appealable in accordance with the procedures for resolving complaints regarding federally funded Part H early intervention services as provided by federal rule at 34 CFR 303.420 through 303.425. The department hereby adopts and incorporates by reference the impartial procedures for resolving individual child complaints regarding federally funded Part H early intervention services published, July 1, 1994, by the United States department of education, at 34 CFR ~~section~~ 303.420 through ~~section~~ 303.425.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-209 MCA

[RULE XVI] 46.8.1906 STAFFING: STAFF COMPETENCIES FOR COMMUNITY HOME, INTENSIVE COMMUNITY HOME, SUPPORTED LIVING, WORK OR DAY SERVICES Subsections (1) through (3)(f) remain as proposed.

(4) For intensive community home, AND intensive work or day services, each staff person must ~~successfully complete~~ BE ENROLLED IN the developmental disabilities client programming technician (DDCPT) curriculum or its equivalent, WITHIN 45 WORKING DAYS OF EMPLOYMENT if competency within the areas covered by such curriculum, has not previously been demonstrated.

~~(a) A new staff person, lacking competency in the areas covered by the DDCPT curriculum, must enroll in the curriculum within 45 working days of the date of hire.~~

Subsection (5) remains as proposed.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-205 MCA

[RULE XIX] 46.8.1101 ADULT AND FAMILY SERVICES: EDUCATION AND TRAINING REQUIREMENTS Subsections (1) through (5) remain as proposed.

(6) Training, formal or incidental, must be provided in the development of ONE OR MORE OF the following areas: motor/physical, communication, self-help and personal care, functional academics, community life, social and sexual, health and safety, home-related skills, adaptive behavior, leisure, work, job-specific training, and self-advocacy.

Subsections (7) through (19) remain as proposed.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-205 MCA

[RULE XXIX] 46.8.1703 FAMILY SERVICES: DEFINITIONS FOR STATE FUNDED AND FEDERALLY FUNDED PART H FAMILY EDUCATION AND SUPPORT SERVICES Subsections (1) through (9) remain as proposed.

(a) individual assessments in nutritional history and dietary intake, anthropometric, biochemical, and clinical variables, feeding skills and feeding problems, and food habits and food preferences~~;~~

Subsections (9)(b) through (18) remain as proposed.

(19) "Respite services" means services to relieve the stress of constant care. Respite care services include, but are not limited to, respite care hours, transportation, and recreation or leisure activities for the child and family. These services are designed to meet the safety and daily care needs of each child and the needs of the child's family so as to reduce family stress generated by provision of constant care to a family member with a developmental disability. RESPITE SERVICES ARE PROVIDED BASED ON THE AVAILABILITY OF FUNDS.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-205 MCA

[RULE XXXII] 46.8.1708 FAMILY SERVICES: FAMILY EDUCATION AND SUPPORT SERVICES REQUIREMENTS Subsections (1) through (5) remain as proposed.

(6) The individualized family service plan (IFSP) must direct the provision of assistance and services to the child.

Subsections (6)(a) and (6)(b) remain as proposed.

(c) The family must be allowed to participate in the planning process at the level they find most comfortable. THE FAMILY MUST RECEIVE WRITTEN NOTIFICATION OF ALL TEAM MEETINGS AND MAY REQUEST WRITTEN NOTIFICATION OF OTHER TEAM MEMBERS.

Subsections (6)(d) through (7) remain as proposed.

(8) THE IFSP MUST BE EVALUATED, REVISED OR REWRITTEN IN RESPONSE TO FAMILY NEED OR AS OTHERWISE NECESSARY.

Subsections (8) through (8)(d) remain as proposed in text but are renumbered (9) through (9)(d).

~~(9)~~(10) Respite services must be provided in conformity with an IFSP or an annual service agreement developed with the family.

Subsections (9)(a) and (9)(b) remain as proposed in text but are renumbered (10)(a) and (10)(b).

(c) RESPITE SERVICES ARE PROVIDED BASED ON THE AVAILABILITY OF FUNDS.

Subsections (10) through (10)(h) remain as proposed in text but are renumbered (11) through (11)(h).

(i) CHILD AND FAMILY PARTICIPATION IN FAMILY SERVICES IS ON A VOLUNTARY BASIS.

Subsections (11) through (14) remain as proposed in text but are renumbered (12) through (15).

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-205 MCA

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

46.8.102 DEFINITIONS For purposes of this chapter, the following definitions apply:

~~(1) "Abuse" means any action causing or threatening physical or mental harm to an individual including neglect, physical abuse, sexual abuse, withholding of basic necessities, the use of unapproved aversive procedures, and the misuse of personal items or monies.~~

(1) "ABUSE" MEANS THE INFLICTION OF PHYSICAL OR MENTAL INJURY OR THE DEPRIVATION OF FOOD, SHELTER, CLOTHING OR SERVICES NECESSARY TO MAINTAIN THE PHYSICAL OR MENTAL HEALTH OF AN OLDER PERSON OR A PERSON WITH A DEVELOPMENTAL DISABILITY WITHOUT LAWFUL AUTHORITY. A DECLARATION MADE PURSUANT TO 50-9-103, MCA CONSTITUTES LAWFUL AUTHORITY.

Subsections (2) through (17) remain as proposed.

(18) "EXPLOITATION" MEANS THE UNREASONABLE USE OF AN OLDER PERSON OR A PERSON WITH A DEVELOPMENTAL DISABILITY, THE PERSON'S

MONEY OR THE PERSON'S PROPERTY TO THE ADVANTAGE OF ANOTHER BY MEANS OF DURESS, MENACE, FRAUD OR UNDUE INFLUENCE.

Subsections (18) through (21)(g) remain as proposed in text but are renumbered (19) through (22)(g).

(h) ~~elient~~ abuse, EXPLOITATION, NEGLECT OR SEXUAL ABUSE;

Subsections (21)(i) through (27) remain as proposed in text but are renumbered (22)(i) through (28).

(29) "NEGLECT" MEANS THE FAILURE OF A GUARDIAN; AN EMPLOYEE OF A PUBLIC OR PRIVATE RESIDENTIAL INSTITUTION, FACILITY, HOME OR AGENCY; OR ANY PERSON LEGALLY RESPONSIBLE IN A RESIDENTIAL SETTING FOR THE WELFARE OF AN OLDER PERSON OR A PERSON WITH A DEVELOPMENTAL DISABILITY TO PROVIDE, TO THE EXTENT OF LEGAL RESPONSIBILITY, FOOD, SHELTER, CLOTHING OR SERVICES NECESSARY TO MAINTAIN THE PHYSICAL OR MENTAL HEALTH OF THE OLDER PERSON OR THE PERSON WITH A DEVELOPMENTAL DISABILITY.

Subsections (28) through (32) remain as proposed in text but are renumbered (30) through (34).

(35) "SEXUAL ABUSE" MEANS THE COMMISSION OF SEXUAL ASSAULT, SEXUAL INTERCOURSE WITHOUT CONSENT, INDECENT EXPOSURE, DEVIATE SEXUAL CONDUCT OR INCEST, AS DESCRIBED IN TITLE 45, PART 5, CHAPTER 5, MCA.

Subsections (33) and (34) remain as proposed in text but are renumbered (36) and (37).

AUTH: Sec. 53-2-201 and 53-20-204 MCA
IMP: Sec. 53-20-203, 53-20-204 and 53-20-205 MCA

46.8.106 CONFIDENTIALITY OF INFORMATION Subsections (1) through (6) remain as proposed.

(7) INFORMATION MAY BE DISCLOSED TO THE EXTENT REQUIRED BY FEDERAL OR STATE LAW.

Subsection (7) remains as proposed in text but is renumbered (8).

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-204 and 53-20-205 MCA

6. The Department is adopting the following rule for the following reasons. Several commentors noted that the Department, in the notice of proposed adoption and amendment, failed to provide eligibility requirements for state funded adult intensive services. The Department agrees with their comments and thus, for consistency and coordination, it is necessary to adopt provisions (ARM 46.8.316) to govern eligibility for state funded adult intensive services concurrently with the other adoption of other rules to govern eligibility generally and for the various other services. The potential recipients of state funded adult intensive services will best be served by the implementation of the eligibility criteria for the service concurrently with the implementation of the criteria for the other services.

46.8.316 ELIGIBILITY: STATE FUNDED ADULT INTENSIVE SERVICES (1) AN ADULT IS ELIGIBLE FOR STATE FUNDED ADULT INTENSIVE SERVICES IF THE PERSON HAS A DEVELOPMENTAL DISABILITY, HAS ONE OR MORE OF THE CHARACTERISTICS LISTED IN SUBSECTION (2) AND, WITHOUT INTENSIVE ADULT SERVICES, WOULD BE IN JEOPARDY OF PLACEMENT IN AN ICF/MR DUE TO THE INABILITY OF THE SERVICES AVAILABLE TO MAINTAIN THE PERSON IN COMMUNITY-BASED SERVICES WITHOUT ADDITIONAL RESOURCES.

(2) CHARACTERISTICS OF PERSONS WITH DEVELOPMENTAL DISABILITIES IN NEED OF INTENSIVE SERVICES ARE:

(a) SEVERE/PROFOUND MENTAL RETARDATION, INCLUDING EXTREME DEFICIENCIES IN SELF-CARE AND DAILY LIVING SKILLS AS COMPARED TO AGE PEERS;

(b) SIGNIFICANT MALADAPTIVE SOCIAL OR INTERPERSONAL BEHAVIOR PATTERNS WHICH REQUIRE AN ONGOING SUPERVISED PROGRAM OF INTERVENTION; OR

(c) SEVERE MEDICAL OR HEALTH RELATED PROBLEMS SUCH AS SENSORY OR PHYSICAL DEFICITS REQUIRING SUBSTANTIAL CARE.

(3) THE PERSON MUST BE DETERMINED BY THE FIELD SERVICES SPECIALIST OR INTENSIVE SERVICES REVIEW COMMITTEE TO MEET THE ELIGIBILITY REQUIREMENTS FOR INTENSIVE SERVICES.

AUTH: Sec. 53-20-204 MCA
IMP: Sec. 53-20-203 and 53-20-209 MCA

7. The Department is repealing ARM 46.8.103 for the following reasons. The Department in the notice of proposed adoption and amendment failed to give notice of the intended repeal of ARM 46.8.103, Eligibility Requirements. ARM 46.8.103 is repealed by this notice. The repeal of ARM 46.8.103 is necessary in that the rule is being superseded by the adoption of ARM rules 46.8.301 through 46.8.325. Full text of ARM 46.8.103 can be found at page 46-491. AUTH: 53-20-204, MCA; IMP: 53-20-209, MCA.

8. The Department has thoroughly considered all commentary received:

COMMENT: Is the requirement in ARM [Rule XVI] 46.8.1906(4), concerning the completion of the DDCPT curriculum by staff, applicable to staff in all day services or staff in intensive day services? The language of the provision appears to make the requirement applicable to all day services settings.

RESPONSE: The requirement is intended to apply only to those day service settings which are intensive in nature. The language of the provision has been changed to state the applicability of the requirement correctly.

COMMENT: Respite care should not be a core service in the Part H services. The Part H services, even though an entitlement, are not fully funded currently. The definition of Part H services should not be broadened to include respite care.

RESPONSE: The definition of Part H core services in ARM [Rule XXVIII] 46.8.1702(4), does not mention "respite" as one of the

core services, nor is it the department's intent to make respite an entitlement. However, the department will add language to the respite definition in ARM [Rule XXIX] 46.8.1703 (19), and to the services requirements in ARM [Rule XXXII] 46.8.1708(9), providing that respite services are available relative to funding.

COMMENT: The provisions of ARM [Rule XXIV] 46.8.1608(6)(a) and (6)(b), requiring that a person receiving federally funded intensive adult day or work services be a former resident of an ICF/MR and not earn more than 50% of the minimum wage in the work activity center or sheltered workshop, are discriminatory and defeat the whole idea of what providers are trying to do for people who have intensive needs.

RESPONSE: The department agrees that this language is discriminatory towards and detrimental to the persons affected. This provision, however, is a federal requirement in relation to the medicaid funding and the language of the provision is taken directly from federal authority. The department continues to request that this federal requirement be eliminated.

COMMENT: Rita Schilling, the director of Job Connection, Inc. and one of the members of the committee that worked on developing the rules, submitted a general comment on the rules: "They have seemed clearer every time that I have reviewed them. Providers and the state have exchanged many ideas in this process. We took on an enormous project when we decided to make all of the changes in the contract, budgeting and changing the rules. I am comfortable that it is now time to forge ahead and see what our work accomplishes for our system. I imagine that there will be some changes needed in clarity and content as we work with what we have established. It is impossible to foresee every difficulty before starting with this magnitude of change. The fact that our system is willing to analyze the processes it has put in place to see if they are achieving our purposes is the reason we have such a healthy system. With the issues facing human services we cannot stay stagnate." "I am pleased that we were able to compromise on the staffing rule even though there were so many diverse opinions about what it should and should not contain. I think we will find ways to continue to work on some of the underlying issues that caused major disagreements. It is time for the discussion to be over so that we can start to work with these rules . . . I want to thank your staff for all of the hours of work that I know went into making the changes possible."

RESPONSE: The department thanks Ms. Schilling for her comments and support. The department also thanks all of the committee members and contractors who provided the department with their time, efforts and feedback. This project could not have been completed without their help.

COMMENT: ARM [Rule XXVI] 46.8.1610(4)(a) and (4)(b), requiring certain safety features in supported living settings and specifying the locations for those features, may not be enforceable in settings that are leased or rented from landlords that are not providers of developmental disabilities services. In addition the presence of fire extinguishers may cause a person to attempt to stop a fire rather than evacuating the apartment.

RESPONSE: The department believes that the contractor can inform landlords about how many fire extinguishers and smoke detectors there must be and where they must be located. If the landlord is unable to meet the requirements, then the safety features may be provided by the contractor and be funded in whole or in part by the contractor, the person receiving services or the family of the person receiving services.

The State Fire Marshall states that the language regarding the placement of smoke detectors is correct and that the fire code for developmental disabilities group homes requires that the fire extinguisher must be located in the kitchen area. The department defers to the interpretation of the State Fire Marshall and so the provision will remain as it was originally stated.

The State Fire Marshall states that training for individuals must focus on evacuating the building safely. He also states that providing the required fire extinguishers does not mean that the consumers must be trained in how to use the extinguishers. The extinguishers, if used, are to be used by support staff, family members, neighbors or fire fighters. The department also agrees that the first thing in the individual's mind should be evacuating the building if a fire occurs. In fact, whether or not an individual has that skill or seems capable of learning that skill is a critical decision in determining whether or not a person should be receiving that level of supported living services.

COMMENT: ARM [Rule XIX] 46.8.1101(6), regarding education and training requirements, in stating that "training . . . must be provided in the development of the following areas . . ." seems to say that if training does not occur in all of the areas listed, then the training violates the rule. The "must" in the rule should be changed to "should."

RESPONSE: The department agrees that the language is misleading and will change the rule as suggested.

COMMENT: The following should be added to ARM [Rule XV] 46.8.1905 on staffing for family education and support services:

> "A family support specialist assistant must meet the certification requirements as specified by the family

support specialist certification committee for family support assistants."

RESPONSE: The family support specialist assistant language has not been included in the rules because the certification process for family support specialist assistants is not yet finalized and should not be referred to until the process is established in rule. Once the certification process is completed, tested and published, the rule will be amended as requested.

COMMENT: The definition of "abuse" in ARM 46.8.102(1) should be changed to that found at 52-3-803(1), MCA. In addition, definitions of "exploitation" as found at 52-3-803(3), MCA, "neglect" as found at 52-3-803(7), MCA and "sexual abuse" as found at 52-3-803(10), MCA should be included. If the terms are added, then "exploitation, neglect and sexual abuse" should be added to ARM 46.8.102(21).

RESPONSE: The department agrees and will change the rules as suggested.

COMMENT: The rules should require provider facilities to meet American Standards Institute (ANSI) or ADA Accessibility Guidelines for accessibility.

RESPONSE: Compliance with the accessibility requirements of the Americans With Disabilities Act are in the first place the responsibility of the provider of services. The state, however, may have responsibilities for assuring that the standards are implemented. Those standards in relation to physical access to service settings are physical standards. The implementation of those standards through these rules may be inappropriate since these rules primarily concern programmatic standards. These rules do not address in detail requirements for physical settings that would be subject to licensing requirements otherwise.

COMMENT: Are federally funded intensive services available for adults who are not medicaid eligible?

RESPONSE: While federally funded intensive services are not available for adults who are not medicaid eligible, there are state funded intensive services available. The eligibility requirements for state funded intensive service were inadvertently left out of the rule notice, but will be included in the final notice.

COMMENT: Are intensive services available to adults who wish to pay privately?

RESPONSE: Private pay relationships do occur. Those relationships, however, are developed and negotiated between the provider and the parties seeking the services. The department

does not license, monitor, determine eligibility for or evaluate the appropriateness of private pay agreements.

COMMENT: Is the eligibility for intensive adult services in ARM [Rule IX] 46.8.317, predicated upon the federal or the state definition for the term "developmental disability?"

RESPONSE: Eligibility for all developmental disability services is based on the state definition, unless otherwise specified. The definition of developmental disability in ARM [Rule I] 46.8.301(1) is the definition provided in state statute at 53-20-202(3), MCA.

COMMENT: The use of an internal grievance procedure in the appeal process for Part H funded family education and support services may not be required before proceeding with the appeal process at 34 CFR 303.420 through 303.425. The rule seems to imply that the internal procedure must be exhausted before the 34 CFR appeal procedure may be used.

RESPONSE: The department agrees and will change the rule to clarify that an appealing party is not required to use the appeal process of the provider.

COMMENT: The department should consider including in the background check requirement in ARM [Rule XIV] 46.8.1902 on staffing a requirement that a check include checking with the protective services agency to determine whether there has been a substantiation of abuse or neglect upon a person seeking a direct care staff position.

RESPONSE: The department will include the requirement for a background check with the protective services agency when the protective services agency has completed implementation of a registry and adopted rules to govern the process and criteria for placement on the registry.

COMMENT: Is there a mechanism internal to the department which can screen, at a minimum, those staff who have committed abuse or neglect against clients while working for other providers or for the department directly?

RESPONSE: The department does not at this time have an internal registry for persons employed by the department or by providers who as direct care staff abuse or neglect a client. The department is looking into ways by which information concerning known abusers may be shared with prospective employers.

COMMENT: Does ARM [Rule XVI] 46.8.1906, concerning staff competencies, require training for direct care staff in non-intensive services? If not, why is there no requirement?

RESPONSE: There are several curricula available to providers which address the competencies specified in this rule. The

department believes that to require use of certain designated curriculum is too prescriptive. The needs of persons served are best met by the providers selecting the training curriculum most suitable to the service and providing verification of the provision of that training and the competency of staff in that training. The exception to this is the DDCPT curriculum, or its equivalent, which has long been a requirement for intensive services.

COMMENT: ARM [Rule XXII] 46.8.1602, regarding Adult Services performance requirements, should include a provision requiring the provider to respect the individual's choice with regard to daily routines and activities. In addition, clients should be allowed the freedom to make daily living choices free from the team decision making process.

RESPONSE: The department believes that recognition and respect for an individual's choice is adequately addressed in ARM [Rule XXI] 46.8.1601 and in ARM 46.8.201 through 46.8.212, concerning the individual planning process.

COMMENT: The language "when needed or requested" should be included at ARM [Rule XXIII] 46.8.1605(5)(c), regarding assistance in the selection of clothing.

RESPONSE: The department believes that the provision of assistance is inherently predicated upon a need or request being present. Therefore the suggested language is not needed.

COMMENT: The provision of ARM [Rule XXIII] 46.8.1605(6), providing that an IP team must approve an individual's decision to remain at home, is inappropriate. What is the basis and authority for this? If this requirement is not changed, then the rule should be clarified to provide that the IP team approval is only required when the person is staying at home on a long term basis.

RESPONSE: The department believes that it is imperative that IP teams be involved in the issue of whether the individualized emergency response system adequately meets the person's particular safety needs. The rule is not intended to limit the individual's choice regarding remaining at home. The rule is directed at the provider and team to assure that the person's choice is respected and to ensure that the person's safety needs are determined and met. The questions regarding whether the individual is capable of using the emergency response system, has received the necessary training to be safe and should be provided further training must be resolved at this level.

COMMENT: What are the differences between a "case manager", a "supported living coordinator", and an "intensive support coordinator"? Are they potentially the same person? Would a person in services be involved with more than one of these?

RESPONSE: The differences between the supported living coordinator and the intensive support coordinator are delineated by the definitions provided in ARM 46.8.102. In essence, a supported living coordinator coordinates the necessary supports for a person receiving supported living services, while an intensive support coordinator coordinates supports for a person receiving intensive family education and support.

Case manager refers to DD case management as a medicaid state plan service. Case management is targeted to persons with developmental disabilities who are 16 years of age and older. A more detailed description of DD case management is found in ARM 46.12.1901 through 46.12.1940.

A person cannot receive reimbursement for providing more than one of these three services. Furthermore, ARM 46.12.1939(7) precludes a provider of direct care services from being a provider of case management services. Supported living coordination and intensive support coordination are both direct services.

A person in supported living may have both a supported living coordinator and a case manager. A person in intensive family education and support may not have both an intensive support coordinator and a case manager.

COMMENT: A definition of crisis management in ARM 46.8.102 would be helpful.

RESPONSE: The term crisis management is being deleted. In order to be consistent with the language in the department's contract for case management services, the phrase "assists individuals through crises situations" will be used to describe the responsibility of the case manager.

COMMENT: Does "family" in ARM 46.8.102(18) include siblings?

RESPONSE: Siblings who live with a child are members of the family because, as provided in the language of the definition, they are others with whom a child lives.

COMMENT: In the definition of "family" in ARM 46.8.102(18) does the term "who are legally responsible for the child's welfare" qualify all three categories listed after the last comma in the sentence, or is it only referencing "other persons".

RESPONSE: The term is only referencing "other persons". The other two groups, others with whom a child lives, and non-custodial parents, would be considered family for the purpose of this rule with or without legal responsibility for the child.

COMMENT: Rule 46.8.106, Confidentiality, should include a provision to allow the disclosure of information to the state

protection and advocacy program. It would eliminate the appearance of conflict between state rules and federal law.

RESPONSE: A new subsection (7) has been included in the rule to provide for the disclosure of information to the extent required by federal or state law. This provision will account for the requirements of 42 USC §6042 and any other pertinent state or federal law.

COMMENT: The Montana Advocacy Program requests that the administrative rules include client rights.

RESPONSE: Client rights will be adopted in administrative rule during the next fiscal year. Work on that adoption is in the work plan for the department staff.

The Department has changed ARM [Rule II] 46.8.302 to provide a comma for grammatical clarification.

The Department has changed, ARM 46.8.307, [Rule VI] ARM 46.8.310, [Rule IX] 46.8.317 and [Rule XI] 46.8.321 to provide for textual clarification by stating the full name for the intensive services review committee.

9. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

Dawn Davis
Rule Reviewer

Director, Social and
Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rule 46.10.403 pertaining to AFDC assistance standards	)))	NOTICE OF THE AMENDMENT OF RULE 46.10.403 PERTAINING TO AFDC ASSISTANCE STANDARDS

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rule 46.10.403 pertaining to AFDC assistance standards at page 801 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.10.403 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: The notice of proposed amendment of ARM 46.10.403 states that the AFDC payment amounts are being increased due to recently published changes in the federal poverty levels. The department should not increase the AFDC payment amount without showing what the increases in the federal poverty levels were. Additionally, when did the department have knowledge of the increases in the federal poverty levels? Will expenditures exceed the legislature's appropriation for AFDC payments as a result of the proposed increase in AFDC payment amounts? If so, did the department inform the legislature that expenditures would exceed appropriations? If so, when was the legislature informed of this?

RESPONSE: The department did advise the legislature that annual increases in the federal poverty levels would result in increased AFDC expenditures for the 1996-1997 biennium. Since the department took into consideration these projected increases in the poverty levels in preparing its estimates of AFDC expenditures, the amount requested from the legislature was enough to cover AFDC expenditures despite the increased payment amounts. Although the amount appropriated in House Bill 2 for AFDC payments is somewhat less than the amount requested, it is anticipated that actual AFDC expenditures during the biennium will not exceed appropriations.

Notice of the 1995 poverty levels were not published in the Federal Register until February, 1995. However, the department was aware prior to their publication that the poverty levels for 1995 would be higher than the levels for 1994 as there has consistently been an inflationary trend. Hence the department knew and advised the legislature that there would be increases

in AFDC payment amounts even if the legislature continued the ADFC payment rates at the same percentage of poverty, 40.5%.

The Governor's Executive Budget for Fiscal Years 1996-1997 submitted to the legislature in November, 1994, specifically noted that increased appropriations for the AFDC program were necessary due to anticipated increases in the federal poverty level as well as increases in the AFDC caseload. Page B36 of the Governor's Executive Budget stated as follows:

> Before time-limited benefits take effect, the department estimates that the average number of AFDC cases will increase, as will the average payment in each case. (Even though the state will continue to pay an AFDC benefit based on 40.5% of the federal poverty rate, the federal poverty rate is recalculated each year and is expected to increase during FY96 and FY97.)

On March 4, 1995, the department prepared a table entitled "Poverty Index--Impacts of Change" which showed projected increases in monthly payment amounts for 1996 and 1997 at different percentages of poverty. This table reflected increases in payment amounts each year based on increases in the federal poverty index. For example, it showed that the monthly payment amount for a family of three at 40.5% of poverty was $416 in 1994 but was projected to be $425 a month in FY96. The 2.14% inflation increase assumed for FY96 in preparing this table is consistent with the actual inflationary increase reflected in the 1995 federal poverty levels.

The department felt it was sufficient in the notice of proposed amendments to the AFDC standards rule to explain that there had been increases in the federal poverty levels without publishing the 1995 poverty levels themselves. They were published in the Federal Register, Vol. 60, No. 27, at page 7772. A copy of the 1995 poverty levels can also be obtained from the department.

COMMENT: The department did not adequately explain why the tables of gross and net monthly income standards and payment amounts for use when there are no adults in the assistance unit and there is no shelter obligation being deleted. Nor did the department indicate what the results of this change will be.

RESPONSE: Data collected from The Economic Assistance Management System (TEAMS), the department's computerized AFDC and food stamp information system, and from a survey of county eligibility staff demonstrated that all "child only" cases (i.e., cases where there is no adult in the assistance unit) surveyed had a shelter obligation. Based on this information, the department's current policy is to deem all child only assistance units to have a shelter obligation. As a result of this policy the child only, no shelter standards and payment

amounts are never used. They are therefore being deleted because they are unnecessary.

There is no fiscal impact as a result of the elimination of these tables because under the department's present policy there were no households whose eligibility and grant amount were being determined using the lower "no shelter" standards and payment amounts.

4. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

5. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the adoption of Rule I and the amendment of rules 46.10.404, 46.10.408, 46.10.409 and 46.10.410 pertaining to AFDC child care services and at-risk child care services	))))))	NOTICE OF THE ADOPTION OF RULE I AND THE AMENDMENT OF RULES 46.10.404, 46.10.408, 46.10.409 AND 46.10.410 PERTAINING TO AFDC CHILD CARE SERVICES AND AT-RISK CHILD CARE SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rule I and the amendment of rules 46.10.404, 46.10.408, 46.10.409 and 46.10.410 pertaining to AFDC child care services and at-risk child care services at page 831 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.10.404 as proposed.

3. The Department has adopted the following rule as proposed with the following changes:

[RULE I] 46.10.810 JOBS CHILD CARE Subsections (1) and (1)(a) remain as proposed.

