MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 18

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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NOTICE SECTION

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

In the matter of the adoption of new rules I through V regarding the regulation of managed care community networks	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULES

TO: All Interested Persons.

1. On October 19, 1995, at 9:30 a.m., a public hearing will be held in conference room of the State Auditor's Office, 126 N. Sanders, Mitchell Building, Room 270, Helena, Montana 59620. The hearing will be to consider the adoption of new rules I through V regarding the regulation of managed care community networks by the commissioner of insurance.

2. The proposed rules are as follows:

RULE I MANAGED CARE COMMUNITY NETWORKS: DEFINITIONS

(1) "Managed care community network" or "network" means an entity other than a health maintenance organization that is owned, operated, or governed by a person and that provides or arranges managed health care services under contract with the Department of Public Health and Human Services of the state of Montana to enrollees of the program.

(2) "Commissioner" means the commissioner of insurance provided for in section 2-15-1903, MCA.

AUTH: Sections 53-6-701 through 53-6-709 and 33-31-115, MCA
IMP: Sections 56-6-701 through 56-6-709 and 33-31-115, MCA

RULE II CRITERIA FOR ASSESSING THE FINANCIAL SOUNDNESS OF A NETWORK (1) The standards used for evaluating the financial condition of regulated companies found in ARM 6.6.3401(1)(a) and (c) through (o) may be used by the commissioner in evaluating the financial soundness of a network.

(2) For the purposes of assessing the financial soundness of a network, the commissioner may use the same discretionary authority available to him pursuant to ARM 6.6.3402, as regards insurers.

(3) In making his determination of the financial soundness of a network, the commissioner must consider the following:

(a) The extent to which a network is composed of providers who directly render health care and are located within the community in which they seek to contract rather than solely arrange or finance the delivery of health care;

(b) The following risk-bearing and management techniques:

(i) hold harmless agreements with health care providers;

(ii) reinsurance protection from sound reinsurers, provided to the network; and (iii) guaranties by others, to the extent that the guarantor appears capable of fulfilling the guaranty; and

(c) The amount of the net worth of the network as reported in its most recent financial statement.

(4) A network which does not comply with the minimum net worth standard of $200,000.00, found in section 33-31-216(9), MCA, shall be considered financially unsound.

AUTH: Sections 53-6-701 through 53-6-709 and 33-31-115, MCA
IMP: Sections 56-6-701 through 56-6-709 and 33-31-115, MCA

RULE III PROTECTION AGAINST INSOLVENCY (1) The commissioner may, in his discretion, require quarterly or monthly financial reports from a network as a means of monitoring the financial condition of a network.

(2) The commissioner may, in his discretion, require the submission of an annual audited financial report from a network.

(3) A network must comply with section 33-31-216, MCA, in order to continue to operate. A network must maintain an appropriate deposit of securities with the commissioner, maintain the minimum net worth of $200,000.00, and provide evidence that it has complied with section 33-31-216(10), MCA.

AUTH: Sections 53-6-701 through 53-6-709 and 33-31-115, MCA
IMP: Sections 56-6-701 through 56-6-709 and 33-31-115, MCA

RULE IV REDUCTION OR ELIMINATION OF REQUIREMENTS (1) The commissioner may reduce or eliminate requirements of Title 33, Chapter 31, MCA, which apply to a network, if it can be demonstrated that the requirement is unnecessary for the operation of the network in a rural area or because of federal requirements for prepaid health plans.

(2) If a network seeks reduction or elimination of a requirement of Title 33, Chapter 31, MCA, regarding its operation in this state, the network must take the following steps:

(a) The network must submit a written request to the commissioner in which the network:

(i) states the specific requirement in Title 33, Chapter 31, MCA, regarding whether it wants a reduction or an elimination; and

(ii) explain why the requirement is unnecessary for its operation.

(3) In evaluating the request of a network for a reduction or an elimination of a requirement, the commissioner:

(a) must have reasonable assurance that the reduction or elimination of the requirement will not result in harm to the public;

(b) may make reasonable requests for additional information from the network necessary to evaluate the network's request; and

(c) may obtain relevant information from other sources deemed to be useful.

(4) The commissioner must either approve or reject the request of the network within 60 days of his receipt of all information relevant to the decision.

AUTH: Sections 53-6-701 through 53-6-709 and 33-31-115, MCA
IMP: Sections 56-6-701 through 56-6-709 and 33-31-115, MCA

RULE V APPLICATION REVIEW FEE (1) The commissioner shall charge the network an application review fee for the commissioner's actual cost of review of the network's application. In no case, however, shall the fee be more than $500.00.

AUTH: Sections 53-6-701 through 53-6-709 and 33-31-115, MCA
IMP: Sections 56-6-701 through 56-6-709 and 33-31-115, MCA

3. Adoption of new rules I through V is necessary because of the passage of Senate Bill 388. This legislation provided for an integrated medicaid managed care program and specified requirements for medicaid managed care networks. The commissioner is required to adopt rules setting forth the criteria for assessing the financial soundness of managed care community network requirements and their reserve requirements. The commissioner was granted the authority to eliminate or reduce any requirement found in Title 33, Chapter 31, MCA, if the commissioner was to find the requirement unnecessary for the operation of a managed care community network in a rural area or because of federal requirements of prepaid health plans.

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 Gary L. Spaeth, P.O. Box 4009, Helena, MT 59604-4009, and must be received no later than October 26, 1995.

5. The State Auditor will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an

accommodation, please contact the State Auditor's Office no later than October 11, 1995, and advise the office of the nature of the accommodation needed. Please contact Jeannie Davies, Montana State Auditor's Office, Room 270, Sam W. Mitchell Building, 126 North Sanders, P.O. Box 4009, Helena, Montana 59604. Telephone (406)-444-2040 or toll free (800)-332-6148, fax (406)-444-3497.

6. Gary Spaeth has been designated to preside over and conduct the hearing.

MARK O'KEEFE
STATE AUDITOR

By: _____
Frank G. Coté
Deputy Insurance Commissioner

_____
Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 18th day of September, 1995.

BEFORE THE BOARD OF DENTISTRY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees	)))	NOTICE OF PROPOSED AMENDMENT OF 8.16.405 FEE SCHEDULE AND 8.16.606 FEE SCHEDULE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Board of Dentistry proposes to amend the above-stated rules.

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

"8.16.405 FEE SCHEDULE

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

(4) Active renewal, in-state	~~133~~	153
(5) Inactive renewal, out-of-state	~~133~~	153

(6) through (9) will remain the same."

Auth: Sec. 37-1-134, 37-4-205, MCA; IMP, Sec. 37-1-134, 37-4-301, 37-4-303, 37-4-306, 37-4-307, MCA

"8.16.606 FEE SCHEDULE

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

(3) Active renewal, in-state	~~100~~	70
(4) Inactive renewal, out-of-state	~~100~~	70

(5) through (11) will remain the same."

Auth: Sec. 37-1-134, 37-4-205, MCA; IMP, Sec. 37-4-402, 37-4-403, 37-4-404, 37-4-406, MCA

REASON: The proposed amendments will re-distribute fees among the various groups of licensees, without raising the overall Board income, to better reflect the administrative work and costs associated with the different licensee groups covered by the Board.

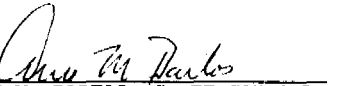
3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Dentistry, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

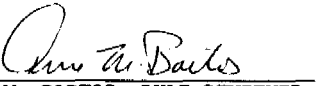
4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Dentistry, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

5. If the Board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the

proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 148 based on the 1481 licensees in Montana.

BOARD OF DENTISTRY
CAROL SCRANTON, D.D.S., CHAIRMAN

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


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

BEFORE THE PROFESSIONAL AND OCCUPATIONAL
LICENSING BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the transfer and proposed amendment, repeal and adoption of rules pertaining to fire prevention and investigation	)))))	NOTICE OF PUBLIC HEARING ON THE TRANSFER AND PROPOSED AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO FIRE PREVENTION AND INVESTIGATION

TO: All Interested Persons:

1. On November 6, 1995, at 9:00 a.m., a public hearing will be held in the conference room of the Professional and Occupational Licensing Bureau, 111 North Jackson, Helena, Montana, to consider the transfer and proposed amendment, repeal and adoption of rules pertaining to fire prevention and investigation.

2. ARM 23.7.121 through 23.7.129, 23.7.131 through 23.7.136 and 23.7.159 are being transferred to the Professional and Occupational Licensing Bureau of the Department of Commerce. The text of these rules will be located in Title 8, Chapter 19 and will be numbered as follows: 23.7.121 through 23.7.129 (8.19.101 through 8.19.109), 23.7.131 through 23.7.136 (8.19.110 through 8.19.115) and 23.7.159 (8.19.116).

3. ARM 23.7.128 (8.19.108), 23.7.132 (8.19.111), 23.7.133 (8.19.112), 23.7.159 (8.19.116) are being proposed for amendment. The amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.19.108 CONTINUING EDUCATION (1) will remain the same.

(2) An endorsee shall obtain a minimum of 8 hours (~~50 to~~ 60 minutes per hour) ~~or 1.5 continuing education units~~ annually and submit copies of continuing education certificates with the application for renewal. Up to 8 hours earned in excess of the 8 hours required in a licensing year may be carried over into the succeeding year. All applicants for renewal of endorsements shall have completed continuing education as provided in this rule as a condition to establish eligibility for renewal. The continuing education requirement will not apply until the endorsee's first full year of endorsement.

(3) will remain the same.

(a) workshops, seminars and educational conferences sponsored by fire protection equipment manufacturers or trade associations; ~~and~~

(b) courses in specialized programs approved by the department~~.~~;

~~(4)~~ (c) ~~Continuing education may also be obtained by~~ correspondence course work approved by the department~~.~~;

~~(5)~~ (d) ~~A~~any continuing education which has been obtained in another state that meets the continuing education requirements of that state ~~may be approved by the department.~~;

(e) college or vocational school course work, approved by the department, which is germane to the profession and contributes directly to the professional competence of the endorsed individual, subject to the following limitations:

(i) the endorsed individual must pass the course;

(ii) one semester credit shall equal 15 hours of continuing education;

(iii) one quarter credit shall equal 10 hours of continuing education.

(f) teaching courses that are germane to the profession. Credit units may be applied in this category based on a report by the endorsed individual. For a one-hour presentation, the presenter will be awarded two hours of continuing education. The following limitations shall apply to requests for credit under this section:

(i) documentation must be submitted showing the licensee as the instructor of the course;

(ii) the course must be addressed to endorsed individuals or apprentices in order to qualify for credit;

(iii) a course outline must be provided to the department; and

(iv) instruction of any course may be submitted for continuing education only once."

Auth: Sec. ~~50-3-102,~~ 50-39-107, MCA; IMP, Sec. 50-39-102, MCA

"8.19.111 ~~LICENSE, ENDORSEMENT AND~~ PROCESSING FEE AND PRORATED FEES ~~(1) Each entity shall pay an annual license fee of $200.~~

~~(2) Each person employed by the licensee to perform services under the license shall obtain from the department an endorsement and pay:~~

~~(a) $100 to sell, service, or install fire alarm systems;~~

~~(b) $100 to sell, service, or install special agent fire suppression systems; and~~

~~(c) $100 to sell, service, or install fire extinguishing systems.~~

~~(3)~~ (1) In the year of first application for a license or endorsement, the applicant shall pay an application processing fee in the amount of $100~~, or an amount sufficient to cover the travel and overhead costs incurred in conducting an inspection of the applicant's facilities, whichever is less~~. This fee shall be in addition to the annual license and/or endorsement fee, and shall not be prorated.

(2) Annual license and endorsement fees in the first year of license or endorsement shall be prorated as follows:

(a) for new applications postmarked or hand-delivered prior to September 1 of the license year in question, the annual fee will be charged as set forth in 50-39-105;

(b) for new applications postmarked or hand-delivered on September 1 through November 30, inclusive, of the license year in question, the annual fee will be charged at 75% of the fee set forth in 50-39-105;

(c) for new applications postmarked or hand-delivered on December 1 through April 15, inclusive, of the license year in question, the annual fee will be charged at 50% of the fee set forth in 50-39-105; and

(d) for applications postmarked or hand-delivered after April 15 and before May 31 of the license year in question, the annual fee will be charged as set forth in 50-39-105, and will cover the remainder of the licensing year in which application is made, as well as the license year immediately following the year in which application is made."

Auth: Sec. ~~50-3-102~~ 50-39-107, MCA; IMP, Sec. ~~50-3-102~~ 50-39-105, MCA

"8.19.112 EXAMINATION FOR ENDORSEMENT (1) and (2) will remain the same.

~~(3) Individuals applying for any endorsement described herein may be issued a provisional endorsement. The provisional endorsement will expire on December 31, 1994. At the time of renewal, the applicant must submit appropriate documentation verifying that the applicant qualifies for endorsement.~~"

Auth: Sec. ~~50-3-102, 50-3-102, 50-3-103,~~ 50-39-107, MCA; IMP, Sec. ~~50-3-102,~~ 50-39-101, 50-39-103, MCA

"8.19.116 RENEWAL OF LICENSE OR ENDORSEMENT (1) and (2) will remain the same.

(3) All fire protection equipment licenses and endorsements shall expire on May 31 of each year. A renewal notice will be sent by the department to each license and endorsement holder to the last address in the department's files no later than April 15 of each year. Failure to receive such notice shall not relieve the license or endorsement holder of the obligation to pay renewal fees and file an application for renewal in such a manner that it is postmarked or hand-delivered to the department on or before May 31.

(4) For licenses and endorsements that were scheduled for a renewal date other than May 31 prior to [the effective date of these amendments], the department will reduce the 1996 annual license fee on a pro-rated basis, 1/12th of the annual fee per month (1/12th reduction for licenses or endorsements scheduled to renew in June of 1996, 2/12ths reduction for licenses or endorsements scheduled to renew in July of 1996, and so on), according to the month in which the license or endorsement was previously scheduled to renew.

~~(3)~~ (5) Upon receipt of the application, the department shall grant a renewal of the license or endorsement if it appears that the applicant meets all of the requirements under ~~ARM 8.19.101~~ the provisions of Title 50, chapter 39, part 1, MCA, and these rules, has committed no act which would constitute ground for suspension or revocation under ~~ARM 8.19.102~~ 50-39-104, and remains properly equipped and staffed to provide the services intended to be performed. ~~The department may require retesting if the applicant fails to meet any of the requirements of this section or if the applicant has not, for a period of 1 year, engaged in the business for which the original license or endorsement was issued.~~

~~(4)~~ (6) Except for applications for the 1996 annual license covered under (4) above, ~~E~~each application for renewal must be accompanied by the fee(s) specified under ~~ARM 8.19.111~~ 50-39-105, MCA."

Auth: Sec. ~~50-3-102~~ 50-39-107, MCA; IMP, 50-39-102, ~~50-39-103, 50-39-104,~~ 50-39-105, ~~50-39-106, 50-39-107~~ MCA

4. ARM 23.7.121 (8.19.101), 23.7.122 (8.19.102), 23.7.124 through 23.7.126 (8.19.104 through 8.19.106), 23.7.129 (8.19.109), 23.7.131 (8.19.110), 23.7.134 (8.19.113) and 23.7.136 (8.19.115) are being proposed for repeal. Text of the rules is currently located at pages 23-361.9 through 23-361.15, Administrative Rules of Montana. The authority sections are 50-3-102, 50-3-103, 50-39-107, MCA. The implementing sections are 50-3-102, 50-39-101, 50-39-102, 50-39-103, 50-39-104, 50-39-105, 50-39-106, 50-39-107, MCA. The reason for the proposed repeal is that the department lacks sufficient statutory authority, under 50-39-107, MCA, to adopt such rules in current form. The rules have previously been adopted by the department of justice, in reliance on the authority of 50-3-103, MCA. This section does not authorize the department of commerce to adopt rules for this program.

5. The proposed new rules will read as follows:

"I DEFINITIONS The following definitions apply to the use of the listed terms in Title 50, chapter 39, part 1, MCA, and in these rules:

(1) "Apprentice" means a person working in a training capacity, for the service or installation of fire alarm systems, special agent fire suppression systems, or fire extinguishing systems, who is studying in accordance with a program approved under the guidelines of (New Rule III).

(2) "Commercial general liability insurance" means insurance that covers bodily injury and property damage, personal and advertising injury and medical payments resulting from, but not limited to, premises/operations claims and products/completed operations claims.

(3) "Endorsement" means a document issued by the department to an individual who has met qualifications which authorizes the individual to sell, service and install fire alarm systems, special agent fire suppression systems, or fire extinguishing systems.

(4) "Entity" means any business, partnership, sole proprietor(ship), organization, association, corporation, firm, governmental organization, fire agency or any other business association.

(5) "Fire alarm system" means a combination of approved compatible devices with the necessary electrical interconnection and energy to produce an alarm signaling the event of fire or system activation but does not include single station smoke or heat detectors.

(6) "Fire extinguisher" means a portable device containing an extinguishing agent that can be expelled under pressure for the purpose of suppressing or extinguishing a fire.

(7) "Fire extinguishing system" means a fire sprinkler system designed in accordance with nationally recognized standards that consists of an assembly of piping or conduits that conveys water, foam or air with or without other agents to dispersal openings or devices to extinguish, control or contain fire and to provide protection from exposure to fire or the products of combustion. Included are underground and overhead piping, ponds, tanks, pumps, extra or special hazard applications and other related components or devices necessary for water supplies.

(8) "Fire protection equipment" means the components of any fire alarm system, special agent fire suppression system, or fire extinguishing system.

(9) "Fire sprinkler system" means a fire extinguishing system.

(10) "Inspection" means and includes the periodic examination of premises, equipment, or procedures or of a licensed or endorsed person or entity to determine whether the person's or entity's business or profession is being conducted in a manner consistent with the public health, safety, and welfare. The term includes the inquiry, analysis, audit, or other pursuit of information, with respect to a written complaint or other information before the DOC, that is carried out for the purpose of assisting the DOC in determining:

(a) whether a person has violated a provision of law justifying discipline against the person;

(b) whether a license should be granted, denied, or conditionally issued; or

(c) whether the DOC should seek an injunction against unlicensed practice.

(11) "Install" means the technical work that may be performed only by an endorsed individual or an apprentice, in the assembly of a fire alarm system or special agent fire suppression system. The term does not include the delivery of supplies, the cutting of pipe, or the threading of pipe through the use of a threading machine. The term does include the following tasks:

(a) inspection of work sites to determine the presence of obstructions and to ascertain that holes will not cause structural weaknesses;

(b) determination of the course or plan of installation;

(b) any bending of pipe as part of the installation;

(c) assembly and installation of metal or nonmetal pipe fittings, including but not limited to those made of brass, copper, lead, glass, and plastic;

(d) joining of piping by any means, including threaded, caulked, wiped, soldered, brazed, fused, or cemented joints;

(e) securing of pipe to the structure by any means, including but not limited to clamps, brackets, hangers, and welds; and

(f) testing the installed system for leaks by any means, including but not limited to testing by increasing pressure in pipes and observing gages attached to pipes for indication of leaks.

(12) "License" means the document issued by the department which authorizes a person or entity to engage in the

business of servicing fire extinguishers or engaging in the business of selling, servicing or installing fire alarm systems, special agent fire suppression systems or fire extinguishing systems.

(13) "NICET" means national institute for certification in engineering technologies.

(14) "Sell", "sale" and associated words mean offering or contracting to transfer, lease, or rent any merchandise, equipment, or service at retail to the public or any member thereof for an agreed sum of money or other consideration.

(15) "Service", when referring to portable fire extinguishers and fire extinguisher cylinders, means maintenance and includes breakdown for replacement of parts or agent, repair, recharging or hydrostatic testing.

(a) When referring to alarm systems, fire extinguishing systems and fire suppression systems, "service" means maintenance and testing required to keep the protective signaling, extinguishing and suppression system and its component parts in an operative condition at all times, together with replacement of the system or its component parts with listed or approved parts, when, for any reason they become undependable, defective or inoperative.

(b) "Service" does not include resetting manual alarm systems which may be reset by properly trained building owners or their designated representative.

(16) "Special agent fire suppression system" means an approved system and components which require individual engineering in accordance with manufacturer specifications and includes dry chemical, carbon dioxide, halogenated, gaseous agent, foam and wet chemical systems; includes pre-engineered system but does not include a fire extinguishing system."

Auth: Sec. 50-39-107, MCA; IMP, Sec. 50-39-101, 50-39-102, 50-39-103, 50-39-104, 50-39-105, 50-39-106, MCA

"II APPLICATION PROCEDURE (1) An application for a license, endorsement, renewal, reinstatement, or apprenticeship program approval must be made on a form provided by the department and completed and signed by the applicant.

(2) The application must be typed or written in ink, signed, and accompanied by the appropriate fee(s) and contain sufficient evidence of the individual's, entity's, or program's qualifications under relevant law.

(3) The department may require an applicant to submit original or certified documents in support of any application. The department may permit such documents to be withdrawn upon substitution of a true and correct copy of same.

(4) Fully-completed applications will be reviewed for compliance with relevant law. The department may request such additional information or clarification of information provided in the application as it deems reasonably necessary to a complete review of the application.

(5) Incomplete applications shall be returned to the applicant with a statement regarding incomplete portions. The applicant shall correct any deficiencies and re-submit the application. Failure to re-submit the application within 60 days shall be treated as a voluntary withdrawal of the

application. After voluntary withdrawal an applicant will be required to submit an entirely new application, with a new application fee, to begin the process again.

(6) The department shall notify the applicant in writing of the results of the evaluation of the application. In the case of a denial, the department shall specify the deficiencies in the application.

(7) All requests for reasonable accommodations under the Americans with Disabilities Act of 1990, 42 U.S.C. 12101, et seq. (ADA) in regard to licensing, endorsement, or an apprenticeship program, must be made on forms provided by the department, must be submitted with the application, and must be supported by medical evidence of the applicant's qualification for reasonable accommodations under the ADA."

Auth: Sec. 50-39-107, MCA; IMP, Sec. 50-39-102, 50-39-103, 50-39-105, MCA

III APPRENTICES-APPROVED PROGRAMS (1) Any person or entity that holds a license under the provisions of Title 50, chapter 39, part 1, MCA, must apply for approval of its apprenticeship program under (New Rule II). All work performed by an apprentice must be subject to direct and task-specific instruction and supervision of an endorsed individual.

(2) In order to qualify for exemption from endorsement under 50-39-101, MCA, an apprentice must work in a training capacity, for the service or installation of fire alarm systems, special agent fire suppression systems, or fire extinguishing systems, in compliance with an apprenticeship program approved by the department.

(3) The department shall approve an apprenticeship program of a licensee, provided that licensee establishes that its apprenticeship program meets one or more of the following:

(a) any program that is approved by the Montana department of labor, pursuant to the provisions of Title 39, chapter 6, part 1, MCA;

(b) any program that is approved by any state, provided that the program meets the requirements of the National Apprenticeship Act, 29 U.S.C. 50; or

(c) any program that is approved in any state by the federal bureau of apprenticeship and training.

(4) Once an apprenticeship program has been approved, the licensee shall provide the department with a list of all apprentices performing work for the licensee. The licensee shall provide the department with updates of such list no later than 30 days after any addition or subtraction of an apprentice from its program."

Auth: Sec. 50-39-107, MCA; IMP, Sec. 50-39-101, MCA

REASON: The transfer and amendment of existing rules and the proposed new rules are necessary to allow the department of commerce to regulate the fire protection equipment program, which was transferred from the department of justice to the department of commerce by House Bill 68 of the 1995 Montana legislative session.

The amendments to ARM 8.19.108 are necessary to provide endorsed individuals with greater options for continuing education previously mandated by the department of justice and authorized by section 50-39-102, MCA.

The amendments to ARM 8.19.111 are necessary to provide for prorated fees to licensees and endorsees. Prorated fees will provide for a fair method of assessing a license or endorsement fee for individuals who become licensed in the middle of a license year.

The amendments to ARM 8.19.112 are necessary to remove a subsection on provisional endorsement that is not supported by the department of commerce's rulemaking authority.

The amendments to ARM 8.19.116 are necessary to standardize the renewal date for all licensed and endorsed individuals and entities. The renewal dates are currently spread over the entire license year. By standardizing the renewal date, staff will be able to process renewal applications more efficiently.

New rule I is necessary to define terms that are used in the statutes and rules in order to adequately inform licensees and endorsees of the meaning of such terms.

New rule II is necessary to establish a process of application processing, and to give adequate notice to applicants of the requirements and processes for applying for licensure, endorsement, and/or approval of an apprenticeship program.

New rule III is necessary to establish criteria for an individual to qualify as an apprentice. The statute mentions that an apprentice is exempt from licensure, but does not define what an apprentice is. This rule specifies qualifications of an apprentice to assure that the public will be protected from unqualified individuals performing licensed or endorsed functions without adequate supervision of an endorsed individual.

6. 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 Terry Knerr, Professional and Occupational Licensing Bureau, Department of Commerce, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than the close of hearing on November 6, 1995.

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

PROFESSIONAL AND OCCUPATIONAL
LICENSING BUREAU
DEPARTMENT OF COMMERCE

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

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ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

BEFORE THE BOARD OF PHARMACY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees and dangerous drugs and adoption of a new rule pertaining to transmission of prescriptions by facsimile	NOTICE OF PROPOSED AMENDMENT OF 8.40.404 FEE SCHEDULE AND 8.40.1215 ADDITIONS, DELETIONS AND RESCHEDULING OF DANGEROUS DRUGS AND THE ADOPTION OF A NEW RULE PERTAINING TO TRANSMISSION OF PRESCRIPTIONS BY FACSIMILE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Board of Pharmacy proposes to amend the above-stated rules.

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

"8.40.404 FEE SCHEDULE

(1) through (11) will remain the same.

(12) Examination fee ~~175.00~~ 275

(13) through (19) will remain the same."

Auth: Sec. 37-1-134, 37-7-201, 50-32-103, MCA; IMP, Sec. 37-1-134, 37-7-201, 37-7-302, 37-7-303, 37-7-321, 37-7-703, MCA

REASON: The proposed fee amendment is necessary because NABP has increased the cost of the NABPLEX exam per candidate, and this must be shown in the fee rule so that the correct fee may be charged.

"8.40.1215 ADDITIONS, DELETIONS, & RESCHEDULING OF DANGEROUS DRUGS (1) through (5)(e)(ii) will remain the same.

(6) The following anabolic steroid containing compounds, mixtures or preparations have been exempted from Schedule III:

(a) Androgyn L.A.
(b) Andro-Estro 90-4
(c) depANDROGYN
(d) DEPO-T.E.
(e) depTESTROGEN
(f) Duomone
(g) Estratest
(h) Estratest HS
(i) PAN ESTRA TEST
(j) Premarin with Methyltestosterone
(k) Synovex H Pellets in process
(l) Synovex H Pellets in process granulation
(m) TEST-ESTRO Cypionates
(n) Testagen
(o) Testosterone Cyp 50 Estradiol Cyp 2
(p) Testosterone Cypionate - Estradiol
(q) Testosterone Enanthate - Estradiol

(r) Testosterone Valerate Injection
(s) Tilapia Sex Reversal Feed (investigational)."
Auth: Sec. 50-32-103, 50-32-203, MCA; IMP, Sec. 50-32-103, 50-32-202, 50-32-203, 50-32-209, 50-32-222, 50-32-223, 50-32-224, 50-32-225, 50-32-226, 50-32-228, 50-32-229, 50-32-231, 50-32-232, MCA

REASON: The listed anabolic steroids have been exempted by the Code of Federal Regulation at 21 CFR §1308.34 (1994) from Schedule III controlled substance list, and the proposed amendment will bring Montana rules in line with the Federal regulations.

3. The proposed new rule will read as follows:

"I TRANSMISSION OF PRESCRIPTIONS BY FACSIMILE (1) A pharmacist may dispense directly any legend drug which requires a prescription to dispense (except as provided in (2) and (3) below for Schedule II, III, IV and V controlled substances), only pursuant to either a written prescription signed by a practitioner or a facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required except for the signature of the practitioner. The prescription shall be maintained in accordance with ARM 8.40.410.

(2) A pharmacist may dispense directly a controlled substance in Schedule II, which is a prescription drug as determined by the Federal Food, Drug and Cosmetic Act, only pursuant to a written prescription signed by the practitioner. A prescription for a Schedule II controlled substance may be transmitted by the practitioner or the practitioner's agent to a pharmacy via facsimile equipment, provided the original written, signed prescription is presented to the pharmacist for review prior to the actual dispensing of the controlled substance. The original prescription shall be maintained in accordance with ARM 8.40.410.

(a) A prescription written for a Schedule II narcotic substance to be compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion may be transmitted by the practitioner or the practitioner's agent to the home infusion pharmacy by facsimile. The facsimile serves as the original written prescription for the purpose of this paragraph and it shall be maintained in accordance with ARM 8.40.410.

(b) A prescription written for a Schedule II substance for a resident of a long term care facility may be transmitted by the practitioner or the practitioner's agent to the dispensing pharmacy by facsimile. The facsimile serves as the original written prescription for purposes of this paragraph and it shall be maintained in accordance with ARM 8.40.410.

(3) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV or V which is a prescription drug as determined under the Federal Food, Drug

and Cosmetic Act, only pursuant to either a written prescription signed by a practitioner or a facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy or pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all information required except for the signature of the practitioner. The prescription shall be maintained in accordance with ARM 8.40.410."

Auth: Sec. 37-7-201, 50-32-103, MCA; IMP, Sec. 37-7-102, 37-7-201, 50-32-208, MCA

REASON: The proposed new rule will allow for transmission of prescriptions by facsimile only under certain regulation, which follow the Code of Federal Regulations standards. Transmission by fax has not previously been allowed, as the rules did not keep up with technological advances. The new rule will clarify which drugs may be dispensed under a faxed prescription, when the original prescription will be required, and what records should be kept by each pharmacist regarding faxed prescriptions.

4. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Pharmacy, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

5. If a person who is directly affected by the proposed amendments and adoption wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Pharmacy, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

6. If the Board receives requests for a public hearing on the proposed amendments and adoption from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who 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 117 based on the 1166 licensees in Montana.

BOARD OF PHARMACY
ED HARRINGTON, PRESIDENT

ANNIE M. BARTOS
RULE REVIEWER

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

Certified to the Secretary of State, September 18, 1995.

BEFORE THE BOARD OF PHYSICAL THERAPY EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to examinations, fees, renewals, temporary licenses, licensure by endorsement, exemptions, foreign-trained applicants, unprofessional conduct and disciplinary actions	NOTICE OF PROPOSED AMENDMENT OF RULES PERTAINING TO THE PRACTICE OF PHYSICAL THERAPY

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Board of Physical Therapy Examiners proposes to amend ARM 8.42.402 through 8.42.406, 8.42.409, 8.42.410, 8.42.412 and 8.42.413 pertaining to the practice of physical therapy.

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

"8.42.402 EXAMINATIONS (1) The examination will be the national physical therapy exam (NPTE) or another equivalent examination as the board may in its discretion approve and adopt for physical therapist applicants. The examination for physical therapist assistants will be the National Physical Therapist Assistant Examination (NPTAE), or another equivalent examination as the board may in its discretion approve and adopt.

(2) Exact examination dates will be established by the current testing service as the national uniform testing date. Applicants must have their complete applications in the board office at least 45 days prior to the examination date.

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

(b) copy of their certificate of graduation or transcripts from a board-approved physical therapy school or physical therapist assistant curriculum;

(c) three statements of good moral character, one of which is a professional reference from a person licensed in the field of physical therapy, and two others from persons with knowledge of the applicant within the past five years. All reference letters must be sent directly to the board office from the reference source;

(d) verification of physical therapy or physical therapist assistant instruction and graduation; and

(e) through (5)(a) will remain the same.

(6) The jurisprudence examination shall be an open book examination covering current Montana physical therapy statutes and rules, subject to Title 37, chapters 1, 2, and 11, Montana

Code Annotated, state and federal narcotic statutes, and standards of care and definition of moral turpitude. The jurisprudence examination must be passed by all examination and endorsement applicants before original licensure will be granted. ~~For examination candidates, the jurisprudence exam will be given concurrently with the NPTE examination.~~ For endorsement candidates separate provisions will be made for taking the jurisprudence examination prior to licensure. Applicants failing the jurisprudence examination must retake said examination until passed. The fee of each retake will be assessed in accordance with the established fee schedule."

Auth: Sec. 37-1-131, 37-11-201, MCA; IMP, Sec. 37-11-303, 37-11-304, MCA

8.42.403 FEES (1) The fees shall be as follows:

(a) Application for NPTE and NPTAE examination (for each examination taken)	$ ~~75.00~~ 125
(b) Application for endorsement	50~~.00~~
(c) Renewal	25~~.00~~
(d) Late renewal (if paid after April 1)	50~~.00~~
(e) Temporary license	50~~.00~~
(f) Original license	25~~.00~~
(g) Jurisprudence re-examination (each retake)	5~~.00~~
(h) Duplicate license	5~~.00~~
(i) Lists	5~~.00~~
(j) NPTE and NPTAE test history verification	55~~.00~~

(2) All fees are non-refundable."