(b) The child for whom the care is provided must be EITHER INCLUDED IN THE AFDC ASSISTANCE UNIT OR A RECIPIENT OF SUPPLEMENTAL SECURITY INCOME (SSI) UNDER TITLE XVI OF THE SOCIAL SECURITY ACT AND MUST BE:

Subsections (1)(b)(i) through (1)(b)(ii)(A) remain as proposed.

(B) ~~is~~ under the supervision of a court.

Subsection (2) remains as proposed.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

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

46.10.408 TRANSITIONAL CHILD CARE, REQUIREMENTS

Subsections (1) and (1)(a) remain as proposed.

(b) age 13 ~~or older if~~ to 18, ~~or if 18, a~~ WHO ARE full-time ~~student~~ STUDENTS expected to complete their school program by age 19~~; and~~ IF THE CHILD:

(i) ~~the child~~ is physically or mentally incapable of caring for himself or herself, as determined by a physician or licensed or certified psychologist; ~~or~~

(ii) IS under the supervision of the court; or ~~and would be a dependent child except for the receipt of supplemental~~

~~security income benefits under Title XVI or foster care benefits under Title IV-E of the Social Security Act.~~

(iii) who would be a dependent child AS DEFINED IN ARM 46.10.110 except for the receipt of benefits under supplemental security income (SSI) under Title XVI or foster care under Title IV-E of the Social Security Act.

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

(5) Families must report changes of income, changes in household composition or address changes ~~(within 10 days)~~. Failure to report any of these changes could result in an overpayment of benefits. When a family receives transitional child care assistance for which it is not eligible or in an amount larger than that to which it is entitled:

Subsections (5)(a) and (5)(b) remain as proposed.

~~(6)~~ (c) TThe family ~~is required to~~ MUST repay the department 100% of the amount which the family was overpaid if an overpayment WAS caused by the department's error or in the family's non-fraudulent error.

Subsections (7) through (9)(a)(ii) remain as proposed in text but are renumbered (6) through (8)(a)(ii).

(iii) whether the family was in violation of the requirements of subsection ~~(2)~~ (3) of this rule; and

Subsection (9)(a)(iv) remains the same in text but is renumbered (8)(a)(iv).

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

46.10.409 SLIDING FEE SCALE FOR TRANSITIONAL CHILD CARE Subsection (1) remains as proposed.

(a) Step-parent income is not deemed, ~~it~~ BUT is counted in full;

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

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

46.10.410 AT-RISK CHILD CARE SERVICES Subsection (1) through (2)(a) remains as proposed.

(i) A family is at risk and is income-eligible for assistance if its gross income is at or below the maximum income for a family of its size set forth in the tables in ARM 46.10.409. All Education income from scholarships, grants, loans ~~and work study~~ will be excluded as well as earned income tax credits, tribal per capita payments, VISTA volunteer stipends, independent living individual needs criteria (INC) payments for youth, food stamp benefits, and foster care payments. All supplemental security income, state supplemental income, in-kind income, earned income of dependent children living in the household, training related reimbursement, AFDC recoupment amount, ~~AA~~lien sponsor deemed income, child support arrearage, earned income tax credit, housing subsidy, irregular or infrequent income of $20 or less and valid loans are exempt. All other gross family income will be counted.

Subsection (2)(b) remains as proposed.

~~(c) If anyone in the immediate family receives either regular AFDC or AFDC-unemployed parent grants, the family is not eligible for at-risk child care.~~

(c) AT-RISK CHILD CARE ASSISTANCE IS AVAILABLE TO A FAMILY ONLY IF THE CARETAKER RELATIVE AS DEFINED IN ARM 46.10.110 IS NOT RECEIVING EITHER REGULAR AFDC OR AFDC-UNEMPLOYED PARENT BENEFITS AND IF THE CHILD FOR WHOM CHILD CARE ASSISTANCE IS NEEDED IS NOT RECEIVING REGULAR AFDC OR AFDC-UNEMPLOYED PARENT BENEFITS.

(d) All children living in the home, who need to be cared for in order for a family member to work, are eligible under this funding source IF THEY MEET THE AGE REQUIREMENTS OF SUBSECTIONS (2)(d)(i) THROUGH (2)(d)(ii)(B). ~~They~~ ~~The children must be under age 13 or if age 13 or older but less than 18 years of age, or if over 18, expected to graduate from their school program by age 19, physically or mentally incapable of self-care or under court supervision.~~ The children do not have to meet AFDC dependent child deprivation criteria provided in ARM 46.10.303. Children in common, step-children, supplemental security income (SSI) or Title IV-E foster care children are eligible. THE CHILD MUST BE:

(i) UNDER THE AGE OF 13 YEARS; OR

(ii) AGE 13 TO 18 AND A FULL-TIME STUDENT EXPECTED TO COMPLETE THE CHILD'S SCHOOL PROGRAM BY AGE 19, PROVIDING THAT THE CHILD REQUIRES CARE BECAUSE THE CHILD IS EITHER:

(A) PHYSICALLY OR MENTALLY INCAPACITATED AS DETERMINED BY A PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST; OR

(B) UNDER THE SUPERVISION OF A COURT.

Subsections (2)(e) through (5)(b)(i) remain as proposed.

(6) The family ~~is not required to~~ MUST repay ~~an overpayment caused~~ the department 100% of the amount which the family was overpaid if an overpayment was caused by the department's error or the family's non-fraudulent error.

Subsections (7) through (9)(a)(iv) remain as proposed.

AUTH: Sec. 53-2-201 and 53-4-212 MCA
IMP: Sec. 53-2-108, 53-2-201, 53-2-606, 53-4-212 and 53-4-231 MCA

5. The Department has thoroughly considered all commentary received:

COMMENT: The rationale states that pursuant to federal mandate, some changes to the rules governing transitional child care are being made so that they will be consistent with the rules for the at-risk program. What is the federal authority mandating consistency between child care assistance programs?

RESPONSE: There is in fact no federal mandate that there be consistency among all federally funded child care programs. Rather the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services, which administers the IV-A child care programs as well at the Block Grant Child

Care program, have urged but not required the state agencies administering these programs to coordinate the requirements for the different child care programs so as to create "seamless" child care delivery systems.

The department is aware of no provision in the AFDC statute or regulations addressing this recommendation to create a seamless system. However, federal regulations governing the Child Care and Development Block Grant at 45 CFR 98.10(e) and 98.12(a) do require coordination with other federal, state, and local child care programs. Additionally, many federal directives regarding IV-A child care, such as Action Transmittal No. CC-ACF-AT-92-6 issued by the ACF on September 21, 1992, have made reference to the desirability of creating seamless child care programs.

Apart from federal requirements or recommendations, it makes sense for the rules of the different child care programs to be as consistent as possible. This makes the rules of the programs less confusing to the families they serve and makes the administration of the programs easier and less error prone.

COMMENT: The department cited 53-4-212 as well as 53-4-719, MCA, as rulemaking authority for [Rule I] pertaining to JOBS child care and ARM 46.10.408 and 46.10.409 pertaining to transitional child care. Section 53-4-212, MCA should not have been cited, because it grants the department authority to make rules only to carry out the provisions of part 2 of Title 53, chapter 4, not part 4 pertaining to the JOBS program and transitional child care.

RESPONSE: The department agrees and has corrected this on the Notice of Adoption.

COMMENT: Subsection (2)(c) of ARM 46.10.410 as the department proposes to amend it states that the family is not eligible for at-risk child care if anyone in the immediate family is receiving AFDC. How is "immediate family" defined for purposes of this rule?

RESPONSE: It is intended that a family not be eligible for at-risk child care if either the caretaker relative (as defined in ARM 46.10.110) or the child for whom child care assistance is needed receives AFDC. Subsection (2)(c) has been changed and now refers to the "caretaker relative" rather than using the term "immediate family."

COMMENT: In the at-risk rule, subsection (6) as proposed to be amended provides that a family is not required to pay 100% of the amount it is overpaid if the overpayment was caused by the department's error or the family's non-fraudulent error. How much will the family be required to repay?

RESPONSE: Currently ARM 46.10.410(6) states that the family is not required to repay overpayments caused by department error or

non-fraudulent error. The notice of proposed amendment changed the rule to say that the family is not required to pay 100% of such an overpayment. This change was made in error. The Department intended to state that the family must pay 100% of such an overpayment. This change in policy is being made because the department was notified by the Administration for Children and Families of the U.S. Department of Health and Human Services, the federal agency which administers the at-risk child care program, that the department must require families to repay all at-risk overpayments, even those due to department error or non-fraudulent household error. The rule is now being amended to state that.

COMMENT: The language in proposed subsections (1)(b) through (1)(b)(iii) of ARM 46.10.408 pertaining to transitional child care and proposed subsection (2)(d) of ARM 46.10.410 pertaining to at-risk child care is similar but not identical to the language of subsections (1)(b)(ii) through (1)(b)(B) of proposed [Rule I] which specify requirements for JOBS child care assistance for children age 13 to 18. Is there any significance to the differences in wording in the three rules, or are the requirements the same for TCC, at-risk, and JOBS child care for children over 13 years of age?

RESPONSE: The requirements are nearly, but not quite, identical in all three programs. In all of these programs child care will be provided for children age 13 to 18 only if the child is a full-time student expected to complete the child's school program by age 19 and if the child requires care because of physical or mental incapacity or because the child is under the supervision of a court. The only difference in requirements for children age 13 to 18 is that in the at-risk program the child is not required to be a dependent child who meets who meets the AFDC deprivation criteria and can be a recipient of SSI or IV-E foster care benefits, and in the TCC program a child who would be a dependent child except for the receipt of SSI or IV-E foster care benefits is eligible.

Since the requirements as to school attendance and need for care are identical in the three programs, the wording of proposed subsections (1)(b) through (1)(b)(ii) of ARM 46.10.408 and subsection (2)(d) of ARM 46.10.410 is being changed to parallel the language of subsections (1)(b) through (1)(b)(ii)(B) of proposed [Rule I]. This will make it clearer that those requirements are the same in each of the programs.

COMMENT: In proposed subsection (9)(a)(iii) of ARM 46.10.408 pertaining to transitional child care, shouldn't the reference be to subsection (3) rather than (2)?

RESPONSE: Yes. The reference has been corrected.

6. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

7. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rule 46.12.204 pertaining to medicaid recipient co-payments	))))	NOTICE OF THE AMENDMENT OF RULE 46.12.204 PERTAINING TO MEDICAID RECIPIENT CO-PAYMENTS

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rule 46.12.204 pertaining to medicaid recipient co-payments at page 806 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.12.204 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: The proposed amendment to change the co-pay cap from $200 per household to $200 per recipient could increase a medical provider's bad debt liability.

RESPONSE: Co-payments are an attempt for appropriate utilization of health care services. According to 42 CFR 447.115 (Code of Federal Regulations), a recipient's inability to pay the co-payment does not lessen his or her liability for the co-payment. Providers currently collect co-payment from non-medicaid eligible individuals who are covered by either private insurance, medicare, or other third party payor. The fact that some medical providers elect not to collect co-payments from medicaid recipients is a matter of choice. Medical providers may want to establish monthly repayment agreements with medicaid recipients.

COMMENT: Co-payments will increase per claim when outpatient hospital services are billed by CPT-4 Code.

RESPONSE: The co-pay rule is not being changed to increase the amount of co-pay per outpatient hospital service. The change in billing certain services will be an accurate reflection of the services provided. Co-payments will increase under the new billing process but are still nominal.

COMMENT: When a case number is assigned to an existing household, there is no link between the new number and the old number and co-payment exceeding the intended limits could be applied. How often does reassignment of household numbers occur and what are the budget projections specific to the co-pay rule change. How much staff time will be saved when employees no longer have to manually make adjustments to the computerized co-

payment tracking system and what will the freed up time be used for?

RESPONSE: It is difficult to define the actual number of households where more than one case number was assigned. In one year, there were 463 recipients who moved in and out of various households and their co-payment history did not follow them due to the current tracking system. The situation is further complicated when there is more than one deprivation code within a household. The current tracking system does not recognize the two case numbers as one household. The amendment to the co-pay rule will provide a procedure that follows the administrative rule. It is impossible for a procedure to follow the current rule due to limitations of the tracking system.

Under the proposed rule change, the department estimates 463 recipients will be positively affected as their co-payment history will follow them. There are approximately 3613 cases with two adults that may experience more co-pay liability with the cap changing to a recipient basis instead of a household basis. Of these 3613 cases, the system does not recognize and therefore, we cannot accurately predict how many of the recipients are pregnant and therefore, co-pay exempt. Due to these unknowns, the department assumes minimal budget impact specific to the change in the co-pay rule. In March, 1995, only 1549 cases met their co-pay cap. There are approximately 36,351 cases where co-pay is applied. There are approximately 129,000 eligible medicaid recipients. Not all of the 129,000 eligible recipients have co-payments applied.

Minimal staff time will be saved by changing to a recipient rather than a household cap (estimate saving of 20 hours per year). Department staff will utilize this time to perform other assigned program duties, e.g. research impact of volume purchase of hearing aids. More importantly, this change will ensure that recipient co-pay caps are applied in a consistent and fair manner.

COMMENT: The department should evaluate services provided by Health Maintenance Organization (HMO) as cost effective before exempting those services from co-pay.

RESPONSE: Federal Regulations at 42 CFR 447.53 requires the services provided by an HMO to be exempt from co-payments. The cost associated with the services provided by an HMO are post-co-payment application (medicaid reimbursement after co-payment applied).

COMMENT: Most Montana medicaid recipients do not have the money to pay the current medicaid co-payment rates. With a family size of four, this rule change will increase the medicaid household responsibility from $200 to $800 per fiscal year, which they cannot afford.

RESPONSE: The co-payment rates established by Montana medicaid are nominal and in accordance with 42 CFR 447.54 (Code of Federal Regulations). The stated concern that a family of four will now have a co-pay liability of $800 is inaccurate as not all four family members would have co-payments applied. Children under the age of 21 and pregnant recipients are exempt from co-payment. In the stated concern, a scenario could exist where two disabled adult children reside within their elderly parents home and all four individuals could be medicaid eligible due to SSI. All four recipients would have individual case numbers relative to the deprivation code of SSI. The current tracking system does not recognize all four case numbers as residing in one household. Therefore, the system applies a co-pay cap of $200 for each case number. Under this scenario, the rule change has no effect.

4. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

5. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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 46.12.509 pertaining to medicaid inpatient and outpatient hospital services	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.503 THROUGH 46.12.509 PERTAINING TO MEDICAID INPATIENT AND OUTPATIENT HOSPITAL SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.503 through 46.12.509 pertaining to medicaid inpatient and outpatient hospital services at page 779 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rules 46.12.503, 46.12.504, 46.12.505, 46.12.506 and 46.12.509 as proposed.

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

46.12.507 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS Subsections (1) through (3)(e)(i) remain as proposed.

(ii) therapeutic services that are incident to physician services and provided under the direct personal supervision of a physician. OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY ARE NOT SUBJECT TO THE DIRECT PHYSICIAN SUPERVISION REQUIREMENT.

Subsection (4) remains as proposed.

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

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT Subsection (1) remains as proposed.

(a2) Except for the services reimbursed as provided in subsections (3) through ~~(9)~~ (7), Aall facilities will be reimbursed on a retrospective basis. Allowable costs will be determined in accordance with ARM 46.12.509(2) and subject to the limitations specified in ARM 46.12.509(2)(a), (b) and (c). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000 for inpatient and outpatient 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.

Subsection (2)(a) remains as proposed.

(3) Except as otherwise specified in these rules, the following outpatient hospital services will be reimbursed under a prospective payment methodology for each service as described in subsections (4) through ~~(9)~~ (7) of this rule.

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

(b) For clinical diagnostic laboratory services where no medicare fee has been assigned, the fee is ~~60%~~ 62% of usual and customary charges for a hospital designated as a sole community hospital as defined in ARM 46.12.503 or ~~62%~~ 60% of usual and customary charges for a hospital that is not designated as a sole community hospital as defined in ARM 46.12.503.

Subsections (4)(c) and (4)(d) remain as proposed.

~~(5) Reimbursement for imaging services will be based on the medicare resource-based relative value scale (RBRVS). The medicaid fees for imaging services are as specified in the medicaid outpatient hospital imaging services fee schedule (May 1995 edition). The imaging services reimbursed under this subsection are the individual imaging services listed in the 7000 series of the Current Procedural Terminology, Fourth Edition (CPT-4). Procedure codes for imaging services subject to this subsection are those listed in Addendum I to Chapter VII, Bill Review, of the Medicare Part A Intermediary Manual, Part 3 (HCFA Pub. 13-3). The medicaid outpatient hospital imaging services fee schedule (May 1995 edition) is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the medicaid outpatient hospital imaging services fee schedule (May 1995 edition). Copies may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.~~

~~(6) Reimbursement for other diagnostic services will be based on the medicare resource-based relative value scale (RBRVS). The medicaid fees for other diagnostic services are as specified in the medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition). The individual diagnostic services reimbursed under this subsection are those listed in the Current Procedural Terminology, Fourth Edition (CPT-4). Procedure codes for other diagnostic services subject to this subsection are listed in Addendum K to Chapter VII, Bill Review, of the Medicare Part A Intermediary Manual, Part 3 (HCFA Pub. 13-3). The medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition) is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition). Copies may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.~~

~~(7)~~(5) Non-emergent emergency room services provided to a PASSPORT recipient, when the PASSPORT provider has not authorized the services, will be reimbursed a prospective fee of $20 per emergency room visit PLUS ANCILLARY REIMBURSEMENT FOR

LABORATORY, IMAGING AND OTHER DIAGNOSTIC SERVICES. The fee is a bundled payment per visit for all outpatient services provided to the patient including, but not limited to, NURSING, pharmacy, supplies AND EQUIPMENT and other OUTPATIENT HOSPITAL services. PHYSICIAN SERVICES ARE SEPARATELY BILLABLE ACCORDING TO THE APPLICABLE RULES GOVERNING BILLING FOR PHYSICIAN SERVICES.

Subsections (8) through (9)(b) remain as proposed in text but are renumbered (6) through (7)(b).

(c) The per diem rates specified in subsections ~~(9)~~(7)(a) and (b) are bundled prospective per diem rates for full-day programs and half-day programs, as defined in ARM 46.12.506. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, BIOLOGICALS, SUPPLIES, EQUIPMENT, therapies, nurses, social workers, psychologists, licensed professional counselors and other outpatient services THAT ARE PART OF OR INCIDENT TO THE PARTIAL HOSPITALIZATION PROGRAM, except as provided in subsection ~~(9)~~(7)(d).

Subsections (9)(d) and (9)(e) remain as proposed in text but are renumbered (7)(d) and (7)(e).

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

4. The Department has thoroughly considered all commentary received:

COMMENT: We support the proposed 3% increase in the DRG base payment rate. While a 3% rate increase is welcome, medicaid rate increases historically have lagged behind inflation. With no weight changes and minimal rate increases, rates fail to keep up with costs. We are concerned specifically that even though the base price is being inflated, the DRGs for delivery and newborn services to mothers and their babies appear under-weighted. The relative weights are particularly low for caesarean section delivery. A sample of hospitals shows that many hospitals are delivering babies for less than 50% of their normal charges, and less than 85% of their actual costs. No hospital among the sample was able to deliver babies within their allowable costs. The small inflation increase is not adequate to lift those DRGs to a reasonable payment level. MHA recommends that the department, within its available appropriation, increase the above referenced DRGs to provide a payment of at least 62% of average charges, which would provide hospitals reasonable payment consistent with actual allowable costs.

RESPONSE: The department believes that the proposed overall inpatient hospital rates are reasonable and adequate and in compliance with all requirements. The department recognizes that when viewed in isolation, individual DRGs may not cover all costs of those particular services. However, it must be recognized that there are other DRGs where payments exceed

costs. The adequacy of reimbursement must be evaluated based upon the overall amount, rather than based upon a few select DRGs. When viewed as a whole, the department believes that the rates meet all requirements.

The department received comments from hospitals regarding reduced payments for obstetric services when the current DRG system was implemented in July 1993. The department's response was:

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

The DRG methodology is applied statewide to all hospitals, with the exception of isolated hospitals, and adjustments to DRG weights to accommodate one service cannot be performed without analyzing the impact on the system as a whole.

The department recognizes that the medicaid DRG reimbursement system needs to be updated periodically to account for cost increases. The DRG weights and thresholds need to be reviewed once again, with special emphasis on the obstetrics DRGs that are allegedly being underpaid. The department has plans to undertake this process, as discussed in the following comment and response. We are committed to an inpatient hospital DRG prospective payment methodology that reimburses hospitals reasonable and adequate rates.

COMMENT: The department should begin immediately the calibration study authorized by the legislature, with review of DRGs for delivery and newborn services and other low paying DRGs being a primary focus of the review.

RESPONSE: The department requested funding from the 1995 legislature to perform this project, as recommended by Abt Associates. Abt recommended that the department make plans to update, recalibrate and improve system features as part of an overall program maintenance. Abt recommended recalibration every three years to update the grouper and recalibrate the weights. The department recognizes the importance of this

recommendation and will conduct the recalibration study authorized by the legislature.

COMMENT: Commentor supports the changes proposed to the catastrophic payment policy. The commentor recommends again that SRS consider any other surplus budget funds to distribute towards catastrophic claims. SRS has the transfer authority to move funds from the hospital budget to fund shortfalls elsewhere, SRS should be willing to transfer other surplus dollars to the hospital program when payment pools fall short of needed amounts.

RESPONSE: The 1993 inpatient hospital study found that catastrophic cases do exist and recommended additional reimbursement for these cases. The study identified approximately 86 cases as catastrophic in the 1988-1991 data. The department implemented a methodology beginning in fiscal year 1994 to provide additional reimbursement for such cases and estimated the funding necessary for catastrophic case reimbursement. The department adopted this additional catastrophic payment methodology in recognition of the occasional extremely high cost cases, which previously had been primarily the burden of the hospitals. In adopting this policy, the department has assumed a great deal of the risk for these cases. The department is making a good faith effort to make the reimbursement system as equitable as possible for all hospitals.

The proposed rules include an estimate of the funding allocated for catastrophic reimbursement. The proposed rule increases or decreases the allocated amount proportionately depending upon the extent to which actual discharges increase or decrease in relation to estimated discharges. The department will not make unlimited funds available for catastrophic reimbursement. The department believes that the proposed rule adequately funds catastrophic reimbursement.

The department makes every effort to estimate the fiscal impact of operating the inpatient hospital program and working with the legislature and provider association to secure appropriate funding. The department does have some discretion to transfer medicaid funds among programs where appropriated funding is lacking or in surplus. Such transfers are determined on a case by case basis depending upon circumstances affecting the Medicaid program as a whole. If the department considered it necessary, such a transfer could be made available to the hospital program. The department does not consider such a transfer necessary at this time.

COMMENT: A commentor questions the accuracy of the department's estimate of 16,000 DRG discharges for state fiscal year 1996. According to department reports, 14,700 actual DRG discharges occurred in state fiscal year 1994, compared to the advance estimate of 26,844 discharges. SRS is anticipating a 9 percent increase in discharges from SFY 94 to SFY 96, even though survey

data suggests discharges are declining in real terms. SRS should explain its methodology for estimating discharges and its affect on the size of the catastrophic and outlier pools.

RESPONSE: The estimate of 26,844 discharges in current ARM 46.12.505 was estimated in the spring of 1993 when DRG discharges were increasing. At the time, the growth rate was projected to be 18% per year over the biennium. In 1991, the total number of discharges for all hospitals was 16,338. Applying a projected 18% increase per year through state fiscal year 1995, the estimate of discharges for FY 1995 was 26,844. Also, when the 26,844 estimate was made it included all Montana hospitals, including the isolated hospitals, even though the isolated hospitals are exempt from the DRG methodology. Obviously, the estimate was higher than actual discharges, as noted by the commentor and the department's data. This error did not impact payments for catastrophic cases in 1994, nor do we expect an impact for 1995 as a result of prorating the catastrophic case payments as outlined in the rule.

The 16,000 discharge estimate was prepared by the department in preparing its budget request for the 1995 legislature. This estimate was prepared in the spring of 1994 using information from paid claims data and early reports from the department's inpatient hospital reporting system. The commentor notes that actual DRG discharges for 1994 were 14,700, based upon reports dated 1/13/95. The 1/13/95 report includes data six months after the 6/30/94 fiscal year end. Generally, this information is not complete, as hospitals continue to have claims paid for any given fiscal year well beyond the fiscal year end. For example, the department's reports dated 10/3/94 identifies 14,172 discharges. The 1/13/95 report identifies 14,716 discharges and the report dated 4/14/95 identifies 14,854 discharges for state fiscal year 1994. Based upon the time lag for complete data, usually one year after the state fiscal year end, the department's estimate is reasonable.

This estimate has a minimal effect on the size of the catastrophic and outlier pools. The outlier pools referred to by the commentor were estimated by the department when establishing the base rate for DRGs. The pools were estimated as a percentage of the estimated medicaid payments for the DRG system. For FY 1994, the estimated medicaid payments were established as 93.5% of total hospital costs. For example, total 1991 hospital costs were $38,066,572 and 93.5% of this figure is $35,592,245. The outlier pool was estimated to represent approximately 7.7% of $35,592,245 and the catastrophic pool approximately 6.4% of $35,592,245. The estimated pools were then used in the calculation of the base rate for the DRG system. To date, outliers are paying on the average 6.65% of the DRG payments for 1994 and catastrophic cases are paying on the average 3.9% of the DRG payments for 1994. The estimate of discharges is used only in the final calculations of

catastrophic cases to determine if the catastrophic case payments need to be prorated.

COMMENT: Hospitals remain opposed to the recommended changes in outpatient payment changes. Montana hospitals and MHA are not opposed to the creation of prospective payment schemes, per se. We are opposed to new schemes which include the same problems as inpatient prospective payments, and which will predictably lead to payment adequacy issues in the future. Chief among the concerns is that incentives for physician and other health care providers are not aligned with the incentives in the department proposals. SRS is also adopting hospital fee schedules even though historical evidence suggests fee schedules promote higher utilization of care. Combining these problems in response to growing outlays of medicaid dollars is hardly a reasonable course of action. Montana hospitals and MHA urges the department to reconsider its policies and continue work toward development of a workable payment system for outpatient services.

RESPONSE: One of the department's goals is to ensure that medicaid recipients receive quality health care, efficiently provided. In contrast to traditional cost reimbursement, prospective payment methods are intended to encourage hospital efficiency, increase fairness by paying similar rates for similar services and reduce the administrative burden of the system for both hospitals and the department.

We are pleased that the association does not oppose prospective payment methods in general. The department's approach is to phase in prospective payment, thereby providing hospitals time to adjust to the new incentives to be efficient. We have consulted extensively with hospitals about payment for outpatient services, and we will continue to welcome specific suggestions about prospective payment methods that would be suitable for Montana. In addition, the department is working on aligning incentives for physicians with those of hospitals and we would entertain any suggestions that the commentor has to accomplish this.

The department believes that the use of fee schedules for physician and hospital services will encourage provider efficiency. Under fee schedules, some providers may increase utilization. The Health Care Financing Administration often builds into its payment rate an assumption that utilization will increase. The department reminds providers that the medicaid rules require that all services be medically necessary. Utilization should be based upon patient medical needs rather than the hospital's financial interests.

COMMENT: Access to physician office care is the only legitimate way to deflect inappropriate use of the emergency room. Passport physicians must be required to provide needed recipient education about wise use of medical care, together with better

access to alternative medical services. The department should amend the Passport to Health program by adopting a standard for timely access to physician office services.

RESPONSE: The department has taken a number of steps to assure physician office access and to educate and guide recipients in utilization decisions. The department utilizes several methods to provide PASSPORT recipients and PASSPORT providers on-going education. The purpose of this education is to provide both the recipient and the provider a description of the program with emphasis on appropriate utilization of medical services. Examples include:

Out-Reach - When medicaid recipients are required to enroll in the PASSPORT program a telephone call is made to the recipient to explain the PASSPORT program and tell them what their responsibilities are. If the recipient cannot be reached by telephone, a card is mailed to the recipient requesting that they call an 800 number. When the recipient calls, the PASSPORT program is reviewed with them.

Check-Stuffers - At least once a year medicaid recipients receive a "check stuffer" which explains the main points of the PASSPORT program. This check stuffer is available to doctors' offices to use in recipient education.

General Medicaid Booklet - A general medicaid booklet which explains the PASSPORT program and other medicaid programs was distributed to all medicaid recipients in July 1994. This booklet is provided free of charge and is available to physicians and hospitals for distribution. The booklets are being distributed by the county offices, doctors' offices, etc.

State-wide information meetings - statewide medicaid informational meetings were held in 1994. Medicaid recipients were encouraged to attend these meetings. The PASSPORT program was explained and recipient questions were answered.

Provider newsletter - PASSPORT providers receive a monthly newsletter. New ideas for recipient education are presented in these newsletters.

Video - A video explaining the PASSPORT program and other managed care programs is being prepared and will be available to county offices for use in recipient education.

Recipient newsletter - A recipient newsletter is being developed and will be mailed to recipients twice a year.

PASSPORT recipient handbook - A PASSPORT recipient handbook is provided to all PASSPORT recipients. This handbook explains the program and responsibilities of the recipient.

Hot line - There is a well-publicized toll-free hotline that PASSPORT recipients can call and get PASSPORT information, enroll in PASSPORT, change a PASSPORT provider and ask general medicaid questions.

The department monitors physician access for PASSPORT recipients through quality assurance reviews. A survey is distributed to a sample of PASSPORT recipients requesting feedback on a variety of issues. One of the specific issues is access to the PASSPORT provider. In recent findings, 44% of recipients responded they could obtain an appointment within one day. The majority of recipients, 94%, responded that they were able to get an appointment within one week. Another assessment was on the length of time a recipient must wait in the office before seeing the health care provider. Responses were overwhelmingly positive, with 75% able to see their provider within 20 minutes.

The department does have requirements and standards for timely access to physician office services, contained in the administrative rules and contracts with PASSPORT physicians. In accordance with ARM 46.12.302, "Providers shall render services to an eligible Medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations." In addition, the medicaid contract with PASSPORT providers specifically states: "The PCP shall not utilize discriminatory practices with regard to enrollees such as separate waiting rooms, separate appointment days, or preference to private pay patients."

COMMENT: MHA urges the department to reconsider the exclusion of cardiac-rehabilitation services from medicaid coverage. The history behind the exclusion is one of an arbitrary and capricious administrative action by SRS. The department should invest in prevention and rehabilitation as a means of reducing future medical costs. Under current policy, SRS pays for high cost treatment of cardio-pulmonary disease, but refuses payment for palliative care and rehabilitation. If the department declines to provide coverage for this important service, the department should provide the reasoning for its exclusion. In addition, MHA also requests that the department make available the historical records the department produced in creating this public policy.

RESPONSE: The current rule excludes coverage of cardiac rehabilitation and other educational programs. The proposed rules merely reorganize the current rules and do not change policy. Current medicaid policy excludes coverage of educational services. This has been the medicaid policy since the early 1980's. The department is researching its records

regarding this policy decision and will make them available to the commentor. The department will not change the administrative rules to cover this service at this time. Changing this policy would have a significant impact on the Medicaid program. Medicaid has received numerous requests to cover cardiac rehabilitation services and other educational programs. The department will review its policy on coverage of these services and will discuss this issue with hospital providers. If the department can document the cost-benefit of providing these services, we will give strong consideration to including them in the future. Any information hospitals can provide to help document this finding would be appreciated.

COMMENT: MHA opposes the department's exclusion of maintenance therapy in the outpatient rules. Such care is covered in the nursing facility setting as part of the daily payment rate, and it should be available to the general medicaid population. The department policy should include coverage for preventive care at lower costs rather than waiting for higher cost care after the deterioration of patient condition over time. How else does the department reason many optional services should be retained in the Medicaid program?

RESPONSE: Maintenance therapy is covered in the nursing facility setting because nursing facilities are required by federal law to provide routine physical therapy services to maintain range of motion for residents. Maintenance therapy is not a covered service under the medicaid therapy rules or under medicare rules and regulations. Basically, this is because it generally does not involve complex and sophisticated therapies and procedures and, consequently, does not require the skill and judgment of a qualified therapist for safety and effectiveness. Limited funding is available and the department cannot cover every service and must exercise discretion to determine the relative priority of various services. The department provides coverage of services such as well-child visits and mental health services, but does not cover maintenance therapy. The proposed changes to the medicaid outpatient hospital rules as they pertain to therapy services are not a new policy of the Medicaid program, but a clarification of current policy. No changes will be made to the proposed rules as requested by the commentor.

COMMENT: The department should modify paragraph (e)(ii) of ARM 46.12.507(3), deleting the requirement that a physician must provide "direct, personal supervision" of outpatient therapeutic services provided outside a hospital. MHA believes the language of paragraph (b)(iii) is more appropriate and factually true. All care rendered by a hospital, regardless of setting, remains the responsibility of the hospital medical staff.

RESPONSE: This portion of the proposed rules was designed to follow medicare guidelines for outpatient hospital services. Hospitals have previously criticized the rules as not clearly defining covered services. The proposed rules specify coverage

by following medicare guidelines in the coverage of outpatient hospital services. The policy this commentor is referring to involves outpatient hospital services provided outside the hospital. Under current medicaid rules, services provided outside the hospital are not covered by medicaid, as the rule covers only "services provided in a hospital."

The proposed change follows medicare in allowing certain outpatient services to be provided outside the hospital. Medicare regulations (HCFA - Pub. 10, 230.2) qualify this policy with a distinction between diagnostic and therapeutic services. Therapeutic services, which must be incident to physician's services, are covered when furnished outside the hospital only if there is direct personal supervision by a physician. Outpatient physical therapy, occupational therapy and speech therapy are not subject to the direct physician supervision requirement. The department will include this exception language in the final rule. The provisions of the proposed rule in ARM 46.12.507(3)(b)(iii) are appropriate with respect to services provided in the hospital, but further restrictions apply when the services are provided outside the hospital.

COMMENT: MHA supports the amendment to the proposed rule to provide 62% of charges to sole community hospitals and 60% of charges to other hospitals for clinical diagnostic lab services. The commentor notes the department has transposed the percentage amounts in the proposed rule.

RESPONSE: We recognize the percentages are transposed and these will be corrected in the final rule.

COMMENT: MHA remains adamantly opposed to the fee schedule proposed for imaging services. The RBRVS fee schedule does not include any hospital cost information. The medicare fee schedule is based on physician office practice costs. It is patently unfair to pay hospitals using this fee schedule as hospitals face tougher standards for personnel and quality than physician office imaging. Plus hospitals provide 24 hour a day, every day, access.

COMMENT: Some commentors compared their current medicaid reimbursement with the proposed SRS fee schedule and have stated that the proposed rate fee is well below the current medicaid reimbursement rates. The proposed fee is based upon physician reimbursement services rather than hospitals. Our costs are not equitable to a physician's office practice and therefore our rates also do not follow. The commentors provided examples of some of the differences.

RESPONSE: The department has deleted the proposed rules regarding fees for imaging and other diagnostic services. The department will review this issue further, develop a revised methodology and propose a new rule at a later date.

The proposed rules were designed to make payment amounts more predictable for hospitals, to encourage efficiency and to simplify medicaid payment methods by making them similar to medicare. The proposed changes included fee schedules for imaging and other diagnostic services based upon 100% of the technical component of the medicare fee schedule. Since the original proposal, Abt has been able to analyze medicare cost reports and to make more precise and reasonable estimates. It is clear that medicaid's current payments for these services are more generous than medicare's. Based upon continuing analysis of the proposed methodology, the department has found that the proposed fee schedule would result in payment levels significantly below current levels. We expected some decrease in payment levels, but we did not expect such a significant decrease as would have occurred. Based upon this finding, the department decided to delay implementation of the imaging and other diagnostic fee schedules until a later date. Therefore, the proposed changes to the outpatient rule for imaging and other diagnostic services has been deleted from the rules.

COMMENT: The proposed medicaid fee schedule for imaging services indicates a zero payment for mammogram screening under HCPCS code 76092. The Health Care Financing Administration (HCFA) covers the performance and interpretation of screening mammogram every one to two years, depending on the beneficiary's age and risk factors. For 1995, the approved payment for the screening of mammogram technical component is $41.40. We suggest that medicaid adopt a similar payment process and reimbursement amount for screening of mammogram as approved by HCFA. We believe that such a rule would encourage the screening of mammogram to aid in early detection of breast cancer and early treatment.

RESPONSE: The department fully agrees with this comment and apologizes for the erroneous zero rate for this procedure. It was purely an oversight on our part that this fee schedule was released with a zero rate for mammography screening. Our consultants identified this zero rate in the medicare fee schedule and recommended options for the department to consider. Medicaid does cover this procedure and it will be reimbursed by medicaid if the service is provided in a certified MQSA (Mammography Quality Standards Act) facility, as determined by the department of health and environmental sciences. A rate for this procedure will be included in the fee schedule for imaging and other diagnostic services to be proposed at a later date.

COMMENT: We oppose the department's proposal to pay hospitals $20 for a "non-emergency", non-authorized emergency room visit. Abt Associates recommended a basic fee for the emergency room consistent with a brief encounter, plus payment for lab and radiology. Because federal law requires hospitals to provide whatever medical services are needed to determine whether a medical emergency exists, hospitals should be paid in accordance with the department's normal policy. One commentor suggests

that the department either adopt Abt's recommendation to allow payment for lab and radiology in addition to the screening fee, or to provide a screening fee of $60.

COMMENT: The proposed emergency room screen fee for non-emergent emergency room services is extremely low and unacceptable. We believe that if we are to adopt a one-time fee, that the fee should be a minimum of $50.00 for the emergency room services, including other ancillary services such as laboratory, imaging, etc.

COMMENT: In regard to the non-emergency fee of $20, we would request you reconsider this policy. While your attempts to steer patients to proper venues for cost effective services is appreciated, please do not penalize hospitals for those patients who need and utilize our services. We would ask that you increase the fee to $50-$60 or allow us to bill for any ancillary services while receiving the $20 screening fee. It seems rather ridiculous that hospitals are asked to provide a multitude of technical services for $20 while you and I take our pet to the veterinarian and expect to pay no less than $50-$60 a visit.

COMMENT: We need to treat patients in the emergency room who demand or need care. The $20.00 reimbursement for unauthorized ER services provided to PASSPORT recipients is unacceptable. We recommend an all inclusive fee of $60.00-$70.00 (minimum) or a lesser fee with all ancillaries and diagnostic services covered separately.

RESPONSE: Abt Associates recommended that the department pay hospitals a screen fee of $20, based on similar fees in other states. Abt Associates recommended that laboratory and radiology services not be paid separately (see page 38 of their report).

The screen fee is one part of the department's efforts to improve continuity of care provided to beneficiaries while ensuring care is provided in the most cost effective setting. On both counts, the emergency room is an inappropriate place for non-emergency care. The PASSPORT program was designed to give recipients a "medical home", and we hope that hospitals will re-direct patients away from the emergency room when they make unnecessary visits.

The screening fee proposed for hospitals is only part of the medicaid reimbursement policy for non-emergent emergency room services. Hospitals need to remember that not all emergency room services will be paid this screen fee. The screen fee applies only to those cases where a PASSPORT recipient receives services in the emergency room that are not authorized by the recipient's PASSPORT provider because they are not medically necessary, and the diagnosis for the service is not on the department's broadly defined list of emergency diagnoses. When

an ER service is provided that does not meet these two criteria, the hospital claim would be paid at $20. The professional services provided by a physician in the ER will continue to be paid under the current medicaid reimbursement rules. The screen fee combined with the physician reimbursement would result in medicaid payment of approximately $45-$91.

If a claim is paid with the screen fee and the hospital disagrees with the PASSPORT provider denial, the hospital can appeal the denial through the PASSPORT program. This appeal could be made if in the opinion of the hospital medical staff the services were considered to be an emergency. In addition, if an ER service requires considerable resources from the lab and imaging department, the claim would more than likely be authorized by the PASSPORT provider. If it is not authorized, the services can be appealed through the PASSPORT program. If these services are subsequently determined to be an emergency the claim will be paid under the current cost based reimbursement methodology.

The department recognizes the hospital's legal and moral obligation to screen all patients to determine whether an emergency condition exists and, if so, to at least stabilize the patient. In the vast majority of cases that might be true emergencies, either the patient's diagnosis will be on the emergency diagnosis list or the PASSPORT provider will approve treatment. The screen fee is not intended to reflect the average cost of screening all patients. Rather, its purpose is to compensate hospitals for the expense of screening those patients who turn out neither to have an emergency nor to have a condition for which the PASSPORT provider authorizes treatments. These cases will obviously be the simpler cases. Hospital providers need to remember that in the recent past, hospitals received no payment for patients whose care was not authorized by the PASSPORT provider. Under the proposed policy hospitals will receive reimbursement for the screen and, if the above conditions apply, cost based reimbursement as usual.

After further consideration, the department has reconsidered the proposed policy on a bundled payment for the screen fee based upon the comments received and additional analysis by the department and Abt Associates. The department will revise the rule to allow hospitals to be paid separately for laboratory, imaging and other diagnostic services in addition to the screen fee. The screen fee will remain at $20, as originally proposed, and represents a bundled fee for all other outpatient hospital services as defined in the rule.

COMMENT: The department's $20 screen fee proposal creates a perverse incentive for physicians and HMOs to dump patients on emergency rooms for routine screening and treatment. If SRS devalues expensive hospital treatment settings there is no barrier to physicians who would decline timely access to the office setting in favor of private paying patients, while

pushing medicaid patients into the emergency room. SRS must properly maintain the relative value of emergency room care to physician care to avoid just this situation. SRS must carefully craft policies which align provider incentives, not continue to put providers at cross purposes.

RESPONSE: As noted above, the department will revise the rule to allow hospitals to be paid separately for the laboratory, imaging and other diagnostic services in addition to the screen fee. The screen fee applies only to cases where the PASSPORT provider has not authorized the service and the diagnosis is not on the department's broadly defined list of emergencies. For all other emergency room visits, the hospital will receive reimbursement under the current cost based methodology. Hospital services are not being "devalued," but rather the department is paying for claims that previously were denied in their entirety.

For cases where the screen fee is paid, non-emergent cases, the hospital is under no obligation to provide treatment. If treatment is provided by the hospital they must obtain the PASSPORT providers authorization. Since physicians are paid on a fee-for-service basis, they forgo revenue when they "dump" patients onto the emergency room. Even if particular physicians wanted to dump patients, the hospital is under no obligation to treat patients in non-emergent cases where the screen fee is paid. The department does not believe its proposed changes would encourage physician to dump patients on hospital emergency rooms. Any physician that would engage in such strategies would do so under the current rule without regard to the level of hospital charges, since the physician is not required to pay for the hospital services.

The department also has quality assurance reviews performed to monitor situations described by the commentor. A PASSPORT provider is under contract with the department to provide management of a recipients health care. Part of this contract is to provide access to primary care services to avoid unnecessary utilization of emergency room services. If a PASSPORT provider was acting as described by the commentor, the department would take necessary action to change the provider's practices or remove the provider from the PASSPORT program. Accordingly, the department doubts that the implementation of a $20 screen fee will result in physicians being any more likely to direct patients to the emergency room than they are now.

When HMOs enroll medicaid beneficiaries, the HMO will be responsible for paying for ER services its enrollees use and at rates no lower than those used by the department. We expect HMOs to discourage patients from using the high-cost services of an emergency room. If for some reason a particular HMO encouraged its beneficiaries to visit the emergency room unnecessarily, this issue would be considered in the department's review of the quality of care the HMO provides.

COMMENT: A commentor offered observations regarding the ICD-9-CM codes that are incorporated in the proposed changes. Massive changes were made in the ICD-9-CM coding book in 1994. Many fifth digits were added and this will affect many of the codes on the emergency diagnosis list. Some codes represent acute, emergent conditions that are not on the list (382.9 acute otitis media; 518.82 respiratory distress; 599.0 urinary tract infection). In addition, why is rape considered traumatic enough to warrant reimbursement for observation, being the only V71 code on the list?

RESPONSE: The department obtained this list of emergency diagnosis codes from the state of Utah, through Abt Associates' study and evaluation of Montana's outpatient hospital reimbursement system. The emergency diagnosis list is a guideline for providers to use with regard to emergency room services for PASSPORT recipients. When a ER service is on the listing, medicaid will consider the claim to be an emergency and the claim will be paid even if the PASSPORT provider did not authorize the service. This listing is very generous according to our consultant and various physicians who have reviewed the list. The department plans to have this list reviewed by a committee of health care professionals. This committee, called the Peer Education and Review Committee (PERC), will review the emergency diagnosis list and make recommendations for the department to consider in updating the list. The comments noted above will be considered by the committee.

COMMENT: The commentor does not oppose the creation of a partial hospitalization program, complete with prospective rates. The commentor does believe that the payment methodology should be updated to include the costs incurred by Shodair and Rivendell Hospitals for adolescent day treatment, and that the rates be tied to current DRG payment levels.

COMMENT: The proposed rates for partial hospitalization are $196 for full-day programs and $147 for half-day programs. These are not lucrative rates but they can be accepted with increased utilization. It is our hope that medicaid has an increased interest in partial hospitalization and will use it when inpatient days are denied certification. We would prefer a full day per diem rate in the range of $225-$250.

RESPONSE: The department welcomes support for the prospective payment approach to reimbursement of partial hospitalization. This program has grown considerably since July 1993 with the close of medicaid reimbursement for freestanding inpatient psychiatric hospitals. We have spent considerable time with this program over the past year talking to providers and reviewing data. We recognize this program growth and as a result, the department has developed medicaid policy and program definition and requirements for partial hospitalization.

The issues raised by the commentor indicate that no prospective payment system can reflect the most up-to-the minute information regarding patterns of care. The rates proposed by Abt Associates, $178 for full-day and $133 for half-day, were based on patterns of care in 1993. The proposed rates were just 2% less than the average interim payments per day the department was making at the time. Any changes in the patterns of care delivered at Shodair and Rivendell will make a difference only to the extent that they affect the average cost of providing partial hospitalization services. This would also hold true for the patterns of care of other partial hospitalization providers in the state.

The rate is linked to medicaid's actual payments for psychiatric inpatient care as a way to maintain partial hospitalization's place in the continuum of care. The continuum of mental health services ranges from acute care hospitalization to treatment in a residential treatment center to partial hospitalization to less intensive outpatient care. In this continuum of care, payment amounts for all services need to be proportionate to the degree of intensity across settings. As such the payment for full-day services was set at 40% of what medicaid actually pays per day of inpatient psychiatric acute care. Treatment provided for half-day services would be paid at 75% of the full-day rate.

Abt Associates used the most recent actual data available at the time of the study which was for the period July through December 1993. Providers have indicated to the department that partial hospitalization programs included services for children, adolescents and adults. The department updated the rate calculations using the same analysis on all inpatient psych DRGs and included more data than was available at the time of the study. This analysis identified a $490 average daily DRG rate, very close to Abt Associate's $460 average daily DRG rate using earlier data.

The $490 average daily medicaid cost per inpatient psych DRGs includes the DRG base, capital payments and any outlier payments. The partial hospitalization rates are therefore set at $196 ($490 x 40%) for full-day services and $147 ($196 x 75%) for half-day services. We understand the argument that this actual figure should be updated to the current period using some measure of price change such as the increase in the DRG base price. Doing so, however, would remove the link to inpatient care as the payment rate is not based solely upon the base rate of DRGs, it includes capital payments and outlier payments. Applying the percentage increase in the DRG base price to the computed partial hospitalization rate inflates other costs of providing care not related to an inflationary percentage.

The department believes the approach used results in reasonable and adequate rates for 1995-1996. Updates to this rate will be made in tandem with actual changes in payments for inpatient psychiatric care. The result should be simpler for all parties

concerned. The proposed fees of $196 and $147 are within the estimated costs of providers. In addition, one partial hospitalization provider presented the department examples of contracts with managed care entities and/or third party payers. In one example, the rate under contract was $195 for a full-day of care and $125 for a half-day of care.

COMMENT: A commentor applauds the department for its efforts on partial hospitalization. There is some concern however regarding the rules on bundled rates. There is concern that recipients may be accessing medical services other than those provided by the hospital, such as pharmacists and therapists. The rule seems to imply that these services received by recipients are bundled into the prospective rate.

RESPONSE: The bundled rate referred to in the proposed rule is not intended to imply that all services a recipient receives through medicaid are part of the prospective rate. The department recognizes that a recipient may receive services outside the hospital setting for other therapies, prescriptions, and physician services. The bundling referred to in the rule is intended for the diagnostic and therapeutic outpatient hospital services provided by the partial hospitalization program or another hospital. For instance, a prescription filled by a pharmacist outside the hospital is not part of the bundled rate. A drug or medication administered by the hospital as part of or incident to the partial hospitalization program is included in the prospective rate. The same logic would apply to therapy services. If a recipient was receiving therapy services as part of the plan of care while in the partial hospitalization program then it is included in the prospective rate. If the recipient received services, not part of the partial hospitalization program plan of care, from a therapist outside the partial hospitalization program then the service is not bundled and can be billed separately. Laboratory services are routinely ordered as part of providing partial hospitalization services. These services are considered to be included in the partial hospitalization rate. The department will add rule language to clarify what is included in the bundled rate.

COMMENT: A commentor had a concern regarding intensive partial hospitalization. How do they transfer someone who is in a partial hospitalization program to the intensive outpatient hospitalization program. How do they certify for the next level of care?

RESPONSE: The intensive outpatient hospitalization (IOP) services are designated as a measure to "step-down" a patient from the partial hospitalization program. During our review of the program several providers requested a step-down program from our utilization review contractor. In some cases, the provider wanted to wean a patient from the partial program but still provide services for a full-day or half-day. The IOP will allow for this step-down in care through authorization by the

utilization review contractor. This service will not be allowed as an entry level program for hospital psych services but is intended as a service to transition a patient to a less restrictive setting.

COMMENT: The department proposes to reimburse dialysis at the medicare composite rate. Our medicare composite rate is 83% of our current medicaid reimbursement amount. Though it barely covers our costs, this is one more decrease in revenue to absorb.

RESPONSE: Given the standardized nature of dialysis services, the department will adopt the medicare reimbursement methodology. Many hospital providers identified to medicaid staff and Abt Associates during the outpatient hospital study, that medicaid should adopt medicare reimbursement principles where possible. Following medicare provides for uniform billing practices between the two payers and eases the administrative burden. For dialysis services, we are aware that medicaid pays more than medicare and we expected a reduction in medicaid payments. This reduction should be minimal, however, because a majority of the dialysis services are covered by medicare, and medicaid pays the crossover amount for co-insurance and deductibles. The medicaid only cases are estimated to be minimal considering nationwide about 7% of ESRD patients do not qualify for medicare.

COMMENT: The administrative rule change process allows for a comment period in the hearing to submit our opinions. The proposed rule was published May 11, 1995, was received by our hospital May 17, 1995. On May 31, 1995, there is a scheduled hearing to review the proposed rule changes. All written comments, data, views and arguments must be submitted to the state no later than June 8, 1995. Since the department has been working on these rules for many months, we believe that there is not a sufficient comment period for us to realistically evaluate the impact of these rules on hospitals in Montana.

RESPONSE: The department has openly involved Montana hospitals and the Montana Hospital Association throughout this project. We have informed providers through presentations at association conventions, meetings with providers, and information provided to MHA. It is our understanding that MHA provided copies of the Abt study to all hospitals requesting input. In addition, the department and MHA formed a group of provider representatives upon which to discuss this project and solicit input. Several presentations were made to this group of providers regarding the recommendations and comment was received which was considered in the final recommendations and the proposed rules. The department feels it has adequately kept providers and MHA informed of the proposed changes. The department has not only met the legal requirements for allowing public comment and participation in these decisions, but has gone well beyond

minimum requirements in order to assure hospitals a full opportunity to participate in the process.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

6. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to medicaid home health services	))))	NOTICE OF THE AMENDMENT OF RULES 46.12.550, 46.12.551 AND 46.12.552 PERTAINING TO MEDICAID HOME HEALTH SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to medicaid home health services at page 808 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.12.551 as proposed.

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

46.12.550 HOME HEALTH SERVICES, DEFINITIONS Subsections (1) through (3)(b) remain as proposed.

(i) SERVICES AVAILABLE UNDER THE personal care ~~attendant~~ services PROGRAM; and

Subsections (3)(b)(ii) through (6) remain as proposed.

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

46.12.552 HOME HEALTH SERVICES, REIMBURSEMENT Subsections (1) through (5)(B) remain as proposed.

(6) For home health agencies located within the borders of the state for services provided on or after July 1, 1995, the reimbursement fee for a home health service, EXCEPT FOR A HOME HEALTH AIDE SERVICE, IS 60% OF THE AVERAGE OF THE PROVIDER'S MEDICARE COST LIMITS FOR SKILLED NURSING, PHYSICAL THERAPY, SPEECH THERAPY AND OCCUPATIONAL THERAPY SERVICES. ~~is the lower of:~~

~~(a) the provider's customary charges; or~~

(a) THE REIMBURSEMENT FEE FOR HOME HEALTH AIDE SERVICES IS 60% OF THE PROVIDER'S MEDICARE COST LIMIT FOR THAT SERVICE.

~~(b) 60% of the provider's medicare cost limit for the category of service.~~

Subsections (7) through (7)(b) remain as proposed.

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

4. The Department has thoroughly considered all commentary received:

COMMENT: Additional language should be added to ARM 46.12.550 (3)(b)(i), relating to the definition of home health services, to clarify that the department is segregating programs rather than excluding specific activities.

RESPONSE: The department has clarified the rule by specifically stating that home health services do not include the services provided through the medicaid personal care services program.

COMMENT: Language should be added to ARM 46.12.551, home health requirements, indicating that the department's review for purposes of prior authorization is intended to determine the medical need for continued agency care rather than to redirect patients to other care providers. The department should not interfere with the recipients' choice of providers.

RESPONSE: The language of the provision does not direct the change of provider or otherwise address the status of the provider. The purpose of the review for prior authorization purposes is to determine the appropriateness in terms of medical necessity of continued care for the person. The review will also address the availability and the appropriateness of other services under the Medicaid program, specifically private duty nursing services provided through the home and community services program.

COMMENT: ARM 46.12.552(1), as amended, does not make any sense and should be deleted.

RESPONSE: The provision provides a general description of the purpose of the rule.

COMMENT: The provisions at ARM 46.12.552(2),(3), and (4), providing reimbursement rates for services delivered prior to the effective date for the new reimbursement rates, should be repealed.

RESPONSE: The provisions will remain in the rule for the duration that there are services delivered subject to those rates for which cost-settlements will be necessary in the future. The continued presence of those provisions will serve to guide the department and providers in the reimbursement of services delivered prior to July 1, 1995 that remain subject to cost settlement.

COMMENT: The new reimbursement rate for in-state providers of home health services at ARM 46.12.552(6)(b) should only include the medicare cost limit. The inclusion of the provider's rate is unnecessary.

RESPONSE: The provider's rate or customary charge has been removed from the rule.

COMMENT: Since the department determined that almost no medicaid clients utilize services to the limit proposed in the rules, the department should not need to develop limits.