Auth: Sec. 37-1-134, 37-11-201, MCA; IMP, Sec. 37-11-201, 37-11-304, 37-11-307, 37-11-308, 37-11-309, MCA

"8.42.404 RENEWAL OF LICENSE (1) and (2) will remain the same.

(3) A person may not practice as a physical therapist or a physical therapist assistant in this state when their license has lapsed for failure to timely renew."

Auth: Sec. 37-11-201, MCA; IMP, Sec. 37-11-308, MCA

"8.42.405 TEMPORARY LICENSES (1) will remain the same.

(2) Applicants for licensure by examination may be issued a temporary license. The temporary license shall identify the licensed physical therapist or physical therapist assistant who shall be responsible for providing direct supervision. After issuance of the temporary license, the applicant must sit for the next scheduled examination. The temporary license shall be valid until the board makes its final determination on licensure. Only one temporary license will be issued per applicant.

(3) If the applicant fails the NPTE or NPTAE, ~~he~~ the applicant may sit for the next scheduled examination. Temporary licenses will not be extended while the applicant is waiting to retake the NPTE or NPTAE examination."

Auth: Sec. 37-1-131, 37-11-201, MCA; IMP, Sec. 37-11-309, MCA

"8.42.406 LICENSURE BY ENDORSEMENT (1) Each applicant applying for licensure by endorsement must have taken the NPTE or the NPTAE or the national registry exam in another state to be considered for licensure by endorsement. All NPTE or NPTAE scores must be reported directly to the board office through the interstate reporting service. All national registry exam scores must be substantiated by the records of the American Congress of Physical Medicine, 80 North Michigan Avenue, Chicago, Illinois 60602. If the applicant supplies the board with results from the NPTE or NPTAE, such results shall be equal to or higher than a scaled score of 600 in order for the individual to be licensed by endorsement. The overall score of those applicants that have taken only the national registry exam, must be in accordance with the pass or fail grades as mandated by the registry. Those applicants failing the national registry exam will not be licensed by endorsement.

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

(b) copy of their certificate of graduation from a board approved physical therapy school or physical therapist assistant curriculum;

(c) will remain the same.

(d) submit three statements of good moral character, one of which is a professional reference from a person licensed in the field of physical therapy, and two others from persons with knowledge of the applicant within the past five years. All reference letters must be sent directly to the board office from the reference source;

(e) copy of all other physical therapy or physical therapists assistant licenses;

(f) will remain the same.

(g) verification of physical therapy or physical therapist assistant instruction and graduation; and

(h) will remain the same.

(3) Applicants applying for licensure by endorsement who have not been actively engaged in the profession of physical therapy or physical therapist assistant in the five years immediately preceding application shall be required to undergo continued study in the field of physical therapy or physical therapist assistant. Continued study may include, but will not be limited to:

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

Auth: Sec. 37-11-201, 37-11-303, 37-11-307, MCA; IMP, Sec. 37-11-101, 37-11-303, 37-11-307, MCA

"8.42.409 EXEMPTIONS (1) Whereas 37-11-101, MCA creates and defines physical therapy students, physical therapyist assistants students, and physical therapy aides, the board interprets such categories as exempt from licensure as physical therapists or physical therapist assistants so long as the supervision requirements stated in 37-11-101, MCA, are strictly adhered to. Such supervision requirements include also those imposed by 37-11-105, MCA.

(2) will remain the same.

~~(3) For purposes of a maintenance plan only, "supervision" and "periodic checks" by a licensed physical therapist, means the monthly or more frequent on site~~

~~management and review, by the licensed physical therapist, of the aide's implementation of the physical therapist designed maintenance plan.~~"

Auth: ~~The portion of this rule implementing 37-11-105, MCA, is advisory only but may be a correct interpretation of the law,~~ Sec. 37-1-131, 37-11-105, 37-11-201, MCA; IMP, Sec. 37-11-101, 37-11-105, MCA

8.42.410 FOREIGN-TRAINED PHYSICAL THERAPIST APPLICANTS (1) Foreign-trained physical therapist applicants shall be subject to the following requirements:

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

(2) Foreign-trained physical therapist assistant applicants are not eligible for licensure."

Auth: Sec. 37-1-131, 37-11-201, MCA; IMP, Sec. 37-11-310, MCA

8.42.412 UNPROFESSIONAL CONDUCT (1) For the purpose of implementing the provisions of 37-11-321(3) and (9), MCA, the board defines immoral or unprofessional conduct, conduct unbecoming a person licensed as a physical therapist or physical therapist assistant, and conduct detrimental to the best interests of the public as follows:

(a) through (d) will remain the same.

(e) An act or acts below the standard of care for physical therapists or physical therapist assistants providing similar treatment;

(f) Suspension, revocation, or restriction of individual's license to practice as a physical therapyist or physical therapist assistant by competent authority in any state, federal, or foreign jurisdiction;

(g) through (m) will remain the same.

(i) accepting and performing physical therapy or physical therapist assistant responsibilities which the licensee knows or has reason to know that he or she is not competent to perform;

(ii) through (w) will remain the same."

Auth: Sec. 37-1-131, 37-11-201, 37-11-321, MCA; IMP, Sec. 37-11-321, MCA

8.42.413 DISCIPLINARY ACTIONS (1) The board reserves the discretion to take appropriate disciplinary action provided for in 37-11-321, MCA, against a licensed physical therapist or physical therapist assistant violating any law or rules of the board, and to decide on a case by case basis the type and extent of disciplinary action it deems appropriate, applying the following considerations:

(a) through (5) will remain the same."

Auth: Sec. 37-1-131, 37-1-136, 37-11-201, MCA; IMP, Sec. 37-1-136, 37-11-321, MCA

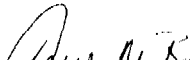
REASON: The proposed amendments are necessary because the 1995 Legislature mandated through SB 171 that licensure of physical therapist assistants be implemented by the board in the state of Montana.

3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Physical Therapy Examiners, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Physical Therapy Examiners, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

5. If the Board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 57 based on the 570 licensees in the state of Montana.

BOARD OF PHYSICAL THERAPY EXAMINERS
CHARLOTTE FANNON, P.T., CHAIRMAN

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


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

BEFORE THE BOARD OF PLUMBERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to definitions and fees and adoption of new rules pertaining to medical gas piping installation endorsements	)))))	NOTICE OF PROPOSED AMENDMENT OF 8.44.402 DEFINITIONS AND 8.44.412 FEE SCHEDULE AND ADOPTION OF NEW RULES PERTAINING TO MEDICAL GAS PIPING INSTALLATION ENDORSEMENTS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Board of Plumbers proposes to amend and adopt the above-stated rules.

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

"8.44.402 DEFINITIONS (1) through (3) will remain the same.

(4) ASME means the American society of mechanical engineers.

(5) Certification means an accreditation from an approved training program, acceptable to the board, which issues documentation such as diplomas, cards or certificates which provide proof the applicant has successfully completed training in the installation of medical gas systems, pursuant to the requirements imposed by NFPA 99C and section IX of the ASME Welding and Brazing Code.

(6) Endorsement means the approval issued by the board, signified by an endorsement card or other credential, which authorizes a person to install medical gas systems within the state of Montana.

(7) NFPA means the national fire protection association."

Auth: Sec. 37-69-202, 37-69-401, MCA; IMP, Sec. 37-69-202, 37-69-401, MCA

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

(8) Medical gas endorsement application fee	30
(9) Medical gas endorsement renewal fee	10"

Auth: Sec. 37-1-134, 37-69-202, 37-69-401, MCA; IMP, Sec. 37-1-134, 37-69-202, 37-69-307, 37-69-401, MCA

3. The proposed new rules will read as follows:

"I MEDICAL GAS ENDORSEMENT REQUIRED (1) Any person performing the installation of a medical gas system(s) in the state of Montana shall first obtain an endorsement from the board.

(2) The installation of a medical gas system(s) includes, but is not limited to, the layout, cutting, joint preparation,

fitting, purging, and brazing, or any other joint making or assembly process required to install a medical gas system(s)."

Auth: Sec. 37-69-202, 37-69-401, MCA; IMP, Sec. 37-69-402, MCA

"II APPLICATION FOR ENDORSEMENT (1) Any person required to obtain a medical gas endorsement shall make application to the board on the form prescribed by the board.

(2) Application for endorsement shall include:

(a) a completed and signed application;

(b) documentation that provides proof the applicant has successfully completed an approved training program acceptable to the board, and has obtained certification in the installation of medical gas systems, based on NFPA 99C and Section IX of the ASME Welding and Brazing Codes;

(c) a recent photograph of the applicant; and

(d) the nonrefundable application fee.

(3) The board will review applications for endorsement on a case-by-case basis and issue endorsements to those applicants meeting the requirements imposed by 37-69-401, MCA.

(4) The board may, at its discretion, require additional documentation from an applicant to verify compliance with the requirements imposed by 37-69-401, MCA."

Auth: Sec. 37-69-202, 37-69-401, MCA; IMP, Sec. 37-69-401, MCA

"III ANNUAL RENEWAL OF ENDORSEMENT (1) All medical gas endorsements shall expire annually. Each endorsement holder must submit a renewal form and the required renewal fee. Failure to submit the annual renewal fee and to renew the endorsement within 30 days following the expiration date shall require the applicant to reapply for endorsement as required by board rule."

Auth: Sec. 37-69-202, 37-69-401, MCA; IMP, Sec. 37-69-401, MCA

"IV ENDORSEMENT VERIFICATION (1) Any person performing work on a medical gas system(s) installation shall have his or her endorsement credentials on their person at all times.

(2) Any person performing work on a medical gas system(s) installation shall present his or her endorsement credentials for examination when requested to do so by any party authorized to examine the credentials."

Auth: Sec. 37-69-202, 37-69-401, MCA; IMP, Sec. 37-69-401, MCA

REASON: The proposed amendments and new rules are necessary because the 1995 Legislature, through HB 252, required the Board of Plumbers to implement a program of issuing endorsements for medical gas system installers.

4. Interested persons may submit their data, views or arguments concerning the proposed amendments and adoptions in writing to the Board of Plumbers, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

5. If a person who is directly affected by the proposed amendments and 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 Board of Plumbers, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., October 26, 1995.

6. If the Board receives requests for a public hearing on the proposed amendments and adoptions from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments and 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 persons directly affected has been determined to be 110 based on the 1101 licensees in Montana.

BOARD OF PLUMBERS
DICK GROVER, CHAIRMAN

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

BEFORE THE WEIGHTS AND MEASURES BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees, commodities, random inspection of packages and petroleum products, and the proposed repeal of a rule pertaining to metric packaging of fluid milk products	NOTICE OF PROPOSED AMENDMENT OF 8.77.107 LICENSE FEE SCHEDULE FOR WEIGHING AND MEASURING DEVICES, 8.77.201 NIST HANDBOOK 130 - UNIFORM LAWS AND REGULATIONS, 8.77.203 RANDOM INSPECTION OF PACKAGES AND 8.77.302 NIST HANDBOOK 130 - UNIFORM LAWS AND REGULATIONS, AND THE PROPOSED REPEAL OF 8.77.202 METRIC PACKAGING OF FLUID MILK PRODUCTS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Weights and Measures Bureau proposes to amend and repeal the above-stated rules.

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

"8.77.107 LICENSE FEE SCHEDULE FOR WEIGHING AND MEASURING DEVICES (1) will remain the same.

(a) each gasoline pump, diesel pump, compressed natural gas dispenser or fuel oil pump ~~measuring device per nozzle $14~~ with a listed maximum delivery rate of 20 gpm or less shall be $14.00 per meter;

(b) each petroleum vehicle tank meter or ~~bulk petroleum meter of 2 inches (5.00 centimeters) and under $50~~ stationary petroleum meter with a maximum listed delivery rate of between 130 gpm and 20 gpm shall be $50 per meter;

(c) ~~each bulk petroleum meter over 2 inches (5.00 centimeters) $60~~ each petroleum vehicle tank meter or stationary petroleum meter with a maximum listed delivery of over 130 gpm shall be $60 per meter;

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

Auth: Sec. 82-15-102, MCA; IMP, Sec. 82-15-105, MCA

REASON: Subsection (1)(a) is being amended because historically each retail pump that was manufactured had a dispensing nozzle and a corresponding measuring chamber or meter. Recently pump manufacturers are making "multiple product dispensers" that while having a separate meter for each product have only one nozzle. By changing the wording from "per nozzle" to "per meter" we will be correctly identifying the part of the dispensing device that we are charging the device owner for testing and the proper charges will be assessed.

Subsection (1)(b) and (c) are being amended because, for testing purposes, the state of Montana has adopted "NIST Handbook 44". The main criteria for correct testing methods for pumps and meters is the device's maximum discharge capacity. By basing the charges on maximum discharge capacity instead of meter outlet size we are better able to show the relationship between prices charged and tests performed. The larger discharge rate requires a more complex, time consuming test with larger equipment to correctly test the device.

"8.77 201 ~~COMMODITIES IN PACKAGE FORM---APPLICATION~~ NIST HANDBOOK 130 - UNIFORM LAWS AND REGULATIONS

~~(1) This regulation shall apply to packages and to commodities in package form, but shall not apply to:~~

~~(a) inner wrappings not intended to be individually sold to the customer;~~

~~(b) shipping containers or wrapping used solely for the transportation of any commodities in bulk or in quantity to manufacturers, packers, or processors, or to wholesale or retail distributors, but in no event shall this exclusion apply to packages of consumer or nonconsumer commodities as defined herein;~~

~~(c) containers used for retail tray pack displays when the container itself is not intended to be sold (e.g., the tray that is used to display individual envelopes of seasonings, gravies, etc. and the tray itself is not intended to be sold);~~

~~(d) commodities put up in variable weights and sizes for sale intact and intended to be either weighed or measured at the time of sale, where no package quantities are represented, and where the method of sale is clearly indicated in close proximity to the quantity being sold; or~~

~~(e) open carriers and transparent wrappers or carriers for containers when the wrappers or carriers do not bear any written, printed, or graphic matter obscuring the label information required by this regulation.~~

~~(2) Definitions.~~

~~(a) Commodity in package form. The term "commodity in package form" means a commodity put up or packaged in any manner in advance of sale in units suitable for either wholesale or retail sale. An individual item or lot of any commodity not in package form as defined in this section, but on which there is marked a selling price based on an established price per unit of weight or of measure, shall be construed to be a commodity in package form. Where the term "package" is used in this regulation, it means "commodity in package form" as here defined.~~

~~(b) Consumer package. package of consumer commodity. A "consumer package" or "package of consumer commodity" means a commodity in package form that is customarily produced or distributed for sale through retail sales agencies or instrumentalities for consumption by individuals, or use by individuals for the purposes of personal care or in the performance of services ordinarily rendered in or about the household or in connection with personal possessions.~~

~~(c) Nonconsumer package. package of nonconsumer commodity. A "nonconsumer package" or "package of nonconsumer~~

~~commodity" means any commodity in package, and particularly a package intended solely for industrial or institutional use or for wholesale distribution.~~

~~(d) Random package. The term "random package" means a package that is one of a lot, shipment, or delivery of packages of the same consumer commodity with varying weights; that is, packages of the same consumer commodity with no fixed pattern of weight.~~

~~(e) Label. The term "label" means any written, printed, or graphic matter affixed to, applied to, attached to, blown into, formed, molded into, embossed on, or appearing upon or adjacent to a consumer commodity or a package containing any consumer commodity, for purposes of branding, identifying, or giving any information with respect to the commodity or to the contents of the package, except an inspector's tag or other nonpromotional matter affixed to or appearing upon a consumer commodity shall not be deemed to be a label requiring the repetition of label information required by this regulation.~~

~~(f) Person. The term "person" means both singular and plural, and shall include any individual, partnership, company, corporation, association, and society.~~

~~(g) Principal display panels, or panels. The term "principal display panel or panels" means that part, or those parts, of a label that is, or are, so designed as to most likely be displayed, presented, shown, or examined under normal and customary conditions of display and purchase. Wherever a principal display panel appears more than once on a package, all requirements pertaining to the "principal display panel" shall pertain to all such "principal display panels."~~

~~(h) Multi unit package. The term "multi unit package" means a package containing two or more individual packages of the same commodity, in the same quantity, with the individual packages intended to be sold as part of the multi unit package but capable of being individually sold in full compliance with all requirements of this regulation.~~

~~(3) Identity.~~

~~(a) Declaration of identity: consumer package. A declaration of identity on a consumer package shall appear on the principal display panel, and shall positively identify the commodity in the package by its common or usual name, description, generic term, or the like.~~

~~(b) Parallel identity declaration. Consumer package. A declaration of identity on a consumer package shall appear generally parallel to the base on which the package rests as it is designed to be displayed.~~

~~(4) Declaration of identity: nonconsumer package. A declaration of identity on a nonconsumer package shall appear on the outside of a package and shall positively identify the commodity in the package by its common or usual name, description, generic term, or the like.~~

~~(5) Declaration of responsibility: consumer and nonconsumer packages.~~

~~(a) Any package kept, offered, or exposed for sale, or sold at any place other than on the premises where packed shall specify conspicuously on the label of the package the name and~~

~~address of the manufacturer, packer, or distributor. The name shall be the actual corporate name, or, when not incorporated, the name under which the business is conducted. The address shall include street address, city, state, and ZIP code; however, the street address may be omitted if this is shown in a current city directory or telephone directory. The requirement for inclusion of the ZIP code shall apply only to labels that have been developed or revised after July 1, 1968.~~

~~(b) If a person manufactures, packs, or distributes a commodity at a place other than his principal place of business, the label may state the principal place of business in lieu of the actual place where the commodity was manufactured or packed or is to be distributed, unless such statement would be misleading. Where the commodity is not manufactured by the person whose name appears on the label, the name shall be qualified by a phrase that reveals the connection such person has with such commodity, such as "manufactured for and packed by _____," "distributed by _____," or any other wording of similar import that expresses the facts.~~

~~(6) Declaration of quantity; consumer packages.~~

~~(a) Largest whole unit. Where this regulation requires that the quantity declaration be in terms of the largest whole unit, the declaration shall, with respect to a particular package, be in terms of the largest whole unit of weight or measure, with any remainder expressed in:~~

~~(i) common or decimal fractions of such largest whole unit; or in~~

~~(ii) the next smaller whole unit, or units, with any further remainder in terms of common or decimal fractions of the smallest unit present in the quantity declaration.~~

~~(b) Net quantity. A declaration of net quantity of the commodity in the package, exclusive of wrappers and any other material packed with such commodity, shall appear on the principal display panel of a consumer package, and unless otherwise specified in this regulation (see subsections(c) through (e) (viii) shall be in terms of the largest whole unit.~~

~~(i) Use of "net weight." The term "net weight" shall be used in conjunction with the declaration of quantity in terms of weight; and terms may either precede or follow the declaration of weight.~~

~~(ii) Lines of print or type. A declaration of quantity may appear on one or more lines of print or type.~~

~~(iii) Terms: weight, liquid measure, or count. The declaration of the quantity of a particular commodity shall be expressed in terms of liquid measure if the commodity is liquid, or in term of weight if the commodity is solid, semisolid, viscous, of a mixture of solid and liquid, or in terms of numerical count. However, if there exists a firmly established general consumer usage and trade custom with respect to the terms used in expressing a declaration of quantity of a particular commodity, such declaration of quantity may be expressed in its traditional terms, if such traditional declaration gives accurate and adequate information as to the quantity of the commodity.~~

~~(iv) Combination declaration: weight or measure. A declaration of quantity in terms of weight or measure shall be accompanied by a declaration of the count or size of the individual units of the commodity, unless a declaration of weight or measure alone is fully informative to the consumer. Such declaration shall appear on the principal display panel. A declaration of quantity in terms of weight shall be combined with appropriate declarations of the measure, count, and size of the individual units unless a declaration of weight alone is fully informative. A declaration of quantity in terms of measure shall be combined with appropriate declarations of the weight, count, and size of the individual units unless a declaration of measure alone is fully informative. A declaration of quantity in terms of count shall be combined with appropriate declarations of the weight, measure, and size of the individual units unless a declaration of count alone is fully informative.~~

~~(c) Units: weight, measure. A declaration of quantity in units of weight shall be in terms of the avoirdupois pound or ounce; units of liquid measure shall be in terms of the United States gallon of 231 cubic inches or liquid quart, liquid pint, of fluid ounce subdivisions of the gallon, and shall express the volume at 68°F (20°C), except in the case of petroleum products, for which the declaration shall express the volume at 60°F (15.6°C), and except also in the case of a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 40°F (4°C); units of linear measure shall be in terms of the yard, foot, or inch; units of area measure, shall be in terms of the square yard, square foot, or square inch; units of dry measure shall be in terms of the United States bushel of 2,150.42 cubic inches, or peck, dry quart, and dry pint subdivisions of the bushel; units of cubic measure shall be in terms of the cubic yard, cubic foot, or cubic inch; provided, that in the case of a commodity packed for export shipment, the declaration of quantity may be in terms of the metric system of weight or measure.~~

~~(i) Abbreviations. Any of the following abbreviations, and none other, may be employed in the quantity statement on a package of commodity: (There normally are no periods following, nor plural forms, of, these abbreviations. For example, "oz" is the abbreviation of both "ounce" and "ounces.")~~

~~avoirdupois~~	~~avdp~~	~~quart~~	~~qt~~
~~cubic~~	~~cu~~	~~square~~	~~sq~~
~~feet of foot~~	~~ft~~	~~weight~~	~~wt~~
~~fluid~~	~~fl~~	~~yard~~	~~yd~~
~~gallon~~	~~gal~~	~~cubic centimeter~~	~~cc~~
~~inch~~	~~in~~	~~gram~~	~~g~~
~~liquid~~	~~liq~~	~~kilogram~~	~~kg~~
~~ounce~~	~~oz~~	~~microgram~~	~~mcg~~
~~pint~~	~~pt~~	~~milligram~~	~~mg~~
~~pound~~	~~lb~~	~~milliliter~~	~~ml~~

~~(d) Units with two or more meanings. When the term "ounce" is employed in a declaration of liquid quantity, the declaration shall identify the particular meaning of the term by the use of the term "fluid"; however, such distinction may be omitted when, by association of terms (for example, as in "1 pint 4 ounces"), the proper meaning is obvious. Whenever the declaration of quantity is in terms of the dry pint or dry quart, the declaration shall include the word "dry".~~

~~(e) Prescribed units.~~

~~(i) Less than one foot, one square foot, one pound, or one pint. The declaration of quantity shall be expressed in the case of length measure of less than one foot, inches and fractions of inches; in the case of area measure of less than one square foot, square inches and fractions of square inches; in the case of weight of less than one pound, ounces and fractions of ounces; in the case of fluid measure of less than one pint, ounces and fractions of ounces; provided, that the quantity declaration appearing on a random package may be expressed in terms of decimal fractions of the largest appropriate unit, the fraction being carried out to not more then two decimal places.~~

~~(ii) Four feet, four square feet, four pounds, one gallon, or more. In the case of length measure of four feet or more, the declaration of quantity shall be expressed in terms of feet followed in parentheses by a declaration of yards with any remainder in terms of feet and inches. In the case of area measure of four square feet or more; weight of four pounds or more; fluid measure of one gallon or more; the declaration of quantity shall be expressed in terms of the largest whole unit.~~

~~(iii) Weight; dual quantity declaration. On packages containing one pound or more but less than four pounds, the declaration shall be expressed in ounces and, in addition, shall be followed by declaration in parentheses, expressed in terms of the largest whole unit: Provided, That the quantity declaration appearing on a random package may be expressed in terms of pounds and decimal fractions of the pound carried out to not more than two decimal places.~~

~~(iv) Fluid measure; dual quantity declaration. On packages containing one pint or more but less than one gallon, the declaration shall be expressed in ounces and, in addition, shall be followed by a declaration in parentheses, expressed in terms of the largest whole unit.~~

~~(vii) Bidimensional commodities. For bidimensional commodities (including roll type commodities) the quantity declaration shall be express, if less than one square foot, in terms of linear inches and fractions of linear inches; if at least one square foot but less than four square feet, in terms of square inches followed in parentheses by a declaration of both the length and width, each being in terms of the largest whole unit; provided, that no square inch declaration is required for a bidimensional commodity of four inches width or less, and that, a dimension of less than two feet may be stated in inches within the parenthetical, and that, commodities consisting of usable individual units (except roll type commodities with individual usable units created by~~

~~perforations, for which see Subsection (c) (viii), count: ply) require a declaration of unit area but not a declaration of total area of all such units. Four square feet or more, in terms of square feet followed in parentheses by a declaration of the length and width in terms of the largest whole unit: provided, that no declaration in square feet is required for a bidimensional commodity with a width of four inches or less, and that, bidimensional commodities, with a width of 4 inches or less, shall have the length expressed in inches followed by a statement in parentheses of the length in the largest whole unit. (Example: 2 inches by 360 inches (10 yards)), and that, no declaration in square feet is required for commodities for which the length and width measurements are critical in terms of end use (such as tablecloths or bedsheets) if such commodities clearly present the length and width measurements of the label.~~

~~(viii) Count: ply. If the commodity is in individually usable units of one or more components or ply, the quantity declaration shall, in addition to complying with other applicable quantity declaration requirements of this regulation, include the number of ply and the total number of usable units. Roll type commodities, when perforated so as to identify individual usable units, shall not be deemed to be made up of usable units; however, such roll type commodities shall be labeled in terms of, total area measurement, number of ply, count of usable units, and dimensions of a single usable unit.~~

~~(f) Fractions. A statement of net quantity of contents of any consumer commodity may contain common or decimal fractions. A common fraction shall be in terms of halves, quarters, eighths, sixteenths, or thirty seconds, reduced to its lowest terms; a decimal fraction shall not be carried out to more than two places, except that:~~

~~(i) if there exists a firmly established general consumer usage and trade custom of employing different common fractions in the net quantity declaration of a particular commodity, they may be employed; and~~

~~(ii) if linear measurements are required in terms of yards or feet, common fractions may be in terms of thirds.~~

~~(g) Supplementary declarations.~~

~~(i) Supplementary quantity declarations. The required quantity declaration may be supplemented by one or more declarations of weight, measure, or count, such declaration appearing other than on a principal display panel. Such supplemental statement of quantity of contents shall not include any terms qualifying a unit of weight, measure, or count that tends to exaggerate the amount of commodity contained in the package (e.g., "giant" quarter, "full" gallon, "when packed", "minimum", or words of similar import).~~

~~(ii) Metric system declarations. A separate statement of the net quantity of contents in terms of the metric system is not regarded as a supplemental statement, and a statement of quantity in terms of the metric system of weight or measure may also appear on the principal display panel or on other panels.~~

~~(h) Qualification of declaration prohibited. In no case shall any declaration of quantity be qualified by the addition of the words "when packed", "minimum", or "not less than", or any words of similar import, nor shall any unit of weight, measure, or count be qualified by any term (such as "jumbo", "giant", "full", or the like) that tends to exaggerate the amount of commodity.~~

~~(7) Declaration of quantity: nonconsumer packages~~

~~(a) Location. A nonconsumer package shall bear on the outside a declaration of the net quantity of contents. Such declaration shall be in terms of the largest whole unit (see subsection (6) (a) largest whole unit).~~

~~(b) Terms: weight, liquid measure, or count. The declaration of the quantity of a particular commodity shall be expressed in terms of liquid measure if the commodity is liquid or in terms of weight if the commodity is solid, semisolid, viscous, or a mixture of solid and liquid, or in terms of numerical count. However, if there exists a firmly established general consumer usage and trade custom with respect to the terms used in expressing a declaration of quantity of a particular commodity, such declaration of quantity may be expressed in the traditional terms, if such traditional declaration gives accurate and adequate information as to the quantity of the commodity.~~

~~(c) Units: weight, measure. Nothing in this subsection shall prohibit the labeling of nonconsumer packages in terms of units of the metric system. A declaration of quantity in units of weight shall be in terms of the avoirdupois pound or ounce; units of liquid measure shall be in terms of the United States gallon 231 cubic inches or liquid quart, liquid pint, or fluid ounce subdivisions of the gallon, and shall express the volume at 68°F (20°C), except in the case of petroleum products, for which the declaration shall express the volume at 60°F (15.6°C), and except also in the case of a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 40°F (4°C); in units of linear measure shall be in terms of the yard, foot, or inch; in units f area measure, shall be in terms of the square yard, square foot, or square inch; in units of dry measure shall be in terms of the United States bushel of 2,150.42 cubic inches, or peck, dry quart and dry pint subdivisions of the bushel; in units of cubic measure shall be in terms of the cubic yard, cubic foot, or cubic inch.~~

~~(i) Abbreviations. Any generally accepted abbreviation of a unit name may be employed in the quantity statement on a package of commodity. (For commonly accepted abbreviations, see subsection (c) (i) abbreviations.)~~

~~(d) Character of declaration: average. The average quantity of contents in the packages of a particular lot, shipment, or delivery shall be least equal the declared quantity, and no unreasonable shortage in any package shall be permitted, even though overages in other packages in the same shipment, delivery, or lot compensate for such shortage.~~

~~(8) Prominence and placement: consumer packages.~~

~~(a) General. All information required to appear on a consumer package shall appear thereon in the English language and shall be prominent, definite, and plain, and shall be conspicuous as to size and style of letters and numbers and as to color of letters and numbers in contrast to color of background. Any required information that is either in hand lettering or hand script shall be entirely clear and equal to printing in legibility.~~

~~(i) Location. The declaration or declarations of quantity of the contents of a package shall appear in the bottom 30 percent of the principal display panel or panels, except as otherwise provided in subsection (10) (g).~~

~~(ii) Style of type or lettering. The declaration or declarations of quantity shall be in such a style of type or lettering as to be boldly, clearly, and conspicuously presented with respect to other type, lettering, or graphic material on the package, except that a declaration of net quantity blown, formed, or molded on a glass or plastic surface is permissible when all label information is blown, formed, or molded on the surface.~~

~~(iii) Color contrast. The declaration or declarations of quantity shall be in a color that contrasts conspicuously with its background, except that a declaration of net quantity blown, formed, or molded on a glass or plastic surface shall not be required to be presented in a contrasting color if no required label information is on the surface in a contrasting color.~~

~~(iv) Free area. The area surrounding the quantity declaration shall be free to printed information, above and below, by a space equal to at least the height of the lettering in the declaration, and to the left and right, by a space equal to twice the width of the letter "n" of the style and size of type used in the declaration.~~

~~(v) Parallel quantity declaration. The quantity declaration shall be presented in such a manner as to be generally parallel to the declaration of identity and to the base on which the package rests as it is designed to be displayed.~~

~~(b) Calculation of area of principal display panel for purposes of type size. Determination of the principal display panel shall exclude tops, bottoms, flanges at tops and bottoms of cans, and shoulders and necks of bottles or jars. The square inch area of the principal display panel shall be in the case of a rectangular container, one entire side which properly can be considered to be the principal display panel, the product of the height times the width of that side; in the case of a cylindrical or nearly cylindrical container, 40 percent of the product of the height of the container times the circumference; or in the case of any other shaped container, 40 percent of the total surface of the container, unless such container presents an obvious principal display panel (e.g., the top of a triangular or circular package of cheese, or the top of a can of shoe polish), the area shall consist of the entire such surface.~~

~~(i) Minimum height of numbers and letters. The height of any letter or number in the required quantity declaration shall be not less than that shown in Table 1 with respect to the square inch area of the panel, and the height of each number of a common fraction shall meet one half the minimum height standards.~~

~~(ii) Numbers and letters; proportion. No number or letter shall be more than three times as high as it is wide.~~

~~TABLE 1. Minimum Height of Numbers and Letters~~

Square inch area of principal display panel	Minimum height of numbers and letters	Minimum height: label information blown, formed, or molded on surface of container
5 square inches and less	1/16 inch	1/8 inch
Greater than 5 quare inches and not greater than 25 square inches.	1/8 inch	3/16 inch
Greater than 25 square inches and not greater than 100 square inches.	3/16 inch	1/4 inch
Greater than 100 square inches and not greater than 400 square inches	1/4 inch	5/16 inch
Greater than 400 square inches.	1/2 inch	9/16 inch

~~(9) Prominence and placement: nonconsumer package general. All information required to appear on a nonconsumer package shall be definitely and clearly stated thereon in the English language. Any required information that is either in hand lettering or hand script shall be entirely clear and equal to printing in legibility.~~

~~(10) Requirements: specific consumer commodities, packages, containers.~~

~~(a) Display card package. For an individual package affixed to a display card, or for a commodity and display card together comprising a package, the type size of the quantity declaration is governed by the dimensions of the display card.~~

~~(b) Eggs. When cartons containing 12 eggs have been designed so as to permit division in half by the retail purchaser, the required quantity declaration shall be so positioned as to have its context destroyed when the carton is divided.~~

~~(c) Aerosols and similar pressurized containers. The declaration of quantity on an aerosol package, and on a similar pressurized package, shall disclose the net quantity of the commodity (including propellant), in terms of weight, that will be expelled when the instructions for use as shown on the container are followed.~~

~~(d) Multi unit packages. Any package containing more than one individual "commodity in package form" (see subsection (2)a)) of the same commodity shall bear on the outside of the package a declaration of:~~

~~(i) the number of individual units;~~

~~(ii) the quantity of each individual unit; and~~

~~(iii) the total quantity of the contents of the multiunit package: provided, that the requirement for a declaration be effective (1) with respect to those labels revised after the effective date of this regulation, or (2) as of January 1, 1970, whichever occurs first. Any such declaration of total quantity shall not be required to include the parenthetical quantity statement of a dual representation.~~

~~(e) Combination packages. Any package containing individual units of dissimilar commodities (such as an antiquing kit, for example) shall bear on the label of the package a quantity declaration of each unit.~~

~~(f) Variety packages. Any package containing individual units of reasonably similar commodities (such as, for example, seasonal gift packages, variety packages of cereal) shall bear on the label of the package a declaration of the total quantity of commodity in the package.~~

~~(d) Cylindrical containers. In the case of cylindrical or nearly cylindrical containers, information required to appear on the principal display panel shall appear within that 40 percent of the circumference which is most likely to be displayed, presented, shown, or examined under customary conditions of display for retail sale.~~

~~(h) Measurement of container type commodities, how expressed.~~

~~(i) General. Commodities designed and sold at retail to be used as containers for other materials or objects, such as bags, cups, boxes, and pans, shall be labeled with the declaration of net quantity as follows: for bag type commodities, in terms of count followed by linear dimensions of the bag (whether packaged in a perforated roll or otherwise.) When the unit bag is characterized by two dimensions because of the absence of a gusset, the width and length will be expressed in inches, except that a dimension of 2 feet or more will be expressed in feet with any remainder in terms of inches or common or decimal fractions of the foot. (Example: "25 bags, 17 in x 20 in" or 100 bags, 20 in x 2 ft 6 in" or 50 bags, 20 in x 2 1/2 ft".) When the unit bag is gusseted, the dimensions will be expressed as width, depth, and length, in terms of inches, except that any dimension of 2 feet or more will be expressed in feet with any remainder in terms of inches or the common or decimal fractions of the foot (Examples: "25 bags, 17 in x 4 in x 20 in" or 100 bags, 20 in x 12 in x 2 1/2 ft".) For other square, oblong, rectangular, or similarly shaped containers, in terms of count followed by length, width, and depth, except depth need not be listed when less than 2 inches. (Example: "2 cake pans, 8 in x 8 in" or :roasting pan, 12 in x 8 in x 3 in".) For circular or other generally round shaped containers, except cups, and the like, in terms of count followed by diameter and depth, except depth need not be listed when~~

~~less than 2 inches. (Example: "4 pie pans, 8 in diameter" or "2 cake pans, 8 in diameter x 4 in".)~~

~~(ii) Capacity. When the functional use of the container is related by label references in standard terms of measure to the capability of holding a specific quantity of substance or class of substances such references shall be a part of the net quantity statement and shall specify capacity as follows: liquid measure for containers which are intended to be used for liquid, semisolids, viscous materials, or mixture of solids and liquids. The expressed capacity will be stated in terms of the largest whole unit (gallon, quart, pint, ounce), with any remainder in terms of the common or decimal fraction of that unit. (Example: freezer boxes "4 boxes, 1 qt capacity, 5 in x 4 x 3 in".) Dry measure for containers which are intended to be used for solids. The expressed capacity will be stated in terms of the largest whole unit (bushel, peck), with any remainder in terms of the common or decimal fraction of that unit. (Example: leaf bags, 8 bags, 6 bushel capacity, 3 ft x 5 ft".) Where containers are used as liners for other more permanent containers, in the same terms as are normally used to express the capacity of the more permanent container. (Example: garbage can liners, "10 liners, 2 ft 6 in x 3 ft 9 in, fits up to 30 gallon cans".) Notwithstanding the above requirements, the net quantity statement for containers such as cups will be listed in terms of count and liquid capacity per units. (Example: "24 cups, 6 fl oz capacity".) For purposes of this section, the use of the terms "capacity", "diameter", and "fluid" is optional.~~

~~(i) Textile products, threads, and yarns.~~

~~(i) Wearing apparel. Wearing apparel (including non-textile apparel and accessories such as leather goods and footwear) sold as single unit items, or if normally sold in pairs (such as hosiery, gloves, and shoes) sold as single unit pairs, shall be exempt from the requirements for a net quantity statement by count, as required by subsection (6)(b)(iii) of this regulation.~~

~~(ii) Textiles. Bedsheets, mattress covers, pillowcases, comforters, quilts, bedspreads, mattress pads, afghans, throws, dresser and other furniture scarfs, curtains, drapes, dish towels, dish cloths, towels, face cloths, utility cloths, bath mats, carpets and rugs shall be exempt from the requirements of subsection (6)(c)(vii) of this regulation: provided, that~~

~~(iii) The quantity statement for fitted sheets and mattress covers shall state, in inches, the length and width of the mattress for which the item is designed, such as "twin", "double", "king", etc. (Example: "twin fitted sheet for 39 x 75 in mattress.")~~

~~(iv) The quantity statement for flat sheets shall state the size designation of the mattress for which the sheet is designed, such as "twin", "double", "king", etc. The quantity statement also shall state, in inches, the length and width of the mattress for which the sheet is designed, followed in parentheses by a statement, in inches, of the length and width of the sheet before hemming. (Ex-~~

~~ample: "double flat sheet for 54 x 75 in mattress (81 x 104 in before hemming)."~~

~~(v) The quantity statement for pillowcases shall state the size designation of the pillow for which the pillowcase is designed, such as "youth", "standard", and "queen", etc. The quantity statement also shall state, in inches, the length and width of the pillow for which the pillowcase is designed, followed in parentheses by a statement, in inches, of the length and width of the pillowcase before hemming. (Example: "standard pillowcase for 20 x 26 in pillow (42 x 36 in before hemming)."~~

~~(vi) The quantity statement for blankets, comforters, quilts, bedspreads, mattress pads, afghans, and throws shall state, in inches, the length and width of the finished item. The quantity statement also may state the length of any ornamentation and the size designation of the mattress for which the item is designed, such as "twin", "double", "king", etc.~~

~~(vii) The quantity statement for tablecloths and napkins shall state, in inches, the length and width of the finished item. The quantity statement also may state parenthetically, in inches, the length and width of the item before hemming and properly identified as such.~~

~~(viii) The quantity statement for curtains, drapes, flags, furniture scarfs, etc. shall state, in inches, the length and width of the finished item. The quantity statement also may state parenthetically, in inches, the length of any ornamentation.~~

~~(ix) The quantity statement for carpets and rugs shall state, in feet, with any remainder in common or decimal fractions of the foot or in inches, the length and width of the item. The quantity statement also may state parenthetically, in inches, the length of any ornamentation.~~

~~(x) The quantity statement for woven dish towels, dish cloths, towels, face cloths, utility cloths, bath mats, etc. shall state, in inches, the length and width of the item. The quantity statement for such items, when knitted, need not state the dimensions.~~

~~(xi) The quantity statement for textile products such as pot holders, fixture and appliance covers, non-rectangular diapers, slip covers, etc. shall be stated in terms of count and may include size designations and dimensions.~~

~~(xii) The quantity statement for other than rectangular textile products identified in subsections (iii) through (x) shall state the geometric shape of the product and the dimensions which are customarily used in describing such geometric shape. (Example: "oval tablecloth 54 x 42 in", representing the maximum length and width in this case.)~~

~~(xiii) The quantity statement for packages of remnants of textile products of assorted sizes, when sold by county, shall be accompanied by the term "irregular dimensions" and the minimum size of such remnants.~~

~~(xiv) Textiles: variations from declared dimensions. For an item with no declared dimension less than 24 inches, a minus variation greater than 3 percent of a declared dimension and a plus variation greater than 6 percent of a~~

~~declared dimension should be considered unreasonable. For an item with a declared dimension less than 24 inches, a minus variation greater than 6 percent of a declared dimension and a plus variation greater than 12 percent of a declared dimension should be considered unreasonable.~~

~~(xv) Exemption: variety textile packages. Variety packages of textiles which are required by reason of subsection (6)(b)(iv) to provide a combination declaration stating the quantity of each individual unit, shall be exempt from the requirements in this regulation for: location (see subsection (8)(a)(i)); free area (see subsection (8)(a)(iv)); and minimum height of numbers and letters (see subsection (8)(b)(i)).~~

~~(j) Packaged seed. Packages of seeds intended for planting shall be labeled in full accord with this regulation except as follows:~~

~~(i) The quantity statement shall appear in the upper thirty percent of the principal display panel.~~

~~(ii) The quantity statements shall be in terms of the largest whole unit of the metric system for all weights up to one fourth ounce, and in the avoirdupois system for all other weights up to eight ounces; packaged seeds eight ounces or more shall not be subject to subsection (j).~~

~~(iii) The quantity statement for seed tapes, pre planters, etc., shall be in terms of count.~~

~~(vi) Subsection (j) shall apply only to labels (1) revised after the effective date of this regulation or (2) as of July 1, 1974, whichever occurs first.~~

~~(11) Exemptions.~~

~~(a) General. Whenever any consumer commodity or package of consumer commodity is exempted from the requirements for dual quantity declaration, the net quantity declaration required to appear on the package shall be in terms of the largest whole unit (except see subsection (10) (d)).~~

~~(b) Random packages. A random package bearing a label conspicuously declaring a net weight, the price per pound, and the total price, shall be exempt from the type size, dual declaration, placement, and free area requirements of this regulation. In the case of a random package packed at one place for subsequent sale at another, neither the price per unit of weight nor the total selling price need appear on the package, provided the package label includes both such prices at the time it is offered or exposed for sale at retail. This exemption shall also apply to uniform weight packages of cheese and cheese products labeled in the same manner and by the same type of equipment as random packages exempted by this section.~~

~~(c) Small confections. Individually wrapped pieces of "penny candy" and other confectionery of less than one half ounce net weight per individual piece shall be exempt from the labeling requirements of this regulation when the container in which such confectionery is shipped is in conformance with the labeling requirements of this regulation. Similarly, when such confectionery items are sold in bags or boxes, such items shall be exempt from the labeling requirements of this regulation, including the required declaration of net quantity of contents, when the declaration of the bag or box meets the requirements of this regulation.~~

~~(d) Individual servings. Individual serving size packages of foods containing less than ½ ounce of less than ½ fluid ounce for use in restaurants, institutions, and passenger carriers, and not intended for sale at retail, shall be exempt from the required declaration of net quantity of contents specified in this regulation.~~

~~(e) Cuts, plugs, and twists of tobacco and cigars. When individual cuts, plugs, and twists of tobacco and individual cigars are shipped or delivered in containers that conform to the labeling requirements of this regulation, such individual cuts, plugs, and twists of tobacco and cigars shall be exempt from such labeling requirements.~~

~~(f) Reusable (returnable) glass containers. Nothing in this regulation shall be deemed to preclude the continued use of reusable (returnable) glass containers: provided, that such glass containers ordered after the effective date of this regulation shall conform to all requirements of this regulation.~~

~~(g) Cigarettes and small cigars. Cartons of cigarettes and small cigars, containing ten individual packages of twenty, labeled in accordance with the requirements of this regulation, shall be exempt from the requirements set forth in subsection (8)(a)(i) location, subsection (8) (b) (i) minimum height of numbers and letters, and subsection (10) (d) multi unit packages: provided, that such cartons bear a declaration of the net quality of commodity in the package.~~

~~(h) Packaged commodities with labeling requirements specified in federal law. Packages of meat and meat products, poultry and poultry products, tobacco and tobacco products, insecticides, fungicides, rodenticides, and alcoholic beverages, shall be exempt from the requirements set forth in subsection (6)(e)(iii) weight: dual declaration, (6)(e)(iv) fluid measure; dual quantity declaration (6)(e)(v) length measures: dual quantity declaration, (6)(e)(vi) area measure: dual quantity declaration, (8)(a)(i) location, and subsection (8)(b)(i) minimum height of numbers and letters: provided, that quantity labeling requirements for such products are specified in federal law, so as to follow reasonably sound principles of providing consumer information.~~

~~(i) Fluid dairy products, ice cream, and similar frozen desserts.~~

~~(i) When packages in ½ liquid pint and ½ gallon containers, are exempt from the requirements and stating net contents of 8 fluid ounces and 64 fluid ounces, which may be expressed as ½ pint and ½ gallon, respectively.~~

~~(ii) When packaged in 1 liquid pint, 1 liquid quart, and ½ gallon containers, are exempt from the dual net contents declaration requirements of (6) (e) (iv).~~

~~(iii) When measured by and packaged in ½ liquid pint, 1 liquid pint, 1 liquid quart, ½ gallon, and 1 gallon measure containers are defined in "Measure Container Code of National Bureau of Standards Handbook 44", are exempt from the requirement of subsection (8) (a) (i) that the declaration of net contents be located within the bottom 30 percent of the principal display panel.~~

~~(iv) Milk and milk products when measured by and packaged in glass or plastic containers of ½ liquid pint, 1 liquid pint, 1 liquid quart, ½ gallon, and 1 gallon capacities are exempt from the placement requirement of subsection (8) (a) (i) that the declaration of net contents be located within the bottom 30 percent of the principal display panel, provided that other required label information is conspicuously displayed on the cap or outside closure, and the required net quantity of contents declaration is conspicuously blown, formed, or molded, on, or permanently applied to that part of the glass or plastic container that is at or above the shoulder of the containers.~~

~~(j) Single strength and less than single strength fruit juice beverages, imitations thereof, and drinking water.~~

~~(i) When packaged in glass, plastic, or fluid milk type paper containers of 8 and 64 fluid ounce capacity, are exempt from the requirements of subsection (6)(e), to the extent that net contents of 8 fluid ounces and 64 fluid ounces (or 2 quarts) may be expressed as ½ pint (or half pint) and ½ gallon (or half gallon), respectively.~~

~~(ii) When packaged in glass, plastic, or fluid milk type paper containers of 1 pint, 1 quart, and ½ gallon capacities, are exempt from the dual net contents declaration requirements of subsection (6)(e)(iv).~~

~~(iii) When packaged in glass or plastic containers of ½ pint, 1 pint, 1 quart, ½ gallon, and 1 gallon capacities, are exempt from the placement requirement of subsection (8) (a) (i) that the declaration of net contents be located within the bottom 30 percent of the principal display panel: provided, that other required label information is conspicuously displayed on the cap or outside closure and the required net quantity of contents declaration is conspicuously blown, formed, or molded into or permanently applied to that part of the glass or plastic container that is at or above the shoulder of the container.~~

~~(k) Soft drink bottles. Bottles of soft drinks shall be exempt from the placement requirements for the declaration of:~~

~~(i) identity, when such declaration appears on the bottle closure, and~~

~~(ii) quantity, when such declaration is blown, formed, or molded on or above the shoulder of the container and when all other information required by this regulation appears only on the bottle closure.~~

~~(l) Multi unit soft drink packages. Multi unit packages of soft drinks are exempt from the requirement for a declaration of:~~

~~(i) responsibility, when such declaration appears on the individual units and is not obscured by the multi unit packaging, or when the outside container bears a statement to the effect that such declaration will be found on the individual units inside; and~~

~~(ii) identity, when such declaration appears on the individual units and is not obscured by the multi unit packaging.~~

~~(m) Butter. When packaged in 4 ounce, 8 ounce, and 1 pound units with continuous label copy wrapping, butter is~~

~~exempt from the requirements that the statement of identity (subsection (3)(a)) and the net quantity declaration (subsection (8)(a)(v)) be generally parallel to the base of the package. When packaged in 8 ounce and 1 pound units, butter is exempt from the requirement for location (subsection (8)(a)(i)) of net quantity declaration and, when packaged in 1 pound units, is exempt from the requirement for dual quantity declaration (subsection (6)(e)(iii)).~~

~~(n) Eggs. Cartons containing 12 eggs shall be exempt from the requirement for location (subsection (8)(a)(i)) of net quantity declaration. When such cartons are designed to permit division in half, each half shall be exempt from the labeling requirements of this regulation if the undivided carton conforms to all such requirements.~~

~~(o) Flour. Packages of wheat flour packaged in units of 2, 5, 10, 25, 50, and 100 pounds shall be exempt from the requirement in this regulation for location (subsection (8)(a)(i)) of the net quantity declaration and, when packaged in units of 2 pounds, shall be exempt also from the requirement for a dual quantity declaration (subsection (6)(e)(iii)).~~

~~(p) Exemption: location: small package. On a principal display panel of five square inches or less, the declaration of quantity need not appear in the bottom 30 percent of the principal display panel if that declaration satisfies the other requirements of this regulation.~~

~~(q) Exemption: decorative container. The principal display panel of a cosmetic marketed in a "boudoir type" container including decorative cosmetic containers of the "cartridge", "pill box", "compact", or "pencil" variety, and those with a capacity of one fourth ounce or less, may be a tear away tag or tape affixed to the decorative container and bearing the mandatory label information as required by this regulation.~~

~~(r) Exemption: combination packages. Combination packages are exempt from the requirements in this regulation for:~~

~~(i) location (see subsection (8)(a)(i));~~

~~(ii) free area (see subsection (8)(a)(iv));~~

~~(iii) minimum height of numbers and letters (see subsection (8)(b)(i)).~~

~~(s) Margarine. Margarine in 1 pound rectangular packages, except for packages containing whipped or soft margarine or packages containing more than four sticks, shall be exempt from the requirement in this regulation for location (see subsection (8)(a)(i)) of the net quantity declaration, and shall be exempt from the requirement for a dual quantity declaration (see subsection (6)(e)(iii)).~~

~~(t) Corn flour. Corn flour packaged in conventional 5, 10, 25, 50, and 100 pound bags shall be exempt from the requirement in this regulation for location (see subsection (8)(a)(i)) of the net quantity declaration.~~

~~(u) Prescription and insulin containing drugs. Prescription and insulin containing drugs subject to the provisions of section 503(b)(1) or 506 of the Federal Food, Drug, and Cosmetic Act shall be exempt from the provisions of this regulation.~~

~~(v) Camera film. Camera film packaged and labeled for retail sale is exempt from the net quantity statement requirement of this regulation which specify how measurement of commodities should be expressed: provided, that~~

~~(i) the net quantity of contents on packages of movie film and bulk still film is expressed in terms of the number of lineal feet of usable film contained therein.~~

~~(ii) the net quantity of contents on packages of still film is expressed in terms of the number of exposures the contents will provide. The length and width measurements of the individual exposures, expressed in millimeters or inches, are authorized as an optional statement. (Example: "36 exposures, 36 x 24 mm" or "12 exposures, 2 1/4 x 2 1/4 in".).~~

~~(w) Paints and kindred products.~~

~~(i) Paints, varnishes, lacquers, thinners, removers, oils, resins, and solvents when packed in one liquid pint and one liquid quart units shall be exempt from dual quantity declaration requirements of subsection (6)(e)(iv)).~~

~~(ii) Tint base paint may be labeled on the principal display panel, as required by this regulation, in terms of a quart or a gallon including the addition of colorant selected by the purchaser, provided that the system employed ensures that the purchaser always obtains a full whole measure; and further provided that in conjunction with the required quantity statement on the principal display panel, a statement indicating that the tint base paint is not to be sold without the addition of colorant is presented; and further provided that the contents of the container, before the addition of colorant, is stated in fluid ounces elsewhere on the label.~~

~~(x) Automotive cooling system antifreeze. Antifreeze, when packed in 1 liquid quart units, in metal or plastic containers, shall be exempt from the dual quantity declaration requirements of subsection (6)(e)(iv).~~

~~(y) Motor oils. motor oils, when packed in 1 liquid quart units, shall be exempt from the dual quantity declaration requirements of subsection (6)(e)(iv). Additionally, motor oil in 1 liquid quart, 1 gallon, 1 1/4 gallon, 2 gallon, and 2 ½ gallon units, bearing the principal display panel on the body of the container, is exempt from the requirements of section (3), identity, to the extent that the SAE grade is required to appear on the principal display panel, provided the SAE grade appears on the can lid and is expressed in letters and numerals in type size of at least one fourth inch.~~

~~(12) Bread - metric sizing~~

~~(a) Each loaf of bread and each unit of a twin or multiple loaf of bread produced or procured for sale, kept, offered or exposed for sale, or sold, whether or not the bread is wrapped or sliced, if not weighing in accordance with Section 30-12-402, MCA, shall weigh 1/4 kg (250)mg, ½ kg (500 mg), 3/4 kg (750), 1 kg (1000 mg) or multiples of ½ kg (500 mg). This rule shall not apply to biscuits, buns or rolls weighing 1/4 kg or less or to "state bread" sold and expressly represented at the time of sale as such.~~

~~(13) Variations to be allowed.~~

~~(a) Packaging variations.~~

~~(i) Variations from declared net quantity. Variations from the declared net weight, measure, or count shall be permitted when caused by unavoidable deviations in weighing, measuring, or counting the contents of individual packages that occur in good packaging practice, but such variations shall not be permitted to such extent that the average of the quantities in the packages of a particular commodity or a lot of the commodity that is kept, offered, or exposed for sale, or sold, is below the quantity stated, and no unreasonable shortage in any package shall be permitted, even though overages in other packages in the same shipment, delivery, or lot compensate for such shortage. Variations above the declared quantity shall not be unreasonably large.~~

~~(ii) Variations resulting from exposure. Variations from the declared weight or measure shall be permitted when caused by ordinary and customary exposure to conditions that normally occur in good distribution practice and that unavoidably result in change of weight or measure, but only after the commodity is introduced into intrastate commerce; provided, that the phrase "introduced into intrastate commerce" as used in this paragraph shall be construed to define the time and the place at which the first sale and delivery of a package is made within the state, the delivery being either directly to the purchaser or to his agent, or to a common carrier for shipment to the purchaser, and this shall be construed as requiring that, so long as a shipment, delivery, or lot of packages of a particular commodity remains in the possession or under the control of the packager or the person who introduces the package into intrastate commerce, exposure variations shall not be permitted.~~

~~(b) Magnitude of permitted variations. The magnitude of variations permitted under subsections (12), (12)(a), (12)(a)(i), and (12)(a)(ii) of this regulation shall, in the case of any shipment, delivery, or lot, be determined by the facts in the individual case.~~

(1) The bureau of weights and measures with the advice and counsel of the national institute of standards and technology hereby adopts the regulations to provide accurate and adequate information on packages as to the identity and quantity of contents so that purchasers can make price and quantity comparison. The regulations are published in the National Institute of Standards and Technology Handbook 130, Part IV, A. Uniform Packaging and Labeling Regulation, B. Uniform Regulation for the Method of Sale of Commodities, C. Uniform Unit Pricing Regulation, 1995 Edition and supplements thereto, or in any publication revising or superseding this edition of Handbook 130. A copy of Handbook 130 can be obtained from the United States Department of Commerce, National Institute of Standards and Technology, National Conference of Weights and Measures, Gaithersburg, Maryland 20899-0001.

~~(14)~~ (2) ~~Revocation of conflicting regulations.~~ All provisions of all orders and regulations heretofore issued on this same subject that are contrary to or inconsistent with the provisions of this regulation, are hereby revoked."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: This amendment is being proposed to formalize requirements, which up to now, have been used as guidelines without formal adoption and to adopt by reference requirements that were previously reprinted in the actual rule from the official document.

"8.77.203 RANDOM INSPECTION OF PACKAGES (1) will remain the same.

(2) The state is divided into ~~six (6)~~ seven inspection regions and it is anticipated that each inspection region will complete approximately 800 random package inspections per year in random areas throughout the inspection region.

(3) will remain the same."

Auth: Sec. 30-12-202, 30-12-207, MCA; IMP, Sec. 30-12-207, MCA

REASON: The Weights and Measures Bureau was reorganized and instead of a roving inspector, the state was divided into 7 regions.

"8.77.302 ~~STANDARDS FOR PETROLEUM PRODUCTS~~ NIST HANDBOOK 130 - UNIFORM LAWS AND REGULATIONS (1) ~~The standards for petroleum products sold in this state shall be as specified in tables 1 through 5 below pages 8-2237 through 8-2240.~~ The weights and measures bureau with the advice and counsel of the national institute of standards and technology hereby adopts the regulations concerning fuel specifications and gasoline-oxygenate blends. The regulations are published in the National Institute of Standards and Technology Handbook 130 Part IV, G. Uniform Regulation of Engine Fuels, Petroleum Products, and Automotive Lubricants, 1996 Edition and supplements thereto, or in any publication revising or superseding this edition of Handbook 130. A copy of Handbook 130 can be obtained from the United States Department of Commerce, National Institute of Standards and Technology, National Conference of Weights and Measures, Gaithersburg, Maryland 20899-0001."

Auth: Sec. 82-15-102, IMP, Sec. 82-15-103, MCA

REASON: This amendment is being proposed because the National Institute of Standards of Technology has adopted the Annual Book of ASTM Standards as a national standard for petroleum products. Montana's standards for petroleum products have been obsolete for years.

3. The Bureau is proposing the repeal of ARM 8.77.202, the text of which is located at page 8-2236, Administrative Rules of Montana. The authority section is 30-12-105, MCA, and the implementing section is 30-12-202, MCA. The reason for the proposed repeal is the
proposed adoption of the National Institute of Standards and Technology Handbook 130, Part IV, B, Uniform Regulation for the Method of Sale of Commodities, 1995 Edition addresses the concern adequately.

4. Interested persons may submit their data, views or arguments concerning the proposed amendments and repeal in writing to the Weights and Measures Bureau, 1520 E. Sixth

Avenue, Room 50, P.O. Box 200512, Helena, Montana 59620-0512, to be received no later than 5:00 p.m., October 26, 1995.

5. If a person who is directly affected by the proposed amendments and repeal 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 Weights and Measures Bureau, 1520 E. Sixth Avenue, Room 50, P.O. Box 200512, Helena, Montana 59620-0512, to be received no later than 5:00 p.m., October 26, 1995.

6. If the Bureau receives requests for a public hearing on the proposed amendments and repeal from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments and repeal, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 150 based on the 1500 licensees in Montana.

WEIGHTS AND MEASURES BUREAU
JACK KANE, BUREAU CHIEF

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

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

BEFORE THE FISH, WILDLIFE AND PARKS COMMISSION
AND THE DEPARTMENT OF FISH, WILDLIFE AND PARKS
OF THE STATE OF MONTANA

In the matter of the proposed adoption of Rules I through XII concerning the future fisheries program, and amendment of Rule 12.2.454 pertaining to categorical exclusions.	))))))	NOTICE OF PROPOSED ADOPTION OF RULES AND AMENDMENT OF 12.2.454 NO PUBLIC HEARING CONTEMPLATED

TO: All interested persons.

1. On November 9, 1995, the Montana Fish, Wildlife and Parks Commission (commission) and Montana Department of Fish, Wildlife and Parks (department) propose to adopt rules to implement the future fisheries improvement program established by the legislature in 87-1-272, MCA (chapter 463, L. 1995, house bill 349). The commission and department also propose to amend ARM 12.2.454 to clarify the actions that qualify for a categorical exclusion under the Montana Environmental Policy Act.

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

RULE I PURPOSE (1) The purpose of these rules is to adopt procedures to implement the future fisheries improvement program established in 87-1-272, MCA. The purpose of the program is to restore essential habitats for the growth and propagation of wild fish populations in lakes, rivers, and streams through voluntary means. Funds may be used for long-term enhancement of streams and stream banks, instream flows, water leasing, lease or purchase of stored water or other voluntary programs to enhance wild fish and their habitats.
AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE II DEFINITIONS As used in these rules, the following definitions apply: (1) "Commission" means the fish, wildlife and parks commission.

(2) "Department" means the department of fish, wildlife and parks.

(3) "Native fish" means fish species that were present in a given water body prior to the influence of European man.

(4) "Program" means the future fisheries improvement program provided for in 87-1-272, MCA, and as implemented in these rules.

(5) "Restoration" means to restore to a natural or near natural condition.

(6) "Review panel" means the future fisheries improvement review panel.

(7) "Wild fish" means fish populations that sustain themselves through natural reproduction in lakes, reservoirs, rivers, or streams.
AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE III ELIGIBLE PERSONS (1) Participants eligible for program funding include private landowners; private, city, county, state, tribal, and federal organizations and all of their agencies or subdivisions; and land occupiers as defined by the Conservation District Act.
AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE IV PROJECT (1) Program funding may be provided for costs of design, planning, administration, construction, maintenance, and monitoring of projects which will restore or enhance fish habitat. Preference will be given to projects that restore habitat for native fishes. Projects must eliminate or significantly reduce the cause of the habitat degradation rather than dealing with symptoms. Potential projects must accomplish one or more of the following:

(a) improve fish passage;

(b) restore naturally functioning stream channel or stream banks;

(c) restore naturally functioning riparian areas;

(d) prevent loss of fish into irrigation diversions;

(e) restore essential habitats for spawning, rearing, over wintering, or avoidance of predators;

(f) improve stream flow in a dewatered reach to improve fisheries;

(g) protect genetically pure native fish populations;

(h) improve wild fish populations in a lake or reservoir.
AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE V PROJECT APPLICATION (1) An application for program funding must be submitted on forms supplied by the department. One copy of the completed application must be submitted to the fisheries division at the department headquarters located in Helena. A copy of the application must also be sent to the regional fisheries manager in the region where the project is located.

(2) Plans, technical designs, detailed sketches, maps, evidence of landowner consent, public support, and other information necessary to evaluate the merits of the project must accompany the application. Applications without adequate information will be returned to the applicant with a description of the information needed to make the application complete.

(3) Applications will be reviewed twice each year and must be received by February 1 and August 1 of each year to be considered for the subsequent funding period.

(4) Applicants proposing more than one project must submit a separate application for each proposal.

(5) Applicants proposing projects on lands other than their own must include written consent of the landowner and any lessee for the project, including an agreement for any maintenance and evaluation activities that may be necessary.
AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE VI PROJECT ELIGIBILITY (1) Project applications will be screened for eligibility by the review panel in February and

August of each year. To be eligible the applicant must demonstrate that the project will:

(a) accomplish one or more of the objectives listed in RULE IV;

(b) be conducted with approval of the landowner on whose property the project is being completed;

(c) not interfere with water or property rights of adjacent landowners;

(d) other appropriate criteria as determined by the review panel.

(2) A list of eligible projects will be sent to the department for scoring and ranking before March 1 and September 1 of each year.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE VII PROJECT RANKING AND APPROVAL (1) Eligible projects will be reviewed, evaluated and ranked by a committee that includes at least three department personnel with a background in fishery biology and an understanding of the habitat requirements of fish.

(2) The department will submit a list of recommended projects to the commission for consideration at public hearings conducted as part of regularly scheduled commission meetings. The commission will grant final approval for project funding.

(3) The department and the commission will use the following criteria to evaluate projects:

(a) the degree to which the project optimizes benefits to public fisheries;

(b) the degree to which the project promotes benefits to other river resources such as water quality, wildlife habitat, recreational opportunity, and aesthetics;

(c) the importance of the river or stream (determined from the Montana interagency database -- a ranking of the habitat and species value of stream reaches);

(d) the level of public support for the project;

(e) the long-term effectiveness of the restoration;

(f) the level of in-kind services or cost-sharing from other sources;

(g) expected benefits relative to cost.

(4) All applicants will receive written notification of action taken on their project's proposal after the commission has made a final decision.

(5) Projects will be approved for funding only if account money is available as requested to complete the projects. Each approved project sponsor must enter into a written agreement with the department on a form prepared by the department.

(6) Projects do not require cost-sharing, but cost-sharing is an important factor in project scoring and ranking. The project applicant's share may consist of in-kind services, other funding sources or both.

(7) When deemed necessary, the department will solicit outside technical design review of projects.

(8) No project completed under this program may restrict or interfere with any water rights or property rights of landowners

adjacent to projects.

(9) Completion of a project on private property does not guarantee pubic access to the site, but public access is considered in evaluating benefits to public fisheries and may be an important factor in project scoring and ranking.

(10) Funds from this account may not be used to acquire any interest in land.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE VIII PERMITS (1) The project applicant is responsible for obtaining all necessary permits required to complete the project. Permits must be obtained prior to project initiation to qualify for payment of funds.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE IX INSPECTION AND PAYMENT BY DEPARTMENT (1) Funds granted from the account shall be used only for purposes described in the final project agreement. Accurate records must be kept by the project applicant or sponsor. Itemized invoices of expenses and receipts approved by the applicant must be submitted to the department for payment.