RESPONSE: The department established limits upon services based upon actual utilization of services. Since 92% of all individuals receive less than 75 skilled nursing visits per year, this limit would affect 8% of our service population. The department seeks to insure that the services are necessary and are being delivered in the most efficient manner by prior authorizing those cases using higher levels of services. The medically necessary definition at ARM 46.12.102(2), is the basis of this decision.

COMMENT: The department should not be limiting access to home health services when the department is seeking to control hospital and nursing facility use. Availability of home health services is important to the viability of the home health organizations that medicaid may be contracting for services from.

RESPONSE: The provisions, relating to use of home health services, are primarily intended to assure that services are provided to persons for whom the services are medically appropriate. Improved oversight of utilization should not result in a significant movement of persons into more restrictive settings.

COMMENT: A hospital provider of home health services opposed adoption of two reimbursement methodologies. One was a rate that is the average of 60% of all agencies cost limits. The other was to establish a fee for all services that would them be compared against usual and customary fees.

RESPONSE: Neither of these methodologies is in the adopted reimbursement methodology.

COMMENT: There should be written confirmation of benefit under the prior authorization system. Could the fax system, as currently used for eligibility information, also be used for prior authorization.

RESPONSE: The department will be utilizing a prior authorization system that may be accomplished via fax machine or telephone. The department will send to the providers a description of this process via letter shortly after July 1, 1995.

COMMENT: The proposed reimbursement rate would adversely affect those agencies that provide the costly high tech home health care or have need of intensive services.

RESPONSE: Due to the substantive inequities in the current reimbursement system, the department chose a reimbursement

system that would address the existing inequities. In addition, the reimbursement system is designed to be simple to administer.

COMMENT: How does the proposed cap accommodate future increases in the cost of providing care.

RESPONSE: The reimbursement rate is not predicated upon reimbursement of actual costs. The rate, however, will change with the medicare cost limit.

COMMENT: Has the department considered how to ration care for patients, if necessitated by the proposed cap on reimbursement.

RESPONSE: The department does not anticipate that the reimbursement rate would result in rationing of care. The rate will not significantly affect total expenditures on home health care by the Medicaid program.

COMMENT: The department should authorize additional services when necessary and in an efficient manner.

RESPONSE: The department's medicaid regional program officers will be prior authorizing visits in excess of the limits adopted in the rules. Each case will be reviewed to determine if the service continues to be medically necessary as defined at ARM 46.12.102. A form will be provided to agencies to complete for this purpose.

COMMENT: The departments should clarify why an interim percentage rate is needed for services provided after July 1, 1995.

RESPONSE: ARM 46.12.552(1) through (5) describes the reimbursement methodology for services provided prior to July 1, 1995. The interim rate applies to the services delivered prior to July 1, 1995. The department will not apply an interim percentage for services delivered after July 1, 1995. The rates for services delivered after July 1, 1995 are those specified in ARM 46.12.552(6) and (7).

COMMENT: The department should repeal ARM 46.12.552(2) of this part. The department cannot adopt rules retroactively reducing the payment amount due providers.

RESPONSE: ARM 46.12.552(2) describes the reimbursement methodology for services provided prior to July 1, 1995. This section of the rule is retained as services delivered in state fiscal year '93, '94 and '95 have not yet been cost settled. It will remain in effect until the cost settlements for all services provided prior to July 1, 1995 are completed.

COMMENT: Many comments were received stating that the proposed reimbursement methodology is not sufficient to cover the costs of providing home health care services.

The reimbursement methodology reimburses most providers at approximately the same level of payment they currently receive after cost settlement occurs. The rule change is intended to establish a more equitable reimbursement rate, to establish a reimbursement methodology that eliminates cost settling, and to establish a reimbursement rate that did not raise the total expenditures for the program. The department examined the current reimbursement levels of 32 providers and noted that only 2 of these providers receive a reimbursement level equal or greater than their medicare average cost. The current methodology has been in place since 1991 and the department has received only one formal appeal of the methodology, indicating to the department that the current reimbursement level, after cost settlement, is sufficient to provide quality services.

The reimbursement methodology as adopted has been modified from the methodology as proposed to allow for the weighting of all skilled services. This methodology will provide reimbursement at a slightly higher rate for the skilled services than would have resulted from the methodology as originally proposed. The department will establish one set rate of reimbursement for skilled nursing, physical therapy, speech therapy and occupational therapy for each agency. This will be accomplished by averaging 60% of the medicare cost limit for each category of service to create a single rate. The reimbursement for home health aid services will remain at 60% of the provider's medicare cost limit for home health aid services.

COMMENT: The proposed rule reducing the provider's medicare cost limit to 60% per category of service does not indicate the cost limit in reference to medicaid.

RESPONSE: ARM 46.12.552(6)(a) and (b) provides the framework for reimbursing for services after July 1, 1995. The department is not reducing the medicare cost limit of the agency. The department is establishing that the rate of reimbursement shall be no more than 60% of this cost limit. The medicare cost limit is a benchmark of cost limits published by the Health Care Financing Administration.

COMMENT: If the cost limit stated is the medicare cost cap, when was it published and what is the effective date?

RESPONSE: This information was published on February 14, 1995 in the Federal Register on page 8389 under the title "Medicare Program: Schedule of Limits on Home Health Agency Cost Per Visit." The effective date section states: "The revised schedule of limits on HHA costs set forth in this notice is effective for cost reporting periods beginning on or after July 1, 1993. The OBRA '93 provision providing that there be no changes in the HHA cost limits for cost reporting periods on or after July 1, 1994 and before July 1, 1996, as set forth in this notice, is [also] effective for cost reporting periods which begin on or after July 1, 1994."

COMMENT: The new reimbursement methodology is far below the average cost of $77.89 for a skilled nursing visit based upon a survey of 16 agencies.

RESPONSE: The department is not bound to reimburse the cost of providing services. This figure appears to be misleading as it does not account for the affect of cost settlement. The department is settling on an average of $58.72 per visit, based on FY92 cost settlement data for 31 agencies. Since a majority of these agencies settle on the medicaid index fee, which does not adjust yearly after 1991, this average is not expected to change.

COMMENT: Various alternative rates of reimbursement were suggested including: reimbursement at 80% of the medicare upper cost limit for the first year with some sort of review system after that; reimbursement at 75% of the medicare upper cost limit; and 95% of the medicare upper cost limit.

RESPONSE: The department has set the reimbursement at 60% of the medicare cost limit. The suggested higher rates would result in an increase over current reimbursement, which is not the intent of this rule amendment.

COMMENT: The reimbursement rate will result in a loss over the reimbursement received under the current methodology because the cost analysis used by the department was based on 1991 settled costs rather than on 1995 costs.

RESPONSE: The analysis was based on settlements of the state FY92 as this is the most recent set of complete data available to the state. These figures were indexed forward to reflect the projected settlement figures of state FY 95. Additionally, a majority of these settlements were made on the medicaid index fee. This fee stopped growing at the end of state FY91. Unless agencies have significantly reduced their charges or cost, the medicaid index fee will be the amount the department cost settles on for state FY 93, 94 & 95.

COMMENT: The department should adopt a later effective date due to the fact that the notice was not received in a timely manner.

RESPONSE: The effective date is July 1, 1995. Delaying the implementation date would subject providers to cost settlement on a partial year and recipients would be subject to pro-rated limits if a different date was selected.

Notice of the rule amendments was published on May 11, 1995 in Issue No. 9 of the Montana Administrative Register published by the Secretary of State. A hearing on the proposed rule changes was held on June 1, 1995. Interested persons and entities were able to submit written comments up to the date of June 8, 1995. Copies of the proposed changes to the rules were sent out to all

persons who had in past specifically asked to be informed of changes in home health rules.

COMMENT: The department should adopt a ratio of medicaid payments to provider costs consistent with the levels allowed hospitals, nursing homes and pharmacies.

RESPONSE: The federal regulations give states options for setting reimbursement methodologies that by necessity vary by provider type. The legislature has directed the department to eliminate cost based reimbursement. The department believes the proposed methodology is adequate and meets the legislative intent to contain costs.

COMMENT: The department is creating a disincentive to provide services to medicaid recipients due to the fact that reimbursement is not adequate.

RESPONSE: The reimbursement methodology has been modified in the final adoption to include a weight for all skilled services. The department will reimburse at one set rate for skilled nursing, physical therapy, speech therapy, and occupational therapy. The fiscal impact of the change in reimbursement methodology, is minimal and to the advantage of the providers. The department does not believe a disincentive is being created based on the reimbursement methodology. Most providers will receive reimbursement prospectively at approximately the level they are currently receiving after cost settlement occurs.

COMMENT: The department should provide for a mechanism to adjust the reimbursement rate.

RESPONSE: The department choose the medicare cost limit as a basis for reimbursement because it would provide an adjustment approximately every two years.

COMMENT: An incentive payment should be provided for agencies with cost effective operations.

RESPONSE: The department is willing to review and consider any incentive proposals that are brought to its attention. The development of an incentive aspect to reimbursement would be a long term project.

COMMENT: The state can not make a change in payment methodology unless an amendment to the state plan has been submitted to and approved by the Health Care Financing Administration in accordance with 42 CFR 447.201.

RESPONSE: The department has until the end of the quarter in which a change in reimbursement methodology takes effect to submit the state plan to HCFA. For the proposed changes, September 30, 1995 is the deadline to submit the state plan amendment to HCFA.

COMMENT: The department, in accordance with 42 CFR 447.205, must provide notice describing the proposed change in reimbursement methodologies, give an estimate of any expected increase or decrease in the annual aggregate expenditures, explain why the agency is changing its methods and standards, and provide the opportunity for public review of the proposed changes and the submission of written comments.

RESPONSE: The department met with the Montana Association of Home Health Agencies on the 20th of April and provided a description of the proposed change, an explanation of the change and requested written comments to the department through the rules process. The first notice of the proposed rules included a description of the proposed changes, and explanation of such changes as well as the methods on which to comment.

In addition the department will also publish the economic impact of the reimbursement methodology in the Great Falls Tribune, the Missoulian and the Billings Gazette on Sunday June 18, 1995. This notice includes a method to comment.

COMMENT: The Montana Medicaid program must establish its rate setting methodology with due consideration of the four mandated federal factors of economy, efficiency, quality of care and access to services.

RESPONSE: The department did address these issues when the methodology was established.

The economic impact was calculated based upon data available from the last cost settled year, and indicates a minimal impact on the agencies. This proposed methodology is much more efficient as the provider receives essentially the same level of reimbursement under this method, as the previous method, but will not be subject to cost settling. This also will eliminate recouping of funds by the department.

Currently, there are no significant quality of care or access problems. Quality of care and access to services should not be affected by the change in reimbursement methodology because the economic impact on most agencies will be minimal. There will be significant positive impacts for recipients of services from those agencies that have historically settled on a extremely low rate. Those agencies will now receive a higher more reasonable level of reimbursement.

COMMENT: The state must engage in an analysis of actual costs of home health agencies to determine whether its proposed methodology can be supported under the federal standards.

RESPONSE: The department performed numerous analyses on cost reporting data before proposing the intended methodology.

COMMENT: Since the proposed medicaid reimbursement is at 60% of the medicare cost limit and the medicare reimbursement is predicated on the medicare certification for conditions of participation, which conditions of participation will a home health provider not be subject to for purposes of serving medicaid recipients?

RESPONSE: The use of the medicare cost report in the medicaid reimbursement rate does not incorporate any requirements that the medicare reimbursement may be predicated upon.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

6. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the adoption of Rule I and the amendment of rules 46.12.555, 46.12.556 and 46.12.557 pertaining to medicaid personal care services	)))))	NOTICE OF THE ADOPTION OF RULE I AND THE AMENDMENT OF RULES 46.12.555, 46.12.556 AND 46.12.557 PERTAINING TO MEDICAID PERSONAL CARE SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed adoption of Rule I and the amendment of rules 46.12.555, 46.12.556 and 46.12.557 pertaining to medicaid personal care services at page 814 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.12.557 as proposed.

3. The Department has adopted [RULE I] 46.12.558, PERSONAL CARE SERVICES, PROVIDER COMPLIANCE as proposed.

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

46.12.555 PERSONAL CARE, PURPOSE, SERVICES, ~~DEFINITION~~ PROVIDED, AND LIMITATIONS

Subsections (1) through (4)(d) remain as proposed.

(5) Escort services are provided by a personal care attendant who accompanies the recipient. ~~Escort services are limited to accompanying the recipient~~ to a medical examination, treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are available ~~only when the recipient is unable to perform these tasks except with the aid of a personal care attendant~~ TO A RECIPIENT WHO REQUIRES PERSONAL CARE SERVICES ENROUTE OR AT THE DESTINATION, WHEN A FAMILY MEMBER OR CAREGIVER IS UNABLE TO ACCOMPANY THEM.

Subsections (6) through (8)(a)(xvi) remain as proposed.

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

46.12.556 PERSONAL CARE SERVICES, REQUIREMENTS

Subsections (1) through (5) remain as proposed.

(6) The type and amount of ~~P~~personal care services must be specified in a plan of care which governs delivery of services. The plan of care for a recipient ~~is~~ must be ~~ordered~~ APPROVED by a physician and developed by a ~~registered~~ licensed nurse employed by ~~or contracted with the contract~~ a provider. THE APPROVAL OF THE SERVICE PLAN MUST BE RENEWED AT LEAST ANNUALLY. The plan of care shall be delivered DEVELOPED based upon the

~~result~~ COMPLETION of the DEPARTMENT'S RECIPIENT ~~recipient's needs~~ profile ~~as determined~~ by the ~~department~~ PROVIDER.

Subsections (7) through (14)(f) remain as proposed.

(g) A DESCRIPTION OF THE PROPOSED SERVICE AREA WHICH MUST BE DEFINED TO INCLUDE AT A MINIMUM COVERAGE OF THE ENTIRE AREA OF AT LEAST ONE COUNTY OR INDIAN RESERVATION.

Subsections (15) through (18) remain as proposed.

(19) Personal care services are not available to recipients who live in homes which are not SAFELY accessible by ~~automobiles~~ NORMAL MODES OF TRANSPORTATION.

Subsections (20) through (20)(a) remain as proposed. Subsections (20)(c) and (20)(d) remain as proposed in text but are renumbered (20)(d) and (20)(e). Subsection (18)(g) remains as proposed in text but is renumbered (20)(b). Subsections (20)(e) and (20)(f) remain as proposed in text but are renumbered (20)(f) and (20)(c). Subsection (20)(g) remains as proposed. Subsection (21) remains as proposed.

(~~20~~22) The ~~department will provide~~ provider shall give at least 10 days advance notice to a recipient when personal care services are terminated for ~~any of the~~ reasons listed in ~~subsections (14)(a) through (e), (h), (i) and (k)~~ subsections (20)~~(e)~~(d) through (20)(g).

(23) The provider may immediately but temporarily suspend services for the reasons listed in subsections ~~(20)(f)~~ (20)(a) THROUGH (20)(c). Following the temporary suspension of services the provider may enter into ~~a contract~~ AN AGREEMENT with the recipient to ensure that the violations of subsections ~~(20)(f)~~ (20)(a) THROUGH (20)(c) do not reoccur. If the recipient fails to abide by the term of the agreement services may be permanently terminated.

Subsections (24) and (25) remain as proposed.

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

5. The Department has thoroughly considered all commentary received:

COMMENT: The definition of services as "medically necessary" was questioned based upon the limited amount of supervision and intervention by a supervising nurse.

RESPONSE: The department utilizes the term "medically necessary" as defined in ARM 46.12.102(2)(a) through (e). Medically necessary is not defined as an interval of time, it is based on the type of service being required.

COMMENT: The definition of escort needs to be clarified to include the type of tasks which are included in this service.

RESPONSE: The department has amended the rule to so provide.

COMMENT: The department should consider extending assistance with animals to include pets who provide companionship to recipients.

RESPONSE: The intent of this rule is to provide assistance with the care of an animal trained to assist the recipient in living independently. The department recognizes the therapeutic value of pets, however this would expand the scope and consequently the cost of services.

COMMENT: The department should consider reimbursing family members for providing personal care services.

RESPONSE: Section 42 CFR 440.170(f) (Code of Federal Rregulations) prohibits payment for personal care services to a recipient's family member.

COMMENT: Commentors suggested that the term physicians "order" be removed and the term "approval" inserted instead.

RESPONSE: The department has amended the rule to so provide.

COMMENT: The department should indicate the period of time the physician's approval covers.

RESPONSE: The department has amended the rule to require an annual review.

COMMENT: The department should add language to ARM 46.12.555(6) to indicate recipient participation in the completion of the recipient profile.

RESPONSE: The recipient profile gathers information from various sources including the recipient and/or the recipient's representative. The department feels the design of the profile includes participation of the recipient and does not believe the rule needs to be amended.

COMMENT: The department should clarify who is to utilize the recipient profile.

RESPONSE: The department is providing the profile for implementation by the provider. The rule has been amended for clarification purposes.

COMMENT: The department should rework ARM 46.12.556(14)(a) through (f) to allow for the inclusion of self-employed individuals.

RESPONSE: The department is unable to provide for such an inclusion. Under state and federal wage laws, if payments are made to these individuals, they would arguably be employees of the state.

COMMENT: Commentors felt that the requirement of a four month financial solvency for providers should be removed as it may exclude smaller vendors and that vendors should not go without payment for four months.

RESPONSE: The department added this requirement as providers are not guaranteed immediate reimbursement for services. Reimbursement is granted when an appropriately completed "clean" claim is presented for payment. If the agency has difficulty in processing the claim, the provider may not receive reimbursement for a significant period of time. If a cash reserve is not available, attendants will go unpaid and recipients will potentially face service interruptions.

COMMENT: Commentor would like the geographical area that a provider is willing to serve defined.

RESPONSE: The department agrees, additional language has been added to ARM 46.12.556(14) to define a minimal service area as a county or Indian reservation.

COMMENT: The department should consider amending ARM 46.12.556 (17) to allow respite services for medical reasons as an exception to the rule.

RESPONSE: The Personal Care Services program is designed to deliver assistance with activities of daily living to promote the individual's independence and delay institutionalization. While providing such services, the caregiver may be relieved of some of these tasks. The design of the program provides for some support of the informal caregiver. Providing respite would require recipient oversight for a specific period of time. Services under this program are task oriented and time limited, which does not allow for the inclusion of respite services. Some respite services are available to individuals enrolled in the Home and Community Based Services program.

COMMENT: The department should explain the intent of ARM 46.12.556(18).

RESPONSE: ARM 46.12.556(18) references the efficient delivery of services. It should be read in conjunction with the department's definition of "medically necessary" in ARM 46.12.102 (2)(e), which states, "there is no other equally effective, more conservative or substantially less costly course of treatment more suitable for the recipient requesting the service".

COMMENT: The department should eliminate "verbal abuse" from ARM 46.12.556(18)(a) as a reason for termination as it is subjective.

RESPONSE: The department feels that the recipients have a responsibility to treat their attendants in an appropriate

manner, including verbally. Although there may be a subjective element to verbal abuse, complaints have been made in the past on this issue. If services are denied, the recipient has the right to request a hearing to determine if the verbal abuse is real and whether it merits termination of services. Through the hearing process a determination can be made regarding the behavior of the recipient. A determination of the inappropriateness of the verbal abuse will take into consideration the injury deficit or disability of the individual.

COMMENT: The department should remove ARM 46.12.556(19), as all individuals who qualify for personal care services should receive them, regardless of where they live.

RESPONSE: The department will modify the text of this rule to include 'safely' accessible and replace automobile with normal modes of transportation. Providers do have a responsibility to provide services, however it should be in a safe manner and this includes the safety of the attendant enroute to the recipient's home.

COMMENT: The department should modify ARM 46.12.556(18)(g) to clarify why a recipient can refuse personal care services.

RESPONSE: Recipients can refuse services at any time as long as they are willing to deal with the outcomes of their refusal. The recipient may not ask for services not outlined in the plan of care, which would include asking attendants to perform unauthorized tasks or tasks in an unsafe or inappropriate manner.

COMMENT: The notice period should be extended to two weeks, if not one month.

RESPONSE: The notice period is ten days, to be consistent with other medicaid programs based on ARM 46.12.216(6). In addition, the provider must discuss all cases of potential termination prior to providing notice with the department. The department will insure that all recipients have been given adequate notice.

COMMENT: Commentors suggested that language in ARM 46.12.556 (23) be clarified to include methods of resolving problems prior to immediately suspending services.

RESPONSE: The rule has been amended for clarification purposes.

COMMENT: Commentors suggested alternative rates of $2.72, $2.74, $2.75 and $3.09.

RESPONSE: The department has re-examined the reimbursement methodology and has chosen to remain at the $2.64 rate of reimbursement. In order to adjust this rate, the department must receive sufficient justification from providers, which

could be used in turn, to seek additional funding through the legislative process.

COMMENT: Commentors provided general and specific comments regarding the method of establishing the reimbursement rates and offered alternatives. Commentors questioned why the proposed rate is lower than the current contracted rate.

RESPONSE: The current contractor was reimbursed on a cost based contract with all expenses attributable to the program factored in. The department does not want to continue this approach and established a new rate based upon the reasonable costs of providing service. The rate is based upon the delivery of slightly more than four million units and includes such factors as:

PCA wages & benefits; including training time and direct care
Nurse wages & benefits; training, supervision, administration
Scheduler/Clerical wages & benefits
On-call and travel time
Minimal overtime
Employer taxes
Normal office expenses
OSHA requirements
Mileage; with an offset for medical mileage income
Liability insurance
Administrative expense (legal fees and the like)

COMMENT: During the hearing the department stated the rate does not include such items as PCA training time, scheduling time, recipient profiles/intakes, supervision time, administrative time and travel time. The department should amend the rate to $3.09 to include these costs.

RESPONSE: The commentor misunderstood the response of the department. These factors are in the reimbursement rate established by the department. The misinterpretation results from the difference between what is a reimbursable visit and what is included in the reimbursement rate. Nurse supervision time spent in a recipient's home completing the initial or recertification profile, training the attendant in the home, problem solving with the recipient in the home and case conference time spent with other agencies, are all reimbursable as nurse supervision. PCA training time, scheduling time, administrative time and travel time were all included in the calculation of the reimbursement rate. The department will not adopt the suggested rate.

COMMENT: Since the department is not paying for mileage, how does the department expect rural services to be delivered?

RESPONSE: Travel time is not billable to the department. Travel time was utilized as a factor in developing the unit rate, therefore the department has covered the cost. Reimbursement for excess mileage was discussed at the hearing. The department suggested to individuals present to provide written documentation to justify this addition. No comment or justification for add on mileage was presented to the department.

COMMENT: Commentors stated the department is not taking into consideration that it costs more, administratively, to manage a multi-vendor system.

RESPONSE: The department does realize that a multi-vendor system has some administrative costs to it. However, the department does not have to reimburse for all costs which providers feel are necessary. The department has established the rate with significant coverage for administrative expenses.

COMMENT: Commentor wants to know who and why the decision was made to set a prospective rate, rather than provide a cost based system.

RESPONSE: The cost-based system was utilized when the department utilized a competitive bidding procedure to procure personal care services. The awarded contract forced the department to adjust the rate to reflect rising employer costs. The department selected a prospective payment method over a cost based method, to simplify reimbursement and provide an incentive for providers to contain cost. Cost-based reimbursement involves continual negotiation, varying rates and cost-settlement. Under prospective payment, the department can take advantage of efficient use of resources, while providers who are cost effective can retain income. The decision was made by Nancy Ellery, Division Administrator, Joyce De Cunzo, HCBS Supervisor and Barbara Smith, Program Manager.

COMMENT: Commentors suggested the adoption of a third party grievance system.

RESPONSE: The department requires the provider to provide notice to the recipient at intake of their grievance procedure. If a recipient does not have their issues resolved at this level they may utilize the department's fair hearing process. An individual may request and use assistance from any third party they choose. We believe recipient's rights are well protected with the current grievance system.

COMMENT: Commentors wanted to know who would be performing the compliance reviews and would the provider receive reimbursement for this time?

RESPONSE: The regional program officers of the Home and Community Based Service Section of the Medicaid Services

Division will be conducting these reviews under the guidance of the personal care program manager and the section supervisor. Minimal provider time will be spent in review. All providers of medicaid service are bound by federal law to make their records available for review.

COMMENT: The department should include recipient satisfaction as part of the compliance review process.

RESPONSE: The department included this in [RULE I] 46.12.558 (5)(a).

COMMENT: The department should consider contracting for training to outside agencies or organizations, rather than having this be the responsibility of the provider.

RESPONSE: The department notes the benefits of such a training program, but declines adoption of such policy at this time because of the added costs.

COMMENT: What is the definition of a properly trained nurse as used in these rules?

RESPONSE: The definition of a properly trained nurse is included in the department's policy and procedure manual for personal care services. Nurse supervisors must have documented training or experience in basic principles of supervision, interpersonal communication skills and knowledge of the personal care services program.

COMMENT: The department should change the name from personal care services to personal assistance services.

RESPONSE: The department retains personal care services because that is the name the federal government uses for this service.

COMMENT: The department should consider the adoption of a Passport type program to reduce the continual movement of recipients to different providers.

RESPONSE: The department established a multi-vendor program to provide a choice of providers to recipients. Restricting how often these individuals can change personal care providers would not support individual choice. Under the Passport program, the client can change their choice of Passport provider but the ability to change is extremely limited.

COMMENT: Commentor thinks the department should have a standard training curriculum.

RESPONSE: The department has established the mandatory portions of the training program. The provider must include these topics in their training program. The department believes this method

will allow for greater flexibility for properly training attendants.

COMMENT: Commentor wanted to know if the nurse would be liable if the nurse delegates duties and a problem occurs.

RESPONSE: The delegation of nursing duties would be subject to the rules of the nurse practice act. Issues of liability are outside the scope of these rules.

COMMENT: The department did not address training in the rules. How will training be handled?

RESPONSE: The guidelines for training are included in the department's personal care services policy manual. This policy manual will be given to enrolled providers.

COMMENT: The department should clarify ARM 46.12.556(16)(a), "if the parent is otherwise unable to provide the service".

RESPONSE: The rule is intended to allow for the delivery of personal care services to children whose parents are unable to perform the task alone, who require assistance to provide the task or if the age of the child is such that normally the parent would not be providing the assistance.

COMMENT: The department needs to clarify the term "accessible by car" in ARM 46.12.556(19).

RESPONSE: The rule was modified to read, "safely accessible by normal modes of transportation". The rule was included to eliminate dangerous travel required to provide services to some individuals. The use of snowmobiles, cross country skis and snowshoes, although normal for Montana winters, is not covered by this rule.

COMMENT: The department needs to justify the inclusion of portal to portal in the rate, and indicate what percentage of the rate it is.

RESPONSE: The rate includes portal-to-portal time and mileage. Mileage alone accounts for 2% of the rate, or $0.21. Time was allocated under the wage portion of the rate and it was based on 1 hour of pay for every 35 miles traveled. This accounts for approximately 1% of the rate, or $0.11. Total attributable for portal to portal is $0.33 per unit.

The mileage amount was adjusted for the mileage revenue providers will receive for providing medical escort services. Escort services are billable units and would not fall under portal to portal.

6. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

7. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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 46.12.599 pertaining to medicaid residential treatment services	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.590 THROUGH 46.12.593 AND 46.12.599 PERTAINING TO MEDICAID RESIDENTIAL TREATMENT SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.590 through 46.12.593 and 46.12.599 pertaining to medicaid residential treatment services at page 768 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.12.593 as proposed.

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

46.12.590 RESIDENTIAL TREATMENT SERVICES, PURPOSE AND DEFINITIONS Subsections (1) and (2) remain as proposed.

(a) "Residential treatment services" means ~~services that are~~ residential psychiatric care provided in accordance with these rules and applicable state and federal requirements, including but not limited to 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. Residential treatment services are services that ~~meet~~ COMPLY WITH ~~those provisions~~ the requirements of these rules and the above-cited federal regulations and are provided in a residential treatment facility that is devoted to the provision of residential psychiatric care for persons under the age of 21.

Subsections (2)(b) through (2)(n) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-139 and 53-6-141 MCA

46.12.591 RESIDENTIAL TREATMENT SERVICES, PARTICIPATION REQUIREMENTS Subsection (1) remains as proposed.

(2) ~~Providers of r~~Residential treatment services~~ are eligible for reimbursement under~~ providers, as a condition of participation in the Montana medicaid program ~~if they~~ must ~~meet~~ COMPLY WITH the following requirements:

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

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-139 and 53-6-141 MCA

46.12.592 RESIDENTIAL TREATMENT SERVICES, REIMBURSEMENT Subsections (1) through (5)(a) remain as proposed.

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

Subsections (5)(c) through (14) remain as proposed.

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

46.12.599 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW ~~AND CONTROL~~ AND INSPECTIONS OF CARE Subsections (1) and (1)(a) remain as proposed.

(b) The department may contract with and designate public or private agencies or entities, or a combination of public and private agencies and entities, to perform utilization review, inspections of care and other functions under this ~~section~~ RULE as an agent of the department. Any contracted or designated agent must ~~meet~~ COMPLY WITH the requirements of this ~~section~~ RULE. The department must give residential treatment services providers advance written notice of a change in the designated agent. ~~The~~ WHEN A NOTICE IS REQUIRED BY THIS SUBSECTION, THE notice must specify the scope of the agent's duties, the geographical area of the agent's authority and the agent's name, address, telephone number and facsimile number.

Subsections (2) and (2)(a) remain as proposed.

(i) be completed, signed and dated prior to, but no more than ~~15~~ 30 days before, admission; and

(ii) be made by an independent team of health care professionals that includes a physician, that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry and that has knowledge of the recipient's situation, including the recipient's ~~medical~~ PSYCHIATRIC condition.

Subsections (2)(b) through (2)(b)(i)(A) remain as proposed.

(B) 90 days after the eligibility determination for ~~recipient's~~ RECIPIENTS determined eligible after discharge from the facility;

Subsections (2)(b)(ii) through (3)(b) remain as proposed.

(c) For additional periods of the recipient's stay after the period covered by the initial or admission authorization, the provider must request a continued stay authorization and must submit supporting documentation. The request and supporting documentation must be received no more than 5 and no less than 2 WORKING days before the end of the previous authorized span.

(4) The department's utilization review agent must review an admission or initial authorization request or a continued stay authorization request, make a determination on the request and notify the provider and the recipient's parent or guardian

of any ~~adverse~~ determination within 3 working days of receipt of a request, unless the provider has not submitted the documentation or information necessary to make a determination. The agent must transmit authorization information regarding authorized spans to the department's fiscal agent within 3 working days of a determination.

(a) If the provider's request is incomplete, the agent must notify the provider, within 1 working day of receipt of an incomplete request, that the request is incomplete and must identify the additional information or documentation necessary to make a determination. ~~Such notification~~ NOTIFICATION OF AN INCOMPLETE REQUEST by the agent to the provider is not required if the provider's request indicates that the provider will be sending additional documentation or information to support the request, in which case the burden shall be upon the provider to submit the additional documentation or information or to notify the agent in writing that nothing further will be sent and that the provider requests the agent to make a determination upon the request as submitted.

(5) If the department's utilization review agent in whole or in part denies an admission or initial authorization request or a continued stay authorization request, the provider or the recipient's parent or guardian may within 10 days of the date of THE MAILING OF the notice request that the department's utilization review agent conduct an informal reconsideration of the determination. The agent may include in the informal reconsideration a peer to peer review and must include a peer to peer review if requested by the provider in its request for informal reconsideration. A peer to peer review must be ~~scheduled by the agent to be~~ held within 10 days of the request for informal reconsideration, but may be ~~scheduled~~ HELD at a later time with the AGENT'S AND provider's MUTUAL written consent.

(a) The agent may request additional supporting information or documentation. The information and documentation presented by the provider may include only information documented in the FACILITY'S RECORDS ~~recipient's medical record as of the date of admission or end of the most recent previous authorized span. The agent may not consider information that is not documented in the recipient's medical record~~.

(b) The agent must make a determination on the informal reconsideration and notify the provider and the recipient's parent or guardian of the determination within 3 working days after the agent has received the written request and supporting documentation, including any additional documentation or information requested by the agent, and HAS completed the peer to peer review, if any.

(c) A provider, parent or guardian dissatisfied with the determination on informal reconsideration may request an administrative review AND FAIR HEARING according to the provisions of ARM ~~Title 46, chapter 2, subchapter 2~~ 46.12.597. A provider or a recipient's parent or guardian that does not timely request an informal reconsideration will be deemed to

have accepted the agent's determination and is not entitled to any further notice or appeal opportunity.

Subsection (6) remains as proposed.

(a) Providers must make the required notifications, submissions and requests to the department's utilization review agent by facsimile transmission. ~~Required certificates of need, supporting documentation and similar materials must be submitted by written facsimile transmission~~ or overnight mail.

(b) The department's utilization review agent must notify the provider and the recipient's parent or guardian in writing of any ~~adverse~~ determination on an initial authorization request, a continued stay authorization request, an informal reconsideration request or an administrative review request. A notice must be addressed separately to the provider and to the recipient's parent or guardian. The agent must transmit the provider notice by facsimile and send the original to the provider by U.S. mail. The agent must notify the recipient's parent or guardian by U.S. mail.

(c) A notice OF AN ADVERSE DETERMINATION under subsection (6)(b) must contain the following:

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

(d) If the agent fails to provide notice, or fails to timely provide notice, or if a notice ~~under~~ REQUIRED BY subsection (6)(b) fails to comply substantially with the requirements of subsection (6)(c), the remedy shall be provision of a new notice which does comply substantially with subsection (6)(c) and a new opportunity to contest the determination specified in the notice. A failure to give adequate or timely notice under subsection (6)(b) OR (6)(c) shall not entitle the provider or recipient to an authorization. A provider or recipient is not entitled to an authorization absent a showing and determination of medical necessity.

(7) When required to be submitted under this rule, supporting documentation includes all or any portion of the ~~recipient's medical record~~ FACILITY'S RECORDS as necessary to demonstrate the medical necessity of residential treatment services and where the context allows, includes a certificate of need conforming with the requirements of subsection (2).

Subsections (8) through (12) remain as proposed.

AUTH: Sec. 2-4-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: What is the purpose for eliminating the current definition of "estimated economic life" in ARM 46.12.590?

RESPONSE: This term is used in the determination of allowable depreciation costs. The concept of useful lives is defined through the medicare provider reimbursement manual (HCFA-Pub. 15), which is incorporated by reference in ARM 46.12.592. The

department is eliminating the definition because it is redundant.

COMMENT: In ARM 46.12.590(2)(a)(i), the definition of residential treatment services includes "only treatment or services provided in accordance with all applicable licensure, certification and accreditation requirements and these rules." The rule should indicate at least that all treatment and services provided in accordance with licensure, certification and accreditation requirements applicable to residential treatment facilities.

RESPONSE: The department does not see a difference in the meaning or effect of the suggested language and that proposed in the rule.

COMMENT: The department should amend the definition of "occupancy rate" in ARM 46.12.590(2)(n). The language "average number of beds available" should be deleted and the language "number of licensed beds" should be substituted.

RESPONSE: The department will not make this change. The purpose of the current definition is to function with the minimum occupancy level for purposes of determining the provider's allowable capital costs under ARM 46.12.592(10). The intent of this rule is limit the extent to which the medicaid program pays for excess bed capacity. The effect of the suggested change would be to require medicaid to pay for excess bed capacity, which the department considers to be an inefficient and unwise expenditure of tax dollars. This issue has been addressed in prior rule proceedings and the department will continue the current policy.

COMMENT: The definition of "patient day" in ARM 46.12.590(2)(p) should be revised to allow providers to bill and be paid by medicaid for days when runaway residents are absent from the facility. The current practice is that the department pays if the resident returns within 3 days. Otherwise, the department does not pay. The rule should be revised to provide specifically for payment and should define the day of discharge.

RESPONSE: The department disagrees with the statement that current practice allows payment if a runaway returns within 3 days. Department policy is that no payment is allowed for any day that is not within the definition of patient day as stated in the rule. If providers have been paid under the circumstances described in the comment, the department or its agent probably were not aware of the resident's absence. The department will recover any such payments of which it becomes aware. The department believes that the term "day of discharge" is self-explanatory and need not be defined in the rule.

COMMENT: In ARM 46.12.591(1), the term "medicaid providers" should be revised to "residential treatment facilities."

RESPONSE: The department disagrees. There are rules in ARM 46.12.590 through 46.12.599 generally applicable to residential treatment facilities. In addition, there are rules generally applicable to medicaid providers which apply to residential treatment facilities, for example, ARM 46.12.303. The rule reiterates that the general provider rules also apply to residential treatment facilities.

COMMENT: In ARM 46.12.592, the department has made some changes to consistently use the term "patient day" rather than "day." This change has been missed in ARM 46.12.592(5)(b). In ARM 46.12.592(1), the rule should allow payment on a "per patient day basis" rather than "for each patient day."

RESPONSE: The department has made the suggested change to ARM 46.12.592(5)(b). The department believes the proposed language in ARM 46.12.592(1) accurately states the department's intent and it will be retained.

COMMENT: The last phrase of proposed ARM 46.12.592(1)(a) should be deleted or made more specific to refer to applicable licensure, certification and accreditation requirements.

RESPONSE: The department disagrees. This phrase merely avoids any implication that by complying with some of the rule requirements, the provider is entitled to payment. All requirements must be met, including licensure, certification and accreditation requirements and the requirements stated in ARM Title 46, chapter 12.

COMMENT: Why is the language regarding appeal of audit adjustments being removed from ARM 46.12.593(2)? Does the department intend to eliminate the right to appeal audit adjustments?

RESPONSE: The language is being removed to avoid the implication that the appeal process for cost settlements includes two separate appeals, one appeal for the audit adjustments and then one appeal for the resulting overpayment or underpayment determination. The department intends that the provider may appeal audit adjustments and the resulting settlement determination together in one administrative review and fair hearing procedure.

COMMENT: The words "AND CONTROL" should be removed from the title to ARM 46.12.599.

RESPONSE: Titles are not substantive rule provisions. The inclusion of the noted words has no substantive effect and appears to merely repeat the word "review," although both words are used in the federal regulations. The department will remove the words as suggested, but does not intend that the removal have any substantive effect on the provisions of the rule itself.

COMMENT: The department should limit the scope of review permitted in proposed ARM 46.12.599(1) to provide that the department or its agent may review only those cases of medicaid eligible residents where the provider is seeking medicaid payment. Why would medicaid review a case if the provider were not seeking medicaid payment? The rule should state specific timeframes as to when the department will make these evaluations.

RESPONSE: The department will not limit its ability to conduct reviews of services for any medicaid recipient at any time it deems appropriate. One example of review where the facility may not be seeking medicaid payment is an inspection of care ("IOC"), where the department must review all medicaid eligible cases. The department does not believe that it would be appropriate to abandon its legal authority to review all cases involving medicaid eligible patients. The department does not anticipate wasting its time with such reviews but would conduct a review when it finds a specific purpose in doing so.

COMMENT: The department should add the words "utilization review" before the word "agent" where it appears in proposed ARM 46.12.599(1).

RESPONSE: The department disagrees. The department potentially may engage different agents for its routine utilization review activities and for other reviews, such as IOCs or special review of particular cases.

COMMENT: The department should revise proposed ARM 46.12.599(1)(b) to allow the department to contract only after selecting a contractor through a request for proposal ("RFP").

RESPONSE: The department will not include this limitation. State law determines when an RFP or other similar process must be used and there is no reason to address procurement requirements in this rule.

COMMENT: In ARM 46.12.599(1)(b), the rule should require the agent to "comply with" rather than "meet" the rule requirements.

RESPONSE: There is no apparent difference in the substance of these words, but the department will adopt the suggested language where proposed and elsewhere in the rules for consistency.

COMMENT: In ARM 46.12.599(1)(b), the rule should require the agent to comply with the requirements of 46.12.599 and any other applicable medicaid statutes and regulations.

RESPONSE: The department disagrees. The agent is responsible for fulfilling the responsibilities required by its contract with the department. The department may itself elect to perform certain related medicaid responsibilities or to contract with

other entities for performance of certain responsibilities. The intent of the rule section is to specify the agent's activities in relation to providers in the utilization review process, not to impose other responsibilities on the agent that are properly the subject of its contract with the department.

COMMENT: Proposed ARM 46.12.599(1)(b) would require the department to provide advance written notice to providers of a change in the designated review agent. The rule should require that the department provide at least 90 days advance written notice to allow providers to make necessary adjustments for the change. The rule should also require notice of an initial designation of an agent and of any change in the scope of the agent's duties.

RESPONSE: The department does not believe that a requirement for 90 days advance notice is feasible. Especially in cases involving procurement through the RFP process, there rarely is adequate opportunity to provide a lengthy period of advance notice. The department agrees that it should provide as much advance notice as possible under the circumstances and it will make every effort to do so, but it will not unduly limit its flexibility by adopting the suggested requirement. Since agents are currently designated and conducting reviews, any further designation will be a change and subject to the rule, and it is not necessary to refer to initial designations.

COMMENT: The proposed rules require that a complete and accurate certificate of need ("CON") be completed by a certain date. The proposed rule does not address certain circumstances that may occur frequently in the process. For example, the date of actual admission may vary from the proposed admission date stated in the CON as initially prepared.

RESPONSE: The department presently is revising the provider manual relating to the UR process and is developing new CON forms. The new forms and the related instructions differentiate between the proposed and actual dates of admission. The department believes that this change will address the admission date problem.

COMMENT: The proposed rule requires the utilization review ("UR") agent to notify providers of incomplete requests for authorization, but not of incorrect information. The provider may have an incorrect medicaid recipient identification number, but an authorization is issued by the UR agency nonetheless. The department should require the UR agent to verify the recipient's eligibility and ID number before issuing an authorization and to notify the provider if there is a problem with eligibility or the recipient identification number.

RESPONSE: It is not the function of the UR agent to verify eligibility or to assist providers with eligibility issues.

The department currently provides a number of methods by which providers may obtain or verify eligibility information. Providers can verify eligibility by using the MMIS voice response unit through an 800 number, may arrange access to the department's TEAMS eligibility system, may call the county office and/or may require a medicaid ID card from the recipient. The department does not believe it is necessary to duplicate these methods by paying additional funds to have the UR agent verify eligibility for providers.

COMMENT: The department should continue its current practice of allowing providers to obtain and submit CONs after the precertification by the UR agent.

RESPONSE: Current department policy requires that the CON be completed before the precertification. If the UR agent is permitting the practice described in the comment, this is incorrect. The department believes that it is essential to have the CON prior to authorization to assure that community alternatives have been considered and that inpatient care actually is necessary.

COMMENT: The rule should require that a CON be completed prior to admission only if the recipient has been determined eligible for medicaid as of the day prior to admission. This would allow some period for the provider to check eligibility and determine whether to obtain an independent team CON prior to admission.

RESPONSE: The department believes the proposed rule appropriately requires independent team CONs be completed prior to admission if the recipient is determined eligible as of the time of admission. If a medicaid application is pending on the patient's behalf, the facility can avoid any risk by simply obtaining an independent team CON prior to admission. This CON would then serve in case the patient were determined eligible either before or after admission.

COMMENT: The proposed rule requires that independent team CONs be completed no more than 15 days prior to admission. Cases may arise when a facility is fully occupied on a given day and the patient cannot be admitted until an opening is available. This may extend beyond the valid period of the CON and require a new CON be obtained. The department should extend the 15-day period to 30 days, consistent with current policy.

RESPONSE: The department will extend the proposed 15-day period to 30 days as suggested.

COMMENT: Proposed ARM 46.12.599(2)(a)(ii) requires that the independent team completing the CON have knowledge of the recipient's situation, including the recipient's medical condition. This seems too broad, as it may be construed to require physicals or other screening tools to assure that the team is fully aware of medical facts, even though the medical

facts may not be relevant to the proposed psychiatric admission. Moreover, this language is not contained in the CFR and it is not needed in this rule.

RESPONSE: The department will change the word "medical" to "psychiatric." The corresponding CFR provisions have required interpretation and the department believes that it is necessary to be more specific about the independent team composition.

COMMENT: In proposed ARM 46.12.599(2)(b)(i)(A), the department requires that a facility CON be completed within 14 days after an eligibility determination for recipients determined eligible after admission. The department should allow 14 days after notice to the provider of the eligibility determination, to assure the provider adequate opportunity to complete the CON after finding out about the determination. The same applies to ARM 46.12.599(2)(b)(i)(B) where it should be 90 days after receipt of written notice of an eligibility determination.

RESPONSE: The department will not adopt this suggestion. The suggested changes would require the department's eligibility workers to notify providers of eligibility determinations, when those workers in many cases do not have any way to know what providers to notify. It is the provider's responsibility to inquire about and monitor the recipient's eligibility status, including whether or not an application has been filed and whether a determination has been made. As noted in a previous response, there are a number of options available for providers to obtain this information. Also, the department believes the 14-day provision in subsection (2)(b)(i)(B) is necessary to assure early certification of need in these cases.

COMMENT: Proposed ARM 46.12.599(2)(c) requires that all CONs be actually and personally signed by each team member. There is no problem in having the actual signature of those who sign. But the facility's in-house team may include as many as 10 or 15 persons and it is impossible to have every team member to sign. Further, a new CON is required every 30 days, which further compounds this problem. There is no good reason to have all 15 persons sign. Perhaps this requirement should apply to independent team CONs.

RESPONSE: The department believes it is important to require the signatures of all of both independent and facility-based teams member. However, it is not necessary that the actual facility team include the number of persons suggested in the comment. Federal regulations at 42 CFR 441.153 require that the facility CON be completed by the same team responsible for the plan of care under 42 CFR 441.156. That regulation actually requires a minimum of only 2 persons. The provider may determine the composition of the team within the parameters of the federal regulation. Further, only one CON is required for any one recipient's entire stay in the facility. A new CON is not required every 30 days as suggested in the comment. Federal

regulations at 42 CFR 441.155(c) require that the individual plan of care be reviewed by the team every 30 days to determine that services being provided are or were required on an inpatient basis and to recommend indicated changes in the plan of care. This review and determination is not a CON that would be subject to the requirements of proposed ARM 46.12.599(2), and the signature of every team member on the plan of care review would not be required by proposed ARM 46.12.599.

COMMENT: The department should limit the medicaid non-payment to only that portion of the stay that has not been authorized by the UR agent.

RESPONSE: The rule as proposed provides only that medicaid reimbursement is not available for the unauthorized portion of the stay. The rule does not deny medicaid reimbursement for authorized portions of a stay on grounds that other portions of the same stay were not authorized.

COMMENT: Proposed ARM 46.12.599(3)(c) should require only that the provider submit the required materials within the specified period, not that the materials actually be received within that period. The provider has no control over the date of receipt. Also, the 2 to 5 day span should be a span of 2 to 5 working days.

RESPONSE: The department believes that the provider does have control over the date of receipt. Under proposed ARM 46.12.599 (6)(a), providers will make the submission by fax transmission or overnight mail. These transmission methods allow the provider to control very specifically the time of receipt by the UR agent. The department will adopt the suggestion regarding working days.

COMMENT: The 2 to 5 day span should be lengthened to allow the provider to request authorization earlier. Authorizations can take more than 5 days to obtain, and the provider should not have to take the risk during the additional period.

RESPONSE: The department does not believe it is necessary to change the period to 7 days. The longer the period, the less current the information used to determine necessity for the future period. Also, the longer time it has taken to obtain authorizations has resulted primarily from the involvement of URM in the process. The department is taking steps to reduce such delays.

COMMENT: The language in ARM 46.12.599(4) should be revised to require the UR agent to transmit authorization information to the fiscal agent within 24 hours, rather than within 3 working days of a determination as proposed.

RESPONSE: The department recently doubled the frequency of authorization transmissions from the UR agent to the fiscal

agent. Previously, the information was transmitted once a week. Currently it is transmitted twice a week. The fiscal agent adjudicates claims only twice a week and a more frequent transmission would not make a difference in the period required to process claims. The department believes that the 3 working day period is reasonable.

COMMENT: In proposed ARM 46.12.599(4)(a), the second sentence should be revised to specifically identify the referenced notification.

RESPONSE: The department will make the suggested change.

COMMENT: In proposed ARM 46.12.599(5), the 10 day period for request of an informal reconsideration should be a period of 10 working days.

RESPONSE: The department believes the working day provision is appropriate for shorter time periods such as 5 or fewer days, but is not necessary for periods of greater length. The 10 day provision is adequate for the purpose of the proposed rule. The department will not adopt the suggested change.

COMMENT: Proposed ARM 46.12.599(5) should require the UR agent to actually hold the peer to peer review within 10 days of the request, unless the provider consents to a later time.

RESPONSE: As suggested, the department will require the UR agent to actually hold the peer to peer within the 10-day period. However, the department will allow the peer to peer to be held later than 10 days after the request only if both the UR agent and the provider consent. If the agent will be required to provide the necessary staff and resources to assure that the review is held within 10 days, then providers must also be prepared to proceed. This rule will help to avoid long delays in completion of the review process and corresponding disputes about who caused the delay.

COMMENT: Proposed ARM 46.12.599(6)(a) requires use of fax transmissions for certain materials. The department should simply allow use of fax, overnight or certified mail for all submissions by providers. Also, subsection (6)(b) should require the UR agent to mail all notices by certified U.S. mail.

RESPONSE: The department will revise the language of the proposed rule to allow use of either fax or overnight mail for provider submissions. Certified mail would be too slow for this particular purpose. The department believes that requiring use of certified mail for all UR agent notices is unnecessary and would significantly increase the cost of the UR process. The department will not require the UR agent to use certified mail.

COMMENT: The department should omit the word "substantially" from proposed ARM 46.12.599(6)(d). This will simply cause litigation as to what is substantial compliance.

RESPONSE: The department believes that the substantial compliance rule is reasonable and accords with legal requirements. The department expects to make every effort to comply with both the letter and the substance of the rule. But errors are occasionally made. As long as the notice is effective for its intended purpose and satisfies due process requirements, errors should not provide a technical loophole to excuse providers from their responsibility to pursue cases on a timely basis. The department will retain the proposed language.

COMMENT: The department should specify in the rule the scope of information that the UR agent may request before issuing an authorization. Some information requests by the agent may have gone too far.

RESPONSE: The department believes that the information and documentation necessary to determine medical necessity may vary on a case by case basis, and may include anything relevant to that determination. The department will direct the UR agent to limit its requests to items that are necessary to the determination.

COMMENT: The department should set forth in the rule the timeframes for requesting administrative review and fair hearing. That information is missing from ARM 46.12.599.

RESPONSE: Information regarding the administrative review and fair hearing processes is already specified in ARM 46.12.597, 46.12.509A and 46.2.201, et seq. The department does not believe that it is necessary to reiterate that information in this rule section.

COMMENT: The department should have access to all records pertinent to treatment of medicaid recipients as provided for in proposed ARM 46.12.599(1)(a). However, other sections of the proposed rule would exclude from consideration records other than medical records. Not all evidence of a person's need for treatment is typically documented in the medical record. Other records, such as school records, for example, may also support medical necessity and should be considered. This proposed rule stacks the deck against providers and against the department's provider agencies in seeking placement and treatment.

RESPONSE: The Department recognizes that psychiatric treatment for children and adolescents involves a number of factors which require consideration. It is not the department's intent to exclude information relevant to a determination of medical necessity. The department will eliminate the specific limitation to the medical record. However, in individual cases,

whether or not certain information is included in the medical record may be an indication to medical reviewers that the provider did not seriously consider the information to be pertinent to the patient's medical need or course of treatment. Moreover, the provider's records should demonstrate the medical necessity of the services. Provider's should keep a record of information and documents it believes demonstrate medical necessity.

COMMENT: In proposed ARM 46.12.599(5)(a), the department seeks to further restrict information that may be considered in the determination to information that is documented in the medical record at the time of the UR agent's review determination. Requests for authorization are made prospectively and providers are predicting that the patient's acuity will require the facility's care during a future time frame. Because administrative reviews can take up to and greater than 3 to 4 weeks, it is inappropriate to exclude from consideration additional information which documents a patient's actual acuity. More current information is very useful to reviewers and should be considered to assure that better decisions are made for children. It appears the department has proposed this rule just to sustain its decisions and to protect agency ego, rather than seriously determine the actual needs of the recipient. This comes at the expense of making the right decision for the child. This also is an illegal attempt to exclude admission of admissible evidence.

RESPONSE: The intent of the proposed rule was to allow a determination of whether there are specific documented conditions which warrant residential treatment. The department has been concerned that during the course of time required to schedule and conduct the next stage of review, the facility may develop circumstances and information in an effort to justify continued treatment. The department believes it is incumbent on the provider to submit complete information at the time authorization is requested so that a accurate determination can be made when the request is originally received.

The department does agree that there are a number of practical problems with the proposed rule. In an effort to prevent an inappropriate practice, the rule may also prevent consideration of valid and relevant information useful to the determination. In addition, the rule could have the negative effect of focusing appeals on whether the reviewer was correct at the time rather than on the direct issue of medical necessity. The department will not adopt the proposed restriction on the information that may be considered in the review and appeal process. However, the department will reserve the authority to take appropriate action through retrospective review in any case where it appears that information or documentation has been developed inappropriately.

COMMENT: The department has reserved the right in the proposed rule to make a later and presumably contrary decision regarding

an authorization "at any time". This provision of the rule should be removed. It would be patently unfair to allow the department to renege on a determination. Providers should be entitled to rely on the department's determination at the time of an authorization.

RESPONSE: The proposed rule in ARM 46.12.599(10) states that an authorization by the department or its utilization review agent under this section is not a final or conclusive determination of medical necessity and does not prevent the department or its agent from evaluating or determining the medical necessity of service or items at any time. This proposed rule simply states longstanding and current department policy. It is important to understand the purpose and nature of the utilization review process. This process is a screening tool to require an advance demonstration that requirements are met. However, the determinations are made based upon portions of the record submitted by the provider, rather than upon a review of a full record or a direct inquiry by the department. This department does not intend to simply second guess or renege on earlier determinations. Additional review could occur where critical information was not earlier divulged by the provider, where there is reason to suspect fraud or for other appropriate reasons. The alternative to this rule would be a far more intensive and lengthy review based upon a complete record prior to a determination, an approach that none would favor. The department will reserve the authority to review medical necessity at any time.

COMMENT: ARM 46.12.599(10) only allows a provider to request that the department look into the matter if a determination is late. The department does not provide an affirmative action to the provider's benefit if the department or its agents fail to timely perform their functions. This still leaves the provider at risk while waiting for a determination. The department should provide a sanction against the UR agent if the agent fails to comply, such as requiring the agent to pay for the treatment out of its own funds rather than medicaid funds.

RESPONSE: The rule is intended to inform providers of how to proceed when they have not received a determination or notice they believe they have requested. The department has provided for an affirmative remedy under ARM 46.12.599(6)(d) when the agent fails to provide notice, or fails to provide timely notice after all information requested has been received. This section allows for the provider to be notified properly and to receive a new opportunity to appeal. The department does take seriously any failure by its agent to timely and properly perform its functions. The department believes that this is a matter to be addressed in its contract with the agent. The department is considering specific contractual provisions that would penalize a contractor financially for failure to perform. However, the department will not provide that a delay in the issuance of determination or notice will result in payment to a provider.

Payment will be made only after a determination that requirements have been met.