(2) Payment may be made in installments for completed work as the project progresses. Upon completion of a project, a final inspection and payment will be made within 45 days by the department. If the department determines after inspection that the project is not complete, final payment shall be withheld pending completion and reinspection.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE X PROJECT MAINTENANCE (1) Projects funded under the program such as fences, bridges, fish screens, or other channel restoration measures will become the property of the landowner. Fish habitat improvement projects such as spawning channel development, fish barrier removal, fish screens, and riparian enhancements must be maintained for the useful life of the project by the applicant.

(2) Projects with demonstrated benefits to public fisheries and conservation of rivers may be eligible for maintenance funding under this program. The application procedure and review and approval processes for maintenance projects are the same as for new projects.

(3) Additional funding may be available to complete a project if a natural catastrophic event damages or destroys the project. Requests for additional funding will be evaluated by the review panel, department, and commission.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE XI PROJECT MONITORING (1) Restoration projects shall be evaluated by either the applicant or the department according to terms stipulated in the project agreement. Monitoring will be conducted on each completed project. The type and frequency of monitoring will be established by the department.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

RULE XII EFFECT OF RULE VIOLATIONS (1) Any person or organization falsifying financial statements or using program funds for purposes other than the intended project will be disqualified from further participation in the program and will be required to reimburse the department for any compensation received.

AUTH: 87-1-201, 87-1-301, MCA; IMP: 87-1-272, 87-1-273, MCA

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

12.2.454 ACTIONS THAT QUALIFY FOR A CATEGORICAL EXCLUSION (1) The following types of actions do not individually, collectively, or cumulatively require the preparation of an environmental assessment or an environmental impact statement unless the action involves one or more of the extraordinary circumstances stated in (2) below:

(a) through (f) remain the same.

(g) inventory, survey or engineering activities for design or development of plans for river restoration and future fisheries improvement program projects;

(h) maintenance or repair of existing river restoration and future fisheries improvement program projects~~.~~;

(i) procurement of a water lease or purchase of stored water;

(j) improvement in fish habitat in lakes or reservoirs that do not pose a hazard to navigation.

(2) Remains the same.

AUTH: 2-3-103, 2-4-201, MCA; IMP: 2-3-104, 75-1-201, MCA

4. Rationale: The Montana legislature enacted the future fisheries improvement program in 87-1-272, MCA (chapter 463, L. 1995). These rules are needed to implement the program by providing procedures for processing applications for funding of fisheries habitat enhancement projects. ARM 12.2.454 must also be amended to clarify that the categorical exclusions from the Montana Environmental Policy Act review provided in that rule will also apply to certain projects funded under the future fisheries improvement program.

5. Interested parties may submit their data, views, or arguments concerning the proposed rules in writing to Glenn Phillips, Fisheries Division, Montana Department of Fish, Wildlife and Parks, P.O. Box 200701, Helena, Montana 59620-0701, no later than October 31, 1995.

6. If a person who is directly affected by the proposed adoption or amendment wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Glenn Phillips, Fisheries Division, Montana Department of Fish, Wildlife and Parks, P.O. Box 200701, Helena, Montana 59620-0701, no later than October 31, 1995.

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

committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be in excess of 25 based on the potential number of landowners and fisherman in Montana.

FISH, WILDLIFE AND PARKS COMMISSION AND MONTANA DEPARTMENT OF FISH, WILDLIFE AND PARKS

Robert N. Lane
Reviewer

Patrick J. Graham, Commission Secretary and Department Director

Certified to the Secretary of State on September 18, 1995.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the adoption of new rule I regarding temporary water standards for Daisy Creek, Stillwater River, Fisher Creek, and the Clark's Fork of the Yellowstone River.	)))))	NOTICE OF CANCELLATION OF PUBLIC HEARING FOR PROPOSED ADOPTION OF NEW RULE

(Water Quality)

To: All Interested Persons

1. On August 24, 1995, the board filed notice of public hearing for the proposed adoption of the above captioned rule in the 1995 Montana Administrative Register, Issue No. 16.

2. The public hearing, scheduled for October 6, 1995, regarding Crown Butte Mines, Inc., (CBMI) proposal for the adoption of temporary water quality standards, has been canceled. During the Board's October 6, 1995, meeting, the board will set a new date extending the time for receiving oral and written comment and a new date for a public hearing, notice of which will be published in the Montana Administrative Register.

BOARD OF ENVIRONMENTAL REVIEW

JOHN F. NORTH
Rule Reviewer

CINDY E. YOUNKIN, Chairperson

Certified to the Secretary of State September 18, 1995.

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

In the Matter of the Amendment, Transfer and Adoption of Rules Pertaining to Training and Certification of Non-Sworn Officers and Coroners	NOTICE OF PROPOSED AMENDMENT, TRANSFER AND ADOPTION OF RULES NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On November 1, 1995, the Board of Crime Control proposes to:

(1) transfer and amend the following rules:

ARM 23.14.425 to 23.14.500;
ARM 23.14.501 to 23.14.506; and
ARM 23.14.502 to 23.14.507.

(2) transfer the following rules:

ARM 23.14.423 to 23.14.521;
ARM 23.14.424 to 23.14.522;
ARM 23.14.508 to 23.14.551; and
ARM 23.14.509 to 23.14.552.

(3) adopt rules I through XIV.

These changes are being proposed in order to establish training and certification standards for public safety communications officers, detention officers, and juvenile probation officers, as well as to establish standards for coroner education. In addition, the rules are being rearranged into what is hoped will be a more logical sequence.

2. The rules proposed to be transferred and amended are as follows (titles are already underlined; new material is underlined as well; material to be deleted is interlined):

23.14.~~425~~500 REFERENCED ADMINISTRATIVE RULES OF MONTANA APPLY TO ~~FULL TIME AND PART TIME DETENTION~~ NON-SWORN OFFICERS (1) ~~By reference~~ Unless a particular rule states otherwise, the following Administrative Rules of Montana are adopted by reference and apply to ~~detention officer~~ all non-sworn officer certification and training covered in this subchapter:

(a) through (e) remain the same.

(2) remains the same.

AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA

23.14.~~501~~506 MINIMUM STANDARDS FOR THE EMPLOYMENT OF PUBLIC SAFETY COMMUNICATIONS OFFICER (1) Any person employed in the state of Montana as a public safety communications officer after the effective date of this rule~~,~~ must:

(a) meet or exceed the minimum standards set forth in 7-31-202, MCA~~.~~; and

(b) meet or exceed the training requirements of the Montana Board of Crime Control, which the public safety communication officer's employer has adopted pursuant to 7-31-203, MCA.

(2) The term "public safety communications officer" (PSCO) is defined in 7-31-201, MCA.

AUTH: Sec. 7-31-202, MCA IMP: Sec. 7-31-203, MCA.

23.14.~~502~~507 REQUIREMENTS FOR PUBLIC SAFETY COMMUNICATIONS OFFICER BASIC CERTIFICATI~~ON~~E (1) ~~Communications officers must meet or exceed the minimum employment standards established for such officers.~~ To be awarded the public safety communications officer basic certificate, a person:

(~~1~~a) ~~Communications officers~~ shall have successfully completed a forty (40) hour public safety communications officers basic course as provided by MLEA or equivalent training as determined by the POST advisory council~~.~~; and

(~~3~~b) ~~Communications officers~~ shall have served at least six months with the present employment agency and shall be satisfactorily performing his/her duties as attested to by the head of that agency.

(~~4~~2) Communications officers who have successfully met the minimum employment standards and who have successfully completed a forty (40) or eighty (80) hour public safety communicators basic training course at MLEA from November 1984 through November 1991 are eligible for their basic certificate.

(~~5~~3) A communications officer who has successfully met the employment standards and qualifications and the educational requirements of this ~~section~~rule and who has completed a six month term of employment shall, upon application to the POST advisory council, be issued a basic certificate by the council certifying that the communications officer has met all the basic qualifying public safety communications officer standards of this state.

AUTH: Sec. 7-31-203, MCA IMP: Sec. 7-31-203, MCA

3. The rules proposed to be transferred are as follows:

ARM 23.14.423 will become ARM 23.14.521, it is currently on ARM p. 23-430; AUTH: 44-4-301, MCA; IMP: 7-32-303 & 44-4-301, MCA;

ARM 23.14.424 will become ARM 23.14.522, it is currently on ARM p. 23-435; AUTH: 44-4-301, MCA; IMP: 44-4-301, MCA;

ARM 23.14.508 will become ARM 23.14.551, it is currently on ARM p. 23-442; AUTH: 44-4-301, MCA; IMP: 46-23-1003, MCA;

ARM 23.14.509 will become ARM 23.14.552, it is currently on ARM p. 23-442; AUTH: 44-4-301, MCA; IMP: 46-3-1003, MCA.

4. Proposed new rules I through IV pertain to public safety communications officers, Rules V through IX pertain to detention officers, Rules X through XII pertain to juvenile probation officers, and Rules XIII and XIV pertain to coroner education. The proposed rules are as follows:

RULE I NOTICE OF APPOINTMENT OR TERMINATION OF NON-SWORN OFFICERS (1) Within ten (10) days of the appointment, termination, resignation, or death of any non-sworn officer in this sub-chapter, written notice thereof must be given to the board of crime control by the employing authority.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE II REQUIREMENTS FOR THE PUBLIC SAFETY COMMUNICATIONS OFFICER INTERMEDIATE CERTIFICATE (1) To be awarded the public safety communications officer intermediate certificate, a person must:

(a) meet the qualifications for appointment as a PSCO set forth in statute and possess the PSCO basic certificate or equivalent;

(b) have served at least one year with his or her employing agency, have completed the probationary period prescribed by that agency, and be satisfactorily performing his or her duties as attested to by the head of the employing public safety communications agency; and

(c) possess one of the following combinations of education, experience and training points:

(i) 4 years experience and 4 training points; or

(ii) 5 years experience, 3 training points, and a CJIN certificate; or

(iii)4 years experience, 2 training points, and an associate degree; or

(iv) 3 years experience, 2 training points, and a baccalaureate degree.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 7-31-203, MCA

RULE III REQUIREMENTS FOR THE PUBLIC SAFETY COMMUNICATIONS OFFICER ADVANCED CERTIFICATE (1) To be awarded the PSCO advanced certificate, a person must:

(a) possess the PSCO intermediate certificate;

(b) have completed a minimum of 40 hours of professional development courses such as, hazardous materials, EMD, stress management, management of critical incident, incident command system, and a legal aspect course that are recognized by the POST advisory council;

(c) have completed at least 8 years service with a public safety communications agency except with holders of college degrees; and

(d) have acquired the following points related to combinations of education, training and experience:

(i) eight years experience and 4 training points; or

(ii) ten years experience and 3 training points; or

(iii) eight years experience, 2 training points, and an associate degree; or

(iv) six years experience, 2 training points, and a baccalaureate or masters degree.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 7-31-203, MCA

RULE IV REQUIREMENTS FOR THE PUBLIC SAFETY COMMUNICATIONS OFFICER SUPERVISORY CERTIFICATE (1) To be awarded the PSCO supervisory certificate, a person must:

(a) possess the PSCO intermediate certificate;

(b) have successfully completed the supervisory course at MLEA or the equivalency as designated by the POST advisory council (minimum first line supervisor-type course); and

(c) currently and for one year prior to the date of application have served satisfactorily as a first-level supervisor as attested to by the head of the employing agency.

(2) public safety communication officers with out-of-state experience and training at the supervisory level who are employed at that level by public safety communications agencies are eligible for the PSCO supervisory certificate if:

(a) they currently and for one year prior to the date of application have served satisfactorily at the supervisory level as attested to by the head of the employing agency;

(b) the council determines their training to be equivalent to the supervisory course, and the officer successfully completes an equivalency test which has been approved by the council and administered by MLEA. Successful passage of the equivalency test means achieving a cumulative score of 75% or more. The council will require those who fail the equivalency test to successfully complete the supervisory course at MLEA; and

(c) successfully complete the legal training school at MLEA.

(3) A first-level supervisor is a position above the operational level for which commensurate pay is authorized; it is occupied by an officer who, in the upward chain of command, principally is responsible for the direct supervision of employees of an agency or is subject to assignment of such responsibilities.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 7-31-203, MCA

RULE V REQUIREMENTS FOR THE PUBLIC SAFETY COMMUNICATIONS OFFICER COMMAND CERTIFICATE (1) To be awarded the PSCO command certificate, a person must:

(a) possess the PSCO supervisory certificate;

(b) have successfully completed the command or mid-management course at MLEA or the equivalency as designated by the POST advisory council (minimum 40-hour mid-management type course); and

(c) currently and for one year prior to the date of appointment have served satisfactorily at the command or mid-management level as attested to by the head of the employing agency.

(2) Public safety communications officers with out-of-state experience and training at the command level who are employed at that level by Montana public safety communications agencies are eligible for the PSCO command certificate if they:

(a) currently and for a period of one year prior to the date of application have served satisfactorily at the command or

mid-management level as attested to by the head of the employing agency;

(b) have successfully completed a command or mid-management course recognized by the POST advisory council as equivalent to such course requirements in Montana; and

(c) have passed a POST advisory council background review. The council shall review the officer's training, education and experience to determine if the officer meets or exceeds all of the requirements for the command certificate. If so, the council will award the certificate. If not, the council shall deny the application and notify the officer what is necessary for the officer to meet the requirements.

(3) The command or mid-management level is a position above the first-level supervisor for which commensurate pay is authorized; it is occupied by an officer who, in the upward chain of command, principally is responsible for directing and coordinating functional units of an agency or is subject to assignment of such responsibilities.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 7-31-203, MCA

RULE VI REQUIREMENTS FOR THE PUBLIC SAFETY COMMUNICATIONS OFFICER ADMINISTRATIVE CERTIFICATE (1) To be awarded the PSCO administrative certificate, a person must:

(a) possess the PSCO advanced certificate;

(b) have successfully completed the administrative or management courses at MLEA or the equivalency as designated by the POST advisory council (minimum 80 hour Administrative type course); and

(c) currently and for a period of one year prior to the date of application shall have served satisfactorily at the administrative or management level of the employing agency.

(2) Public safety communications officers with out-of-state experience and training at the administrative level who are employed at that level by public safety communications agencies are eligible for the PSCO command certificate if they:

(a) currently and for a period of one year prior to the date of the application have served satisfactorily at the administrative level as attested to by the head of the employing agency, or if the applicant is the head of the employing agency, to the knowledge of the POST advisory council, is serving satisfactorily;

(b) have successfully completed an administrative course recognized by the POST advisory council as equivalent to such course requirements in Montana; and

(c) have successfully passed a POST advisory council background review. The council shall review the officer's training, education and experience to determine if the officer meets or exceeds all of the requirements for the administrative certificate. If so, the council will award the certificate. If not, the council shall deny the application and notify the officer as to what is necessary for the officer to meet the requirements.

(3) The administrative or management level is the top position for which commensurate pay is authorized, occupied by an officer who, in the upward chain of command, is either responsible for administering the agency or has broad administrative authority or is subject to assignment of such responsibilities and most commonly is a public safety communications administrator.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 7-31-203, MCA

RULE VII REQUIREMENTS FOR THE DETENTION OFFICER INTERMEDIATE CERTIFICATE (1) To be awarded the detention officer intermediate certificate, a person must:

(a) possess the detention officer basic certificate;

(b) have served at least one year with and have completed the probationary period prescribed by present employing agency, and be satisfactorily performing his or her duties as attested to by the head of the employing detention/holding facility; and

(c) possess one or more of the following combinations of education, experience, and training points:

(i) 4 years experience and 10 training points;

(ii) 5 years experience and 8 training points;

(iii) 4 years experience, 7 training points, and an associate degree; or

(iv) 3 years experience, 7 training points, and a baccalaureate degree.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE VIII REQUIREMENTS FOR THE DETENTION OFFICER ADVANCED CERTIFICATE (1) To be awarded the detention officer advanced certificate, a person must:

(a) possess the detention officer intermediate certificate;

(b) have completed a minimum of 80-hours of professional development courses such as, incident command system, first responder, suicide prevention, collection/preservation of evidence, weaponless defensive tactics, interpersonal communication, and crime scene preservation or correspondence courses through NSA, AJA, and ACA that are recognized by the POST advisory council;

(c) have completed at least 8 years service with a detention or holding facility, except holders with college degrees;

(d) possess one of the following combinations of education, experience, and training points:

(i) shall have eight years experience and 4 training points (in addition to the minimum of 80 hours);

(ii) ten years experience and 3 training points;

(iii) eight years experience, 2 additional training points, and an associate degree; or

(iv) six years experience, 2 additional training points, and a baccalaureate or masters degree.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE IX REQUIREMENTS FOR THE DETENTION OFFICER SUPERVISORY CERTIFICATE (1) To be awarded the detention officer supervisory certificate, a person must:

(a) possess the detention officer advanced certificate;

(b) have successfully completed the supervisory course at MLEA or the equivalency as designated by the POST advisory council (minimum first line supervisor type course); and

(c) currently and for one year prior to the date of application, have served satisfactorily as a first-level supervisor as attested to by the head of the employing agency.

(2) Detention officers with out-of-state experience and training at the supervisory level who are employed at that level by detention/holding facilities are eligible for the detention officer supervisory certificate if:

(a) they currently and for one year prior to the date of application have served satisfactorily at the supervisory level as attested to by the head of their employing agency; and

(b) the council determines that their training is equivalent to a supervisory course.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE X REQUIREMENTS FOR THE DETENTION OFFICER COMMAND CERTIFICATE (1) To be awarded the detention officer command certificate, a person must:

(a) possess the detention officer supervisory certificate;

(b) have successfully completed the command or mid-management course at MLEA or the equivalency as designated by the POST advisory council (minimum 40-hour mid-management type course); and

(c) currently and for one year prior to the date of appointment have served satisfactorily at the command or mid-management level as attested to by the head of the employing agency.

(2) Detention officers with out-of-state experience and training at the command level who are employed at that level by detention/holding facility are eligible for the detention officer command certificate if:

(a) they currently and for a period of one year prior to the date of application shall have served satisfactorily at the command or mid-management level as attested to by the head of the employing agency;

(b) have successfully completed a command or mid-management course recognized by the POST advisory council as equivalent to such course requirements in Montana; and

(c) have passed a POST Advisory Council background review. The council shall review the officer's training, education and experience to determine if the officer meets or exceeds all of the requirements for the command certificate. If so, the council may award the certificate. If not, the council shall deny the application and notify the officer what is necessary for the officer to meet the requirements.

(3) The command or mid-management level is a position above the first-level supervisor for which commensurate pay is

authorized, occupied by a detention officer who, in the upward chain of command, principally is responsible for directing and coordinating functional units of an agency or is subject to assignment of such responsibilities.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE XI REQUIREMENTS FOR THE DETENTION OFFICER ADMINISTRATIVE CERTIFICATE (1) To be awarded the detention officer administrative certificate, a person must:

(a) possess the advanced detention officer certificate;

(b) have successfully completed the administrative or management courses at MLEA or the equivalency as designated by the POST advisory council (minimum 80 hour administrative type course); and

(c) currently and for a period of one year prior to the date of application have served satisfactorily at the administrative or management level of the employing agency.

(2) Detention officers with out-of-state experience and training at the administrative level who are employed at that level by detention/holding facilities are eligible for the detention officer administrative certificate if they:

(a) currently and for a period of one year prior to the date of the application have served satisfactorily at the administrative level as attested to by the head of the employing agency, or if the applicant is the head of the employing agency, serving satisfactorily as to the knowledge of the POST advisory council;

(b) have successfully completed an administrative course recognized by the POST advisory council as equivalent to such course requirements in Montana; and

(c) have passed a POST Advisory Council background review. The council shall review the officer's training, education and experience to determine if the officer meets or exceeds all of the requirements for the administrative certificate. If so, the council may award the certificate. If not, the council shall deny the application and notify the officer as to what is necessary for the officer to meet the requirements.

(3) The administrative or management level is the top position for which commensurate pay is authorized, occupied by an officer who, in the upward chain of command, is either responsible for administering the agency, has broad administrative authority or is subject to assignment of such responsibilities. The officer most commonly is a detention administrator.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

RULE XII MINIMUM QUALIFICATIONS FOR JUVENILE PROBATION OFFICERS AND RECORD KEEPING (1) Any person employed in the State of Montana as a Juvenile Probation Officer, whether a Chief, an Officer, a Deputy, or a Part-Time Officer, must:

(a) meet or exceed the appropriate standards set forth in 41-5-701, 41-5-702, and 41-5-705, MCA;

(b) meet or exceed the training requirements of the Montana Board of Crime Control established pursuant to 41-5-702, MCA.

(2) The Peace Officers Standards and Training Council will maintain a record of P.O.S.T. credited hours of training for each Juvenile Probation Officer.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 41-5-705, MCA

RULE XIII REQUIREMENTS FOR THE JUVENILE PROBATION OFFICER BASIC CERTIFICATE (1) To be awarded the juvenile probation officer basic certificate, a person must:

(a) have completed a 40-hour Basic training course as provided by the Montana Law Enforcement Academy or equivalent training as determined by the Peace Officers Standards and Training Advisory Council; and

(b) have served at least one year with the present employing agency and have completed a one year probation period and be satisfactorily performing their duties as attested to by the head of that agency.

(2) A Juvenile Probation Officer who has successfully met the employment standards, qualifications and the educational requirements of this rule and who has completed a one year term of employment shall, upon application to the Peace Officers Standards and Training Advisory Council, be issued a Basic Certificate by the council certifying that the Juvenile Probation Officer has met all standards of this State.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 41-5-702, MCA

RULE XIV CORONER EDUCATION AND CONTINUED EDUCATION AND EXTENSION OF TIME LIMIT FOR CONTINUED CERTIFICATION

(1) Coroner education shall be conducted by the board of crime control as set forth in 7-4-2905, MCA.

(2) The board of crime control, through the POST council, may extend the 2 year time limit requirement for the continuation of coroner's certification, set forth in 7-4-2905, MCA, upon the written application of the coroner or the appointing authority of the deputy. The application must explain the circumstances which necessitate the extension.

(3) Factors considered in granting or denying an extension include, but are not limited to:

(a) illness of the coroner/deputy coroner or his/her immediate family member;

(b) absence of reasonable access to the coroner's advanced course; or

(c) an unreasonable shortage of personnel.

(4) The council may not grant an extension to exceed 180 days.

(5) The council will not grant extensions after the expiration of the two year time limit.

AUTH: Sec. 7-4-2905, MCA IMP: Sec. 7-4-2905, MCA

5. The amendments are proposed for the sake of consistency. New rules I through IX are proposed for adoption to increase professionalism and ensure continued education as requested by the public safety communicators association and the detention officers association. Rules X through XII are proposed to meet the requirements of HB 474 passed by the 1995 legislature. Rule XIII is proposed to meet the requirements of Sec. 7-4-2905, MCA.

6. Interested parties may submit their data, views, or arguments concerning the proposed amendment and adoption of rules in writing to the Board of Crime Control, 303 North Roberts, Helena, Montana, 59620, no later than October 28, 1995.

7. If a person who is directly affected by the proposed amendment and adoption of rules wishes to submit his data, or express views and arguments at a public hearing, he must make a written request for a hearing and submit this request, along with any written comments he has, to the Board of Crime Control, 303 North Roberts, Helena, Montana, 59620, no later than October 28, 1995.

8. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 30, based on the total number of non-sworn officers in the State of Montana.

MONTANA BOARD OF CRIME CONTROL

By: 
ELLIS E. KISER, Executive Director


Rule Reviewer

Certified to the Secretary of State, September 14, 1995.

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

In the matter of the proposed amendment and repeal of rules of the Peace Officer Standards and Training Advisory Council pertaining to the revocation and/or suspension of peace officer certification	)))))	NOTICE OF PROPOSED AMENDMENT AND REPEAL OF RULES NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On November 1, 1995, the Montana Board of Crime Control proposes to amend ARM 23.14.802, 23.14.804, 23.14.807, and 23.14.808. The Board also proposes to repeal ARM 23.14.805, 23.14.806, 23.14.809, and 23.14.810. No public hearing is contemplated.

2. The rules proposed to be repealed are as follows:

ARM 23.14.805, AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA, at pp. 23-459.3 and 23-459.4, Administrative Rules of Montana;

ARM 23.14.806, AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA, at pp. 23-459.4 and 23-459.5, Administrative Rules of Montana;

ARM 23.14.809, AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA, at pg. 23-459.6, Administrative Rules of Montana; and

ARM 23.14.810 AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA, at pg. 23-459.7 of the Administrative Rules of Montana.

3. The rules proposed to be amended provide as follows (new material underlined, excised material interlined):

23.14.802 GROUNDS FOR SUSPENSION OR REVOCATION OF MONTANA PEACE OFFICERS' STANDARDS AND TRAINING CERTIFICATION (1) The Montana board of crime control, peace officer standards and training advisory council, shall consider and rule on any complaint made against a public safety officer that may result in the revocation or suspension of that officer's certification.

(2) The grounds for suspension or revocation of the certification of public safety officers are as follows:

(a) Willful falsification of material information in ~~order to obtain or maintain certification~~ conjunction with official duties;

(b) A physical or mental condition that substantially limits the person's ability to perform the essential duties of a public safety officer, or poses a direct threat to the health and safety of the public or fellow officers, and that cannot be eliminated by reasonable accommodation;

(c) through (e) remain the same.

(f) Neglect of duty or willful violation of orders or regulations;

(g) Conduct unbecoming an officer;

(h) Willful violation of the law enforcement code of ethics set forth in these rules;

(~~f~~i) Other conduct or a pattern of conduct which tends to significantly undermine public confidence in the law enforcement profession;

(~~g~~j) Failure to meet the minimum standards for employment set forth in these rules; or

(~~h~~k) Failure to meet the minimum training requirements provided in these rules.

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

23.14.804 COMMENCEMENT OF FORMAL PROCEEDINGS FOR SUSPENSION OR REVOCATION OF CERTIFICATION (1) Formal proceedings may be commenced only after the filing of a complaint as described in these rules, the director's determination that formal proceedings are necessary, the designation of a presiding officer, and the ~~board's~~ issuance of a written order to show cause and notice of opportunity for hearing.

(2) Formal proceedings for decertification are subject to the Montana Administrative Procedure Act, and must be conducted pursuant to that Act.

(~~2~~3) If the director determines that formal proceedings are necessary, the respondent must be afforded reasonable notice. The order and notice shall contain ~~at least~~, in addition to those things required by the Montana Administrative Procedure Act:

(a) The name and address of the complainant, if any;

(b) A statement, in plain language, of the nature and circumstances of the incident complained of;

~~(c) Reference to the particular section(s) of the statutes or rules alleged to have been violated;~~

~~(d) A statement of the time, place and nature of the hearing;~~ and

(~~e~~c) A statement that failure to answer the complaint may result in default.

(~~3~~4) The respondent or his counsel may examine the original complaint ~~unless the presiding officer determines that the demand of individual privacy clearly exceeds the merits of public disclosure~~.

(~~4~~5) In formal proceedings, the respondent must file an answer, or be in default. The answer shall contain at least~~:~~

~~(a) An acknowledgement of the time and place of the hearing; and~~

~~(b)~~ A~~a~~ statement of grounds of opposition to each allegation of the complaint which the respondent opposes.

(~~5~~6) Service shall be made in a manner consistent with Montana law.

(~~6~~7) If a review of the conduct of a person holding a certificate subject to decertification under these rules is pending before any court, board, tribunal or agency, the ~~council~~ director may, in ~~its~~ his discretion, stay any proceedings for decertification pending before the council for so long as the council deems necessary.

(~~7~~8) In the event the respondent fails to answer, appear or otherwise defend a complaint against him of which the respondent had notice, the ~~council~~ presiding officer may enter an order based on the allegations of the complaint. However, the ~~council~~presiding officer may only enter an order based solely on the allegations of the complaint if the ~~council~~ presiding officer is acting either on a verified complaint or has conducted a proceeding at which the complainant's evidence was presented. The ~~council~~ presiding officer shall enter an order containing findings of fact, conclusions of law, and an opinion.

(~~8~~9) Any party may represent himself, or may at his own expense be represented by an attorney licensed to practice law in the state.

(~~9~~10) A representative from the office of the attorney general ~~shall~~ may present ~~to the council~~ the case of the complainant.

(~~10~~11) The ~~council~~ presiding officer may utilize a legal advisor to ~~be present and advise the council~~ assist in conducting the hearing. If the ~~council's~~presiding officer's legal advisor is employed by the office of the attorney general, his contact with the representative from the office of the attorney general who presents the case of the petitioner shall be restricted to that permitted by ~~recognized professional standards~~ law.

(~~11~~12) Unless required for disposition of ex parte matters authorized by law, after issuance of notice of hearing, the ~~council~~ presiding officer may not communicate with any party or his representative in connection with any issue of fact or law in such case except upon notice and opportunity for all parties to participate.

AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301, 2-4-603 MCA

23.14.807 DECISION AND ORDER (1) ~~Following a hearing, the council shall enter a written decision and order containing findings of fact, conclusions of law, a reasoned opinion, and an order, stated separately. The decision and order shall be sent by certified mail to the respondent and his counsel. This rule does not preclude the council from giving preliminary, nonbinding notice to the parties prior to the filing of the council's written decision and order~~ Pursuant to § 2-4-621, MCA, the Montana Board of Crime Control hereby designates the members of the Peace Officer Standards and Training Advisory Council as the officials of the agency who are to render the final decision in contested cases under this subchapter.

(2) and (3) remain the same.

AUTH: Sec. 44-4-301 MCA IMP: Sec. 44-4-301 MCA

23.14.808 RECORD OF PROCEEDINGS (1) The record shall consist of the items enumerated in 2-4-614, MCA and, in the event that a stenographic record of oral proceedings has not been requested, a tape recording of oral proceedings if one is available.

~~(a) The complaint, the order to show cause and notice of hearing, and the answer;~~

~~(b) All evidence offered or considered;~~

~~(c) All objections and rulings thereon;~~

~~(d) All other matters requested to be placed in the record;~~

~~(e) The council's decision and order; and~~

~~(f) A recording of the hearing held. The recording need not be transcribed, unless requested by a party. The requesting party shall bear the cost of transcription.~~

AUTH: Sec. 44-4-301, MCA IMP: Sec. 44-4-301, MCA

4. RATIONALE: The Board proposes the amendment and repeal of these rules in order to bring the rules regarding the decertification procedure of the POST council into compliance with the requirements of Montana law, i.e., that parties to contested case proceedings held under any provision relating to licensure to pursue a profession or occupation must utilize formal contested case proceedings under the Montana Administrative Procedure Act. Also, the Board seeks to designate the POST council as the officials of the agency who render the final decision, so that appeals from decisions of the POST council may be taken directly to district court.

5. Interested persons may present their data, views or arguments to Ellis E. Kiser, Executive Director, Montana Board of Crime Control, 303 N. Roberts, Room 463, P.O. Box 201408, Helena, MT 59620-1408, no later than October 28, 1995.

6. If a person who is directly affected by the proposed amendment and adoption of rules wishes to submit data, views or arguments at a public hearing, s/he must make a written request for a hearing and submit this request, along with any written comments, to the Board of Crime Control, 303 North Roberts, Helena, Montana, 59620, no later than October 28, 1995.

7. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 160, based on the total number of certified peace officers in the State of Montana.

MONTANA BOARD OF CRIME CONTROL

By: _____
ELLIS E. KISER, EXECUTIVE DIRECTOR

_____
RULE REVIEWER

Certified to the Secretary of State, September 14, 1995.

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

In the matter of the proposed amendment of ARM 24.21.414 concerning wage rates for certain apprenticeship programs	) NOTICE OF PUBLIC HEARING ON) THE PROPOSED AMENDMENT) OF ARM 24.21.414))

TO ALL INTERESTED PERSONS:

1. On October 20, 1995, at 10:00 a.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 North Roberts, Helena, Montana, to consider the amendment of ARM 24.21.414, and the adoption of wage rates related to certain non-urban apprenticeship programs in the building construction industry.

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., October 16, 1995, to advise us of the nature of the accommodation that you need. Please contact the Apprenticeship Program, Job Service Division, Attn: Dan Miles, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-4511; TDD (406) 444-0532; fax (406) 444-3037. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Mr. Miles.

2. The Department of Labor and Industry proposes to amend ARM 24.21.414 as follows: (new matter underlined, deleted matter interlined)

24.21.414 WAGE RATES TO BE PAID IN BUILDING CONSTRUCTION OCCUPATIONS (1) For the purpose of this rule, "building construction occupation":

(a) has the same meaning as provided in the most recent version of the "Montana Prevailing Wage Rates -- Building Construction" publication, adopted by the department of labor and industry by reference in ARM 24.16.9007; or

(b) means an occupation that:

(i) is licensed by the state of Montana;

(ii) is recognized by the registration agency as being apprenticeable; and

(iii) but for the fact that the occupation relates to work of a residential character, would be included in the most recent version of the "Montana Prevailing Wage Rates -- Building Construction" publication.