COMMENT: The department should add language in ARM 46.12.599(1)(b) to specify that only persons qualified and necessary to perform an IOC be permitted access to medical records. Providers have expressed concern that SRS staffers without credentials are sometimes afforded access to medical records when that access is not pertinent to the IOC or UR.

RESPONSE: The comment apparently suggests that department staff who have responsibility to administer the medicaid residential treatment services program should not be permitted to accompany reviewers at the facilities or review medical records during inspections of care. The department strongly disagrees with this suggestion. Department staff are responsible to administer the program, including compliance with federal utilization review and inspection of care requirements. It is critical that these staff retain their legal authority to review records and observe facility operations. Also, this provides department staff with an opportunity to learn a great deal about providers and the services they provide by accompanying teams during the IOCs.

COMMENT: The "may" in proposed ARM 46.12.599(12) should be changed to a "must."

RESPONSE: The department disagrees. The intent of the rule is to express a permissive authority of the department as to the medicaid provider, not to impose a mandate upon the department. Federal regulations determine when the department must conduct the inspection of care.

COMMENT: There is a conflict between controlling medicaid expenditures and providing critical access to mental health treatment for Montana youth. Department policies shift too often, and a period of stable public policy in this area is critical to providing safe and effective treatment to youth. Current policy leads to bouncing children from one treatment setting to another. The department often overrules DFS placement decisions in the interest of reducing costs. The authority and responsibility for placement should reside in one agency with a single mission and direction. The current process contains paperwork and monitoring elements that are costly and counterproductive to the goal of cost effective residential treatment.

RESPONSE: The department agrees that consistency and stability should be pursued to the extent possible. However, there are sometimes conflicts between legally mandated missions of different agencies. Federal law requires that certain criteria be met before medicaid may pay for services. Other agencies may operate under different criteria, and may decide upon a course of treatment that does not meet requirements for medicaid

payment. Consistency is not always possible, but all parties involved should continue to improve efforts at cooperation and consistency to the extent possible within the law. While stability may also be desirable, it must be balanced with a need to change services in an effort to develop the continuum of services and to make more efficient use of available funds. The department expects the pending agency reorganization to provide a significant opportunity to improve services to Montana children.

COMMENT: The proposed rules fail to address several important aspects of the issues that have arisen between providers and the department, including content of prior authorization notices, the numbers issued, timeliness of issuance of a prior authorization notice, prior authorization spans, dates of authorizations, lengths of authorized spans and timeliness of reporting of authorized spans. These issues should be address.

RESPONSE: The rules do address the timeliness of reporting of prior authorization spans. The rules regarding the timing and issuance of adverse prior authorization notices were intended to be applied to approvals as well as adverse determinations. The department will revise the rule language to so provide. We do not believe the remaining issues noted warrant treatment in the rules.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

6. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rules 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 and 46.12.1025 pertaining to medicaid transportation services	))))))	NOTICE OF THE AMENDMENT OF RULES 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 AND 46.12.1025 PERTAINING TO MEDICAID TRANSPORTATION SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 and 46.12.1025 pertaining to medicaid transportation services at page 821 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rules 46.12.1001, 46.12.1002 and 46.12.1025 as proposed.

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

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT Subsections (1) through (2)(b) remain as proposed.

(c) ~~regularly scheduled,~~ COMMERICAL ground TRANSPORTATION, including taxis and limousine service for trips up to 16 miles total - usual fee not to exceed a total of $10.07 for a one way trip ~~or not to exceed a total of $17.98 for a round trip~~;

(d) ~~regularly scheduled~~ COMMERICAL ground TRANSPORTATION, including taxis and limousine service for trips exceeding 16 miles - $.63 per mile that a person is a passenger.

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

(4) No payment is available for ~~travel and~~ PERSONAL VEHICLE MILEAGE OR per diem costs that total less than $10.00 in a calendar month.

Subsection (5) remains as proposed.

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

46.12.1012 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REQUIREMENTS Subsection (1) remains as proposed.

(2) Coverage of specialized nonemergency medical transportation is limited to transportation of persons with disabilities for the purpose of obtaining nonemergency medical SERVICES covered by the medicaid program.

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

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

46.12.1015 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT Subsections (1) through (2) remain as proposed.

(a) Transportation under 16 miles.....$10.07 one way
~~$17.98 round trip~~

Transportation over 16 miles.....$ .63 per mile

Waiting time for transportation over 16 miles.....$ 5.03 per hour
Computed in 15 minute increments or fraction thereof

Waiting time for under 16 miles....No payment
When one way transportation is over 16 miles and the unloaded miles exceed ten percent of the loaded miles, the miles from the departure point to the pick-up point plus the miles from the delivery point to the departure point shall be paid for at the rate of.....$ .33 per mile

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

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

46.12.1022 AMBULANCE SERVICES, REQUIREMENTS Subsections (1) through (10) remain as proposed.

~~(11) Coverage of ambulance services is not available for costs for the service incurred during a retroactive eligibility period.~~

Subsection (12) remains as proposed in text but is renumbered (11).

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

4. The Department has thoroughly considered all commentary received:

COMMENT: A recipient wrote stating that a specific transportation provider may go out of business due to the rule changes and that the loss of the provider's services would jeopardize the health of the recipient.

RESPONSE: The department recognizes the need for persons to have access to medical care. There are many providers willing to provide transport for medicaid recipients. Those providers, however, need authority from the Public Service Commission for changes in the services they provide.

COMMENT: Several comments were received asking the department to defer implementation of the new fee schedule for a specific provider.

RESPONSE: The department will not delay implementation. A postponement would result in program expenditures exceeding the projected budget for the program.

COMMENT: The department should not change the rules until the department can show there is a need to improve the comprehension of the rules.

RESPONSE: The department in the adoption of the changes to the rules determined that, in addition to substantive programmatic changes noted in the rationale accompanying the first notice, clarification of the rules should be undertaken.

The choice of structure and language for rules is a matter that is within the discretion of the department to determine. The department strives on its own initiative and at the behest of the public to improve the structure and language of the various rules it must adopt for purposes of implementing programs as authorized by the relevant legal authorities.

COMMENT: The department should not change ARM 46.12.1002 to incur program savings. The department has a managed care program to incur program savings in the coverage of transportation services. If this company has not incurred the savings, then the managed care is either not working or the company should be dismissed from doing business with the state.

RESPONSE: In addition to provisions for cost-savings purposes, the amendments to ARM 46.12.1002, concerning requirements for transportation and per diem coverage, include measures that clarify the administration of the program for the department and the providers.

Apparently, managed care program refers to the medicaid transportation management system. Through that system, the state is realizing cost savings.

Data from an interim ambulance expenditure report for September 1994, the start date for the medicaid transportation management system, through March 1995 indicates the department is experiencing at least a 33% savings in ambulance services.

The department has additional objectives, besides cost savings, for developing the system. The nature and performance of the

transportation management system had no bearing on the decision to proceed with the changes to the rules. The department would have adjusted payments with or without the system in place.

COMMENT: The department should not change ARM 46.12.1002 because the department simply says that the limitation of coverage for transportation to mileage fees is necessary to preclude providers from seeking further reimbursement through ancillary fees. The department has not made a reasonable effort to show in writing that the change is necessary.

RESPONSE: ARM 46.12.1002, concerning transportation and per diem reimbursement, prior to amending did not expressly preclude reimbursement for various fees other than mileage based fees. While under a Public Service Commission authority, a commercial carrier can establish fares for services such as waiting time, unloaded or deadhead mileage and call-out fees, the department considers some of these expenses unreasonable. For example, a provider may use waiting time to conduct other business. A provider also has the control to use all legs of a transport to reduce unloaded mileage.

COMMENT: The department should not change ARM 46.12.1002 until it is shown that the changes will improve administration of the program.

RESPONSE: The amendments to ARM 46.12.1002 provide for improved administration of the program by stating limitations upon coverage with specificity and by providing certain procedures to govern the process of reimbursement.

COMMENT: The department should not change ARM 46.12.1005 until it is shown that the changes will improve comprehension of the rules and administration of reimbursement.

RESPONSE: The amendments to ARM 46.12.1005, concerning transportation and per diem reimbursement, provide for improved administration of the program by simplifying the reimbursement system for transportation. In addition, there will be some savings resulting from the limitations upon service coverage incorporated into ARM 46.12.1002.

COMMENT: The department should not revise the reimbursement for transportation and per diem to incur program savings. The department has not fixed the "black hole" yet of ITM not even paying all the bills that are suppose to be paid for by medicaid to providers. The department started a managed care concept that now is not saving the money and therefore the Department is simply cutting the costs by across the board cuts in per diem rates. The department should eliminate ITM and save the money we are paying them if cuts must be made. The department should eliminate managed care since it is a failure.

RESPONSE: The department is revising the reimbursement rates to provide for better cost controls for coverage of transportation and per diem services. There will be cost savings as a result. These savings are prudent and are in accord with the department's overall goals for the Medicaid program.

The state contracted through a competitive process for the administration of transportation services covered by the Montana Medicaid program. The purpose of that contract is to provide a single management entity to review and process requests for transportation coverage made by medicaid recipients. The approach improved administrative efficiencies resulting in significant savings for the program. The contractor is Integrated Transport Management, Inc., (ITM). Among the responsibilities for ITM under the contract are prior authorization of all nonemergency travel and review of all ambulance claims prior to payment.

ITM does not reimburse providers. ITM issues a prior authorization number when appropriate and the providers still submit their claims to Consultec for payment.

There was a problem with electronic data transmissions between ITM and the contractor for medicaid billing operations, Consultec. However, the problem has been fixed. Only a few minor errors have recently been brought to the department's attention. These were easily corrected by contacting Consultec or ITM. The department does continue to evaluate and monitor this matter to insure that the data exchange is accurate.

Cost savings have been incurred with emergency and nonemergency transportation services since the advent of the medicaid transportation management system and prior authorization process. However, the success of the system is not measured only by cost savings. Even as cost savings are occurring, more medicaid recipients are benefiting from transportation services since the system was implemented. Under the system, transportation services are being developed in previously underserved areas of the state. In addition, transportation services are being authorized in a more consistent manner statewide.

The new transportation management system is working well. The department will not eliminate the system or replace the contractors.

COMMENT: The department should not amend ARM 46.12.1022. The department in a hearing before the legislature appropriations committee was asked what the department was going to cut to save money. The department did not say once they were cutting these costs mentioned in this amendment. The department should not now have the right to cut these costs. The department had a meeting with members of transportation providers with some

members present. Never once did the department say they were going to cut their costs back.

Before the department amends ARM 46.12.1022, it should show the program savings to be incurred in anticipated dollar amounts.

RESPONSE: The amendments to ARM 46.12.1022, concerning ambulance service requirements, and to ARM 46.12.1025, concerning ambulance service reimbursement, do not change the reimbursement rates for ambulance services. Consequently, cost savings may not occur due to the changes.

Some of the changes to the rules are a result of actions which occurred after the legislative appropriations committee.

The notice of the rule amendments was submitted to the Secretary of State on May 1, 1995. Adequate public notice was given. Also, the department sent a letter to all interested parties in May of 1994. Those who expressed interest in further information about changes to the medicaid transportation program were also sent notice of the proposed amendments.

The department met with members of the Montana Passenger Carrier Association to specifically discuss the proposed amendments to nonemergency transportation. It was the understanding of the department that all members of the Association were aware of the meeting.

COMMENT: The department does not have the right to cut these services unless there is a budget shortfall in medicaid. If there is a budget shortfall in medicaid then the department should cut those programs that were listed in a letter from the director of the department to providers on March 2 saying what programs would be cut.

RESPONSE: The department is not eliminating services to medicaid recipients.

COMMENT: A provider recently increased their call out fee and mileage rate. The provider assists clients in and out of buildings and, as requested by social services, remains with a client for the duration of the client's medical appointments and have been asked by social services to stay with a client during an actual appointment and write down what the doctor says and report it back to the client's social worker.

RESPONSE: The department does not expect a commercial transportation provider to provide assistance in other activities or to obtain and relate medical information between medical professionals and direct care providers.

The department recognizes two categories of commercial ground transport.

The first category of covered transportation services is called commercial transportation and refers to transports via taxicabs and bus.

The second category of covered transportation services is specialized nonemergency transportation which refers to wheelchair and stretcher vans. Specialized nonemergency transportation is used when an individual has a handicap or physical limitation that precludes their use of usual forms of public transportation such as taxicab and bus. Specialized nonemergency transportation includes wheelchair/stretcher vans. Specialized nonemergency transportation providers transport individuals who have a handicap or physical limitation which precludes their use of usual forms of transportation. Their vehicles are equipped with wheelchair lifts or other specialized apparatus.

The changes in reimbursement provide for more appropriate reimbursement in relation to the service being provided. The department can not justify paying higher reimbursement rates for regular commercial transportation as compared to specialized nonemergency transportation. There are many situations where the Department reimburses less for the more sophisticated level of transportation services.

Currently, commercial transportation providers are reimbursed their usual and customary fees as established under the Public Service Commission. One commercial provider has a one-way call-out fee of $11.00 and is reimbursed $1.50 per mile. A ten mile round trip of five miles each way costs the State $37.00. For the same trip via wheelchair van, a provider is reimbursed $17.98.

In the same example, if the commercial provider has a 100 mile round trip of 50 miles each way, the state pays $172.00. For the same trip via wheelchair van, the cost to the State is $63.00.

In some cases, only one transportation provider can currently provide services in an area. Even though there may be the possibility of using less expensive transportation services such as taxi services, those services are not available because the Public Service Commission has precluded the entry of other providers.

COMMENT: The department should increase reimbursement rates to meet state and federal requirements, particularly those requirements, effective in 1996, for the Americans With Disabilities Act.

One provider, at a minimum, recommended that the reimbursement rate for one-way only transfers be set at the rate of $12.00 per fare plus $1.00 for additional attenders. The provider also requested changing rates to $.80 per loaded mile and $.45 per

unloaded mile for out of town trips. Another provider requested $1.25 per loaded mile.

RESPONSE: The department has determined that at this time it is prudent and reasonable to reimburse commercial providers at $.63 per loaded mile. For specialized nonemergency transportation, the department will reimburse $.63 per loaded mile and $.33 per unloaded mile as described in the rule.

The department will reimburse the same fare for an attendant as for the client.

COMMENT: The rationale for the 16 mile limitation on in-town travel for regular commercial ground transportation is unclear.

RESPONSE: The 16 mile limitation has been in place for a number of years. It was a limitation based on total round trip mileage. The limitation when adopted was considered reasonable in terms of local trip mileage for most persons. The department in the final notice is retaining the 16 mile limitation but applying it on a one way trip basis. Consequently, the mileage to which the local mileage reimbursement applies will be increased. The department believes that a 16 mile one way trip is reasonable in terms of local trip mileage under current circumstances.

COMMENT: The preclusion of coverage at ARM 46.12.1005(4) for costs of less than $10 should not apply to commercial carriers.

RESPONSE: The $10.00 limitation on coverage applies only to costs in relation to use of personal vehicles or to the costs of meals when commercial carriers are used. The provision has been changed to specifically state the limitation.

COMMENT: Reimbursement of all transportation, whether by taxicabs or nonemergency specialized transportation, should be considered on a one way basis.

RESPONSE: The department agrees and has changed the provision at ARM 46.12.1005(2) and ARM 46.12.1015(2)(a) to provide that the basis of the reimbursement rate will be one way trips. The department, beginning July 1, 1995, will discontinue processing round trips. What is currently considered a round trip will be processed as two one-way trips.

The department has determined that the proposed provision at ARM 46.12.1022(11), precluding coverage of ambulance services received by a person during a period of retroactive eligibility, should not be adopted. The proposed provision has not been adopted.

ARM 46.12.1015, Specialized Nonemergency Medical Transportation, Reimbursement, is amended to remove the round trip basis for limitation on local trip reimbursement. This change is

necessary to conform the local trip basis of this service with that of commercial ground transportation in ARM 46.12.1005.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

6. The rules will become effective July 1, 1995.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rules 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1241, 46.12.1249, 46.12.1254, 46.12.1260 and 46.12.1265 pertaining to medicaid nursing facility services	)	NOTICE OF THE AMENDMENT OF RULES 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1241, 46.12.1249, 46.12.1254, 46.12.1260 AND 46.12.1265 PERTAINING TO MEDICAID NURSING FACILITY SERVICES

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1237, 46.12.1249, 46.12.1254, 46.12.1260 and 46.12.1265 pertaining to medicaid nursing facility services at page 790 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rules 46.12.1222, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1249, 46.12.1254, 46.12.1260 and 46.12.1265 as proposed.

3. The Department has amended the following rule(s) as proposed with the following changes:

46.12.1223 PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS Subsections (1) through (2) remain as proposed.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal medicaid participation requirements. Department sanctions or actions may include ~~but are not limited to~~ imposition of any remedy or combination of remedies ~~that a state is permitted to impose under~~ PROVIDED BY STATE OR federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

Subsections (3) through (3)(c) remain as proposed.

~~(4) A provider must mail to the department a copy of each notice of transfer or discharge provided to a resident of the provider's facility pursuant to 42 CFR 483.12(a)(4), (5) and (6). The copy of the notice must be mailed to the department within 3 days after the notice is mailed or provided to the resident. At the same time, the provider must mail to the department a list including the names and addresses of the resident, any responsible party or guardian that acts on the~~

~~resident's behalf and any known legal counsel representing the resident with respect to the transfer or discharge issue. The notice and list must be mailed to the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.~~

(4) A PROVIDER MUST NOTIFY A RESIDENT OR THE RESIDENT'S REPRESENTATIVE OF A TRANSFER OR DISCHARGE AS REQUIRED BY 42 CFR 483.12(a)(4), (5) AND (6). THE NOTICE MUST BE PROVIDED USING THE FORM PRESCRIBED BY THE DEPARTMENT. IN ADDITION TO THE NOTICE CONTENTS REQUIRED BY 42 CFR 483.12, THE NOTICE MUST INFORM THE RECIPIENT OF THE RECIPIENT'S RIGHT TO A HEARING, THE METHOD BY WHICH THE RECIPIENT MAY OBTAIN A HEARING AND THAT THE RECIPIENT MAY REPRESENT HERSELF OR HIMSELF OR MAY BE REPRESENTED BY LEGAL COUNSEL, A RELATIVE, A FRIEND OR OTHER SPOKESPERSON. NOTICE FORMS ARE AVAILABLE UPON REQUEST FROM THE DEPARTMENT. REQUESTS FOR NOTICE FORMS MAY BE MADE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, MEDICAID SERVICES DIVISION, 111 N. SANDERS, P.O. BOX 4210, HELENA, MT 59604-4210.

AUTH: Sec. 53-6-108 [as amended by sec. 14, ch. 354, L. 1995], 53-6-111 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107 [as amended by sec. 13, ch. 354, L. 1995], 53-6-111 and 53-6-113 MCA

46.12.1226 NURSING FACILITY REIMBURSEMENT Subsections (1) through (3)(b) remain as proposed.

(c) A provider's per diem rate effective July 1 of the rate year AND THROUGHOUT THE RATE YEAR shall not exceed the provider's average per diem private pay rate for a semi-private bed, plus the average cost, if any, of items separately billed to private pay residents, in effect on July 1 of the rate year 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. The rate specified by the provider in this survey will be referred to as the reported rate.

Subsections (3)(c)(i) through (13) remain as proposed.

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

46.12.1231 DIRECT NURSING PERSONNEL COST COMPONENT Subsections (1) through (3) remain as proposed.

(4) The direct nursing personnel cost limit is ~~130%~~ ~~120%~~ 116% 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

46.12.1241 CHANGE IN PROVIDER DEFINED Subsections (1) through (1)(b)(ii) remain as proposed.

(iii) the current or former partners from whom the new partner acquires an interest do not retain ~~the~~ A right of control over the partnership arising from the transferred interest.

Subsections (1)(c) through (1)(c)(ii) remain as proposed.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility OR A LEASEHOLD INTEREST IN THE NURSING FACILITY; and

(ii) the right to control and manage the business of the nursing facility.

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

(i) a spouse, ancestor, descendant, sibling, UNCLE, AUNT, NIECE, NEPHEW or a spouse of an ancestor, descendant, ~~or~~ sibling, UNCLE, AUNT, NIECE OR NEPHEW; or

(ii) a sole proprietorship, partnership or corporation OR OTHER ENTITY in which a spouse, ancestor, descendant, sibling, uncle, aunt, niece, nephew or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable, to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated corporation" means a corporation that is NOT A RELATED PARTY AND THAT IS controlled and managed by a board of directors comprised of entirely different persons and by different officers.

Subsections (3) and (4) remain as proposed.

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

4. The Department has thoroughly considered all commentary received:

COMMENT: This new subsection deals with notice of transfer or discharge. It requires providers to mail a copy of every notice of transfer or discharge to SRS within three days of giving notice to the resident. It also requires nursing facilities to provide the department with a list of the names and addresses of the resident, any responsible party or guardian that acts on the resident's behalf and any known legal counsel representing the resident with respect to the transfer or discharge issue. This new subsection represents an unnecessary administrative paperwork burden on facilities to which we strongly object.

The definition of "transfer or discharge" is poorly defined in the federal rules and open to various interpretation. Giving residents information regarding the appeal process and how to contact the state ombudsman and other agencies is certainly appropriate if the transfer or discharge is not voluntary. On the other hand, a resident happily being discharged home is not interested in this information. It would appear that this

proposal would require notification every time a resident is transferred to a hospital, every time a resident moves into or out of a facility's medicare distinct part, and every time a resident is discharged to home or to another health-care facility.

Under federal law and regulation, providers are required to give notice to residents being transferred or discharged. The regulations are specific as to what that notice is to include. It includes notice that the resident may appeal to the state and it includes information about how to contact the state ombudsman. Federal law and regulation also specifies that states will develop an "appeals process". This proposed rule change subscribes to unnecessary duplication. Facilities are already being surveyed to assure compliance with this regulatory requirement. It should not be necessary to provide SRS with this information as we see nothing in federal law or regulation requiring facilities to do so.

While the department cites 42 CFR 431.206(b)(3) as the underlying federal requirement for this proposed amendment, to the best of our knowledge no other state has interpreted this CFR cite as requiring personal written notification of appeal rights and other matters.

Other states have provided this information in the following ways: (1) provided this information to medicaid recipients upon application for benefits and provided long-term care facilities with signs noting these rights and further noting the procedures to be followed by an affected medicaid recipient or (2) state notice of appeal rights to each resident being transferred or discharged through a state form, provided to nursing homes and require that facilities provide it to each resident being transferred or discharged.

Facilitating the appeals process might make it easier to pursue an appeal. The use of a mandatory notification form with an appeal request as part of the form (similar to the current Medicaid denial of benefits notification process) would be the easiest way to ensure mandatory notification.

RESPONSE: The department has considered all of the comments that it has received concerning the notice requirements to the State Medicaid Agency when notice is provided to a nursing facility recipient that they will be transferred or discharged from the facility.

Nursing facility participation requirements at 42 CFR 483.12 provide for the transfer and discharge requirements, process and content of the notice that must be given by nursing facilities prior to transfer and discharge of a resident from their facility. Additionally, there are requirements found at 42 CFR 431.206 and 42 CFR 431.210 which mandate that the state agency must establish a hearings process, and at the time a skilled

nursing facility or a nursing facility notifies a resident that he or she is to be transferred or discharged, the state must also inform the recipient in writing of his right to a hearing, of the method by which he may obtain a hearing and that he may represent himself or use legal counsel, a relative, a friend or other spokesman in the hearings process. These requirements specifically require the state agency to provide the notice at the same time the facility provides the notice and prescribe that the notice must be in writing.

The intent of the proposed rule was not to insure compliance with the regulatory requirements of 42 CFR 483.12 for participation by nursing facilities. These requirements are reviewed by the survey agency as appropriate. This proposed rule language was intended to provide a means for the state to receive notice of the proposed transfer or discharge so that the state agency can comply with specific state agency notice requirements of 42 CFR 431.206.

The department has discussed these notice regulations with a Health Care Financing Administration representative and has asked for a written verification as to whether a formal written notice provided by a nursing facility, which includes the items required by 42 CFR 483.12 and the requirements found in 42 CFR 431.206 and 42 CFR 431.210, will meet federal approval. Based on the comments received and the discussions with the Health Care Financing Administration the department will modify the proposed rule to provide that a nursing facility will be required to provide a notice, on a form developed by the Department, which complies with all requirements for notice when a transfer or discharge is being undertaken. The department believes that an attached appeal request form that can be used by a recipient if they wish to appeal the transfer or discharge decision would be helpful in expediting the process and will seek to incorporate this provision into the form that the department develops.

COMMENT: The department is proposing to change its current rule that a facility must hold the same bed that a resident occupied prior to a transfer to a hospital until the resident returns from the hospital stay. Under the proposed change, a facility would not have to hold the same bed, but simply have a bed available for the resident upon return. I can see no good rationale for such a change. If the facility must hold a bed, why not the same bed? The proposed change puts a resident at an extreme disadvantage, since they are not present to have any input into the decision or ensure an orderly move of their possessions. Facilities making such a change during a resident's absence are guilty of at least poor judgment and timing and at worst could cause detrimental psychosocial and health effects for a resident. Since the majority of bed holds are only for a short period of time, why not wait until the resident is present and can exercise their rights regarding such changes?

Changing a resident's room during the resident's absence may violate other federal resident rights requirements. Under 42 CFR 483.10(b)(11)(ii)(A), a facility is required to provide a resident or their representative with a prompt notification of room or roommate change. The accommodation of needs requirements (42 CFR 483.15(e)(2)) also stipulate that residents have input into such changes and be able to state their preferences if such moves are made. Accomplishing these criteria would be extremely difficult if the resident is out of the facility. It could be further complicated if the resident were unable to receive the notification and state preferences because of the illness that necessitated the transfer.

If the department decides to go ahead with this proposed change, I would highly recommend language be added to the rule stressing facilities still need to meet the above criteria.

Finally, I support the additional language to this section of the rules which clarifies the fact that facilities cannot bill a resident for a bed hold under any circumstances. To further clarify the requirements, I would recommend that the language be extended to specify not only residents but their representatives. In those instances where this practice has been a problem, the facility will actually try to get the resident's family to pay for the bed hold rather than the resident. This is mainly due to the resident being ill or because other family members are handling finances for the resident.

RESPONSE: These proposed additions to the administrative rules are to provide clarification rather than to adopt a change in policy. It never has been the department's interpretation that the same bed must be held for an individual that is absent from the facility for hospitalization or for other long absences. Federal regulations do not specify a policy on bed holds, but they require a facility to provide written information upon a transfer of a resident to a hospital or before allowing a resident to go on a therapeutic leave of the duration of the bed-hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility. The administrative rule provisions concerning bed holds specify when a bed must be held for an individual receiving medical services, and under what circumstances the Medicaid program will reimburse for the holding of a bed under these absences. Therapeutic home visits and hospital hold days are not a federal requirement but are a state option for which each state adopts individualized criteria for reimbursement and length of bed hold periods.

Federal regulations at 42 CFR 483.10(b)(11)(D)(ii)(A) require that a facility must immediately inform the resident and, if known, the resident's legal representative or an interested family member when there is a change in room or roommate assignment. These clarifications in the administrative rules do

not replace the facility's requirement to provide notice prior to a change in room. The department believes that most nursing facilities hold exactly the same bed for a resident who is absent from the facility until their return. However, in some situations the nursing facility may have a need to move residents into new rooms in order to accommodate individuals on the waiting list needing nursing facility placements. If there are several residents out of the facility on therapeutic home visit or in the hospital a situation may occur where a facility may find it difficult to fill empty beds in the same rooms with residents who are on a therapeutic home visit or are hospitalized. Due to medical complexity of the residents being admitted or because of the gender of the resident who is absent they may not be able to fill from the waiting list unless residents are moved to accommodate these situations. The department believes that most facilities will only move absent residents to new rooms when absolutely necessary and will be required to comply with the federal notice requirements outlined above.