(2) Building construction occupation apprentice wages must conform to the following standards:

(a) Apprentice wages must start at no less than 50% of the applicable journeyman hourly wage, subject to a lower wage if

required by a collective bargaining agreement in effect for that apprenticeable trade in the area or region where the work is performed, or a higher wage if required by other applicable federal or state law.

(b) The apprentice wage must progressively increase consistent with the hours spent on the job and related supplemental instruction completed. Apprentice wages may not be less than 85% of the applicable journeyman hourly wage during the final period of training unless a lower wage is required by a collective bargaining agreement in effect for that apprenticeable trade in the area or region where the work is to be performed.

(3) For work in Cascade, Flathead, Gallatin, Lewis & Clark, Missoula, Silver Bow and Yellowstone counties, the applicable journeyman hourly wage is the state's standard hourly prevailing rate of wages for those areas as established by the commissioner of labor under the authority granted in Title 18, chapter 2, part 4, Montana Code Annotated, and adopted in ARM 24.16.9007. If a standard hourly prevailing wage for a building construction occupation is not listed in the most recent version of the "Montana Prevailing Wage Rates -- Building Construction" publication, then the department may establish a wage by a survey of the wage for that occupation in the county, using the same general survey methodology as provided elsewhere in this rule.

(4) The applicable journeyman wage for the areas outside of the counties listed in (3) is the weighted average of the journeyman wage in the same region, as determined by survey.

(a) The department will biennially survey registered apprenticeship program sponsors that are not located in the counties listed in (3). In determining the location of the program sponsor, the department will consider the primary location of the employing entity that provides the apprentice's training. Montana human services regions will be used for the survey. The applicable journeyman wage is the weighted average for the corresponding apprenticeable occupation for each region.

(b) The biennial survey of registered apprenticeship sponsors may be coordinated with the surveys used to calculate the standard hourly prevailing rate of wages. The department, in order to coordinate the biennial surveys referred to in this paragraph, may undertake an initial interim survey that is followed in less than 2 years by the biennial survey.

(c)(i) If there are no survey responses for a particular occupation in a given region, the applicable wage rate for that occupation in that survey region is the highest of:

(A) the recognized journeyman wage rates applicable to that occupation;

(B) provided for in a registered apprenticeship standard;

(C) for program sponsors located in that region, other than in a county listed in (3).

(ii) The rate is ascertained by the registration agency based upon its review of registered apprenticeship documents.

(iii) If there is no registered apprenticeship program for a given occupation in the survey region, then a rate will not be

established for the survey period.

(5) The department will publish and incorporate by reference the 1995 edition of the publication entitled "State of Montana Base Journey-Level Rates for Apprentice Wages" which sets forth the building construction industry occupations journeyman wage rates in the five regions of Montana, excluding the seven largest counties, in order to set the apprentice wage rates provided by (3) and (4). A copy of the ~~wage rate~~ publication is available from ~~the apprenticeship training program~~ Kate Kahle, research and analysis bureau, department of labor and industry, 1327 Lockey, P.O. Box 1728, Helena, MT 59624-1728.

(6) Apprenticeship sponsors shall pay their apprentices the appropriate apprentice wage for the county or region in which the job is located, but in no event may the wage be lower than the wage specified in the apprenticeship program standard.

(7) This rule applies to apprenticeship agreements registered with the department on or after December 1, 1995.

AUTH: Sec. 39-6-101 MCA
IMP: Sec. 39-6-101 and 39-6-106 MCA

REASON: There is reasonable necessity for amendment of this rule in order to provide for a methodology for establishing a wage rate when program sponsors do not respond to wage surveys. The Department recently conducted its wage survey of registered non-urban apprenticeship programs sponsors in the building construction industry, as contemplated by recently adopted ARM 24.21.414. The Department did not receive survey responses from sponsors in certain occupations in the surveyed areas and without survey data or the proposed alternate methodology, the Department cannot provide the wage rates contemplated by the rule. There is also reasonable necessity for the adoption of the base wage rates in order to implement the provisions of ARM 24.21.414(5). This adoption of rates is the initial set of rates adopted under the rule. Future rates will be adopted on a biennial basis via the rule-making process.

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

Dan Miles
Apprenticeship Program
Job Service Division
Department of Labor and Industry
P.O. Box 1728
Helena, Montana 59624-1728

and must be received by no later than 5:00 p.m., October 27, 1995.

4. The Department proposes to make the amendments effective December 1, 1995. The Department reserves the right to adopt only portions of proposed amendments, or to adopt some or all of the proposals at a later date.

5. 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
David A. Scott
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: September 18, 1995.

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

In the matter of the proposed amendment of Rule 36.2.608 pertaining to fees for environmental impact statements	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

To: All Interested Persons.

1. On October 30, 1995, the Department of Natural Resources and Conservation proposes to amend Rule 36.2.608 pertaining to fees for environmental impact statements.

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

36.2.608 EXCEPTIONS (1) This sub-chapter shall not apply to any applicant for a ~~certificate under the Major Facility Siting Act (Title 75, Chapter 20, MCA) or for a~~ water use permit or approval under section 85-2-124, MCA.

AUTH: 75-1-202, MCA
IMP: 75-1-202 and 75-1-207, MCA

3. Rule 36.2.608 is being amended because pursuant to Chapter 418, Laws of Montana 1995, the Department of Natural Resources and Conservation no longer has jurisdiction under the Major Facility Siting Act to issue certificates.

4. Interested parties may submit their data, views, or arguments concerning the proposed amendment in writing to Don MacIntyre, Department of Natural Resources and Conservation, 1520 E. Sixth Avenue, Helena, Montana 59620, on or before October 27, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express their data, views, and arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments to Don MacIntyre, Department of Natural Resources and Conservation, 1520 E. Sixth Avenue, Helena, Montana 59620. The request must be received on or before October 27, 1995.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly

affected has been determined to be greater than 25 based on the number of persons affected by potential certificates that may be processed over the next few years.

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE,
RULE REVIEWER

Certified to the Secretary of State Sept. 18, 1995.

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

In the matter of a new rule to reject, modify, or condition permit applications in the Sixmile Creek Basin	))))	NOTICE OF PUBLIC HEARING

TO: All Interested Persons

1. On November 14, 1995 at 7:00 PM a public hearing will be held in the Visitor Center of the Nine Mile Ranger Station on Remount Road near Alberton, to consider the adoption of new Rule I.

2. The proposed new rule provides as follows:

"RULE I. SIXMILE CREEK BASIN CLOSURE (1) Sixmile Creek Basin means the Sixmile Creek drainage area, a tributary to the Clark Fork River located in hydrologic basin 76M, in Missoula County, Montana. The Sixmile Creek Basin designated as the closure area is all that drainage and headwaters originating in Township 16 North, Range 21 and 22 West, MPM flowing southwesterly through Township 15 North, Range 21 and 22 West, MPM to its confluence with the Clark Fork River in Section 27, Township 15 North, Range 22 West, MPM. The entire Sixmile Creek drainage, including the West Fork of Sixmile Creek and all unnamed tributaries, is contained in the closure area as outlined on file map page 4.

(2) The department shall reject all surface water applications to appropriate water within the Sixmile Creek Basin for any diversions, including infiltration galleries, for consumptive uses of water during the period from June 1 through September 15.

(3) Applications for nonconsumptive uses shall be accepted and processed. Any permit if issued shall be modified or conditioned to provide that there will be no decrease in the source of supply, no disruption in the stream conditions, and no adverse effect to prior appropriators within the reach of stream between the point of diversion and the point of return. The applicant for a nonconsumptive use shall provide sufficient factual information upon which the department can determine the applicant's ability to meet the conditions imposed by this rule.

(4) Applications for storage to appropriate water only outside the closure period from which water could subsequently be used during any portion of the year shall be received and processed except for form no. 605, application for provisional permit for completed stockwater pit or reservoir. Form no. 605 shall be rejected.

(5) Emergency appropriations of water as defined in ARM 36.12.101(6) and 36.12.105 shall be exempt from these rules.

(6) These rules apply only to applications received by the department after the date of adoption of these rules.

(7) The department may, if it determines changed

circumstances justify it, reopen the basin to additional appropriations and amend these rules accordingly after public notice and hearing."

AUTH: 85-2-319, MCA
IMP: 85-2-319, MCA

3. Rationale: This rule is necessary for the protection of existing water rights in the Sixmile Creek Basin. Unappropriated water is not available to new appropriations in the basin during certain times of the year. On April 14, 1995 a petition was filed pursuant to 85-2-319, MCA with the Department of Natural Resources and Conservation. The petition requested the basin be closed year-round to all new appropriations of water, except for off stream storage ponds which divert water outside of the irrigation season and which are used during the irrigation season for irrigation purposes. The petitioners claim water has been highly over-appropriated in this basin. Any additional new water rights would adversely affect storage, domestic, irrigation and stock rights presently being utilized.

In response to the petition the Department conducted a water availability analysis of the basin. As a result of the study the Department is proposing to reject new surface water permit applications for consumptive uses from June 1 through September 15. The intent of this rule is to preserve existing stream flows during this critical time for senior appropriators.

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 Teresa McLaughlin, Department of Natural Resources and Conservation, PO Box 202301, Helena, MT 59620-2301 no later than November 17, 1995.

5. Vivian Lighthizer has been designated to preside at and conduct the hearing.

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

BY: _____
Arthur R. Clinch, Director

_____
Donald D. MacIntyre, Rule Reviewer

Certified to the Secretary of State September 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the amendment of rules 46.11.112 and 46.11.125 and the repeal of rule 46.11.120 pertaining to the food stamp budgeting methods and monthly reporting requirements	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.11.112 AND 46.11.125 AND THE REPEAL OF RULE 46.11.120 PERTAINING TO THE FOOD STAMP BUDGETING METHODS AND MONTHLY REPORTING REQUIREMENTS

TO: All Interested Persons

1. On October 20, 1995, at 9:30 a.m., a public hearing will be held in Room 306 of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.11.112 and 46.11.125 and the repeal of rule 46.11.120 pertaining to the food stamp budgeting methods and monthly reporting requirements.

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 October 6, 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 amended provide as follows:

46.11.112 FOOD STAMPS, DEFINITIONS (1) "Beginning month" means the first month ~~in~~ for which the household ~~applies for benefits and the month thereafter~~ is certified to receive food stamps. A beginning month cannot be any month which immediately follows a month in which the household was certified.

(2) through (4) remains the same.

~~(5) "Retrospective budgeting" means the computation of a household's food stamp allotment for a benefit month based on actual income, household composition and other financial information which existed in a previous budget month.~~

AUTH: Sec. 53-2-201 MCA
IMP: Sec. 53-2-201 and 53-2-306 MCA

46.11.125 FOOD STAMPS, DETERMINING ELIGIBILITY AND BENEFITS (1) All households shall have their eligibility and the amount of food stamps they are entitled to receive determined using prospective budgeting.

~~(2) The amount of benefits a household is entitled to shall be determined using prospective budgeting except as provided in subsection (3).~~

~~(3) For households with continuous countable earned income as defined in ARM 46.11.120, the amount of benefits is determined using prospective budgeting for the first 2 months of eligibility and using retrospective budgeting for the third month of eligibility and each subsequent month as long as the household continues to receive earned income.~~

~~(a) When a household which has continuous countable earned income ceases receiving the earned income, prospective budgeting to determine benefits will commence the month following the month of last receipt of earned income or the month following the month in which last receipt of earned income is reported, whichever is later.~~

(4) remains the same in text but is renumbered to (2).

~~(5) Retrospective budgeting means using actual income received and other circumstances which existed 2 months prior to the month for which the amount of benefits is being determined. For example, the amount of benefits for April is based on actual income and circumstances in the month of February.~~

~~(6) Income received in the first two months of eligibility shall not be included in retrospectively budgeted income in the third and fourth months' of eligibility when:~~

~~(a) the income is from a source which no longer provides income to the household; and~~

~~(b) the income was included in the household's prospective budget in the first two months' of eligibility.~~

~~(7)~~ (3) Lease, royalty, and rental income which is received periodically but not on a monthly basis and which is expected to continue shall be determined ~~for~~ based on the ~~prior~~ 12 month period ~~beginning from~~ immediately prior to the month of application, ~~and~~ The projected income shall be prorated over the current 12 month period. Once a cycle of income proration is established, it shall remain in effect for one year. However, if any portion of the prior period's income is expected to stop in the current period, then this portion shall not be considered as income in the current period.

AUTH: Sec. 53-2-201 MCA
IMP: Sec. 53-2-201 and 53-2-306 MCA

3. The rule 46.11.120 as proposed to be repealed is on page 46-955 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201 MCA
IMP: Sec. 53-2-201 and 53-2-306 MCA

4. Pursuant to federal regulations governing the Food Stamp program at 7 CFR 273.21(b), states have the option of using either prospective or retrospective budgeting to determine benefit amount. ARM 46.11.120 and 46.11.125 currently provide that certain food stamp recipients must file monthly reports and have their benefit amount calculated using retrospective budgeting. The department now proposes to amend its rules to eliminate monthly reporting and retrospective budgeting. These changes are being made to simplify the process for calculating

benefits and to keep the food stamp rules consistent with the rules of the Aid to Families with Dependent Children (AFDC) program, which is also opting to eliminate monthly reporting and retrospective budgeting.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than October 26, 1995.

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, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the amendment of rules 46.10.108, 46.10.207, 46.10.403, 46.10.513 and 46.10.708 pertaining to AFDC monthly reporting and budgeting methods	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.10.108, 46.10.207, 46.10.403, 46.10.513 AND 46.10.708 PERTAINING TO AFDC MONTHLY REPORTING AND BUDGETING METHODS

TO: All Interested Persons

1. On October 20, 1995, at 9:45 a.m., a public hearing will be held in Room 306 of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.10.108, 46.10.207, 46.10.403, 46.10.513 and 46.10.708 pertaining to AFDC monthly reporting and budgeting methods.

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 October 6, 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 amended provide as follows:

46.10.108 OVERPAYMENTS AND UNDERPAYMENTS (1) through (3)(a)(i) remain the same.

(ii) willful failure by the applicant or recipient to report changes in income, resources, household composition, or other circumstances affecting eligibility or benefit amount within 10 days of the date the change occurs ~~or on a monthly report when required~~; and

(3)(a)(iii) through (3)(c) remain the same.

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

46.10.207 NOTICE OF ADVERSE ACTION (1) through (1)(h) remain the same.

(i) a special allowance granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance would automatically terminate at the end of the specified period~~;~~.

~~(j) a monthly report is received from a recipient that contains information that is used to reduce or terminate assistance; or~~

~~(k) a monthly report was not received from a recipient required to submit one as provided in ARM 46.10.210 by the eighth day of the month or was incomplete when it was received, and assistance is reduced or terminated on this basis.~~

(2) and (3) remain the same.

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

46.10.403 TABLE OF ASSISTANCE STANDARDS; METHODS OF COMPUTING PAYMENTS (1) and (1)(a) remain the same.

(2) Eligibility for assistance is always determined prospectively for all applicants and recipients, that is, based on the department's best estimate of income and other circumstances which will exist in a future month or months. An eligible applicant or recipient's benefit for a particular month is also computed using ~~either retrospective or~~ prospective budgeting as set forth in ~~subsection (4)~~ (6) of this rule.

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

(4) Monthly gross income as defined in ARM 46.10.505 is compared to the gross monthly income (GMI) standard and, after specified disregards, to the net monthly income (NMI) standard. If the assistance unit's gross income exceeds the GMI standard or their net income exceeds the NMI standard, the assistance unit is ineligible for assistance. ~~At application, to determine eligibility~~ Eligibility and benefit amount ~~for the first 2 months of assistance,~~ are determined by comparing income ~~is compared~~ to the standards using prospective budgeting. ~~After the initial 2 consecutive months of assistance, eligibility is determined using prospective budgeting for all recipients, and benefit amount is computed using retrospective budgeting for all recipients required to report monthly and using prospective budgeting for all other recipients.~~ Monthly income is compared to the full standard even though the payment may only cover part of the month. If monthly income exceeds either the GMI or NMI standards, the assistance unit is not eligible for any part of the benefit month. The assistance unit may also be ineligible as provided in ~~subsection~~ (5) of this rule.

(4)(a) remains the same.

~~(b) For purposes of this rule, "retrospective budgeting" means that the benefit amount for a particular month is based on actual income and circumstances which existed in the second month before the month for which the benefit amount is being computed. For example, actual income and circumstances in the month of January would be used to compute the benefit amount for March.~~

~~(c) When comparing gross monthly income to the gross monthly income standard, for assistance units with earned income or who live with persons with earned income whose income is deemed to the assistance unit, the budget month is the same as the benefit month for the first 2 months of eligibility and for the third and subsequent months of eligibility the budget month is 2 months prior to the benefit month. For assistance units with no earned income and who do not live with persons with~~

~~earned income whose income is deemed to the assistance unit, the budget month is the same as the benefit month for the first 2 months of eligibility and for the third and subsequent months of eligibility.~~

~~(d) When comparing net monthly income to the net monthly income standards, for assistance units with earned income or who live with persons with earned income whose income is deemed to the assistance unit, the budget month is the same as the benefit month for the first 2 months of eligibility, and for the third and subsequent months of eligibility the budget month is 2 months prior to the benefit month. For assistance units with no earned income and who do not live with persons with earned income whose income is deemed to the assistance unit, the budget month is the same as the benefit month for the first 2 months of eligibility and for the third and subsequent months of eligibility.~~

(b) When comparing income to the income standards the budget month is the same as the benefit month.

(4)(e) through (4)(h) remain the same in text but are renumbered (4)(c) through (4)(f). (5) through (6)(b) remain the same.

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

46.10.513 LIMITS ON DISREGARDS (1) and (2) remain the same.

~~(a) the recipient failed without good cause to return the monthly report by the 8th of the month as provided in ARM 46.10.108 (4);~~

(2)(b) remains the same in text but is renumbered (2)(a).

~~(c)~~ (b) the applicant or recipient earner refused without good cause to accept a bona fide employment within the period of 30 days preceding the benefit month; or

(2)(d) remains the same in text but is renumbered (2)(c).

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

46.10.708 AFDC WORK SUPPLEMENTATION PROGRAM, AFDC ELIGIBILITY; RESIDUAL GRANT (1) remains the same.

(2) AFDC eligibility for WSP participants shall be determined by prospective budgeting, as described in ARM 46.10.505, excluding WSP wages. The amount of the participant's residual grant shall be determined by ~~retrospective~~ prospective budgeting, as described in ARM 46.10.505, including WSP wages as earned income.

(3) remains the same.

(a) The residual grant shall be the amount of the benefit standard for an assistance unit of that size, as provided in ARM 46.10.403, less that household's net income for the month, as determined by ~~retrospective~~ prospective budgeting including WSP wages as earned income and subject to the provisions of ARM 46.10.711(4).

(b) The participant and his household shall be ineligible for a residual grant if household income, determined prospectively ~~and retrospectively~~ excluding WSP wages, exceeds either:

(3)(b)(i) and (3)(b)(ii) remain the same.

(c) Participants with gross wages, including WSP wages, ~~retrospectively~~ prospectively determined to exceed 185% of the NMI standard specified in ARM 46.10.403 shall not be eligible for a residual grant.

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

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-241, 53-4-703 and 53-4-720 MCA

3. Prior to 1990, federal law governing the Aid to Families with Dependent Children (AFDC) program mandated that the states require certain recipients of AFDC to file a monthly report with information about the assistance unit's income, family composition, and other circumstances which may affect the assistance unit's continued eligibility and amount of assistance. Recipients required to file these monthly reports included those with earned income or with a recent work history.

Information obtained from monthly reports is used to determine the assistance unit's benefit amount for a future month using retrospective budgeting, i.e., computation of grant amount based on actual income and circumstances which existed in a previous month. This is in accordance with 45 CFR 233.31(a), which requires states to use retrospective budgeting to determine the amount of assistance after the first two months of eligibility for households filing monthly reports.

However, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) amended section 602(a)(13) and (14) of the Social Security Act, 42 U.S.C. §602(a)(13) and (14), to give the states the option of determining which recipients, if any, will be required to report monthly. As amended by OBRA '90, section 602(a)(13) and (14) further provides that retrospective budgeting can be used to determine benefit amount only for recipients which the state requires to file monthly reports.

The department has now chosen the option of eliminating the monthly reporting requirement for all recipients because it determined that the cost of sending monthly reports and processing the completed reports was not justified by the amount saved by obtaining information about family income and circumstances monthly. Since the department will no longer have recipients filing monthly reports, the department will no longer be using retrospective budgeting to determine the amount of assistance for any households.

The elimination of monthly reporting and retrospective budgeting will not only be cost effective and simplify determinations of

benefit amount; it will also make the rules of the AFDC program consistent with those of the Food Stamp program, which also is abolishing monthly reporting and retrospective budgeting. The amendment of ARM 46.10.108, 46.10.207, 46.10.403, 46.10.513 and 46.10.708 is necessary to eliminate the monthly reporting requirement and to provide that all determinations of benefit amount will be made using prospective budgeting, i.e., based on an estimate of income and circumstances which will exist in the future.

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 October 26, 1995.

5. 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, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

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

In the Matter of Proposed Adoption of Rules Regarding Affiliated Interest Reporting Requirements and Policy Guidelines, and New Rules Regarding Minimum Rate Case Filing Standards for Electric, Gas, Water and Telephone Utilities.	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF NEW RULES I - XXIX

TO: All Interested Persons

1. On Wednesday, November 8, 1995 at 9:00 a.m. at the offices of the Montana Public Service Commission, 1701 Prospect Avenue, Helena, Montana, the Commission will hold a hearing to consider the proposals identified in the above titles and described in the following paragraphs, all related to affiliated interests and transactions.

2. If adopted, Rules I and II below will be incorporated under both Minimum Rate Case Filing Standards for Electric, Gas and Private Water Utilities (currently Title 38, Chapter 5, Sub-Chapter 1) and Minimum Rate Case Filing Requirements for Telephone Utilities (currently Title 38, Chapter 5, Sub-Chapter 28).

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

Minimum Rate Case Filing Standards

RULE I. PRE-FILED DIRECT TESTIMONY AND EXHIBITS (1) A utility requesting cost recovery of affiliated transactions shall include the following information in the testimony and exhibits filed with its application:

(a) Quantitative and qualitative information which demonstrates that ratepayers are not harmed by the affiliated relationships and corresponding transactions with the public utility;

(b) A demonstration that the policy guidelines [Rule V] of the commission for transactions conducted between public utilities and affiliates have been adhered to;

(c) The utility's proposed treatment of affiliated entity organizational, start up, or additional regulatory costs which have resulted from affiliated interest activities;

(d) An indication and description of the types of transactions, including the cost of such transactions, which have

occurred between the public utility and its affiliated entities during the test period results of operations as filed with the commission;

(e) A description of the policies, procedures and internal controls which the utility relies upon in its relationships and related transactions with affiliated entities, including a demonstration that cost separation and allocation systems are fair and reasonable;

(f) Identification of any transfer of business opportunities between a utility and its affiliates and an explanation as to the expected benefits to ratepayers;

(g) A complete explanation of transactions with new affiliated entities and any expansion or alteration of previously existing affiliated transactions;

(h) A detailed explanation of any market or proprietary information or other research and development information which is shared between the utility and affiliated entities;

(i) A description of the policies and procedures used for any employee sharing programs and employee transfers between the utility and affiliated entities;

(j) An explanation of utility common stock dividend policy and similar policies which relate to the parent corporation and affiliated entities, and, where applicable, an explanation of industry specific target dividend payout percentages and policies; and

(k) An explanation of any known impacts that the business ventures of affiliated entities have had relative to the utility's capital structure, cost of capital, the level of capital it has needed to attract from external markets and its credit standing. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101 MCA

RULE II. WORKING PAPERS (1) Working papers which are sufficient to support the testimony and exhibits filed pursuant to [Rule I] shall be prepared prior to the filing. Such work papers will be maintained and made available to the commission or its representatives upon request. Any request for such working papers shall be answered within 15 working days upon receipt of said request by the utility. In the event that there shall be a delay beyond said period the utility shall notify the commission and present a written explanation of the need for delay or extension. A reasonable request for extension or delay, upon the showing of good cause by the utility, will not be unreasonably withheld by the commission. In addition to the working paper support, the following specific material normally prepared by either the utility, the parent corporation or affiliated entities, related to the test period and subsequent periods, shall be available for the commission's review and analysis:

(a) Copies of monthly and annual financial reports concerning affiliated entities;

(b) Copies of annual budget to actual results of operations variance reports, including any available explanations;

(c) Copies of accounting analyses of balance sheet accounts, including surplus and capital surplus accounts;

(d) Copies of consolidating work papers and schedules supporting the consolidated financial statements of the parent companies or the public utility;

(e) Copies of consolidated income tax work papers and schedules, including any allocation of consolidated income tax benefits;

(f) Copies of market analyses and review studies performed by or on behalf of affiliated entities which conduct business with the public utility;

(g) Copies of invoices which are representative of sales of goods or services made in markets which are external to the corporate group of companies, and

(h) Copies of board of director minutes for the parent corporation, the public utility and each of the affiliated entities which the public utility conducts business with. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-2-101, MCA

Affiliated Interest Reporting Requirements and Policy Guidelines

RULE III. PURPOSE (1) The purpose of these reporting requirements and policy guidelines is to ensure that only costs necessary to the provision of utility services are reflected in rates, and that affiliated transactions of utilities under Montana public service commission (commission) jurisdiction do not cause deterioration of utility service or increased costs to ratepayers. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE IV. GENERAL (1) The policy guidelines set out below have been adopted by the commission to ensure adequate regulatory oversight over affiliate relationships of reporting companies. The policy guidelines will generally apply unless it can be demonstrated by reporting companies, on a case-by-case basis, that other relevant factors need to be considered. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE V. POLICY GUIDELINES (1) Commission policy guidelines on actions relative to affiliate relationships and corresponding transactions with reporting companies are as follows:

(a) A public utility shall demonstrate that its diversification efforts and dealings with affiliates are fair and reasonable. A utility must also demonstrate that its utility customers have not been harmed by the affiliate relationships and related transactions;

(b) The net benefit of using utility assets to provide unregulated services outside of the ordinary scope of the

provision of utility services, will be, in whole or in part, credited to ratepayers;

(c) Written notification through an advice letter filing shall be provided to the commission concerning the sale or transfer of utility property to an affiliate no later than concurrent with the transaction being completed. However, sales of operating units and systems are subject to commission approval;

(d) Written notification shall be provided through an advice letter filing to the commission no later than the date concurrent with the completion of a newly agreed to transaction for the provision of goods or services between the public utility and its affiliates;

(e) Relative to affiliated entities established through diversification for the benefit of shareholders, the public utility will not be allowed to recover organizational, start up, or additional regulatory costs from its utility ratepayers. However, any known and quantifiable ratepayer benefit resulting from such activities can be used to offset such costs;

(f) Recoverable costs will be adjusted if it can be demonstrated that quality of service has been weakened and/or cost increases have resulted from the transfer of key personnel from the public utility to unregulated affiliates;

(g) Affiliated interest business ventures shall not be funded or financed in any way that places the public utility's credit standing or utility property in jeopardy;

(h) For costs associated with transactions between a public utility and affiliates to be recoverable from ratepayers, the regulated utility must conform to the advice letter information filing requirements at [Rule XXIX];

(i) If affiliated interest transaction costs are to be considered as recoverable costs from ratepayers, the books of account and related records of affiliates who transact business with the public utility must be available for audit and review by commission representatives. Also, the affiliate records must be kept in such a manner as to facilitate the requisite review and audit process;

(j) Utilities that diversify or do business with affiliated entities shall accurately segregate costs and revenues between regulated and nonregulated accounts;

(k) When asset transfers or sales are made by an affiliate to a public utility, the transaction shall be recorded at the lower of net book value or fair market value. When such transactions flow from the public utility to an affiliate, if no tariff filed with the commission is applicable, the transaction shall be recorded at the higher of net book value or fair market value;

(l) When goods or services are provided by a public utility to an affiliate, they shall be recorded at either the tariffed rates or the higher of the utility's cost or market. When goods or services are provided to a public utility by an

affiliate, they shall be recorded at either the tariffed rates or the lower of the affiliates cost or market. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE VI. DEFINITIONS These definitions apply only to the affiliated interest reporting requirements and policy guidelines rules, and to minimum rate case filing requirements rules for electric, gas, water and telephone utilities.

(1) "Affiliate" means any person, corporation, partnership or other entity over which the reporting company, its parent corporation, or a subsidiary company within the overall corporate structure can exercise, directly or indirectly, a high degree of control.

(2) "Affiliated transaction" means a transfer or sale of assets, or a provision of goods or services between a reporting company's accounts and accounts for nonregulated or other regulated activities of a separate entity which is an affiliate. It also relates to the aforementioned activities between accounts for the regulated and nonregulated segments of a single public utility.

(3) "Annual report" means the report filed with the commission pursuant to these rules.

(4) "Asset" means any tangible or intangible property or other rights, entitlements, business opportunities, or other things of value to which the reporting company or affiliate, either directly or indirectly, holds claims.

(5) "Comparative" means a tabular comparison of the reporting year and the immediately preceding year as required by the context of these rules.

(6) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of management and policies of an entity.

(7) "Cost" means fully distributed cost, including labor related benefits and taxes, the utility's jurisdictional authorized rate of return and all other related general overheads and administrative costs.

(8) "Fair market value" means the demonstrated sales price that could be obtained by selling an asset in an arm's length open market transaction to a nonaffiliated entity, as determined by commonly accepted valuation principles.

(9) "Intracompany transactions" mean transactions between regulated and unregulated operating divisions within a public utility.

(10) "Intercompany transactions" mean transactions between a public utility and another company over which the public utility, directly or indirectly, can exercise a high degree of control.

(11) "Market or market rate" means the lowest price which is available from nonaffiliated suppliers for comparable assets or a provision of goods or services.

(12) "Net book value" means original cost less accumulated depreciation, amortization or depletion.

(13) "Nonregulated service" means a service which is not a public utility service as defined by 69-3-101, MCA, or a service which the commission has determined to be exempt from regulation.

(14) "Reporting company" means the public utility filing an annual report with the commission pursuant to [Rules VIII through XXIX].

(15) "Reporting year" means the 12-month accounting period, either a calendar year or a fiscal year ended, adopted by the reporting company. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE VII. EXEMPTION TESTS (1) Companies regulated by the commission are exempt from annual reporting requirements under [Rules XI and XXIX] if either of the following exemption tests are met:

(a) The company only supplies utility services in Montana to market segments which are deemed to be competitive and are not subject to rate level regulation by the commission;

(b) Telecommunication companies with less than 5,000 access lines located within Montana. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE VIII. MINIMUM AFFILIATED INTEREST ANNUAL REPORTING (1) If a reporting company meets any of the following tests it shall file a minimum affiliated interest annual report pursuant to [Rule XXVIII], shall comply with [Rule XXIX], and shall not be required to file an annual report pursuant to [Rules XI through XXVII]:

(a) Annual Montana regulated revenues are less than $15.0 million;

(b) The reporting company provides all of its services in FCC regulated areas and/or in competitive markets; and

(c) The reporting company or its parent corporation's equity securities are not publicly traded and the parent corporation is organized as a municipality or a cooperative. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE IX. REPORTING DEADLINE AND APPLICABILITY (1) By May 1, all calendar year public utilities shall file with the commission, unless otherwise specified in these rules, an annual report for the reporting year. Fiscal year public utilities shall file by November 1. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE X. GENERAL REQUIREMENTS (1) Where applicable, when the annual report is submitted for a multi-jurisdictional

reporting company, the company shall report on a total company and a Montana allocated basis.

(2) Outside of the context of a rate case, or special request for information pursuant to 69-3-203(2), MCA, these rules contain all of the affiliated transaction and related information reporting requirements for a reporting company. As such, changes to reporting requirements will be addressed through changes to these rules.

(3) Pursuant to 69-3-203, MCA, public utilities subject to the jurisdiction of the commission are required to file other information and supporting schedules on an annual basis. Upon the adoption of these rules, information and schedules required for such reporting, relating specifically to affiliated transaction reporting, will be removed from such other reporting requirements.

(4) Schedules developed for other purposes can be substituted for schedules in the annual report if such schedules conform to these reporting requirements.

(5) Upon the adoption of these rules, the staff of the commission will develop appropriate reporting forms and schedules for the purpose of reporting the required information.

(6) If, in the opinion of the reporting company, compliance with these rules requires the disclosure of a trade secret, or otherwise confidential information, the reporting company shall, not later than 30 days prior to the annual report due date, request a protective order. The request shall contain a nonproprietary description of the information for which protection is sought, the reasons the information is protectable under Montana law, and an explanation of the length of time the information needs to be protected. Following the issuance of a protective order the reporting company shall file the protected material on yellow paper clearly marked confidential, and shall file a nonproprietary description of the protected material with the annual report. Information filed under protective order becomes a permanent part of commission records.

(7) Every reporting company, not subject to Rule VIII, shall report, on schedules and forms specified, the information described in [Rules XI through XXVII]. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XI. REPORTING REQUIREMENTS -- ORGANIZATIONAL CHART AND INFORMATION (1) Provide a block or line organizational chart depicting, on a legal and operational basis, the reporting company and its affiliates' corporate organization. The operational organization chart shall illustrate the manner in which the reported entities actually operate their business on a daily basis. The following information shall be provided:

(a) The name, title, address and telephone number of the person responsible for the preparation and filing of the annual report;

(b) A narrative describing the corporate organization of the reporting company and its affiliates, including a general statement as to the business purpose of the entities within the operational organization structure;

(c) The percentage of voting securities held by each of the entities within the corporate organization. If a corporation, or other business entity held any control over the reporting company or its affiliates at the end of the reporting year, state the name of the corporation or organization, the manner in which control was held and the extent of the control;

(d) The legal name and state of incorporation for each of the entities shown on the legal organizational chart;

(e) A description of the nature of the business and affiliated transactions conducted between the parent corporation, the reporting company and affiliates, generally indicating the business purpose and goods, products or services provided;

(f) If the reporting company conducts business through structures which are not separate legal entities, a description of the structures relied upon;

(g) An updated listing of members of board of directors and board committee members of each entity shown on the operational organization chart, including a list of any changes, with general explanations, since the last reporting year; and

(h) An updated list of officers, setting out the name, title and length of service in such position, for the parent corporation, the reporting company and affiliates. For each of the officers identified for the parent corporation and reporting company, provide a list of board and officer positions held by such officers in each of the entities shown on the operational organization chart. Additionally, provide a list of any changes, including general explanations, since the last reporting year. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XII. REPORTING REQUIREMENTS -- ORGANIZATIONAL CHANGE (1) If the organizational structure of which the reporting company is part has changed through the sale or transfer of ownership since the last reporting year, provide the following:

(a) Identify and describe the change;

(b) A summary, including account numbers and related descriptions, of the journal entries used to record the transactions; and

(c) A general description of the business purpose for the transaction. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XIII. REPORTING REQUIREMENTS -- SALE OR TRANSFER OF CAPITAL ASSETS (1) For each sale or transfer, in whole or in part, of Montana jurisdictional capital assets with a total

company value (higher of original cost or selling price) of $25,000 or more, provide the following:

(a) Describe the assets sold or transferred;

(b) Indicate the established price of the sale or transfer, the net book value and the method used to determine the price; and

(c) Attach and incorporate by reference a copy of the journal entries used to record the transactions.

(2) Where the addition of Montana jurisdictional capital assets results from the sale or transfer of such assets, in whole or in part, to a reporting company from affiliates, the reporting company shall provide the same information as set out in [Rule XIII] above. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XIV. REPORTING REQUIREMENTS -- CAPITAL BUDGET REPORTING (1) For capital budget reporting, listed separately for the consolidated parent corporation and shown on a stand-alone basis for the reporting company, provide a listing by capital budget functional category and amount for the reporting year. For each functional category shown, provide a separation between capital budget amounts directly assigned to Montana and those system assets which will be allocated to Montana. Additionally, provide detailed sources and application of funds statements, separated by internal and external sources, relative to the consolidated and stand-alone reporting company capital budget amounts reported. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XV. REPORTING REQUIREMENTS -- CAPITAL STRUCTURE (1) Provide a numerical determination of the reporting companies stand-alone regulated utility capital structure. To provide this information, start with either a consolidated or combined capital structure, then remove on an affiliate-by-affiliate basis the amounts applicable to such activities. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XVI. REPORTING REQUIREMENTS -- ALLOCATION OF COMMON COSTS (1) Reporting companies, other than telecommunications utilities, shall provide information concerning the allocations of corporate or other overhead costs common to or shared between the reporting company and any affiliate or unregulated activity, in the following manner:

(a) A description of the functions or services to which the allocated costs pertain;

(b) A description of the method used to make the allocations, including a description of the work order, department number, business unit number or other means employed to identify the costs subject to allocation;

(c) A statement showing the historical information used to develop the cost allocation percentages, any appropriate adjustments and a description and support for the adjustments made;

(d) A description of any modifications to the cost identification and allocation methodology since the last annual report;

(e) A statement, including descriptions, showing overhead costs by functional support area and type of expense for which costs are assigned and allocated to the corporate group for further distribution to the reporting company and the affiliates;

(f) By functional area, provide a statement showing direct, indirect and total corporate group or other overhead costs, including:

(i) The assignment and allocation basis used;

(ii) Costs assigned and allocated to each of the operating entities; and

(iii) An explanation of any functional area of costs assigned directly to the reporting company.

(g) A comparative statement of the reporting year to the previous reporting period showing dollar and percentage variances. Where such variance exceeds ± 10 percent and is greater than $10,000, provide a general explanation of such variances; and

(h) Provide an executive summary of the cost allocation manual used to allocate overhead costs and common costs between regulated and nonregulated services. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XVII. REPORTING REQUIREMENTS -- COST ALLOCATION - TELECOMMUNICATIONS (1) Reporting companies that are telecommunications utilities shall provide the reporting company's relevant cost allocation manuals, such as an FCC cost allocation manual, or any subsequent material modifications thereto. The following information shall also be provided:

(a) An executive summary of the cost allocation manual and methodology;

(b) A copy of current FCC cost allocation audit reports and relevant responses filed by the reporting company; and

(c) A listing and general explanation of Montana nonregulated products and services which are accorded incidental accounting treatment. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XVIII. REPORTING REQUIREMENTS -- AFFILIATE TRANSACTION REPORTING (1) For affiliates transaction reporting, two schedules shall be provided:

(a) A schedule for products, goods and services provided by the reporting company to affiliates; and

(b) A schedule for products, goods and services provided by affiliates to the reporting company. The schedules provided shall include the following information:

(i) The name of the affiliate;

(ii) A general description of each of the products, goods and services provided;

(iii) A general description of the method used to determine the transfer price (e.g., tariff, cost, market), and a disclosure as to whether a written agreement has been entered into by the parties;

(iv) Total charges for each entity reported by type of products or services provided;

(v) A statement as to whether any sales were made to parties outside of the corporate group of entities;

(vi) The percentage of affiliate revenues represented by charges to the reporting company and for sales to external markets;

(vii) For both schedules, include the total reporting company revenues received from affiliates and the total expenditures paid to affiliates;

(viii) A comparative statement of the reporting company's payments to affiliates. Where the calculated variance exceeds ± 10 percent and is greater than $10,000, provide a brief explanation of such variance;

(ix) A statement and supporting information as to whether a competitive market exists for like or similar products and services;

(x) Identify and describe any new products and services added during the reporting year;

(xi) A summary of incidental non-ongoing charges, on a one-line basis, including a general description of such charges;

(xii) For affiliates of the reporting company for the reporting year, provide the following financial statistics:

(A) The percentage return on average common equity book value;

(B) The percentage return on average depreciated long-term assets; and

(C) The ratio of sales to after tax earnings; and

(xiii) For affiliates of the reporting company, provide a general explanation of any material losses recorded during the reporting year. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XIX. REPORTING REQUIREMENTS -- CASH MANAGEMENT AND INTERCOMPANY LOAN FACILITIES (1) Concerning cash management processes and intercompany loan facilities for loans made to or from affiliates, the reporting company shall provide the following:

(a) A detailed description of the reporting company's cash management procedures and policies, including, if its cash is

managed by a parent or affiliate, the procedures and policies of said parent or affiliate for cash management;

(b) For each affiliate, a statement showing the level of transactions related to accounts receivable and payable which are conducted by either the parent or the reporting company on behalf of the affiliates. The information to be reported, for both of the accounts receivable and payable categories, shall be on the basis of monthly total amounts, average daily monthly amounts and on an average amount for the entire reporting year. Also, a statement showing any charges for the monthly services which were being provided; and

(c) A description of intercompany borrowing or loan facility agreements between the parent corporation, the reporting company and affiliates. As a minimum requirement, the information provided shall include:

(i) A listing of each party to the agreement;

(ii) The terms and conditions for loans made under the agreement;

(iii) A statement as to whether the agreement applies to the dollar level of timing differences when the parent corporation or reporting company pays an affiliate's accounts payable and receives payments relative to the affiliate's accounts receivable; and

(iv) A statement showing the average monthly interest rate charged during the reporting year. Also, include an explanation as to how each of the interest rates were determined. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XX. REPORTING REQUIREMENTS -- LENDING TO OR BORROWING FROM AN AFFILIATE (1) Where a reporting company either loans funds to or borrows funds from an affiliate, for a term exceeding one year, the following information shall be provided for the reporting year:

(a) A description of the terms and conditions of the agreement, including:

(i) The dollar amount of the loan;

(ii) The general terms and conditions of the agreement;

(iii) The remaining balance owed;

(iv) The rate of interest to be paid or earned;

(v) The security provided for the loan;

(vi) The method for determining penalties applicable to late payments; and

(vii) The term of the agreement.

(b) A summary of all other existing long-term contracts or agreements entered into by the parties to the loan agreement, including date of the agreement, the original amount of the loan, the remaining balance of the loan, the date of maturity, and any security provided;

(c) A statement describing the relationship between the parties to the loan agreement;

(d) Where an affiliate is the borrower, for the reporting year provide an income statement for the affiliate showing actual and adjusted results of operations. The adjusted results of operations should annualize the costs of the financing over the entire accounting period. Also, any other measurable benefits and costs shall be included in the normalized results of operations; and

(e) A statement as to whether any regulatory approvals are required in order to allow the transaction to be consummated. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXI. REPORTING REQUIREMENTS -- GUARANTY OF INDEBTEDNESS (1) Where a reporting company guarantees indebtedness, other than a joint purchasing agreement, and such indebtedness exceeds $25,000 and is for a term of one year or more, the reporting company shall provide:

(a) A description of the securities for which the guarantee is provided, including the terms and conditions of such agreement;

(b) A description of the need for the guarantee or credit support; and

(c) Provide similar information as described above under [Rule XX(1)(b) through (1)(e)]. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXII. REPORTING REQUIREMENTS -- ISSUANCE OF SECURITIES (1) Each reporting company or parent corporation subject to the provisions of 69-3-501 through 69-3-507, MCA, shall set out in a schedule information identifying applications made in the reporting year to obtain commission authority to issue securities, including:

(a) The date and assigned docket number of the application;

(b) A summary description of the application, indicating the type of security, duration, amount of capital subject to the application, other relevant terms and conditions and a statement of the use of the proceeds subject to the application;

(c) The date of commission approval;

(d) The status of the reporting company's issuance of securities for which commission approval has been granted;

(e) In accordance with 69-3-501 through 69-3-507, MCA, if the purpose of the issuance of securities was for the "acquisition of property" or "for any other purpose approved by the commission," a detailed description of the use of the proceeds;

(f) A sources and applications of funds statement for the reporting year. The statement needs to reflect detailed financial information on the basis of total consolidated or

combined parent corporation and stand-alone reporting company information. Also, the sources and applications of funds statement shall exclude allowance for funds used during construction (AFUDC) considerations;

(g) For the reporting year, separately stated for the reporting company, the parent corporation and each of the affiliates, develop a listing of common stock dividends, earnings available and the dividend payout percentages; and

(h) If available, for the reporting company and the affiliates, develop a summary of industry-specific average or target dividend payout percentages. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXIII. REPORTING REQUIREMENTS -- CONSOLIDATED INCOME TAXES (1) Where consolidated income taxes are allocated between the reporting company and affiliates, a reporting company shall provide:

(a) A copy of the relevant agreement;

(b) A summary description of the agreement, which shall include:

(i) A listing of the corporate entities among which taxes are allocated;

(ii) Internal procedures and policies governing the preparation and filing of the consolidated tax return;

(iii) A statement as to how each party to the agreement records income taxes;

(iv) The policies used to allocate tax benefits and losses to each party; and

(v) An explanation of the method used to resolve disputes.

(c) Identification of the entity responsible for the preparation of the consolidated tax return;

(d) A statement as to how the costs of the consolidated income tax return activities are shared by the parties to the agreement; and

(e) If the agreement is modified during the reporting year, a description of each modification or revision. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXIV. REPORTING REQUIREMENTS -- SALE OF OWNERSHIP INTEREST (1) Where a parent corporation or the reporting company sells all or a material part of its ownership interest in an affiliate, the reporting company shall provide the following:

(a) The name and address of the principal business office of the acquiring company;

(b) A summary of the terms and conditions of the agreement;

(c) A schedule showing the affiliates long-term assets, other assets, long-term liabilities, other liabilities and owners equity; and

(d) A summary of the accounting entries, including account numbers and descriptions, used to record the transactions upon the selling entities' books of account. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXV. REPORTING REQUIREMENTS -- EMPLOYEE TRANSFER INFORMATION (1) The minimum level of employee categories for which information shall be provided is executive, management, professional/technical and other. Employee transfer information shall be reported as follows:

(a) For each affiliate, for the defined employee categories, provide the number of employees transferred to the parent corporation or the reporting company; and

(b) For the parent corporation and the reporting company, for the defined employee categories, provide the number of employees transferred to each of the other affiliates. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXVI. REPORTING REQUIREMENTS -- PURCHASE OF GOODS OR SERVICES FROM AN AFFILIATE (1) If the reporting company paid an affiliate for the provision of products, goods, or services during the reporting year, for which full cost recovery was not allowed by the commission through regulated rates, the reporting company shall provide the following information:

(a) A description of the affiliated services provided for which full cost recovery was disallowed;

(b) The amount of the payments made by the reporting company during the reporting year and an estimate of the amount which was not recovered through the reporting company's regulated rates; and

(c) A description of any compensatory actions taken by the parent corporation, the reporting company, or the affiliate to allow for the cash flow difference (e.g., allowed recovery through rates versus payments made to the affiliate) to be returned to the reporting company. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXVII. REPORTING REQUIREMENTS -- MANAGEMENT AGREEMENTS - RURAL UTILITIES SERVICE (1) Reporting companies that file management agreements with the rural utilities service (RUS) shall include copies of such agreements in the reporting companies annual report. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXVIII. MINIMUM AFFILIATED INTEREST ANNUAL REPORTING REQUIREMENTS (1) Reporting companies who meet the minimum filing standard tests set out in [Rule VIII] and are not exempted pursuant to [Rule VII], shall only be required to file the following information as an annual report:

(a) The name, title, address and telephone number of the person responsible for the preparation and filing of the annual report;

(b) A legal and an operational organization structure and a listing of officers and directors for each entity, including:

(i) A narrative description of the corporate organization of the reporting company and its affiliates, including a general statement as to the business purpose of the entities within the operational organization structure; and

(ii) A description of the nature of the business and transactions conducted between the parent corporation, the reporting company and affiliates, generally indicating the products or services provided.

(c) If the organizational structure of which the reporting company is a part has changed through the sale or transfer of ownership since the last reporting year, provide a general description of the change;

(d) For each sale or transfer of Montana jurisdictional capital assets with a total company combined value (higher of original cost or selling price) of $25,000 or more, provide the following:

(i) A description of the assets sold or transferred;

(ii) The established price of the sale or transfer, the net book value and the method used to determine the price; and

(iii) A summary of the journal entries, including the amount, the account number and related description, used to record the transaction.

(e) Reporting companies who receive an allocation of corporate or other overhead costs common to or shared between the reporting company and any affiliate or unregulated activity, shall provide the following:

(i) A description of the functions or services to which the allocated costs pertain;

(ii) A description of the method used to identify the shared costs and the methodology used to allocate the costs;

(iii) A statement by functional area showing the total shared costs, the allocation basis used and the allocated cost to other entities and the reporting company; and

(iv) An explanation of any changes in the cost identification and allocation methodology used since the last reporting year.

(f) For affiliated transaction reporting, two separate schedules are to be included:

(i) A schedule for products, goods and services provided by the reporting company to the affiliate; and

(ii) A schedule for products, goods and services provided by the affiliate to the reporting company. The schedules provided shall include the following information:

(A) The name of the affiliate;

(B) A general description of each of the products, goods and services provided;

(C) A general description of the method used to determine the transfer price (e.g., tariff, cost, market);

(D) The total charges for each entity reported by type of product, goods and or services provided; and

(E) Provide copies of a relevant agreement or a description of the terms and conditions of such agreements.

(g) Where applicable, the reporting company shall provide a general description of the terms and conditions of the following types of agreements:

(i) Cash management agreements, policies and procedures;

(ii) Long-term, one year or longer, loan agreements; and/or

(iii) Guarantees or credit support agreements. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

RULE XXIX. ADVICE LETTER FILINGS (1) The reporting company shall notify the commission through an advice letter filing, no earlier than 90 days prior to the occurrence and no later than concurrent with the occurrence, of certain affiliate activities or transactions.

(2) Reporting companies shall file advice letters with the commission relative to new or modified parent corporation or affiliate activities or transactions, concerning the following:

(a) The provision of reporting company products, goods, assets and services, to affiliates, excluding those services provided under a regulated rate or schedule of rates;

(b) The provision of parent corporation products, goods, assets and services to the reporting company. This shall apply equally to modifications to the corporate overhead cost identification and allocation methodology;

(c) The provision of affiliates' products, goods, assets and services to reporting companies, excluding those services provided under a regulated rate or schedule of rates;

(d) Loan agreements between the reporting company, affiliates and the parent corporation;

(e) Guarantees or credit support provided for affiliate indebtedness by the reporting company;

(f) New or modified income tax treaties or written income tax allocation policies; and

(g) Cash management policies which have an impact on the reporting company and its affiliates.

(3) The general information which shall be included, where applicable, in advice letter filings by reporting companies is as follows:

(a) The name, title, address and telephone number of the person authorized, on behalf of the reporting company, to

receive notices, inquiries and other forms of communications regarding the advice letter filing;

(b) A statement describing the relationship between the reporting company and the affiliate;

(c) A detailed description of the types of products, goods, assets or services which are to be provided to the reporting company or the affiliate;

(d) A description of the method or methods relied upon in pricing the product, goods, assets or services being provided;

(e) A copy of any agreements or contracts entered into by the parties, including an overview of any changes and a summary of terms and conditions;

(f) An estimate of the annual or one-time cost of the product, goods, assets or services and which accounts will be used to record the transactions; and

(g) A statement of the purpose, facts and reasons which were relied upon by the reporting company in its decision to enter into the agreement or adopt the revised policy. AUTH: Sec. 69-3-103, MCA; IMP, Secs. 69-3-102, 69-3-106 and 69-3-203, MCA

4. Rationale: Section 69-3-201, MCA, provides that the charge for reasonably adequate utility service be reasonable and just. A reasonable charge for utility service should reflect only those costs necessary to the provision of the service. In order to ensure a reasonable charge for utility service the Commission must review relevant affiliated transactions and interests of utility companies. These rules facilitate that review by requiring regular reporting of affiliated interests and transactions, as well as by requiring that information on and justification for affiliated transactions be included in rate case filings. In addition, these rules apprise utilities of certain basic Commission policies on affiliated transactions. These policies should serve to inform the management decisions of utility companies.

5. Interested parties may submit their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted (original and 10 copies) to Robin McHugh, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601 no later than October 30, 1995.

6. The Montana Consumer Counsel, 34 West Sixth Avenue, P.O. Box 201703, Helena, Montana 59620-1703, (406) 444-2771, is available and may be contacted to represent consumer interests in this matter.

NANCY MCGAFFREE, Chair

Reviewed By Robin A. McHugh

CERTIFIED TO THE SECRETARY OF STATE SEPTEMBER 18, 1995.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.22.1311 relating to Industrial Machinery and Equipment Trend Factors	NOTICE OF THE PROPOSED AMENDMENT of ARM 42.22.1311 relating to Industrial Machinery and Equipment Trend Factors

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Department of Revenue proposes to amend ARM 42.22.1311 relating to industrial machinery and equipment trend factors. These amendments are the same as the ones which the department noticed up for emergency action in 1995 MAR 9, page 857.

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

42.22.1311 INDUSTRIAL MACHINERY AND EQUIPMENT TREND FACTORS (1) The department of revenue will utilize the machinery and equipment trend factors which are set forth on the following tables. The trend factors will be used to value industrial machinery and equipment for ad valorem tax purposes pursuant to ARM 42.22.1306. The department uses annual cost indexes from Marshall Valuation Service. The current index is divided by the annual index for each year to arrive at a trending factor. Each major industry has its own trend table. Where no index existed in the Marshall Valuation Service for a particular industry, that industry was grouped with other industries using similar equipment.

1995 INDUSTRIAL MACHINERY & EQUIPMENT TREND FACTORS

Trend Table	Description	Life
(1)	Aircraft/Airframe Mfg.	15
(4)	Alcohol Plant	15
(2)	Baking	12
(21)	Bentonite	20
(3)	Bottling	12
(4)	Brewing & Distilling	20
(5)	Candy & Confectionery	20
(25)	Cardboard Container	20
(6)	Cement Manufacturing	20
(14)	Cereal Products	16
(7)	Chemical Manufacturing	12
(8)	Clay Products	15
(21)	Coal Crushing & Handling	20

(28)	Coal Fired Power Gener.	16
(6)	Concrete Products	18
(6)	Concrete Ready Mix	18
(9)	Contractor Equipment	10
(10)	Creamery & Dairy	12
(16)	Egg Packing	20
(11)	Electric Power Equipment	16
(12)	Electrical Equipment Mfg.	10
(12)	Electronic Component Mfg.	10
(14)	Feed Milling	16
(30)	Fertilizer Distribution	10
(7)	Fertilizer Manufacturing	12
(13)	Fish Cannery	12
(14)	Flour, Cereal & Feed	16
(14)	Flour Milling	16
(20)	Foundry	15
(15)	Fruit Cannery	12
(16)	Fruit Packing	12
(31)	Furniture Manufacturing	10
(4)	Gasohol Plant	15
(32)	Glass Manufacturing	15
(14)	Grain Handling Facilities	16
(21)	Graphite Products	20
(21)	Gypsum	20
(21)	Heap Leach Mechanical	20
(21)	Heap Leach Pads	5
(15)	Honey Processing	12
(11)	Hydroelectric Generation	20
(9)	Industrial Shop Equipment	10
(17)	Laundry & Drycleaning	10
(29)	Leather Fabrication	20
(21)	Lime/Calcium Benefication	20
(18)	Logging Equipment	10
(19)	Meat Packing	12
(20)	Metal Fabrication	20
(20)	Metal Machining & Milling	15
(20)	Metal Working	20
(21)	Mining & Milling	15
(23)	Natural Gas Processing	16
(21)	Nonferrous Smelting	15
(23)	Oil Refining	16
(21)	Open Pit Mining/Quarrying	15
(21)	Ore Milling/Concentrating	15
(7)	Oxygen Generation	20
(22)	Paint Manufacturing	12
(30)	Peat Moss/Compost Plant	20
(23)	Petroleum	16
(21)	Phosphate Benefication	20
(32)	Plastic Products Mfg.	20
(18)	Pole Treating Equipment	10
(32)	Polystyrene	20
(24)	Printing	12

(25)	Pulp & Paper Mfg.	13
(26)	Refrigeration	12
(20)	Rifle Manufacturing	15
(27)	Rubber & Vulcanizing	15
(18)	Sawmill Equipment	~~12~~ 10
(14)	Seed Treating & Cleaning	16
(6)	Stationary Asphalt Plant	15
(28)	Steam Power Generation	16
(21)	Stone Products	15
(23)	Sugar Refinery	18
(23)	Sulphur Manufacturing	12
(21)	Talc Benefication	20
(29)	Textile Fabrication	10
(21)	Underground Mining	10
(14)	Vegetable Oil Extraction	20
(21)	Vermiculite Processing	20
(30)	Warehousing	10
(14)	Wood Pellet Plant	16
(31)	Wood Products, Reconstituted	~~12~~ 10
(31)	Woodworking	~~12~~ 20

The remainder of this rule remains the same.
AUTH: Sec. 15-1-201 MCA.
IMP: Secs. 15-6-138 and 15-8-111 MCA.

3. ARM 42.22.1311 is proposed to be amended because in reviewing the amendments made to ARM 42.22.1311 on December 23, 1994, the Department determined there were three errors to the table found in (1) entitled "1995 Industrial Machinery & Equipment Trend Factors." The Department did an emergency amendment which was effective May 11, 1995.

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

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

no later than October 26, 1995.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than October 26, 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

adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision, or agency; or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be greater than 25.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State September 6, 1995

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.15.506 relating to Computation of Residential Property Tax Credit for Elderly	NOTICE OF THE PROPOSED AMENDMENT OF ARM 42.15.506 RELATING TO COMPUTATION OF RESIDENTIAL PROPERTY TAX CREDIT FOR ELDERLY NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On November 9, 1995, the Department of Revenue proposes to amend ARM 42.15.506 relating to Computation of Residential Property Tax Credit for Elderly.

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

42.15.506 COMPUTATION OF RESIDENTIAL PROPERTY TAX CREDIT FOR ELDERLY (1) When the taxpayer owns the dwelling but rents the land or owns the land and rents the dwelling, he shall add the rent-equivalent tax paid on the rented property to the property tax paid on the owned property. The total shall then be reduced as provided by 15-30-176(4), MCA. The tax credit will be the reduced amount or $400, whichever is less. Effective for taxable years beginning after December 31, 1982 and before January 1, 1995, the maximum allowable credit is $400. For tax years beginning after December 31, 1994, the maximum allowable credit is $1,000.

(2) A taxpayer shall not be entitled to rent-equivalent tax paid on either a rented dwelling or rented land which is not subject to ad valorem taxes in Montana during the claim period except for those units rented from a state, county or city housing authority.

(3) When a taxpayer lives in a rest home, the rent allowed in calculation of the property tax credit is the lesser of $20 per day or the actual rent paid.

(4) Where one spouse lives in a rest home and the other lives at a different address, they are only allowed to take the rent at the rest home or the rent/taxes of the other house but not both.

AUTH: Sec. 15-30-305 MCA
IMP: Sec. 15-30-176 MCA

3. ARM 42.15.506 is being amended to clarify legislative intent. The legislature changed the law because property taxes have increased over the last several years, so the maximum elderly property tax/renter credit should also be increased to keep up with this rise.

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

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

no later than October 26, 1995.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than October 26, 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 adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision, or agency; or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be greater than 25.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State September 6, 1995

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT) of ARM 42.15.316 relating to) Extensions and Late Pay) Penalty)	NOTICE OF THE PROPOSED AMENDMENT OF ARM 42.15.316 RELATING TO EXTENSIONS AND LATE PAY PENALTY NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On October 28, 1995, the Department of Revenue proposes to amend ARM 42.15.315 relating to Extensions and Late Pay Penalty.

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

42.15.316 EXTENSIONS - LATE PAY PENALTY (1) Effective with tax years beginning after December 31, ~~1990~~ 1994 a ~~six-month~~ four-month extension of time to file an individual income tax return may be obtained by a taxpayer only if the following conditions are met:

(a) A properly completed Montana application for automatic extension (form EXT) is either delivered to the department or postmarked on or before the original due date of the return. The due date is April 15th for calendar year taxpayers or the 15th day of the 4th month following the close of the taxable year for fiscal year taxpayers.

(b) At the time of making the application, the taxpayer has paid either through withholding, estimated tax payments, payments with the extension request, or a combination of all three, either of the following:

(i) ~~95%~~ 90% of their current year's income tax liability; or

(ii) 100% of their prior year's income tax liability.

(2) For this purpose, a taxpayer's tax liability is defined as the tax less any income tax credits (excluding the refundable elderly homeowner credit, withholding, and estimated tax payments).

(3) For purposes of subsection (1) (b), in determining a taxpayer's percentage level of payment, the total of their Montana withholding tax, any estimated payments plus any payment made with the application for extension are divided by the taxpayer's total tax liability.

Example: A taxpayer has a current year tax liability of $10,000 before any income tax credits. The taxpayer has an income tax credit of $600, withholding of $4,000, an estimated tax payment of $2,000 and an elderly homeowner credit of $400. The taxpayer's prior year

tax liability after credits was $12,000. If the taxpayer requests ~~an~~ a four-month extension, the amount of payment required is calculated as follows:

		PREVIOUS YEAR	CURRENT YEAR
Total tax liability before credits	=	$12,000	$10,000
Less income tax credits	=	-0-	(600)
Total tax liability	=	$12,000	$ 9,400
		X 100%	X ~~95%~~ 90%
Amount required to be paid	=	$12,000	$ ~~8,930~~ 8,460
LESS CURRENT YEAR PAYMENTS:			
Montana withholding	=	$ 4,000	$ 4,000
Estimated tax payments	=	2,000	2,000
Elderly homeowner credit	=	400	400
Total payments		$ 6,400	$ 6,400
threshold figures		$ 5,600	$ ~~2,530~~ 2,060

After subtracting the withholding, estimated tax and elderly homeowner credit, the amount of ~~$2,530~~ 2,060 (the lesser of the two) is the amount required to be paid in order to receive an extension.

(4) If a taxpayer obtains an extension and does not meet either of the required payment thresholds in subsection (1) (b), a late pay penalty of 10% is imposed on the underpayment. Late file penalties will not apply.

(5) The underpayment is calculated as the difference between the lesser of:

(a) ~~95%~~ 90% of the current year's income tax liability after credits, less the amount of payments from withholding, estimated tax, and payments with the extension; or

(b) 100% of the prior year's income tax liability after credits, less the amount of payments from withholding, estimated tax, and payments with the extension.

(6) In the case where a taxpayer is single the prior year and married the current year and wishes to file a married filing joint return, they are required to pay either ~~95%~~ 90% of the current year's income tax liability or 100% of the combined tax liabilities of both taxpayer's prior year single return.

(7) In the case where a taxpayer is married the prior year and single the current year, they are required to pay either ~~95%~~ 90% of their current year's income tax liability or 50% of the tax liability of the taxpayer's prior year return.

(8) Additional time of up to two months will be granted if good cause exists and the taxpayer submits a second extension request which is delivered to the department or postmarked by the due date of the original extension and if the requirements of the four-month extension have been satisfied. A copy of federal form 2688 listing good cause is acceptable. The department reserves the right to disapprove an extension if good cause does not exist.

~~(8)~~ (9) Interest is charged at 9% per annum or 3/4% per month on the underpayment of taxes from the original due date of the return.

~~(9)~~ (10) An extension of time to file does not extend the time to pay. When a return is filed before the extension date and payment is not made, the return is subject to late pay penalties.

~~(10)~~ (11) Taxpayers who are either first time filers, or have a zero or negative taxable income for the previous year, are considered to have paid 100% of the previous year's tax for purposes of meeting the requirements in subsection (1)(b).

AUTH: Sec. 15-30-305 MCA

IMP: Sec. 15-30-144 MCA

3. The proposed amendments are being proposed to conform to the statutory changes made by the 1995 Legislature. The law was amended to conform the timing for filing of Montana income tax extensions to the same as the federal returns. For management of resources for processing income tax returns, this would allow the department to better estimate how many returns were not filed after the first extension was due on August 15.

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

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

no later than October 26, 1995.

5. If a person who is directly affected by the proposed amendments wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than October 26, 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 adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision, or agency; or from an association having no less than 25 members who will be

directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be greater than 25.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State September 6, 1995

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 2.5.403 concerning the application of preferences to contracts involving federal funds in state purchasing.	)))))	NOTICE OF ADOPTION OF AMENDMENT TO RULE

TO: All Interested Persons:

1. On August 10, 1995 the Department of Administration published a notice of public hearing on the proposed amendment to the above-stated rule at page 1466, 1995 Montana Administrative Register, issue number 15.

2. The Department has amended the rule exactly as proposed.

3. No written or oral comments were received at the hearing. The Department did receive an oral comment and a written comment in general support of the amendment prior to the hearing.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Lois Menzies, Director
Department of Administration

Certified to the Secretary of State on September 11, 1995.

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

In the matter of the amendment to rule 6.6.5101 and the repeal of rules 6.6.5103 through 6.6.5125	)))	**NOTICE OF AMENDMENT AND REPEAL OF RULES REGARDING THE SMALL EMPLOYER HEALTH REINSURANCE PROGRAM**

TO: All Interested Persons.

1. On August 10, 1995, the State Auditor and Commissioner of Insurance (Auditor) published notice at pages 1468 through 1469 of the Montana Administrative Register, Issue No. 15, to consider the amendment of ARM 6.6.5101 and the repeal of ARM 6.6.5103 through 6.6.5125.

2. On September 7, 1995, a public hearing was held in Helena concerning the proposed revisions of the small employer health reinsurance act. There were no persons testifying but one comment was received.