The department believes that it is not necessary to add additional language to state that the recipients representative may not be charged for hospital bed hold days. If a recipient is not responsible for payment for any services, no family member can be made responsible for these items or forced to reimburse for them.

Admission documents that are provided to recipients and responsible parties spell out the items and services that can be charged to a resident and those that are considered to be reimbursable under the medicaid per diem rate or billable separately to medicaid. The department reviews these admission documents, and in some circumstances a review is performed by the survey agency when appropriate, to insure that the lists are complete and the items that can be charged to residents are clearly indicated and in compliance with state and federal laws.

COMMENT: One commentor believed the new subsection dealing with the imposition of sanctions should refer to both state and federal laws and regulations, as the department's rule making authority must be the result of state law on the subject. Additionally, they believe the language is vague and fails to put any provider on notice as to how the department will impose sanctions, which sanctions will be imposed under which circumstances, due process rights of providers and numerous other details. We believe this rule should be removed and the department should undertake a separate rule making proceeding on the issue of sanctions.

RESPONSE: The department will incorporate language into the final rule concerning the reference to both state and federal laws and regulations as they apply to the sanction and enforcement provisions. On July 1, 1995, federal enforcement regulations become effective and a new survey process will be

implemented. The state must implement the provisions of the sanction and enforcement regulations and be bound by these regulations in the imposition of sanctions and enforcement, remedies applied, civil monetary penalties and due process requirements of these regulations. The department will consider adoption of specific rules in these enforcement areas as it deems appropriate in order to implement these federal regulations and the authority provided for under state laws. The department believes current laws and regulations adequately address these issues. The department has revised the final rule language to limit sanctions to those provided by state or federal law.

COMMENT: The changes to the property section of the payment rules propose no substantive alterations. Despite several years of unkept promises, the department is once again failing to respond to the concerns of the industry relative to property payments. The property cost component has been in dire need of improvement for many years. It does not provide adequate funding for new facilities and provides little incentive for older facilities to make necessary improvements. The department did a study, put together a task force, and has promised an additional task force to work on this issue--but it has been at least five or six years and still nothing has happened. It is important that this component be improved to be more equitable and to provide the proper incentives to insure that residents' physical environment is safe and pleasant.

COMMENT: One commentor requested that the department institute a fair-rental property payment methodology.

COMMENT: Concerns were voiced about the department's decision to "freeze" the maximum property rate at $11.00 per day. Montana's nursing homes are old, and growing older. State mandates for up-to-date facilities have not been relaxed, even while the cost to build, remodel or update plants have continued to skyrocket. Many providers are also waiting for the department to act on its promise of revamping the property rates. The current department policy exacerbates the shortage of beds in some markets, and retards provider efforts to update their facilities.

RESPONSE: Commentors are correct that the department previously completed a property reimbursement study, but has not implemented a new property methodology. The department held a symposium in November 1994, which included a look at the property study and additional property information and the department made a commitment to form working groups to work toward property system changes. The department has not committed to a fair rental value system or any specific property methodology for the future. In fiscal year 1995 the department increased the property cap to $11.00 or up to a $1.36 increase over fiscal year 1994 reimbursement rates. In the proposed rules the department proposes no change to the cap of $11.00 but

allows providers to again receive up to the $1.36 increase over their 1995 reimbursement levels. Under this rule, providers will remain at their 1995 rate if that rate already exceeded their costs, or otherwise would receive the lower of an increase up to their cost per day or an increase of $1.36, subject to the $11.00 cap.

Providers are quick to advocate changes in the property component without considering that property rates may be calculated upon an entirely different basis than under the present system and that property rates are likely to shift considerably up or down for many facilities under a new methodology. These changes may impact the increases received in this year's or prior year's property rates significantly. There have recently been several providers that have completed remodeling and new construction projects within the current reimbursement limits and qualified for rate adjustments under these rule provisions. It is not clear why commentors believe that there is no incentive to renovate and add beds when there are currently so many providers that in fact are doing exactly this very thing.

The department continues to be committed to look at the property reimbursement system in conjunction with other changes being considered for reimbursement in the area of MDS and patient acuity adjustments.

COMMENT: The definition of a change in provider implies a change in leases will not be regarded as a change of owner or provider. In a call to department staff this provider was told that this new definition applies to a lease situation as well. This rule language is unclear.

RESPONSE: The department proposed clarifying language in the change in provider definition which many providers supported. These changes are necessary to deal with paper transactions where control of the facility is not impacted but rather a stock or corporate restructuring has occurred. Previously these activities triggered a change in provider and a new reimbursement rate calculation using a more current rate period. The department intended this language to apply to lease situations when an unrelated party acquires the leasehold or interest in the facility and the right to control and manage. We will provide additional language to clarify that these rules apply to lease transactions. The department will also add clarifying language in definition of a related party to make it more clear who will be considered a related party under these rules.

COMMENT: The proposed amendments to these subsections change the operating cost component in two ways: they reduce the operating cost cap from 115% to 105% of the median operating costs and they reduce the allowable incentive from 40% to 30% of

the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

We oppose both of these changes and believe they are being made solely because of budgetary constraints. We believe that providers are continually asked by regulators and inspectors to provide more care and services. There is increased emphasis on quality of life, which translates into increased costs in the activities and social services areas, which of course are part of the operating component. Increased paper work and documentation also continues to add to our costs.

While we believe that limitations used in setting rates should promote efficiencies and economies, the reduction of the operating cap from 115% down to 105% of median operating costs is inappropriately narrow. Significant legitimate variations exist among providers in the effective delivery of the wide-range of services covered by this cost center. Unduly restricting these variations is not in the long-term interest of the state, its long-term care providers or the residents of our facilities. We would suggest that the 115% limitation has been effective in controlling these operating costs while still allowing for appropriate variations. For these reasons, we oppose this reduction and would, in fact, propose that the cap be raised to 125% of the median operating costs in the state.

The May 22 spreadsheet proposed by the department further lowers the incentive factor (from 30% to 23%), simply adding insult to injury. Those facilities which have traditionally kept their costs low are the facilities hurt by this additional cut. Why would SRS want to provide less incentive for facilities to keep their operating costs down? We believe that the lower the incentive factor, the more likely facilities will be to increase operating costs to "maximize reimbursement" rather than to keep costs down to benefit from an ever-shrinking "incentive factor". I believe that this change would eliminate the incentive for holding down costs and would penalize efficiently run facilities and would assist in supporting less efficiently run facilities with high costs. The incentive factor is used to help meet operation costs incurred during the year.

The purpose of this allowance is to encourage cost containment in non-nursing cost areas. Under the present methodology, the state is already reaping over 60% of those savings; under the proposed methodology, the state seeks to greedily increase its share to over 70% of the savings. Coupled with the reductions caused by the decrease in the operating cost component limitation noted above, the effect is to greatly reduce the effectiveness of this incentive allowance.

Prior to 1982 (13 years ago), facilities could qualify for an incentive allowance of up to $1.50 per patient day; the average incentive payment in 1982 was approximately $0.99 per patient day. On an inflation-adjusted basis, the department is now

effectively proposing to reduce the cost-containment allowance below where it stood in 1982. We feel that exactly the opposite path should be taken instead. An increase in the operating component limitation coupled with an increase from 40% up to 50% in the savings-sharing methodology would be far more appropriate than what is being proposed. We therefore ask the department to reconsider this proposed amendment.

Under the most current rate spreadsheet, the median operating cost per day is $38.99, and the 105% cap is $40.94 per day. More than one-half (51) of all facilities are subject to the cap, which allows costs just $1.95 more than the median bed day value. Facilities costs range from $24.99 to $65.92 per day. The proposed median cap is just too low compared to the broad range of daily operating costs.

It is clear to our providers that the two-fold reduction to the calculation of an operating incentive is a random move made by the department to bring the rates into alignment with the legislative budget set for the medicaid system. Our facilities expend endless time each year in an attempt to be prudent and cost conscious providers of services for the state. The "incentive" was to reap some benefit in the form of a higher medicaid rate based on the incentive allowance calculation while saving the State of Montana thousands of dollars monthly. The reductions proposed have the effect of penalizing those who truly save the state dollars in the medicaid system while rewarding the less efficient operator.

One commentor supported the reduction of the incentive payment rather than lowering the overall rate caps. However, this commentor also believes that the reduction of the incentive factor may promote more cost growth in the future.

RESPONSE: The department proposed to reduce the percentage on the operating component as well as the operating incentive component in the first rule notice. The department has rebased the reimbursement system to 1994 cost report information and continues to apply the DRI inflationary adjustment to provider costs in computing reimbursement levels for fiscal year 1996.

The department continues to further the basic goals of the reimbursement methodology to maximize reimbursement of nursing services and nursing costs while providing an incentive to operate efficiently and contain costs. These adjustments in percentages have been set with these reimbursement goals in mind and in conjunction with the adjustment of the reimbursement components to incorporate new base period costs, inflationary trends, new median cost computations, adequacy of the reimbursement levels through the department's findings processes and appropriation levels. All of the reimbursement factors must be considered as a whole to determine the adequacy of reimbursement levels and not isolated to one component of reimbursement. Percentages have previously been adjusted in

order to provide for the maximum amount of reimbursement to be distributed in the most appropriate manner to all facilities participating in the program. These percentages have been adjusted upward in some instances but can be adjusted downward in conjunction with the other reimbursement components in order to maximize the system of reimbursement as a whole.

The department will adopt the following percentages for fiscal year 1996 reimbursement. Operating cost component percentage at 105% of the operating cost component median and an operating incentive equal to the lesser of 10% of the median operating costs or 30% of the difference between the provider's inflated base year per diem operating costs and the operating cost limit. While the operating incentive is discretionary from the department's standpoint as it reimburses providers for costs not incurred, it provides an incentive for providers to consider how to incur facility operation cost in an efficient manner and provides a mechanism for facilities to be recognized for cost containment while still meeting participation requirements.

The operating cost median has increased by $2.67 between 1995 and 1996 or from $36.32 to $38.99 due to rebasing the system to 1994 costs and application of inflation. The operating incentive upper limit has increased from $3.63 in 1995 to $3.90 in 1996 by applying the 10% factor to the median operating cost component. The maximum allowable operating cost component has decreased from $41.77 in 1995 to $40.94 in 1996 based on the change in percentages from 115% to 105% in the operating area.

Based on the department's findings process we believe this reimbursement level is adequate to meet the costs that must be incurred by efficiently and economically operated nursing facilities in Montana.

COMMENT: The proposed amendment to the nursing cost component reduces the cap from 130% to 120%. We oppose this change and believe it is being proposed solely because of budget constraints. We also continue to be very concerned about the accuracy of this component. As you know, facility costs for nursing wages and benefits for the 1994 cost report period are divided by a patient assessment score (PAS) in effect for all or a portion of that period. The result becomes the "hourly wage" which is then inflated and multiplied by the current patient assessment score. The "hourly wage" is more fiction than fact since it is not determined using the actual staffing that generated the costs for the period. In addition, although for many providers more than one PA score is operative during the cost report year, the PA scores are not blended; instead only one is used. We believe this methodology "under pays" facilities who staffed below the PA score during the rate year and "over pay" facilities who staffed above the PA score during the rate year.

This component, among the formula variables, provides broad flexibility to facilities to invest in direct care staff and deliver adequate patient care. The formula allows a facility to cover its costs with a combination of staffing levels and compensation independent of a fixed Department philosophy. One provider may pay above average wages, but keep staffing to the bare minimum, while another may pay average wages, but be able to afford slightly higher than required staffing. In adopting this formula approach SRS adopted a stated goal to provide the means for facilities to provide higher staffing levels. This policy is consistent with federal and state rules to improve the quality of care and enhance the quality of life nursing home residents experience.

SRS' proposal to reduce the reimbursement afforded to providers runs counter to this public policy. SRS should retain the current nursing benchmark at 130% of the median cost.

One commentor supported the reduction of the hourly nursing cost cap from 130% down to 120% of the statewide median average wage. While it is vital that facilities be able to recruit and retain qualified nursing staff, the 130% cap served only to promote inefficiencies on the part of some facilities. The proposed limit of 120% should be more than adequate to allow for legitimate wage levels and inherent geographic variations.

RESPONSE: The department has considered all of the comments received regarding the direct nursing component. The department commented about the validity of the current methodology regarding the calculation of the direct nursing component and the use of the patient assessment information extensively in last year's comments and responses. The department believes that the use of the PAS, which is a measurement of the relative acuity and care needs of residents served by facilities is a reasonable approach to determining efficient and economical nursing costs. Moreover, we believe that the mix of information used in the current calculation will tend to encourage providers to staff carefully based upon resident needs rather than reimbursement impacts, because understaffing or overstaffing will have a balanced rate result under the methodology. The department does agree that this approach does not in every case provide a precise indication of staffing needs during the corresponding period and that further consideration is warranted to determine whether an approach could be developed that would achieve better results. The department will consider the changes in the case mix adjustment factor in conjunction with computerization of the minimum data set and its use as an assessment tool in the next year. The computerization requirement will assist the department in converting to a new acuity measure for reimbursement which will use MDS information and eliminate duplication for providers. The development and implementation of such a system may also provide additional options to address the concerns that have been raised regarding the nursing wage computation.

The department proposed to reduce the percentage on the nursing cost component in the first rule notice to 120%. The department has rebased the reimbursement system to 1994 cost report information and continues to apply the DRI inflationary adjustment to providers costs in computing reimbursement levels for fiscal year 1996.

The department continues to further the basic goals of the reimbursement methodology to maximize reimbursement of nursing services and nursing costs while providing an incentive to operate efficiently and contain costs. These adjustments in percentages have been set with these reimbursement goals in mind and in conjunction with the adjustment of the reimbursement components to incorporate new base period costs, inflationary trends, patient assessment information, new median cost computations, adequacy of the reimbursement levels through the departments findings processes and appropriation levels. The department has continued to update the information in the rate spreadsheet from the first notice rule and finds that based on the updated information we will adopt a direct nursing personnel cost limit median of 116%. All of the reimbursement factors must be considered as a whole to determine the adequacy of reimbursement levels and not isolated to one component of reimbursement. Percentages have previously been adjusted in order to provide for the maximum amount of reimbursement to be distributed in the most appropriate manner to all facilities participating in the program. These percentages have been adjusted upward in some instances but can be adjusted downward in conjunction with the other reimbursement components in order to maximize the system of reimbursement as a whole.

The department continues to believe that this methodology projects nursing costs with reasonable accuracy and results in reasonable and adequate reimbursement in the nursing area. The department will continue to used this methodology in the computation of the direct nursing component in fiscal year 1996 rate setting.

COMMENT: Our PAS has fluctuated from 3.56 to 3.98 over the nine month period from July through March. The nine month average is greater than the six month average used in our reimbursement rate and our PAS currently approaches 3.80 as reflected in the April printout. It would be interesting to see what a nine-month average PAS would generate in the formula. That figure probably more accurately reflects what has happened to a facility as it relates to the nursing component.

RESPONSE: The department, at the request of providers, specified in the fiscal year 1995 rules the six month period that will be used to compute the patient assessment average for all providers. This six month average is taken from the period October through March preceding the rate period. This allows the department to use the most current patient assessment information available in the calculation of the direct nursing

component. The use of nine months is not under consideration by the department. The most current information available at the time that reimbursement is established is used in this computation. Variations occur from month to month, but when averaged over the six month period this is reflective of the care being provided in facilities. The nursing hourly wage is calculated by taking base period nursing costs and dividing by the product of occupied days during the cost reporting period and the PAS that most closely corresponds to the base period. The resulting cost per hour is then inflated to the midpoint of the rate period and is compared to the median upper limit. The current PAS average is then applied to the cost per hour to compute the total direct nursing component. Under this computation, the base period components that most closely correspond to each other are used to calculate the nursing hourly wage, that wage is inflated forward and then multiplied by the current PAS. The department believes that this methodology projects nursing costs with reasonable accuracy and results in reasonable and adequate reimbursement. The department will continue to use this computation for the direct nursing component in fiscal year 1996 rate setting.

COMMENT: One commentor recommended that the department consider expanding the list of separately billable items to include specialized equipment made necessary due to survey findings, quality of life regulations and other state and federal rules. Nursing facilities are ordered to provide interim, often times costly, services and physical plant modifications after SRS has established the payment rate. The formula does not compensate providers for material changes in operations during the rate year. Allowing certain items to be billed in addition to the per diem rate or providing an appeal mechanism for a mid-year rate adjustment would address this problem. In addition, one commentor indicated that accommodation of needs is required by the federal government for patients with special needs. Facilities that are capped can't get reimbursed for special needs items if they don't already have them such as special wheelchairs for short patients who can't use a regular wheelchair. This jeopardizes the quality of services that are provided.

RESPONSE: The department already has in place a mechanism to pay for items that are outside the routine nursing services definition, which are to be included in the per diem rate paid to a nursing facility. These separately billable ancillary items and services are listed in ARM 46.12.1245. Many other items and services are billable by a durable medical equipment supplier or other service providers in conjunction with the applicable department rules for these services.

Items such as standard wheelchairs are included in the per diem rate computation and are usually recognized as a cost for reimbursement purposes through a depreciation allowance on the cost report. Nursing facilities need to be aware of the new

types of equipment that become available and consider purchase of these items in their inventory of supplies and equipment to be used routinely and generally available for use by residents, in conjunction with the types of residents that are routinely admitted to their facility. This matching of residents to supplies routinely needed will meet the quality of life requirements under state and federal laws and will allow facilities to purchase items that are really necessary for the majority of the population's use in the facility. An example would be a large portion of the residents in nursing facilities are women who are very small. New wheelchair purchases should consider the needs of the population in the facility, and the upgrading of inventory by having an assortment of sizes would be appropriate to meet the needs of the general population in the facility. Hemi-height chairs and wheelchairs without special modifications should be considered standard chairs for the most part and provided by the nursing facility as appropriate to meet the medical needs of residents in the facility.

Specialized and nonstandard items can still be made available to the resident through programs such as durable medical equipment when medically appropriate and, if necessary, prior approved by department staff.

COMMENT: The change in reimbursement proposed by the department in the May 22 spreadsheet results in a total of 64 Montana long-term care facilities which will not receive actual costs of care for medicaid patients for FY 1996 (based upon the state's own calculation of costs). The weighted average loss per medicaid patient day will be $4.60 under this revised proposal. The unweighted average loss, as shown on the state's spreadsheet, is $8.14 per patient day. Either way, the state is in effect expecting Montana long-term care facilities to subsidize the cost of care to Montana Medicaid residents to the tune of $6,912,533.

RESPONSE: The department issued the May 22 spreadsheet to provider representatives, at their request, as an example of where reimbursement changes and updates of costs had occurred since the first rule notice spreadsheet was issued. The May 22 spreadsheet showed the effects of reducing the operating incentive from 30% to 23% and lowering the direct nursing component from 120% to 119%. The final rules will adopt the following percentages: operating cost limits at 105% of median operating costs, direct nursing personnel cost limit at 116%, and incentive allowance equal to the lesser of 10% of median operating costs or 30% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit. The rate methodology shown by the May 22 spreadsheet will not be adopted by the department.

COMMENT: We are adamantly opposed to the department's latest interpretation of the private pay rate limit. The department proposed to clarify that the private pay limitation applies to

the rate in effect on July 1 of the rate year. We believe that the department policy goes well beyond the intent of the legislature by imposing a limit on July 1 of each year and disregards interim rate changes by providers whose rate cycles don't match the state fiscal year. We recommend that rather than clarifying current policy, current policy be changed to reflect that facilities that are limited by their private pay rate on July 1 may receive a medicaid rate increase at a later date if their private pay rate increased later in the year. SRS would not pay any provider more than what they charge private pay residents but would in fact provide equity to those providers whose rate decisions are made at a time other than July 1.

RESPONSE: The department was directed to implement the private pay limit as part of a legislative cost containment provision that is included in House Bill 2, the general appropriations bill, during the 1993 legislative session. The legislative language limits a facility's medicaid rate to no more than the facility's private pay rate. The department will survey nursing facilities to determine the private pay rate effective July 1, 1995. If the private pay rate is less than the July 1 medicaid rate computed under the reimbursement formula, then the facility's medicaid reimbursement is limited to the facility private pay rate. This limit applies for the entire year. The private pay limit will be based upon the private pay rate effective July 1 and rates will not be adjusted upward for private pay rate increases occurring during the year. To monitor private pay rates and to continually adjust rates would be costly and is not administratively feasible. Each facility needs to evaluate the cost of providing nursing facility care and compare this to the private pay charges in order to determine if the private pay rate is reflective of the cost of providing care for the year beginning July 1. Based on this analysis, some private pay rates may need to be raised, not because of the limit on the medicaid rate but because the cost of providing this care is greater than what is being charged to the private paying resident for this care. This continues to be the policy that the department adopted in the fiscal year 1994 rules and is not a new interpretation in how the department has applied the private pay limit. There will be no adjustments to the computed medicaid rate established on July 1 if facilities who are limited increase their private pay rates during the year.

COMMENT: The department received requests for information and documents concerning the reimbursement process from specific providers through the rule comment process.

RESPONSE: The department will respond separately to these requests for information and documents to those commentors that requested them.

COMMENT: The rule changes fail to meet the Boren standards. Two thirds of the facilities will receive less than actual cost for services. The changes made by the department are solely budget driven and unfairly penalize the facilities. It seems to be clear that whenever there is a change in the percentages, it always a reduction. The funding appears to be questionable to cover the costs of resident care within the facility and I fail to see adequate coverage in the facilities as a result of your rate making processes. The state has no legitimate definition of an "efficiently and economically operated facility" other than one that can operate on whatever the legislature appropriates.

RESPONSE: The department disagrees with the assertions that the reimbursement methodology fails to comply with the requirements of the Boren Amendment. The department has engaged in an extensive findings process which has resulted in the adoption of the reimbursement system in place under these rules. The department does not rely upon the rate component median percentages or other similar parameters in the methodology to "implicitly define" an economically and efficiently operated facility. Rather, the department in a separate process has explicitly and carefully identified the cost that must be incurred by an efficiently and economically operated provider. The department's explicit standards have not changed from the previous rate year. A comparison of the costs that must be incurred to the rates generated by the system indicates that the department's rates meet the Boren Amendment standards. The department believes its cost projections used in this process are valid and reasonable. The department has also made appropriate findings regarding quality of care and access to services. There is no legal requirement that a particular percentage of facilities receive rates which cover all of their actual costs. The department has reviewed the numbers of facilities which are reimbursed all costs and certain percentages of their costs. The department believes that the system meets both the substantive and procedural requirements of the Boren Amendment.

COMMENT: We question the department's policy of defining efficiency solely based upon a facility's costs compared to a median cost standard. The formula theoretically provides reasonable payment rates and incentives to all facilities. But in reality, the department rations payments to facilities with higher costs without regard to the reasons for those higher costs. SRS should determine a facility's efficiency based upon their experience compared to other, similarly structured and operated facilities. To accomplish this goal the department should measure relative efficiency of facilities with their peers, rather that rating each facility on a single continuum.

RESPONSE: The comment reveals a misunderstanding of how the department defines efficiency. As explained in the previous response, the "median cost standard" is not the department's

efficiency definition. The "peer grouping" proposal would result in a significant change in how the department currently views all nursing facilities in the reimbursement process. The department may consider these issues as part of the working groups that will be developed to look at ongoing changes to the reimbursement methodology.

COMMENT: Commentors believe that any significant changes to the proposed rules which lower the operating, nursing or incentive caps from the original proposal will require additional notice and hearing as they represent substantive changes from the department's original proposal and impact provider rates.

RESPONSE: The department disagrees. Providers have been given notice of changes being proposed and have been given opportunity to comment on these changes. The department has worked with association representatives on additional changes being proposed and has carefully considered the comments received from providers as a result of this rule drafting process. In the first rule notice, the department proposed changes in the various percentages in the component caps and operating incentive. Based upon consideration of comment, ongoing analysis and receipt of additional cost data, additional combinations of percentages have been considered. The public generally and providers particularly were on notice that the department was considering where to set the percentages and that they could comment on the specific proposals and other proposals they might wish to make. The department disagrees that the changes being adopted require additional notice prior to adoption.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

6. The rules will become effective July 1, 1995.

Dawn Sliva
Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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

In the matter of the amendment of rule 46.12.3803 pertaining to medically needy income standards	)))	NOTICE OF THE AMENDMENT OF RULE 46.12.3803 PERTAINING TO MEDICALLY NEEDY INCOME STANDARDS

TO: All Interested Persons

1. On May 11, 1995, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rule 46.12.3803 pertaining to medically needy income standards at page 766 of the 1995 Montana Administrative Register, issue number 9.

2. The Department has amended rule 46.12.3803 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: The department stated that the amendment of ARM 46.12.3803 was necessary because the medically needy income standards are based on the AFDC standards, which are increasing effective July 1, 1995 due to increases in the federal poverty levels. Did the legislature say that the medically needy standards should be increased as well as the AFDC standards or is it required by law that medically needy standards be increased when AFDC standards are raised?

RESPONSE: The medically needy standards are being increased due to federal requirements rather than at the direction of the legislature. Federal regulations governing the Medically Needy program at 42 CFR 435.811 specify that the medically needy income standard shall be no lower than the standards used in the most closely related cash assistance program, which is AFDC. Because of this requirement the medically needy standards must be increased when the AFDC standards increase.

Although the legislature did not direct that the medically needy standards be increased, the legislature was aware that increases in AFDC payment amounts would necessitate increases in the medically needy standards as well. The legislature was advised in written testimony that the medically needy income standards are based on the maximum AFDC benefit amounts and therefore knew that medically needy standards must be increased when AFDC payment amounts are raised.

The department took into consideration the effect of the increases in the medically needy standards in its request for funding for the program. Therefore it is anticipated that the

amount appropriated in House Bill 2 for the Medically Needy program will be adequate despite the increase in the standards.

4. The rule will become effective July 1, 1995.

5. Effective July 1, 1995, and in accordance with Chapter 546 of the 1995 Legislature, the Department of Social and Rehabilitation Services is abolished and its duties and programs will be assumed by the new Department of Public Health and Human Services. In accordance with 2-15-135, MCA, all references in these rules to the Department of Social and Rehabilitation Services will be changed to the Department of Public Health and Human Services.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 19, 1995.

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, 1995. This table includes those rules adopted during the period April 1, 1995 through June 30, 1995 and any proposed rule action that was 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, 1995, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1994 and 1995 Montana Administrative Register.

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SOCIAL AND REHABILITATION SERVICES, Department of, Title 46

BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 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 effective in May 1995, appear. Vacancies scheduled to appear from July 1, 1995, through September 30, 1995, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a 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 June 1, 1995.