3. The Auditor adopts the rule amendment as proposed and repeals the rules as proposed except for the change in authority cite and correction of rule number as shown below:

6.6.5103 DEFINITIONS
6.6.5105 BOARD OF DIRECTORS OF PROGRAM
6.6.5107 SUPPORT COMMITTEES
6.6.5109 SELECTION, POWERS, AND DUTIES OF ADMINISTERING CARRIER
6.6.5111 REINSURANCE WITH THE PROGRAM
6.6.5113 AUDIT FUNCTIONS
6.6.5115 ASSESSMENTS
6.6.5117 REPORTS OF REINSURED RISKS
6.6.5119 FINANCIAL RECORD KEEPING AND ADMINISTRATION
6.6.5121 ERRORS, ADJUSTMENTS, PENALTIES, AND SUBMISSION OF DISPUTES
6.6.5123 PROPOSALS FOR AMENDMENTS TO PLAN

6.6.51265 STANDARDS FOR PRODUCER COMPENSATION LEVELS AND FAIR MARKETING OF PLANS

AUTH: ~~1-3-201~~33-1-311 AND 33-22-1819, MCA
IMP: 33-22-1819, MCA

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

COMMENT: The authority for the repeal of the rules is questioned.

RESPONSE: The comment is correct and the authority is accordingly changed.

MARK O'KEEFE
STATE AUDITOR

By: _____
Frank G. Coté
Deputy Insurance Commissioner

_____
Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 18th day of September, 1995.

BEFORE THE PROFESSIONAL AND OCCUPATIONAL
LICENSING BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the transfer of rules pertaining to fireworks wholesaler permits	)	NOTICE OF TRANSFER OF 8.70.1401 AND 8.70.1402 PERTAINING TO FIREWORKS WHOLESALER PERMITS

TO: All Interested Persons:

1. The Department of Commerce has administratively transferred the rules pertaining to fireworks wholesaler permits from the Building Codes Bureau to the Professional and Occupational Licensing Bureau. The Professional and Occupational Licensing Bureau has determined that ARM 8.70.1401 and 8.70.1402 will be numbered as ARM 8.19.301 and 8.19.302 respectively, when replacement pages are completed for the September 30, 1995 filing date.

2. This transfer was effective July 1, 1995.

3. The authority and implementing sections will remain the same.

DEPARTMENT OF COMMERCE

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, September 18, 1995.

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

In the matter of the amendment of ARM 12.6.801 relating to the boating closure on the upper end of Hauser Reservoir from October 15 through December 15 of each year.	)))))	NOTICE OF THE AMENDMENT OF ARM 12.6.801

To: All Interested Persons.

1. On July 27, 1995, the Fish, Wildlife and Parks Commission (commission) published notice of the proposed amendment of the above-captioned rule at page 1386, 1995 Montana Administrative Register, issue number 14.

2. The commission has adopted the rule amendment as proposed.

AUTH: 87-1-303, 23-1-106, MCA; IMP: 87-1-303, 23-1-106, MCA

3. No adverse comments or testimony were received.

4. 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.

RULE REVIEWER

Robert N. Lane

FISH, WILDLIFE AND PARKS COMMISSION

Patrick J. Graham, Secretary

Certified to the Secretary of State on September 18, 1995.

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the amendment of rules 16.44.102, 110, 126, 16.44.202, 16.44.303, 305, 306, 334, 335, 16.44.402, 16.44.612, 16.44.702, and 16.44.1101, concerning incorporations by reference of federal regulations, definitions, and regulatory requirements governing hazardous waste and used oil; and the repeal of 16.14.589, prohibiting used oil as dust suppressant.	NOTICE OF AMENDMENT OF RULES AND REPEAL OF ARM 16.14.589 (Hazardous Waste)

To: All Interested Persons

1. On July 27, 1995, the department published notice of the proposed amendment of the above-captioned rules and the repeal of ARM 16.14.589 at page 1402 of the Montana Administrative Register, Issue No. 14.

2. The department adopted the rules as proposed with no changes. The department has repealed 16.14.589 as proposed.

3. The department thoroughly considered all comments received. Those comments and department responses follow:

COMMENT: The Montana Department of Transportation submitted the following comment: The Montana Department of Environmental Quality (DEQ) is proposing to adopt rules that regulate the management of used oil. DEQ is proposing to adopt the federal regulations that are codified in 40 CFR Part 279. It is our understanding that the proposed state rules will be consistent with the federal regulations and will not be more stringent. * * * These rules will require MDT to conduct analyses on our used motor oil and to keep acceptance and delivery records. Secondary containment, contingency plans and biennial reporting will be required for our transfer facilities. Compliance with these proposed used oil rules will require an investment in manpower and money.

RESPONSE: The Department of Environmental Quality (department) agrees that the proposed state rules concerning used oil management are consistent with the federal rules found at 40 CFR Part 279. Upon final adoption, the state rules will be equivalent to the federal regulations. The department also recognizes that expenditures of time and money will be required of certain generators and handlers of used oil in order to comply with the requirements of the proposed rules. The proposed rules will require precautionary measures designed to prevent discharges of used oil to the environment, and will

require analysis, recordkeeping and reporting of certain used oil generators and handlers. The department believes the additional expenditures necessitated by these requirements are justified by the additional protection to human health and the environment afforded by the proposed rules. Therefore, the department has adopted the rules as proposed.

Mark A. Simonich, Director

Certified to the Secretary of State September 18, 1995.

Reviewed by:

John F. North, Rule Reviewer

BEFORE THE DEPARTMENT OF JUSTICE
STATE OF MONTANA

In the matter of the adoption of new rules I, II, III, IV, V, VI, VII and VIII specifying the procedure for review, approval, supervision and revocation of cooperative agreements between health care facilities or physicians and the issuance and revocation of certificates of public advantage	))))))))	NOTICE OF ADOPTION OF NEW RULES PERTAINING TO PROCEDURES FOR COOPERATIVE AGREEMENTS BETWEEN HEALTH CARE FACILITIES OR PHYSICIANS AND THE ISSUANCE AND REVOCATION OF CERTIFICATES OF PUBLIC ADVANTAGE

TO: All Interested Persons

1. On June 15, 1995, the Department of Justice published a notice at page 1006 of the Montana Administrative Register, Issue No. 11, of the proposed adoption of the above-captioned rules, specifying the procedure for review, approval, supervision and revocation of cooperative agreements between health care facilities or physicians and the issuance and revocation of certificates of public advantage.

2. The agency has adopted Rule I (23.18.101) as proposed.

3. The agency has adopted Rule II with the following changes:

RULE II (23.18.102) APPLICATION PROCEDURE Subsections (1)(a) through (1)(d) remain as proposed.

(e) a verified statement signed by a responsible officer of each party to the application or, if one or more of the applicants is an individual, signed by the individual applicant, attesting to the accuracy and completeness of the enclosed information;

Subsections (f)(i) and (f)(ii) remain as proposed.

(iii) a description of each party's contribution of capital, equipment, labor, services, or other value to the transaction, ~~as well as each party's nonmonetary involvement in the arrangement;~~ if any;

Subsection (f)(iv) remains as proposed.

(v) identification of any other ~~tangential~~ services or products ~~associated with the services or products~~ that are ~~the subject of~~ reasonably likely to be affected by the proposed agreement or transaction;

Subsections (f)(vi) through (f)(x) remain as proposed.

(xi) a description of the previous history of dealings between the parties to the application, including, but not limited to, their relationship as competitors and any prior joint ventures or other collaborative arrangements between the parties or their principals;

Subsections (f)(xii) through (f)(xiii) remain as proposed.

(xiv) identification of business plans, reports, studies, or other documents that discuss each party's projected performance in the market, business strategies, competitive analyses and financial projections, including any documents prepared in anticipation of the cooperative agreement, merger or consolidation, as well as those prepared prior to contemplation of the transaction;

Subsections (f)(xv) through (2) remain as proposed.

(3) If the application involves an agreement with a health maintenance organization, the applicant must submit proof that the requirements of Title 33, chapter 31, MCA, have been met.

(4) The application and accompanying documents are public documents, except for any trade secrets, as defined by 30-14-402(4), MCA, or information otherwise required by law to be kept confidential. Information in the application may be kept confidential if it is determined by the department to be proprietary or protected by personal privacy interests. If the applicants believe the application contains any information which must be kept confidential, such information must be clearly identified and duplicate applications must be submitted, one application with full information for the department's use and one redacted application available for release to the public. A written statement must accompany the application, explaining the legal basis for protection of any information as confidential.

Subsection (4) remains as proposed in text but is renumbered (5).

~~(5)~~ (6) Once the application is complete, the department shall cause notice of the application to be published in the ~~Special Notices~~ Notice section of the Montana Administrative Register and sent to any person who has requested to be placed on a list to receive notice of applications. All costs associated with publication of notice shall be borne by the applicants. A person may be placed on a list to receive notice by sending his or her name and address to: Attorney General's Office, 215 North Sanders, P.O. Box 201401, Helena, Montana, 59620-1401.

Subsection (6) remains as proposed in text but is renumbered (7).

AUTH: Sec. 50-4-612, MCA
IMP: Sec. ~~50-4-601 through~~ 50-4-603, 50-4-612 MCA

4. The agency has adopted Rule III with the following changes:

RULE III (23.18.103) PROCEDURE FOR REVIEW OF APPLICATIONS

Subsections (1) and (2) remain as proposed.

(3) The department may seek advice and consultation from other entities, including but not limited to the department of public health and human services, the state health care advisory council, and the commissioner of insurance. Any written comment provided by such entities regarding the application is public information and available upon request to the applicants or any other person.

(4) The department's decision to issue or deny the certificate must be in writing and must contain all terms and conditions, if any, imposed by the department, and findings of fact and conclusions of law in support of its decision.

AUTH: Sec. 50-4-612 MCA
IMP: Sec. 50-4-603 ~~50-4-601 through 50-4-612,~~ MCA

5. The agency has adopted Rule IV with the following changes:

RULE IV (23.18.104) STANDARDS FOR CERTIFICATION Subsections (1)(a) through (c) remain as proposed.

(d) savings to health care consumers resulting from anticipated cost efficiencies;

Subsections (d) through (g) remain as proposed in text but are renumbered (e) through (h).

Subsections (2) through (4)(b) remain as proposed.

(c) result in fewer, or shorter, hospital stays without detriment to the patient's health;

Subsection (4)(d) remains as proposed.

(e) result in lower complication rates;

(f) result in shorter patient waiting periods;

Subsections (e) and (f) remain the same in text but are renumbered (g) and (h).

Subsection (5) remains as proposed.

(6) A certificate of public advantage will not be awarded in connection with an agreement involving a health maintenance organization unless the transaction has been approved by the commissioner of insurance as required by Title 33, chapter 31, MCA.

(7) The department shall maintain on file all cooperative, merger and consolidation agreements for which a certificate of public advantage remains in effect. Any party to a cooperative agreement or transaction who terminates the agreement shall file a notice of termination with the department within 30 days after termination.

AUTH: Sec. 50-4-612 MCA
IMP: Sec. 50-4-603 ~~50-4-601 through 50-4-612,~~ MCA

6. The agency has adopted Rule V with the following changes:

RULE V (23.18.105) RECONSIDERATION Subsections (1) and (2) remain as proposed.

AUTH: Sec. 50-4-612 MCA
IMP: Sec. ~~50-4-601 through~~ 50-4-604, 50-4-612 MCA

7. The agency has adopted Rule VI with the following changes:

RULE VI (23.18.106) ACTIVE SUPERVISION OF APPROVED TRANSACTIONS Subsections (1)(a) through (b)(ii) remain as proposed.

(iii) a narrative analysis of the benefits and disadvantages to health care consumers in Montana resulting from the implementation of the cooperative agreement, including benefits or disadvantages not previously identified.

(2) The department may require specific data relating to cost, access to health care, and quality of health care, or any other information it determines to be reasonably necessary to its inquiry~~, and~~. The department may conduct such audits of the books, records, and other documents pertaining to the agreement or transaction and of the operations under the agreement, merger, or consolidation as ~~the department~~ it determines to be reasonably necessary~~. Any such audit shall be~~ for the purpose of evaluating whether there has been compliance with the cooperative, merger or consolidation agreement approved by the department and whether any terms and conditions imposed by the department have been met, or to determine whether grounds exist for revocation under 50-4-609, MCA. The expense of the audit must be borne by the certificate holder(s). The audit report shall be considered confidential and shall not be disclosed by the department unless confidentiality is waived by the parties or disclosure is required by order of a district court after notice to the certificate holder(s).

(3) The department may solicit and consider public comment on any progress report required by this rule. The department may request additional oral or written information from the certificate holder(s) or from any other source. In assessing issues of health care costs, access, and quality, the department may receive information from any affected person, and may require a survey of patients, professionals, or other persons affected by the cooperative agreement, merger or consolidation. The costs of the survey must be borne by the certificate holder(s).

(4) Any person may notify the department of conduct of the certificate holder(s) that is alleged to violate the cooperative, merger or consolidation agreement approved by the department or any terms and conditions imposed by the department. The notice must be in writing and include a statement of facts supporting the allegation of a violation. Upon receipt of such notice, the department may conduct any inquiry it finds appropriate. It is within the department's discretion to review any notice of violation, and a review may be conducted independently or in conjunction with the annual review provided by this rule.

(5) The department may request additional information from the certificate holder(s) at any time during the ~~implementation~~ term of the cooperative agreement, merger or consolidation. The parties shall respond within 30 days to any additional requests for information requested by the department.

Subsection (5) remains as proposed in text but is renumbered (6).

AUTH: Sec. 50-4-612 MCA
IMP: Sec. ~~50-4-601 through~~ 50-4-612, 50-4-622 MCA

8. The agency has adopted Rule VII with the following changes:

RULE VII (23.18.107) REVOCATION OF CERTIFICATES (1) The department may revoke a certificate of public advantage if it determines that:

(a) its approval of the cooperative agreement, merger or consolidation was procured by material fraud or misrepresentation of matters related to the department's determination as to improvements in cost, access or quality of health care;

Subsection (b) remains as proposed.

(c) despite compliance with the terms and conditions of the certificate, the agreement or transaction is not resulting in lower health care costs, ~~or in~~ improved access to health care, or higher quality health care without undue increase in health care costs;

Subsections (1)(d) and (e) and (2) remain as proposed.

AUTH: Sec. 50-4-612, MCA
IMP: Sec. ~~50-4-601 through~~ 50-4-609, 50-4-612 MCA

9. The agency has adopted Rule VIII with the following changes:

RULE VIII (23.18.108) FEES Subsections (1)(a)(i) and (ii) remain as proposed.

(b) In addition to the initial application fee, the applicants for a certificate of public advantage shall be jointly and severally obligated to pay the actual costs and expenses of the department reasonably incurred in conducting its review of the application, including but not limited to the costs associated with retention of any accounting, technical, or legal assistance determined necessary by the department.

Subsections (c) and (d) remain as proposed.

(2) Each annual report submitted under ~~[Sec. 6, Ch. 526, L. 1995]~~ 50-4-622 must be accompanied by an application fee in the following amount:

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

AUTH: ~~Sec. 7, Ch. 526, L. 1995~~ Sec. 50-4-623 MCA
IMP: ~~Ch. 526, L. 1995, sec. 50-4-601 through~~ Sec. 50-4-612, 50-4-623 MCA

10. Comments were received and are summarized and responded to as follows:

COMMENT: In written comments, the Montana Deaconess Medical Center and Columbus Hospital in Great Falls, Montana, suggest that Rule VI exceeds what is necessary to achieve the legislative purpose of conferring state action immunity and is not necessary to ensure that the public interest is served. The hospitals do not, however, object to the Rule as long as the review process does not become unreasonable or unduly burdensome. The hospitals

also suggest that Rule VIII should be amended to include a requirement of reasonableness of the department's costs. The hospitals also submitted comments at the public hearing, through their attorney Joe Sims, which primarily responded to objections submitted by others to the rules.

RESPONSE: Section 50-4-622, MCA, requires holders of a certificate of public advantage to submit at least annual progress reports to the department, and provides no exception for mergers or consolidations. Rule VI implements this requirement, as well as the express requirement of 50-4-612 that the rules effect active supervision by the department of agreements between health care facilities. Rule VIII has been amended to reflect a standard of reasonableness for the department's costs.

COMMENT: The Missoula law firm of Garlington, Lohn, and Robinson submitted written comments suggesting deletion of those portions of the proposed rules that contemplate the independent significance of competition or of any factors other than issues of cost, access and quality (Rule IV(2)(c) and (d), first sentence of Rule IV(5), and modification of second sentence of Rule IV(5)). The firm also suggests that the rules be amended to require findings of fact and conclusions of law to support each decision of the agency throughout the approval and review process. Finally, the firm suggests that the proposed rules contemplate the potential for revocation of a certificate of public advantage on grounds not authorized by the statute and should be amended.

RESPONSE: The department finds that existing conditions of the marketplace in which the cooperative agreement, merger, or consolidation is occurring are relevant to its evaluation of the impacts of the transaction. If the existing competitive environment would better achieve the goals of lower costs, greater access or improved quality, that is relevant to the determination whether a certificate should be awarded. Abuse of private economic power is a factor to be considered in evaluating cost to consumers. With respect to the second comment, Rules III and VI have been amended to incorporate a requirement of written findings and conclusions; written findings are required by statute for reconsideration and revocation determinations and, to some extent, as part of the department's review of progress reports. Finally, Rule VII has been amended to clarify that the grounds for revocation must relate to the seminal issues of cost, access and quality.

COMMENT: Written comments submitted by St. Vincent Hospital in Billings suggest amendments to clarify, by changing "or" to "and" in Rule I, that certificates may be granted to any combination of agreements between health care facilities, physicians, or both. The hospital also suggests that certain requirements in Rule II(1)(f) for information to be supplied in the application process are overly broad, and that provision should be made to keep personal income confidential. The

hospital submitted several comments regarding the time periods for the department's review and decisionmaking process and suggests that the rules be amended to make a public hearing discretionary and to allow audits only upon good cause. The hospital requests an amendment to place a reasonable limit on the period of active supervision. The hospital also suggests that limits be placed on the fees so that the applicant is not subject to unlimited costs. Finally, the hospital suggests amendment to Rule III so that comments made by others are available to the applicant.

RESPONSE: Many of the suggestions made by St. Vincent Hospital are contrary to or covered by the enabling statutes, which require a public hearing on every application and specify time frames for the department's actions. Section 50-4-603 requires disclosure of any consideration passing to any person under the terms of the agreement. The statutes also require annual progress reports and do not contemplate a period after which such reports are no longer required. Some modifications have been made to the rules in response to the hospital's suggestions, including the addition of clarifying language to Rule II(1)(f)(xi) and the clarification of reasonableness standards in Rules VI and VIII. In addition, Rule II(4) has been amended to allow information to be kept confidential if competitively sensitive or protected by privacy interests. The department finds further specification of time limits to be unnecessary in view of the limits imposed by statute and the promptness standards imposed in the rules.

COMMENTS: Dr. Paul Gorsuch of Great Falls submitted both written comments and oral testimony pertaining primarily to the adequacy of the rules to ensure improvements in cost, access and quality. Dr. Gorsuch suggests that the rules be broadened to allow more public input and that the standards by which issues of cost, access and quality will be judged be stated with greater specificity. He suggests a number of specific items that should be included in the rules, such as particular cost data, report cards used by federal agencies, and other itemized information. Dr. Gorsuch also suggests that opportunity for input from patients and providers be expanded.

RESPONSE: In response to Dr. Gorsuch's suggestions, the following changes have been made to the rules: Rule IV(4) has been amended to specify additional factors the department may consider in making determinations of quality, and Rule VI has been amended to clarify that the department may require a survey of patients, professionals, or other persons affected by implementation of the agreement. A new subsection (4) has also been added to Rule VI, specifying that any person may notify the department of conduct alleged to be in violation of the certificate awarded by the department. Many of Dr. Gorsuch's other comments arise in the context of the anticipated application of the two Great Falls hospitals for a certificate of public advantage for a proposed merger of the facilities.

Although a number of his specific recommendations may certainly be appropriate in the context of a hospital merger, they may not be applicable to other types of cooperative agreements. The rules provide adequate flexibility to allow consideration of facts and circumstances particular to the transaction at issue and for inclusion of specific terms and conditions appropriate for the transaction. For example, even though each potential indicia of quality has not been specified in the rules, Rule IV(4) allows the department to consider any features likely to improve or reduce the quality of health care.

COMMENT: Thomas Gundlach, representing the Competition Preservation Coalition, suggests that the underlying legislation and the proposed rules fail to meet federal standards for active supervision because there is no regulatory board established, no independent ratemaking authority, no provision for prior approval of rate charges, and inadequate information required in the progress reports. Mr. Gundlach also suggests that the rules create an impermissible conflict of interest by allowing the department to recover from the applicants all costs associated with its retention of services necessary to review and supervise the proposed action. Mr. Gundlach suggests that the rules be amended to provide authority for a private party to petition the department to review conduct of the certificate holder that allegedly violates the law or conditions imposed by the department. Finally, he suggests that the rules fail to provide for adequate staffing to conduct on-going supervision.

RESPONSE: To the extent Mr. Gundlach's comments address perceived shortcomings in the legislation itself or its underlying wisdom, such matters are beyond the scope of the rulemaking process. However, the department finds that the rules as adopted satisfy state action immunity standards requiring the state to actively supervise cooperative agreements, mergers and consolidations authorized by 50-4-601, MCA. The enabling statute and these rules authorize and require the department to participate in the establishment of the details of each transaction, including the imposition of appropriate terms and conditions--which may or may not include the specific terms and conditions suggested in the comments. The rules further provide for active monitoring and oversight of cooperative agreements to determine whether these terms and conditions have been satisfied and whether the statutory objectives for which the agreement was approved are being met. In situations where the department determines that this is not the case, appropriate enforcement mechanisms are available to seek compliance or otherwise ensure that the statutory objectives are satisfied. Rule VI also has been amended to allow private parties to notify the department of alleged violations. Finally, section 50-4-623 expressly authorizes the department to charge fees to offset its costs in conducting the review and supervision of cooperative agreements, including costs for securing services necessary to adequately perform those functions. That the costs are ultimately borne by the regulated parties, rather than state taxpayers, does not

undermine the department's regulatory authority and creates no conflict of interest. The department notes that costs associated with pre-merger notification under the Hart Scott Rodino Act, 15 U.S.C. § 18a, are reimbursed to the federal government through application fees paid by the interested parties.

COMMENT: Written and oral comments were submitted by the Montana Hospital Association, generally supportive of the rules but suggesting several changes. First, the association suggests that the disclosure requirements in Rule II are too cumbersome for small mergers or joint ventures and provision should be made for waiver. Second, it suggests that Rule II(f)(xiv) should be limited to documents materially relied on by the parties in determining to apply for a certificate. Finally, the association objects to the open-ended fee schedule and suggests that the department will have no incentive to keep its costs down in conducting the review and supervision.

RESPONSE: Rule II(2) provides that the department may waive any of the disclosure requirements it finds to be inapplicable due to the nature of the agreement or transaction at issue. Rule II(1)(f)(xiv) has been clarified, but the department finds that the association's suggestion would inappropriately narrow the information sought by this provision. The department finds that projections of market performance and related information may be relevant to issues of health care costs, access or quality even if not "materially relied on" by the parties. Finally, Rule VIII has been clarified to reflect a standard of reasonableness.

COMMENT: Cheryl Reichert, M.D., Ph.D., submitted written comments stating in general terms her belief that increased regulation will not lower health care costs and suggesting that the rules should allow the submission of viewpoints of patients and the perspective of health care providers. She also suggests that the rules do not go far enough to assess the costs associated with a merger.

RESPONSE: The rules offer an opportunity for public input at all stages of the process, beginning with the initial review of an application. Rule VI has been amended to allow private citizens to notify the department of alleged violations by the certificate holder, and the rule also provides for the consideration of information from any affected person. Insofar as the assessment of costs is concerned, the rules are designed to be flexible enough to apply to all types of cooperative agreements; particular cost information and data may be required as appropriate for individual applications and progress reports.

COMMENT: The Montana Hospitals Rate Review System submitted written comments suggesting in general that the rules provide flexibility to accommodate all types of transactions, and specifically suggesting an amendment to Rule III(3) to make sure the department is not restricted to receiving information only from the agencies identified in that subsection.

RESPONSE: Rule III(3) has been amended as suggested. The rules have been drafted to allow flexibility within the limits of the enabling statute. For example, Rule II(2) allows waiver of any inapplicable disclosure requirements and Rule IV includes broad provisions allowing the department to consider any features of the agreement that pertain to cost, access, or quality.

COMMENT: Written comments were submitted by Blue Cross and Blue Shield of Montana, suggesting a number of amendments to the rules. An amendment was suggested to Rule II(1)(c) to require identification of all individuals who are owners of or principals in any entity which is a party to an application. Several amendments were suggested to extend the disclosure requirements to "services or products reasonably likely to be impacted by" the agreement or transaction. It was also suggested that Rule IV be amended to specify a burden of proof and that Rule VII be amended to prohibit the department from revoking a certificate in the case of a merger if the cost of undoing the merger would outweigh the benefit. Additionally, a number of both substantive and non-substantive stylistic changes were suggested.

RESPONSE: The department included several amendments as suggested by Blue Cross and Blue Shield. Rule II(1)(e) was clarified to include individual applicants; Rule II(1)(f)(v) was amended to require identification of services or products likely to be impacted by the agreement; Rule II(1)(f)(xi) was amended to include disclosure of prior dealings between the parties or their principals; Rule II(1)(f)(xiv) was amended to provide clarification; and several stylistic suggestions were incorporated. Rule IV was not amended to specify a burden of proof, since the standard of review for the agency's action is specified by statute. Rule VII was not amended as suggested, because the amendment would conflict with statutory language. Other stylistic suggestions of a non-substantive nature were not incorporated.

COMMENT: The Office of the State Auditor submitted written and oral comments suggesting that the rules be amended to recognize the Insurance Commissioner's responsibilities in the area of transactions involving health maintenance organizations, which are included in the definition of "health care facility" in section 50-5-101(19), MCA.

RESPONSE: An amendment has been made to Rules II and IV requiring compliance with Title 33, chapter 31, MCA, before any application involving a health maintenance organization will be considered.

COMMENT: Written and oral comments were submitted on behalf of Interim HealthCare of Cascade County, through its president, Otis Kline, and through its attorneys, Luxan & Murfitt. Interim suggests that the provisions for ongoing supervision following a merger are not adequate, in that the rules should provide for the filing of complaints by third parties regarding noncompliance,

that the department should have full power to investigate violations, and that the department should have full power to enforce terms and conditions of the certificate. Interim also suggests that the rules should provide for assurances from a merged hospital that referral of patients to post-hospital services will be fair and objective.

RESPONSE: Rule VI has been amended to authorize third parties to notify the department of alleged violations by the certificate holder. Under section 50-4-621, MCA, the attorney general has authority to bring an action to enforce any terms or conditions of the certificate or to enjoin any material violation. Finally, the comment concerning home health services following hospital discharge is more appropriately addressed in the context of a specific transaction, and could be included, if applicable, in the terms and conditions of a particular certificate.

COMMENT: The Secretary of State's Office suggests that Rule II be amended to provide for the publication of notice of the filing of an application in the Notice Section of the Montana Administrative Register, rather than the Special Notices Section.

RESPONSE: Rule II(5) has been amended as suggested.

COMMENT: Sonja C. Jones, R.N., submitted written comments raising several questions about the proposed merger of the Great Falls hospitals and suggesting specific items that should be included in the application. Ms. Jones suggests that the application should be signed by all officers of a corporate applicant, that any list of affected products or services must include local availability of those products or services, that a merger should be voted on by the community, that the applicant should be required to describe how it will enhance quality, that active supervision should be conducted by independent parties rather than the certificate holder, that issues of quality should include treatment and ratio of staff, that comments should be circulated to all interested parties, and that the rules should place a limit on how much money may be spent to accomplish a merger.

RESPONSE: Regarding the active supervision component, Rule VI has been amended to clarify the extent of input that will be allowed from third parties, including notification to the department of alleged violations by the certificate holder. Since a corporate entity may act through an authorized official, it is unnecessary to require signatures of all officers; likewise, the state cannot regulate the amount of money a private entity chooses to spend on its affairs, nor does it have the legal authority to require a community vote. Rule II does require the reciprocal exchange of comments; comments by third parties must be supplied to the applicant, and the applicant in turn is required to supply the third party with a copy of any comments it makes in response. All other information connected

with the application, except information protected by law, is public information and available upon request. Finally, several of Ms. Jones' comments may be appropriate for consideration in the context of a particular application but need not be included as a rule applicable to all transactions.

COMMENT: Jake Allen, M.D., provided oral testimony, suggesting that mergers do not always produce the benefits in services that they claim and that oversight will be lacking if the rules are adopted without amendment. He suggested that the free market best ensures quality of service, but that if the State is committed to substituting regulation for competition more supervision is needed.

RESPONSE: Amendments have been added to Rule VI to clarify some aspects of supervision. The rule is intended to provide a framework for supervision, allowing for case-by-case determination of the supervision needed in a particular transaction; the supervision must be tailored to the situation and the rules allow the department to impose whatever terms and conditions are appropriate.

COMMENT: Tim Nagel provided oral testimony on behalf of Montana MRI, and agreed with others that active supervision is critical. He suggested that merged entities will force small independent providers out of business by boycotting their services in favor of services provided by entities controlled by the merged facility.

RESPONSE: Mr. Nagel did not suggest any specific changes to the Rules, and his comments are appropriately addressed in the context of a specific transaction. The issue of referrals to other health care providers could, in an appropriate situation, be addressed as a term or condition of the certificate.

By: _____
CHRIS D. TWEETEN
Chief Deputy Attorney General

_____
(Rule Reviewer)

Certified to the Secretary of State September 18, 1995.

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

In the matter of the amendment of ARM 24.11.606, 24.11.608, 24.11.610, 24.11.613) 24.11.701, 24.11.801, 24.11.803) 24.11.808, and 24.11.814; the adoption of three new rules and) the repeal of ARM 24.11.1001 through 24.11.1006, related to unemployment insurance taxes	) NOTICE OF AMENDMENT,) ADOPTION, AND REPEAL OF RULES

TO ALL INTERESTED PERSONS:

1. On July 27, 1995, the Department published notice at pages 1388 through 1394 of the Montana Administrative Register, Issue No. 14, to consider the amendment of certain existing rules, the adoption of new rules and the repeal of certain existing rules, all related to unemployment insurance taxes.

2. On August 21, 1995, a public hearing was held in Helena concerning the proposed amendments and repeals. Oral comments were offered at that time. Written comments were received prior to the closing date of August 25, 1995. No comments were made concerning the proposed repeals.

3. After consideration of the comments received on the proposed amendments, the Department has amended ARM 24.11.606, 24.11.608, 24.11.610, 24.11.613, 24.11.701, 24.11.801, 24.11.803, 24.11.808, and 24.11.814 exactly as proposed.

4. After consideration of the comments received on the proposed rules, the Department has adopted the following rules exactly as proposed:

RULE I (24.11.831) DEFINITION OF DIRECT SELLER

RULE II (24.11.835) DETERMINING WHETHER A WORKER IS THE EMPLOYEE OF A TEMPORARY SERVICE CONTRACTOR OR A PROFESSIONAL EMPLOYER ORGANIZATION

RULE III (24.11.609) RATES FOR NEW EMPLOYERS

5. The Department has repealed ARM 24.11.1001 through 24.11.1006 exactly as proposed.

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

Comment 1: Terry Keating, United Staffing of America, suggested in regards to Rule III, that the Department take into

consideration the experience rating factors for a professional employer organization ("PEO") that had an unemployment insurance account established before the effective date of Senate Bill 264, and not automatically assign "new employer" rates.
Response 1: The Department will consider the experience accumulated for established PEO accounts when assigning rates. Those PEO's which are "experience rated" (those that have 3 year's experience) will be assigned a contribution rate based on contributions paid, benefit charges to their account, and their taxable payroll. PEO's that are "new employers" will be assigned a rate pursuant to Rule III.

The Department will not retroactively change contribution rates for PEO's which were assigned "new employer" rates that differ from the rates proposed in Rule III.

Comment 2: Mr. Keating also asked that the Department consider that the PEO is the employer of record for all payroll reporting purposes and be viewed the same as employee leasing or a temporary service company for classification purposes.
Response 2: The Department considers the PEO the employer of record for UI tax purposes, based on the PEO laws established by the 1995 Legislature in Senate Bill 264 (Chapter 344, Laws of 1995). Unemployment insurance tax liability is shared jointly between the PEO and the client. Due to the long-term relationship between the PEO and the client's former employees, the department believes that the industrial classification for PEO's should be based on the industry in which the majority of the workers are placed. This reduces the risk of rate manipulation and will assure adequacy of the unemployment insurance trust fund. The Department believes that new employer rates proposed in Rule III are in line with the intent of the PEO legislation.