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 FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Architects (Commerce)			
Mr. Thomas Geelan Havre Qualifications (if required): public member	Governor	reappointed	5/17/1995 3/27/1998
Ms. Pamela J. Hill Bozeman Qualifications (if required): an architect on staff of a state university of architecture	Governor	reappointed	5/17/1995 3/27/1998
Board of County Printing (Commerce)			
Mr. Roy Aafedt Great Falls Qualifications (if required): county commissioner	Governor	reappointed	5/17/1995 4/1/1997
Ms. Nancy Clark Ryegate Qualifications (if required): public member	Governor	reappointed	5/17/1995 4/1/1997
Ms. Fern Hart Missoula Qualifications (if required): county commissioner	Governor	reappointed	5/17/1995 4/1/1997
Mr. Verle Rademacher White Sulphur Springs Qualifications (if required): representing the printing industry	Governor	reappointed	5/17/1995 4/1/1997
Mr. Curtis Starr Malta Qualifications (if required): representing the printing industry	Governor	reappointed	5/17/1995 4/1/1997

BOARD AND COUNCIL APPOINTEES FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Hail Insurance (Agriculture)			
Mr. Keith Arntzen	Governor	Beirwagon	5/22/1995
Hilger			4/18/1998
Qualifications (if required): public member			
Ms. Rebecca McCabe	Governor	not listed	5/22/1995
Ekalaka			0/0/0
Qualifications (if required): none specified			
Board of Horseracing (Commerce)			
Mr. Joe Erickson	Governor	new position	5/19/1995
Cascade			1/20/1998
Qualifications (if required): being in the horseracing industry in District 3			
Mr. H. Allen Shumate	Governor	new position	5/19/1995
Helena			1/20/1998
Qualifications (if required): being in the horseracing industry in District 4			
Board of Personnel Appeal (Labor and Industry)			
Mr. Tom Foley	Governor	new position	5/25/1995
Helena			1/1/1999
Qualifications (if required): being a substitute board member representing labor			
Mr. Lloyd Doney	Governor	new position	5/25/1995
East Helena			1/1/1999
Qualifications (if required): being a substitute member representing management			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Realty Regulation (Commerce)			
Mr. John Beagle	Governor	Zimdars	5/9/1995
Sidney			5/9/1999
Qualifications (if required): licensed realtor			
Mr. Steven E. Cummings	Governor	reappointed	5/9/1995
Kalispell			5/9/1999
Qualifications (if required): public member			
Department of Agriculture (Agriculture)			
Mr. Ralph Peck	Governor	Giacometto	5/2/1995
Helena			1/1/1997
Qualifications (if required): none specified			
Montana State Veterans Cemetery Advisory Council (Military Affairs)			
Mr. Herb Ballou	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Mr. Dick Baumberger	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Major Joel Cusker	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Ms. Alma Dickey	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana State Veterans Cemetery Advisory Council		(Military Affairs) cont.	
Mr. Lee Dickey Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. James W. Duffy Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. M. Herbert Goodwin Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. Jim Heffernan Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. James F. Jacobsen Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. Robert C. McKenna Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. Mickey Nelson Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997
Mr. Carl L. Nordberg Helena Qualifications (if required): none specified	Director	not listed	5/1/1995 5/1/1997

BOARD AND COUNCIL APPOINTEES FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana State Veterans Cemetery Advisory Council		(Military Affairs) cont.	
Mr. Fred Olson	Director	not listed	5/1/1995
Fort Harrison			5/1/1997
Qualifications (if required): none specified			
Mr. George Paul	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Ms. Irma Paul	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Mr. Ray Read	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Mr. Ruddy Reilly	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Ms. Rose Marie Storey	Director	not listed	5/1/1995
Helena			5/1/1997
Qualifications (if required): none specified			
Reserved Water Rights Compact Commission	(Natural Resources and Conservation)		
Mr. Chris D. Tweeten	Attorney General	reappointed	5/1/1995
Helena			5/1/1999
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
State Library Commission (State Library)			
Ms. Mary Doggett	Governor	reappointed	5/22/1995
White Sulphur Springs			5/22/1998
Qualifications (if required): public member			

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Advisory Council on Chemical Dependency (Corrections & Human Services)		
Rep. Steve Benedict, Hamilton Qualifications (if required): none specified	Director	7/1/1995
Sen. B.F. "Chris" Christiaens, Great Falls Qualifications (if required): none specified	Director	7/1/1995
Justice Janet Eschler, Billings Qualifications (if required): none specified	Director	7/1/1995
Mr. Jim Gamell, Great Falls Qualifications (if required): none specified	Director	7/1/1995
Ms. Judith Gedrose, Helena Qualifications (if required): none specified	Director	7/1/1995
Ms. Sandra Lambert, Miles City Qualifications (if required): none specified	Director	7/1/1995
Mr. Marko Lucich, Butte Qualifications (if required): none specified	Director	7/1/1995
Mr. Curtis Moxley, Chinook Qualifications (if required): none specified	Director	7/1/1995
Ms. Betty Wing, Missoula Qualifications (if required): none specified	Director	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Aging Advisory Council (Governor)		
Father Carl Erickson, Fort Benton	Governor	7/18/1995
Qualifications (if required): representative of Region III		
Mr. R.H. (Buff) Hultman, Drummond	Governor	7/18/1995
Qualifications (if required): representative of Region V		
Ms. Fern Prather, Big Timber	Governor	7/18/1995
Qualifications (if required): representative of Region II		
Ms. Ena D. Simpson, Polson	Governor	7/18/1995
Qualifications (if required): representative of Region VI		
Agricultural Development Council (Agriculture)		
Mr. P.L. "Joe" Boyd, Billings	Governor	7/1/1995
Qualifications (if required): active in agriculture		
Mr. Leo Giacometto, Helena	Governor	7/1/1995
Qualifications (if required): Director of Agriculture		
Mr. Larry Johnson, Kremlin	Governor	7/1/1995
Qualifications (if required): active in agriculture		
Mr. Jon Noel, Helena	Governor	7/1/1995
Qualifications (if required): Director of Commerce		
Alfalfa Leaf-Cutting Bee Advisory Committee (Agriculture)		
Dr. Gary Jensen, Bozeman	Governor	7/1/1995
Qualifications (if required): representative of Montana Cooperative Extension Service		
Mr. Allen Whitmer, Bloomfield	Governor	7/1/1995
Qualifications (if required): representative of a seed association		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Alternative Health Care Board (Commerce)		
Dr. Michael Bergkamp, Helena Qualifications (if required): none listed	Governor	9/1/1995
Ms. Dolly Browder, Missoula Qualifications (if required): certified nurse midwife	Governor	9/1/1995
Dr. Daniel M. Molloy, Billings Qualifications (if required): medical doctor	Governor	9/1/1995
Dr. Tom Rasmussen, Helena Qualifications (if required): public member	Governor	9/1/1995
Board of Architects (Commerce)		
Mr. Thomas Geelan, Havre Qualifications (if required): public member	Governor	7/1/1995
Board of Banking (Commerce)		
Mr. Douglas K. Morton, Kalispell Qualifications (if required): national bank officer	Governor	7/1/1995
Mr. Gary Rebal, Great Falls Qualifications (if required): public member	Governor	7/1/1995
Board of Barbers (Commerce)		
Mr. Max Demars, Big Timber Qualifications (if required): barber	Governor	7/1/1995
Board of Cosmetologists (Commerce)		
Mr. Dick Meyers, Billings Qualifications (if required): licensed cosmetologist	Governor	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Board of Hearing Aid Dispensers (Commerce)		
Ms. Patricia Ingalls, Butte Qualifications (if required): hearing aid dispenser	Governor	7/1/1995
Board of Medical Examiners (Commerce)		
Dr. Gordon Lynn Bell, Glasgow Qualifications (if required): being a medical doctor	Governor	9/1/1995
Dr. Lawrence McEvoy, Clancy Qualifications (if required): doctor of medicine	Governor	9/1/1995
Board of Morticians (Commerce)		
Mr. John J. Michelotti, Billings Qualifications (if required): licensed mortician	Governor	7/1/1995
Board of Nursing (Commerce)		
Ms. Sherri Chatham, Great Falls Qualifications (if required): licensed practical nurse	Governor	7/1/1995
Ms. Nancy Heyer, Missoula Qualifications (if required): registered nurse	Governor	7/1/1995
Board of Pharmacy (Commerce)		
Ms. Patricia M. Mitchell, Dillon Qualifications (if required): pharmacist	Governor	7/1/1995
Board of Physical Therapy Examiners (Commerce)		
Mr. Thomas K. Meagher, Cut Bank Qualifications (if required): physical therapist	Governor	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Board of Private Security Patrol Officers and Investigators (Commerce)		
Mr. Gary Gray, Great Falls	Governor	8/1/1995
Qualifications (if required): contract security member		
Ms. Mary'l G. Luntsford, Kalispell	Governor	8/1/1995
Qualifications (if required): represents a proprietary security company		
Board of Professional Engineers and Land Surveyors (Commerce)		
Mr. David Bowman, Ennis	Governor	7/1/1995
Qualifications (if required): surveyor		
Dr. Fred Walter, Butte	Governor	7/1/1995
Qualifications (if required): engineer		
Board of Public Accountants (Commerce)		
Mr. Gary Nelson, Plentywood	Governor	7/1/1995
Qualifications (if required): certified public accountant		
Board of Radiologic Technologists (Commerce)		
Dr. Stephen Becker, Libby	Governor	7/1/1995
Qualifications (if required): radiologist		
Mr. Jim Winter, Great Falls	Governor	7/1/1995
Qualifications (if required): radiologic technologist		
Board of Sanitarians (Commerce)		
Ms. Melissa Tuemmler, Ulm	Governor	7/1/1995
Qualifications (if required): registered sanitarian		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Board of Veterinary Medicine (Commerce)		
Ms. Catherine L. Kuhl, Superior Qualifications (if required): public member	Governor	7/31/1995
Dr. Minott E. Pruyn, Missoula Qualifications (if required): veterinarian	Governor	7/31/1995
Board of Water Well Contractors (Natural Resources and Conservation)		
Mr. Pat J. Byrne, Great Falls Qualifications (if required): water well contractor	Governor	7/1/1995
Capitol Restoration Commission (Administration)		
Mr. Ralph T. Anderson, Clancy Qualifications (if required): none specified	Governor	9/24/1995
Senator Chet Blaylock, Laurel Qualifications (if required): none specified	Governor	9/24/1995
Senator Robert Brown, Whitefish Qualifications (if required): none specified	Governor	9/24/1995
Ms. Elinor Clack, Havre Qualifications (if required): none specified	Governor	9/20/1995
Ms. Barbara J. Spilker, Helena Qualifications (if required): none specified	Governor	9/24/1995
Mr. Hal G. Stearns, Missoula Qualifications (if required): none specified	Governor	9/20/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Child Support Advisory Council (Social and Rehabilitation Services)		
Ms. Judy Browning, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. James B. Wheelis, Qualifications (if required): none specified	Director	9/1/1995
Senator Sue Bartlett, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. Ken Caruso, Huson Qualifications (if required): none specified	Director	9/1/1995
Ms. Judy Garrity, Helena Qualifications (if required): none specified	Director	9/1/1995
Ms. Rosemary Hertel, Helena Qualifications (if required): none specified	Director	9/1/1995
Ms. Susan Leaphart, Missoula Qualifications (if required): none specified	Director	9/1/1995
Mr. Randle Romney, Helena Qualifications (if required): none specified	Director	9/1/1995
Child Support Services Advisory Council (Social and Rehabilitation Services)		
Mr. Tim Wise, Kalispell Qualifications (if required): none specified	Director	9/1/1995
Mr. Robert R. Zenker, Virginia City Qualifications (if required): none specified	Director	9/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Committee on Telecommunication Services for the Handicapped (Social and Rehabilitation Services)		
Mr. Ron Bibler, Great Falls	Governor	7/1/1995
Qualifications (if required): handicapped member		
Mr. John Delano, Helena	Governor	7/1/1995
Qualifications (if required): 1 of 4 handicapped members, 2 must be deaf or hard hearing		
Mr. Ben Havdahl, Helena	Governor	7/1/1995
Qualifications (if required): 1 of 4 handicapped members, 2 must be deaf or hard hearing		
Community Services Advisory Council (Governor)		
Ms. Norma Bixby, Lame Deer	Governor	7/1/1995
Qualifications (if required): represents Native Americans		
Ms. Candace Bowman, Lewistown	Governor	7/1/1995
Qualifications (if required): public member		
Ms. Susan Callaghan, Butte	Governor	7/1/1995
Qualifications (if required): represents business		
Ms. Nancy Coopersmith, Helena	Governor	7/1/1995
Qualifications (if required): represents Office of Public Instruction		
Mr. George Dennison, Missoula	Governor	7/1/1995
Qualifications (if required): represents University Systems		
Ms. Gertrude Downey, Butte	Governor	7/1/1995
Qualifications (if required): represents non-profit organization		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Community Services Advisory Council (Governor) cont.		
Ms. Patricia J. Gunderson, Belgrade Qualifications (if required): represents labor	Governor	7/1/1995
Ms. Meredith Hariton, Missoula Qualifications (if required): represents program participants, ages 16 through 29	Governor	7/1/1995
Ms. Kay Hopkins, Kalispell Qualifications (if required): represents public	Governor	7/1/1995
Ms. Jan Kenitzer, Baker Qualifications (if required): represents public	Governor	7/1/1995
Ms. Billie Krenzler, Billings Qualifications (if required): represents local government	Governor	7/1/1995
Mr. Joe R. Lovelady, Helena Qualifications (if required): entity receiving assistance under Domestic Volunteer Service Act	Governor	7/1/1995
Mr. Charles McCarthy, Helena Qualifications (if required): represents Department of Family Services	Governor	7/1/1995
Major Loren Oelkers, Helena Qualifications (if required): represents Department of Military Affairs	Governor	7/1/1995
Mr. Andy Oldenburger, Manhattan Qualifications (if required): represents public	Governor	7/1/1995
Dr. Arnold Olsen, Helena Qualifications (if required): represents Fish, Wildlife and Parks	Governor	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Community Services Advisory Council (Governor) cont.		
Ms. Kathy Sova Ramirez, Helena	Governor	7/1/1995
Qualifications (if required): represents non-profit organization		
Mr. Bob Simoneau, Helena	Governor	7/1/1995
Qualifications (if required): represents Department of Labor and Industry		
Mr. Peyton Terry, Glasgow	Governor	7/1/1995
Qualifications (if required): public member		
Council on Physical Fitness and Sports (Governor)		
Ms. Mary Kay Bennett, Helena	Governor	7/12/1995
Qualifications (if required): public member		
Ms. Jeri Domme, Helena	Governor	7/12/1995
Qualifications (if required): public member		
Mr. Ron Egeland, Billings	Governor	7/12/1995
Qualifications (if required): public member		
Mr. Todd Foster, Great falls	Governor	7/12/1995
Qualifications (if required): public member		
Mr. Dick Harte, Bozeman	Governor	7/12/1995
Qualifications (if required): public member		
Ms. Malia Kipp, Missoula	Governor	7/12/1995
Qualifications (if required): public member		
Ms. Cindy Lewis, Helena	Governor	7/12/1995
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Council on Physical Fitness and Sports (Governor) cont.		
Ms. Judy Martz, Butte Qualifications (if required): public member	Governor	7/12/1995
Mr. Robert W. Moon, Helena Qualifications (if required): public member	Governor	7/12/1995
Mr. Bob Norbie, Great Falls Qualifications (if required): public member	Governor	7/12/1995
Mr. Tom Osborne, Billings Qualifications (if required): public member	Governor	7/12/1995
Mr. Hal Rawson, Helena Qualifications (if required): public member	Governor	7/12/1995
Mr. Pat Rummerfield, Colstrip Qualifications (if required): public member	Governor	7/12/1995
Mr. Spencer Sartorius, Helena Qualifications (if required): public member	Governor	7/12/1995
Dr. Brian Sharkey, Missoula Qualifications (if required): public member	Governor	7/12/1995
Ms. Judy Spolstra, Bozeman Qualifications (if required): public member	Governor	7/12/1995
Mr. Dan Thoene, Butte Qualifications (if required): public member	Governor	7/12/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Council on Physical Fitness and Sports (Governor) cont.		
Dr. Manuel White, Helena Qualifications (if required): public member	Governor	7/12/1995
Electrical Board (Commerce)		
Mr. Charles Sweet, Kalispell Qualifications (if required): master electrician	Governor	7/1/1995
Ethics Advisory Council (Secretary of State)		
Ms. Emily Budziak Williams, Bozeman Qualifications (if required): none specified	Secretary of State	8/31/1995
Mr. David Hoffman, Dillon Qualifications (if required): none specified	Secretary of State	8/31/1995
Ms. Betsy Horsman-Witala, Helena Qualifications (if required): none specified	Secretary of State	8/31/1995
Mr. Garth B. Jacobson, Helena Qualifications (if required): none specified	Secretary of State	8/31/1995
Ms. Amy Kelley, Helena Qualifications (if required): none specified	Secretary of State	8/31/1995
Ms. Pam Merrell, Butte Qualifications (if required): none specified	Secretary of State	8/31/1995
Mr. James Polsin, Missoula Qualifications (if required): none specified	Secretary of State	8/31/1995
Mr. John Vincent, Bozeman Qualifications (if required): none specified	Secretary of State	8/31/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Ethics Advisory Council (Secretary of State) cont.		
Ms. Tootie Welker, Helena Qualifications (if required): none specified	Secretary of State	8/31/1995
Governor's Trade Advisory Council (Agriculture)		
Mr. Gregory D. Barkus, Kalispell Qualifications (if required): none specified	Governor	8/31/1995
Mr. James L. Brock, Great Falls Qualifications (if required): none specified	Governor	8/31/1995
Mr. Richard F. Cromer, Butte Qualifications (if required): none specified	Governor	8/31/1995
Ms. Terry Denton Weaver, Billings Qualifications (if required): none specified	Governor	8/31/1995
Mr. Marvin Dye, Helena Qualifications (if required): none specified	Governor	8/31/1995
Ms. Kathy Fisher Ogren, Missoula Qualifications (if required): none specified	Governor	8/31/1995
Ms. Linda Klette Rice, Havre Qualifications (if required): none specified	Governor	8/31/1995
Ms. Alyce Kuehn, Sidney Qualifications (if required): none specified	Governor	8/31/1995
Mr. Eugene P. Lewis, Great Falls Qualifications (if required): none specified	Governor	8/31/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Governor's Trade Advisory Council (Agriculture) cont.		
Ms. Fran Marceau, Kalispell Qualifications (if required): labor representative	Governor	8/29/1995
Ms. Laurie Shadoan, Bozeman Qualifications (if required): none specified	Governor	8/31/1995
Mr. Jim Waldo, Billings Qualifications (if required): labor representative	Governor	8/29/1995
Historical Society Board of Trustees (Historical Society)		
Ms. Ana Brenden, Scobey Qualifications (if required): public member	Governor	7/1/1995
Mr. John Burke, Butte Qualifications (if required): member	Governor	7/1/1995
Mr. Jack Hayne, Dupuyer Qualifications (if required): public member	Governor	7/1/1995
ICC for State Prevention Programs (Governor)		
Ms. Marilyn Thornquist Chakos, Billings Qualifications (if required): experience in private or nonprofit provision of prevention program	Governor	7/1/1995
Incentive Awards Advisory Council (Administration)		
Mr. Jim Adams, Helena Qualifications (if required): general public member	Director	7/1/1995
Ms. Ann Bartel, Great Falls Qualifications (if required): general public member	Director	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Incentive Awards Advisory Council (Administration) cont.		
Mr. Bartley J. Campbell, Helena Qualifications (if required): state employee	Director	7/1/1995
Mr. Russell G. McDonald, Helena Qualifications (if required): state employee	Director	7/1/1995
Mr. Erich Merdinger, Helena Qualifications (if required): state employee	Director	7/1/1995
Ms. M. Carol Ogle, Helena Qualifications (if required): state employee	Director	7/1/1995
Mr. Jim Pellegrini, Helena Qualifications (if required): state employee	Director	7/1/1995
Ms. Janet Reller, Helena Qualifications (if required): state employee	Director	7/1/1995
Mr. Joe Williams, Helena Qualifications (if required): state employee	Director	7/1/1995
Indian Burial Preservation Board (Commerce)		
Ms. Karen Atkinson, Pablo Qualifications (if required): represents Salish Kootenai Tribe	Governor	8/22/1995
Mr. Francis Auld, Elmo Qualifications (if required): represents Salish Kootenai Tribe	Governor	8/22/1995
Mr. Carl Fourstar, Poplar Qualifications (if required): represents Assiniboine Tribe	Governor	8/22/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Indian Burial Preservation Board (Commerce) cont.		
Mr. Dale Herbort, Helena	Governor	8/22/1995
Qualifications (if required): represents Montana Historic Preservation Office		
Dr. Randall Skelton, Missoula	Governor	8/22/1995
Qualifications (if required): physical anthropologist		
Ms. Charline Smith, East Missoula	Governor	8/22/1995
Qualifications (if required): physical anthropologist		
Representative Jay Stovall, Billings	Governor	8/22/1995
Qualifications (if required): public member		
Mr. William Tallbull, Busby	Governor	8/22/1995
Qualifications (if required): represents Northern Cheyenne Tribe		
Mr. Clarence "Curly Bear" Wagner, Browning	Governor	8/22/1995
Qualifications (if required): represents Blackfeet Tribe		
Interagency Coordinating Council for Prevention Programs (Family Services)		
Ms. Robin Morris, Havre	Governor	7/1/1995
Qualifications (if required): representative of prevention programs and services		
Job Training Coordinating Advisory Council (Labor and Industry)		
Ms. Judy Birch, Helena	Governor	7/1/1995
Qualifications (if required): none specified		
Mr. Peter S. Blouke, Helena	Governor	7/1/1995
Qualifications (if required): none specified		
Ms. Barbara Campbell, Deer Lodge	Governor	7/1/1995
Qualifications (if required): represents business		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Job Training Coordinating Advisory Council (Labor and Industry) cont.		
Mr. Fred "Rocky" Clark, Butte	Governor	7/1/1995
Qualifications (if required): represents labor/community-based organizations		
Mr. Rick Day, Helena	Governor	7/1/1995
Qualifications (if required): none specified		
Ms. Jane Delong, Helena	Governor	7/1/1995
Qualifications (if required): represents business		
Ms. JoEllen Estenson, Columbia Falls	Governor	7/1/1995
Qualifications (if required): none specified		
Mr. Hank Hudson, Clancy	Governor	7/1/1995
Qualifications (if required): represents state or local government		
Ms. Helen Kellicut, Deer Lodge	Governor	7/1/1995
Qualifications (if required): represents business		
Mr. Bob Marks, Clancy	Governor	7/1/1995
Qualifications (if required): represents business		
Ms. Sue Matthews, Miles City	Governor	7/1/1995
Qualifications (if required): none specified		
Ms. Felicity McFerrin, Helena	Governor	7/1/1995
Qualifications (if required): represents labor/community-based organizations		
Mr. Steve P. Nelsen, Bozeman	Governor	7/1/1995
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Job Training Coordinating Advisory Council (Labor and Industry) cont.		
Mr. Jon Oldenburg, Lewistown	Governor	7/1/1995
Qualifications (if required): represents labor/community-based organizations		
Mr. David Owen, Helena	Governor	7/1/1995
Qualifications (if required): represents business		
Ms. Diane Ruff, Billings	Governor	7/1/1995
Qualifications (if required): represents business		
Mr. Randy Siemers, Billings	Governor	7/1/1995
Qualifications (if required): none specified		
Ms. Sherry Stevens Wulf, Kalispell	Governor	7/1/1995
Qualifications (if required): none specified		
Senator Mignon Waterman, Helena	Governor	7/1/1995
Qualifications (if required): none specified		
Mr. Noel Williams, Eureka	Governor	7/1/1995
Qualifications (if required): none specified		
Representative Karyl Winslow, Billings	Governor	7/1/1995
Qualifications (if required): none specified		
Judicial Standards Commission (Judicial)		
Ms. Jean Grow, Glendive	Governor	7/1/1995
Qualifications (if required): public member from Congressional District II		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Microbusiness Finance Program Advisory Council (Commerce)		
Ms. Barbara Burke, Missoula Qualifications (if required): none specified	Governor	7/1/1995
Ms. Jamie Kay, Missoula Qualifications (if required): none specified	Governor	7/1/1995
Mr. Richard C. King, Havre Qualifications (if required): none specified	Governor	7/1/1995
Mr. Duane Kurokawa, Wolf Point Qualifications (if required): none specified	Governor	7/1/1995
Mr. Rick Sharp, Butte Qualifications (if required): none specified	Governor	7/1/1995
Montana Library Services Advisory Council (Education)		
Ms. Sue Nissen, Butte Qualifications (if required): none specified	Director	7/1/1995
Montana Mint Committee (Agriculture)		
Mr. Dale Sonstelie, Kalispell Qualifications (if required): active mint grower	Governor	7/1/1995
Motorcycle Safety Advisory Committee (Office of Public Instruction)		
Mr. Robert E. Brown, Glasgow Qualifications (if required): certified motorcycle safety instructor	Superintendent	7/1/1995
Mr. Dal Smilie, Helena Qualifications (if required): represents motorcycle group	Governor	7/1/1995
Mr. Ron Ullom, Red Lodge Qualifications (if required): peace officer	Governor	7/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
Noxious Weed Advisory Council (Agriculture)		
Mr. Charles M. Jarecki, Polson	Director	7/1/1995
Qualifications (if required): member at large		
State Emergency Response Commission (Governor)		
Mr. Steve Barry, Helena	Governor	7/21/1995
Qualifications (if required): represents Department of Justice		
Mr. Pat Brannon, Helena	Governor	7/21/1995
Qualifications (if required): represents Department of Transportation and Highways		
Ms. Beate Galda, Helena	Governor	7/21/1995
Qualifications (if required): represents Fish, Wildlife and Parks		
Mr. Jim Greene, Helena	Governor	7/21/1995
Qualifications (if required): represents Disaster and Emergency Services		
Mr. Marv Jochems, Billings	Governor	7/21/1995
Qualifications (if required): none specified		
Mr. Pat Keim, Helena	Governor	7/21/1995
Qualifications (if required): none specified		
Ms. Yvonne Kobasziar, Great Falls	Governor	7/21/1995
Qualifications (if required): none specified		
Mr. Curt Laingen, Helena	Governor	7/21/1995
Qualifications (if required): none specified		
Mr. Bob Robinson, Helena	Governor	7/21/1995
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
State Emergency Response Commission (Military Affairs) cont.		
Mr. Seldon Weedon, Great Falls Qualifications (if required): none specified	Governor	7/21/1995
State Employee Benefits Advisory Council (Administration)		
Ms. Cathy Kendall, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. Arthur N. Whitney, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. Mark Cress, Helena Qualifications (if required): none specified	Director	9/1/1995
Ms. Nancy Ellery, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. Dave Evenson, Helena Qualifications (if required): none specified	Governor	9/1/1995
Ms. Debbie Gebase, Boulder Qualifications (if required): none specified	Director	9/1/1995
Mr. Ken Givens, Helena Qualifications (if required): none specified	Governor	9/1/1995
Mr. Curt Nichols, Helena Qualifications (if required): none specified	Director	9/1/1995
Mr. Jim Penner, Helena Qualifications (if required): none specified	Governor	9/1/1995

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1995 through September 30, 1995

Board/current position holder	Appointed by	Term end
State Employee Group Benefits Advisory Council (Administration) cont.		
Mr. William Salisbury, Helena	Director	9/1/1995
Qualifications (if required): none specified		
Mr. Thomas Schneider, Helena	Director	9/1/1995
Qualifications (if required): none specified		
Teachers' Retirement Board (Administration)		
Mr. E. Joseph Cross, Billings	Governor	7/1/1995
Qualifications (if required): member of a retirement system		
Tourism Advisory Council (Commerce)		
Ms. Maureen Averill, Bigfork	Governor	7/1/1995
Qualifications (if required): represents Glacier Country		
Ms. Diane Brandt, Glasgow	Governor	7/1/1995
Qualifications (if required): represents Missouri River Country		
Mr. David Hemion, Helena	Governor	7/1/1995
Qualifications (if required): represents Montana Chamber of Commerce		
Ms. Edythe McCleary, Hardin	Governor	7/1/1995
Qualifications (if required): represents Custer Country		
Ms. Lisa Reid Perry, Shepherd	Governor	7/1/1995
Qualifications (if required): public member		
Wheat and Barley Committee (Agriculture)		
Mr. Fred L. Elling, Rudyard	Governor	8/20/1995
Qualifications (if required): republican represents District II		
Ms. Judy Vermulm, Cut Bank	Governor	8/20/1995
Qualifications (if required): democrat represents District III		