Comment 3: Robert P. Hunter, National Association of Professional Employer Organizations (NAPEO), cautioned the Department that it may not be consistent with the intent of the underlying programs to treat PEO-employee relationships the same for purposes of unemployment insurance and workers' compensation.
Response 3: The Department believes that the purpose of Senate Bill 264 was to provide for a common and consistent approach for defining PEO-employee relationships under Montana law. The Department notes that NAPEO provided the model language upon which SB 264 is based. The Department believes that SB 264 was intended to allow PEOs operating in Montana and their Montana clients assurance that there would not be inconsistent treatment of PEO-employee relationships depending on whether unemployment insurance laws or workers' compensation laws were being applied.

Comment 4: Jim Tutweiler, Montana Chamber of Commerce, asked in relation to ARM 24.11.803(2), in what instance would a successor employer not want to acquire the experience rating record (and carry forward the taxable wage base) of the predecessor.

Response 4: The successor employer likely would not want the experience rating record or the accumulated taxable wages of the predecessor if the predecessor had a higher contribution rate than the successor would as a new employer, or if the successor did not keep all of the predecessor's employees.

7. The amendments, adoptions and repeals are effective October 1, 1995, except for the amendment to 24.11.814, which is effective January 1, 1996.

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

David A. Scott
Rule Reviewer

By: David A. Scott
David A. Scott
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: September 18, 1995.

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

In the matter of the amendment of ARM 24.29.704, 24.29.705 and 24.29.720, related to workers' compensation coverage matters, and the repeal of ARM 24.29.3501, 24.29.3502, 24.29.3503, 24.29.3504 and 24.29.3505, pertaining to the state compensation insurance fund	) NOTICE OF AMENDMENT AND REPEAL

TO ALL INTERESTED PERSONS:

1. On July 27, 1995, the Department published notice at pages 1395 through 1398 of the Montana Administrative Register, Issue No. 14, to consider the amendment of ARM 24.29.704, 24.29.705 and 24.29.720, and the repeal of ARM 24.29.3501 through 24.29.3505.

2. On August 21, 1995, a public hearing was held in Helena concerning the proposed amendments and repeals. No oral or written comments were offered by members of the public. No written comments were received prior to the closing date of August 25, 1995.

3. The Department has amended the rules exactly as proposed and has repealed the rules exactly as proposed.

4. The amendments and repeals are effective October 1, 1995, except for the amendment to 24.29.720, which is effective January 1, 1996.

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

David A. Scott
Rule Reviewer

By: David A. Scott
David A. Scott
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: September 18, 1995.

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

In the matter of the repeal of Rules 26.2.628, 26.2.629, 26.2.630, 26.2.634, 26.2.639, and 26.2.641 through 26.2.663 pertaining to rules implementing the Montana environmental policy act	)))))))	NOTICE OF REPEAL

TO: All Interested Persons.

1. Pursuant to Section 500, Chapter 418, Laws of Montana 1995, effective July 1, 1995, policies and objectives in the operation of the department of state lands, and the guidelines for department programs is transferred from the Department of State Lands to the Department of Natural Resources and Conservation. In order to implement that legislation, Rules 26.2.628, 26.2.629, 26.2.630, 26.2.634, 26.2.639, and 26.2.641 through 26.2.663 pertaining to rules implementing the Montana Environmental Policy Act, are hereby repealed.

2. Rules 26.2.628, 26.2.629, and 26.2.630 are on pages 26-50 through 26-52 of the Administrative Rules of Montana. Rules 26.2.634 and 26.2.639 are on pages 26-53 and 26-56 of the Administrative Rules of Montana. Rules 26.2.641 through 26.2.663 are on pages 26-56 through 26-74 of the Administrative Rules of Montana.

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

3. Rules 26.2.641 through 26.2.663 are duplicative of the rules contained in the existing Department of Natural Resources and Conservation MEPA rules.

4. The repeal of these rules is effective July 1, 1995.

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE,
RULE REVIEWER

Certified to the Secretary of State September 18, 1995.

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

In the matter of the transfer of Rules 26.2.701 and 26.2.702, and the amendment of Rule 36.2.701, pertaining to citizen participation in agency decisions	)))))	NOTICE OF TRANSFER AND AMENDMENT OF RULE (Citizen Participation)

TO: All Interested Persons.

1. Pursuant to Section 500, Chapter 418, Laws of Montana 1995, effective July 1, 1995, policies and objectives in providing citizen participation in the operation of the department of state lands, and the guidelines for department programs are transferred from the Department of State Lands to the Department of Natural Resources and Conservation. In order to implement that legislation, ARM 26.2.701 and 26.2.702, inclusive, are transferred to the administrative rules of the Department of Natural Resources and Conservation.

2. The Department of Natural Resources and Conservation has determined that the transferred rules will be numbered as follows:

OLD	NEW	
26.2.701	36.2.701	Policies and Objectives in Providing Citizen Participation in the Operation of the Department of Natural Resources and Conservation
26.2.702	36.2.702	Guidelines for Department Programs

3. Following the transfer, Rule 36.2.702 will be amended as follows:

36.2.702 GUIDELINES FOR DEPARTMENT PROGRAMS Subsections (1) through (7) remain the same.

(8) When the department ~~or commissioner~~ determines that a proposed decision or action is of significant interest to the public, one person shall be designated as contact person with the public on the proposed decision or action. This person should be a departmental employee familiar with the proposed decision or action.

Subsection (9) remains the same.

AUTH: 2-3-103, 2-15-112, MCA
IMP: 2-3-103, MCA

4. The amendment of Rule 36.2.712 is necessary because the Department of State Lands was eliminated by Section 500, Chapter 418, Laws of Montana 1995, and there is no longer a commissioner.

5. The transfers and amendment are effective July 1, 1995.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE, RULE REVIEWER

Certified to the Secretary of State Sept. 15, 1995.

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

In the matter of the repeal of Rules 26.2.703 through 26.2.707 pertaining to citizen participation in agency decisions	)))))	NOTICE OF REPEAL

TO: All Interested Persons.

1. Pursuant to Section 500, Chapter 418, Laws of Montana 1995, effective July 1, 1995, policies and objectives in the operation of the department of state lands, and guidelines for department programs are transferred from the Department of State Lands to the Department of Natural Resources and Conservation. In order to implement that legislation, Rules 26.2.703 through 26.2.707, pertaining to citizen participation in agency decisions, are hereby repealed.

2. Rules 26.2.703 through 26.2.707, the rules repealed, are on pages 26-82 and 26-83 of the Administrative Rules of Montana.

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

3. The repeal of these rules is effective July 1, 1995.

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE,
RULE REVIEWER

Certified to the Secretary of State Sept. 18, 1995.

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

In the matter of the transfer of Rules 26.6.101 through 26.6.610, pertaining to forestry	))))	NOTICE OF TRANSFER (Forestry)

TO: All Interested Persons.

1. Pursuant to Section 500, Chapter 418, Laws of Montana 1995, effective July 1, 1995, policies and objectives in the rules concerning forestry land programs is transferred from the Department of State Lands to the Department of Natural Resources and Conservation. In order to implement that legislation, ARM 26.6.101 through 26.6.610, inclusive, are transferred to the administrative rules of the Department of Natural Resources and Conservation.

2. The Department of Natural Resources and Conservation has determined that the transferred rules will be numbered as follows:

OLD	NEW	
26.6.101	36.9.101	Fire Management and Forest Management Bureaus
26.6.201	36.10.101	Classification of Forest Lands
26.6.202	36.10.102	Firefighting Equipment Required (REPEALED)
26.6.203	36.10.103	Vehicle Exhaust and Spark Arrestor Requirements (REPEALED)
26.6.204	36.10.104	Patrolling and Fire Crews (REPEALED)
26.6.205	36.10.105	Fire Cache (REPEALED)
26.6.206	36.10.106	Forest Activity Restrictions (REPEALED)
26.6.207	36.10.107	Forest Closure-Permits (REPEALED)
26.6.208	36.10.108	Debris Disposal (REPEALED)
26.6.209	36.10.109	Firefighting Equipment Required
26.6.210	36.10.110	Vehicle Exhaust and Spark Arrestor Requirement

26.6.211	36.10.111	Fire Tools
26.6.212	36.10.112	Correction of Hazards and Patrolling
26.6.213	36.10.113	Fire Crew
26.6.214	36.10.114	Smoking and Lunch Fires
26.6.215	36.10.115	Debris Disposal
26.6.216	36.10.116	Notice and Publicity (REPEALED)
26.6.217	36.10.117	Review of Requirements (REPEALED)
26.6.218	36.10.118	Powerline Inspections
26.6.219	36.10.119	Forest Activity Restrictions
26.6.220	36.10.120	Forest Closure
26.6.221	36.10.121	Request for Review
26.6.222	36.10.122	Applicability
26.6.261	36.10.161	Formula to Set Landowner Assessments for Fire Protection
26.6.301	36.10.201	Purpose
26.6.302	36.10.202	Minimum Measures by County Commissioners
26.6.303	36.10.203	Department Analysis of Request
26.6.304	36.10.204	Department Assistance
26.6.401	36.11.101	Cabin Site Maintenance and Restrictions
26.6.402	36.11.102	Christmas Tree Cutting Rules on State Forest Lands
26.6.411	36.11.111	Agreement Not to Export State Logs
26.6.501	36.11.201	Purpose of Fire Hazard Reduction or Management Law and This Sub-chapter
26.6.502	36.11.202	Definitions
26.6.503	36.11.203	Control of Timber Slash and Debris

26.6.504	36.11.204	Reduction of Slash and Debris Along Right-of-Way
26.6.511	36.11.211	Forms
26.6.601	36.11.301	Applicability - Definitions - Effective Date
26.6.602	36.11.302	Width of Streamside Management Zone - Marking Boundary
26.6.603	36.11.303	Broadcast Burning
26.6.604	36.11.304	Equipment Operation in the SMZ
26.6.605	36.11.305	Retention of Trees in the SMZ - Clearcutting
26.6.606	36.11.306	Road Construction in the SMZ
26.6.607	36.11.307	Hazardous or Toxic Materials
26.6.608	36.11.308	Side-casting of Road Material
26.6.609	36.11.309	Depositing Slash
26.6.610	36.11.310	Site-specific Alternative Practices

3. The transfer of Rules 26.6.101 through 26.6.610 is necessary because the Department of State Lands was eliminated by Section 500, Chapter 418, Laws of Montana 1995. In order to provide historical reference, the repealed rules were transfered back from Department of State Lands.

4. The transfer is effective July 1, 1995.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MacINTYRE, REVIEWER

Certified to the Secretary of State Sept. 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rule 46.12.508 pertaining to medicaid reimbursement for outpatient hospital imaging and other diagnostic services	)))))	NOTICE OF THE AMENDMENT OF RULE 46.12.508 PERTAINING TO MEDICAID REIMBURSEMENT FOR OUTPATIENT HOSPITAL IMAGING AND OTHER DIAGNOSTIC SERVICES

TO: All Interested Persons

1. On August 10, 1995, the Department of Public Health and Human Services published notice of the proposed amendment of rule 46.12.508 pertaining to medicaid reimbursement for outpatient hospital imaging and other diagnostic services at page 1560 of the 1995 Montana Administrative Register, issue number 15.

2. The Department has amended rule 46.12.508 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: MHA worked cooperatively with the department in analyzing the outpatient hospital payment rules to establish a prospective payment methodology. Rather than engage in a bona fide study of the current issues the department used the study to implement a pre-conceived agenda. Namely, the department acted to implement a fee schedule which substantially reduces hospital payments. The recommendations of the hospital association, and its hospital members, have been largely ignored by the department. The department is adopting this and other outpatient rules merely to reduce outlays for services delivered to medicaid patients.

RESPONSE: We appreciate the cooperation of the Montana Hospital Association in the study and analysis of outpatient hospital services. Abt Associates completed the outpatient hospital study and prepared a report for the department in November 1994. The department believes the Abt study was reasonable and objective. Therefore we are using this study as a basis to develop and establish prospective payment methodologies. We have outlined our plan for implementation of the study recommendations to the Montana Hospital Association and we have implemented some prospective payment methodologies effective July 1, 1995. The rule changes for imaging and other diagnostic services were targeted for the July 1, 1995 effective date but was delayed.

The department has reviewed each recommendation presented by Abt Associates and considered related issues brought forth by the hospital association and member hospitals. For instance, the

department revised the proposed administrative rules with respect to the emergency room screen fee to allow payment for laboratory and imaging services, at the request of MHA and member hospitals. In addition the department worked with several hospital representatives in the development of the prospective payment methodologies for partial hospitalization services. We believe that we are thoroughly considering the issues with respect to each program's prospective payment methodology, considering the hospital association's global opposition to all prospective payment methodologies.

COMMENT: Abt Associates has recommended a payment system which it initially estimated would be nearly budget neutral to the hospitals and the department, even though Abt failed to provide any meaningful analysis of the impact of its own recommendations. The department agreed to delay the implementation of the radiology fee schedules while it sought better data about the impact of the proposed fee schedules. This action came only after the department learned the proposed fee schedule would cut payments far greater than the department intended. The department now proposes to back into rates which still cut hospital payments by up to $400,000 per year, and will result in payments which are below every hospital's cost to deliver care.

RESPONSE: The report prepared by Abt Associates does include an overview of the simulated impacts on hospitals. Using information and data available at the time of the study, Abt Associates did prepare an analysis and consideration of the impact of their recommendations. This analysis is contained in section 3 of their report, which includes consideration of the existing coding systems, the UB-92 claim form, as well as expected impacts on hospitals. Abt clearly qualifies the estimated impacts on hospitals by program or groups of programs.

The commentor incorrectly suggests that overall the Abt recommendations were initially estimated to be nearly budget neutral. The Abt report does make a reference to budget neutrality by estimating medicaid payments would fall 1% if all hospitals were paid prospectively. This observation was made with regard to the group of outpatient services including emergency room and clinic services, ambulatory surgery, therapies, and other visits. Abt prepared separate narrative and estimates with regard to dialysis visits, psych day treatment visits, observation beds, and ancillary visits such as laboratory tests and imaging services. These separate narratives do not address budget neutrality for the recommended changes. They do however separately address the impacts of the recommended changes both fiscally and administratively.

When Abt Associates prepared the report on outpatient services for imaging services there was no way to make precise estimates of the impact of their recommendation. The fee schedule recommended by Abt is organized by CPT-4 code but this code was

not present on the medicaid claims provided by the department. Use of CPT-4 coding for payment of imaging services was not required by the department for payment of claims. Therefore it was not present on the claims data the department provided Abt Associates. Abt did make a rough estimate, based upon the few instances in which it was possible to map CPT-4 codes to a specific revenue code. In their report they said the recommendation would mean "somewhat lower payments to hospitals overall" for imaging services.

The department and Abt associates continued our analysis of this recommendation. We were later advised by HCFA that it was possible to use the medicare cost reports to estimate the impact of the imaging recommendation. We obtained a sample of medicare cost reports from 1992 which Abt was able to analyze and make more precise and reasonable estimates of the recommendation. Based upon this analysis we found that the proposed fee schedule would result in payment levels significantly below what we are paying under the cost based methodology. It became clear that medicaid's current payment policies for these services are more generous than those of medicare, but that the proposed fee schedule would result in significantly reduced payment level for hospitals. We expected some decrease in payment levels, however, we did not expect as significant a decrease as would have occurred. Based upon this finding the department decided to delay implementation of the imaging and other diagnostic fee schedules.

We continued our analysis of the cost report information and the proposed rule change is based on the medicare cost reports from 1992, most if not all of which have been audited. We recognized from the data that a majority of the hospitals are subject to the blending formula of medicare, meaning hospital costs are blended into the medicare fee schedule. In recognition of this fact, the department believes it is reasonable that medicare data be used to determine the percentage of the technical component that medicaid should use in setting its fee schedule. Considering the fact that the current medicaid payment methodology is more generous than medicare, hospital payments will be reduced in aggregate in an estimated range between $200,000 and $400,000. This will result in medicaid payments similar to medicare at approximately 85% of costs.

COMMENT: Even though the department theorizes that "efficient" hospitals will now be able to respond to the incentives of the system, no hospital will receive adequate payments to provide this crucial service. The department is wrong in its assertion that fee schedules represent a more equitable payment system for hospitals. All hospitals must deliver radiology and diagnostic services around the clock regardless of patient volumes. The department has also failed to consider that hospitals only deliver services ordered by physicians, and sometimes doesn't even see the patient. Hospitals are not allowed by law to refuse to provide services ordered by the physician.

RESPONSE: The Abt report recommended the medicaid program discontinue its retrospective, facility-specific, cost based method of payment and move toward a prospective model. Given the standardized nature of imaging services there is no justification for basing payment on actual costs which may vary widely among different facilities. Payment based on a fee schedule is understandable and certain and provides the sharpest incentives for hospitals to be efficient in providing imaging services and other diagnostic services. The evidence is compelling that prospective payment methods can reduce the rate of cost growth while maintaining patient access to care and taking into account casemix differences across facilities.

The proposed prospective payment methodology uses medicare's list of services and is linked to the medicare rates. Based upon our analysis of medicare cost report information, approximately 56% of the hospitals experienced medicare reimbursement at 80% or more as a percentage of costs. Four of these hospitals were not subjected to the medicare blending of the physicians fee schedule and were reimbursed by medicare at 100% of costs. Considering the average medicare reimbursement as a percentage of costs is 85% and the proposed medicaid fee schedule is targeted to reimburse providers at a similar percentage, hospitals will receive adequate reimbursement to provide this crucial service. This data was obtained from all of the Montana hospital medicare cost report information. It includes hospital radiology and diagnostic services delivered by Montana hospitals around the clock, and ordered by physicians.

COMMENT: The department has failed to consider any hospital costs in creating the technical component of the fee schedule. MHA has argued that hospital costs are not comparable to physician office costs. In fact, the department has no data to measure physician office costs. The current proposal to pay 160% of the physician office technical component itself speaks to the lack of accuracy in the department's plan. Even though the department repeatedly compares its own payments to medicare, the department refuses to blend hospital costs with physician fee schedules in a fashion similar to medicare.

RESPONSE: As we mentioned above a majority of the hospitals are subjected to the blending formula of medicare. Hospital costs are blended into the medicare fee schedule formula which involves both retrospective and prospective elements. The medicare formula is so complex that HCFA recently said that it pays about $1 billion a year more for outpatient services than congress intended. Despite MHA's urging for medicaid to blend hospital costs like medicare it clearly would not be efficient or progressive to emulate medicare exactly.

We are however, linking our proposed payment methodology to the medicare methodology by using the medicare list of services and the medicare physicians fee schedule. Medicare uses the relative weights from the physicians fee schedule in calculating

the blended payments it makes for imaging and other diagnostic services provided in hospital outpatient departments. The medicare formula uses 62% of the global fee schedule for imaging services and 42% of the global fee schedule for other diagnostic services to estimate the technical component for the blending. We have reviewed this estimate and conclude that 62% and 42% of the global fee from the medicare physicians fee schedule approximates the calculated technical component from the medicare physicians fee schedule. Thus we are confident that basing the proposed medicaid fee schedule on the technical component closely resembles the practice used by medicare. It is therefore not necessary to consider hospital costs in the calculation of the physicians fee schedule technical component and/or perform any analysis on physician office costs.

Medicaid has considered hospital costs in the calculation of the proposed medicaid fee schedule by setting the fees at 160% of the technical component of the medicare physicians fee schedule. We recognize, as we have said before, that medicare blends hospital costs in the calculation of medicare reimbursement. We have described above that the technical component mirrors that utilized by medicare in the blending. Thus by grossing up the technical component by 160% we have recognized hospital costs in the calculation of the proposed medicaid fee schedules. The proposed medicaid reimbursement is targeted to reimburse imaging and other diagnostic services at a similar percentage of costs as medicare.

COMMENT: MHA opposes this proposal because it, like the changes to emergency room services, fails to address the base causes of unnecessary use of hospital services. While hospitals agree with department officials that some savings are possible if patients could be directed to lower cost settings, hospitals don't agree that punitive fee schedules resolve that problem. Medicaid recipients do not have adequate access to physician office settings and therefore are diverted to emergency rooms and other outpatient departments for primary care. Hospitals often provide medical services beyond the capacity of physician offices, especially diagnostic radiology services. It is foolish public policy for the state to assert low fees will help divert medicaid recipients to lower cost settings that don't exist.

RESPONSE: The purpose of these proposed rules for imaging and other diagnostic services is not to divert medicaid recipients to lower cost settings. The department's policy intention is to ensure that medicaid beneficiaries receive quality health care, efficiently provided. It is a prospective payment policy that is understandable and certain and provides hospitals incentives to be efficient in providing imaging and other diagnostic services. We recognize that the proposed medicaid fee schedule will result in reduced medicaid reimbursement in the aggregate. We do not believe the proposed fees are low and punitive to hospitals as the commentor suggests. Medicaid and medicare will

now pay similarly for similar services. Under the current cost based methodology medicaid pays 95% of costs on average. Under the proposed prospective payment methodology medicaid will pay about 85% of cost, similar to medicare.

COMMENT: MHA suggests that the department establish a fee adjustment for low volume, rural hospitals. The department should exempt radiology procedures which are available only within a hospital. The department should also amend the fee schedules to reflect, at least partially, hospital costs similar to the medicare fee methodology. Finally, medicaid fees should be implemented in a budget neutral fashion.

RESPONSE: The department has considered hospital costs in the calculation of the medicaid fee schedule as described above. The department will not implement the proposed medicaid fees in a budget neutral fashion. As we mention above, under the current cost based methodology medicaid is more generous than medicare in paying for imaging and other diagnostic services. Based upon this finding and the federal medicare upper limit requirements, medicaid will not set the fees in a budget neutral fashion.

In addition, the department does not believe it is necessary to make special adjustments to the proposed medicaid fee schedule for low volume rural hospitals or exempt radiology procedures which are available only within a hospital. To do so would make the proposed reimbursement methodology administratively burdensome for the department and providers. The proposed fee schedules are simple, understandable, and certain for hospitals and the department.

COMMENT: MHA suggests the department amend the medicaid rules which require physician attestation for inpatient hospital services. Medicare has officially announced the repeal of this requirement, and department officials have indicated that medicaid will follow the federal lead. Although the department did not include the repeal in the first notice, the repeal of the rule will not be opposed by any hospital. Official federal notice is expected in the federal register prior to the final notice of this state regulation.

RESPONSE: The department is aware of this change expected to be made by HCFA with regard to the physician attestation requirement and we have informed the Montana Hospital Association that we will follow medicare to remove this requirement from our administrative rules. The department agrees that it would be convenient to add this change to these proposed rules and we appreciate MHA and their member hospitals support of such a change. The department will prepare a separate administrative rule change notice that will address this change in federal requirements as well as the recent changes in cost reporting requirements.

4. The changes are effective October 1, 1995.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the amendment of rules 46.12.605 and 46.12.606 pertaining to medicaid coverage and reimbursement of dental services	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.605 AND 46.12.606 PERTAINING TO MEDICAID COVERAGE AND REIMBURSEMENT OF DENTAL SERVICES

TO: All Interested Persons

1. On August 10, 1995, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.605 and 46.12.606 pertaining to medicaid coverage and reimbursement of dental services at page 1553 of the 1995 Montana Administrative Register, issue number 15.

2. The Department has amended rule 46.12.606 as proposed.

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

46.12.605 DENTAL SERVICES, REIMBURSEMENT Subsections (1) through (2) remain as proposed.

(a) dental and orthodontic services that are designated in the manual as being reimbursed through the report method, "BR", or are listed in the manual under the fee column are reimbursed by the medicaid program at 65.2% of the billed charge for services provided to adults and 80% of the billed charge for services provided to children. For purposes of this rule, services provided to children are services provided while the recipient is under age ~~21~~ 18. COVERAGE REQUIREMENTS FOR CHILDREN WILL REMAIN THE SAME, ONLY THE REIMBURSEMENT IS CHANGED.

Subsections (3) through (8) remain as proposed.

AUTH: Sec. 53-2-201 and 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: The greatest need for increased fees is for services provided to children under 18. By raising fees for children under 21, there are not adequate funds to sufficiently raise fees for children.

RESPONSE: During the 1995 legislature, authorization was made to increase all childrens' fees to 80% of billed charges. A panel of five dentists from around the state were chosen by the Montana Dental Association to assist in the allocation of the additional funds.

After a number of meetings, it became apparent that increasing all child services to 80% would require more funding then what was available. As a result, the age limit for children has been revised to include individuals under the age of 18. The coverage requirements will remain the same, only the reimbursement is changed. This change will allow the department to meet the appropriations granted by the legislature.

5. The changes will be effective October 1, 1995.

Russell E. Cater
Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the amendment of rules 46.12.805 and 46.12.806 pertaining to medicaid coverage and reimbursement of durable medical equipment	)))))	NOTICE OF THE AMENDMENT OF RULES 46.12.805 AND 46.12.806 PERTAINING TO MEDICAID COVERAGE AND REIMBURSEMENT OF DURABLE MEDICAL EQUIPMENT

TO: All Interested Persons

1. On August 10, 1995, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.805 and 46.12.806 pertaining to medicaid coverage and reimbursement of durable medical equipment at page 1563 of the 1995 Montana Administrative Register, issue number 15.

2. The Department has amended rules 46.12.805 and 46.12.806 as proposed.

3. The Department has thoroughly considered all commentary received:

COMMENT: How did medicaid come up with fees for diapers, shields and pads?

RESPONSE: The department sent surveys to all suppliers that provide diapers for medicaid recipients and asked them about prices charged for diapers, and the amount needed to continue supplying medicaid recipients with diapers. Prices ranged from 40 cents to $1.50. Suppliers on the upper end of the scale were also increasing prices charged to medicaid because they were delivering as well as selling diapers to their medicaid clients. We then looked at suppliers in particular areas and found that there were already suppliers in all areas supplying diapers at 70 cents or less. The department has not received any comments from suppliers indicating that they would not be providing diapers because of the new medicaid fee schedule. The department believes the proposed fee is reasonable and adequate to reimburse providers and assure access for recipients.

COMMENT: Suppliers were concerned that if the recipient was to get diapers from another vendor they might be providing over the 180 diaper limit and not get paid.

RESPONSE: Providers will not be penalized for supplying diapers over the 180 diaper limit if diapers were supplied by another vendor without their knowledge. Suppliers will not be paid for diapers in excess of 180 if they were the supplier furnishing the first 180 diapers.

COMMENT: Will the 180 diaper limit be adequate to cover all population groups that need diapers and how was the limit established?

RESPONSE: Medicaid surveyed suppliers furnishing diapers and solicited their comments on this issue. With very few exceptions they felt that they did not have any recipients that needed to go beyond this limit. Other medicaid agencies were contacted about this limit and the 180 diaper limit was the one used by other states that offered diapers as a covered service. The department believes the 180 diaper limit is adequate to meet the needs of the vast majority of recipients.

COMMENT: Why not prorate rental charges instead of instituting a 15-day minimum rental to pay for the last month's rental of DME equipment?

RESPONSE: The department's computers are capable of prorating payments for a partial month. The rule change was in response to vendors asking to be paid for at least an entire month once a piece of equipment had been placed with a recipient because of the initial up front costs. This should clarify medicaid's position and allow companies placing equipment for a short period to be reimbursed at a rate that more accurately reflects their actual costs.

COMMENT: A recipient rents a wheelchair for three months and it is determined after that time that the recipient needs the chair permanently. A business would rent a different wheelchair out if it is on a temporary basis than if a chair is needed for a lifetime. The rule states that if the cap is reached the recipient owns the chair, but if the business charged for the less costly rental chair and then a recipient needs a permanent chair that is more costly, what will medicaid do?

RESPONSE: Although there is a 12-month cap on rentals, suppliers can bill up to 120% of purchase price. This should eliminate these types of situations. When dealing with wheelchairs there is no fee amount. Wheelchairs are reimbursed at 83% of the manufacturer's list price. Suppliers that have furnished a rental chair should subtract the amount of rental from the amount billed to medicaid for the purchase of that chair.

COMMENT: If medicare is primary, and medicaid secondary, does the recipient have to cap out with medicare first?

RESPONSE: Medicaid's cap on rental only affects straight medicaid chairs. Medicaid will continue to pay the co-insurance and deductible on medicare chairs.

COMMENT: Is the department planning to switch back to K codes?

RESPONSE: Medicaid has adopted K coding in response to medicare adopting K codes. Medicaid has not switched away from the K codes and will continue to use this coding to make it easier for suppliers that are also billing medicare.

COMMENT: Does the recipient always own the equipment after meeting the cap, or does he have the option to continue to rent equipment?

RESPONSE: After the medicaid cap is met, the recipient does own the equipment and additional rent cannot be paid to the supplier.

COMMENT: Will nebulizers be included in the capped rental even though the cost of this item is only $100.00?

RESPONSE: Since medicaid is using the same method of classifying rental items as medicare, the nebulizer will be included in the category of "capped rental." This item is being considered for purchase only, to avoid this problem.

COMMENT: The rule states that all supplies needed to operate equipment during rental month is included in the rental fee. What about items that have expensive supplies that need to be replaced before the equipment can be used by another recipient?

RESPONSE: When such an item exists, the supplier should notify medicaid so that a policy can be developed for that particular item. Medicaid will consider whether it is necessary to either make an additional allowance in the rental fee or, if there is an appropriate code for that supply item, to allow the vendor to bill for the supply.

COMMENT: The dealer is expected to cover charges for repairs during the rental period. Is this realistic with respect to expensive items such as a wheelchair equipped with a ventilator? What about major problems with equipment not covered by warranty?

RESPONSE: All wheelchairs in Montana are covered by a one year warranty. Recent legislation was passed requiring all manufacturers to cover all parts of the wheelchairs for this 12 month period. The cap also allows dealers to bill 120% of purchase price for this item to handle situations like this.

COMMENT: Is it legal to use medicare fees for medicaid services? If reimbursement rates get so low that dealers won't serve medicaid consumers, doesn't this amount to illegal denial of services?

RESPONSE: Medicaid uses the medicare rate for many programs and services provided by medicaid. This is not illegal. Medicaid must pay an adequate rate so that there are providers willing to provide covered services. We are not adopting medicare's fee

schedule, we are using their reimbursement rate for new items only until we have enough information to establish a medicaid fee. Once this is accomplished, the medicare fee is removed from the file.

COMMENT: Why will the department not cover delivery services for diapers?

RESPONSE: ARM 46.12.802(3)(d) states that provider travel is not reimbursable; delivery is a form of provider travel, which is not separately reimbursable for any durable medical equipment. The department believes the proposed fee for diapers is reasonable to reimburse providers and assure access for recipients without an additional delivery fee.

4. The changes are effective October 1, 1995.

Russell E. Cater
Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES OF THE STATE OF MONTANA

In the matter of the adoption of Rules I through XVI pertaining to health maintenance organizations	))))	NOTICE OF THE ADOPTION OF RULES I THROUGH XVI PERTAINING TO HEALTH MAINTENANCE ORGANIZATIONS

TO: All Interested Persons

1. On May 25, 1995, the Department of Public Health and Human Services published notice of the proposed adoption of Rules I through XVI pertaining to health maintenance organizations at page 895 of the 1995 Montana Administrative Register, issue number 10. A chart showing permanent rule numbers is found in paragraph 5 at the end of this notice.

2. The Department has adopted rule [RULE XVI] 46.12.4828, HMO, THIRD PARTY as proposed.

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

46.12.4801 HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS

~~(1)~~ (2) "Capitation rate" means the fee the department pays monthly to an HMO for the provision of covered medical and health services to each enrolled recipient. The fee is reimbursed whether or not the enrolled recipient received services during the month for which the fee is intended. The fee may vary by age, ~~sex,~~ eligibility category and region.

~~(2)~~ (3) "Community-based organizations" means local governmental and nonprofit organizations providing programs of preventive and other health related services. Community-based organizations ~~provide services that~~ include but are not limited to: ~~child immunization, health education, case management, health screening, nutrition, poison prevention, developmental outpatient and health support services and health tracking programs~~ LOCAL FAMILY PLANNING SERVICES; LOCAL WOMEN, INFANTS AND CHILDREN (WIC) PROJECTS; LOCAL PROJECTS OF MONTANA INITIATIVE FOR THE ABATEMENT OF MORTALITY OF INFANTS (MIAMI); HIV TESTING, PARTNER NOTIFICATION AND EARLY INTERVENTION; CHILDHOOD LEAD POISONING PREVENTION SERVICES; CHERISH OUR INDIAN CHILDREN; FOLLOW ME PROGRAMS FOR SPECIAL NEEDS CHILDREN.

(3) remains as proposed in text but is renumbered (4).

(5) "COUNTY OFFICE" MEANS THE LOCATION PEOPLE GO TO APPLY FOR MEDICAID BENEFITS THAT IS EITHER THE DEPARTMENT'S LOCAL OFFICE OF HUMAN SERVICES OR THE HUMAN SERVICES OR WELFARE OFFICE OF A COUNTY.

(4) remains as proposed in text but is renumbered (6).

(7) "DAY" MEANS CALENDAR DAYS, EXCEPT WHERE THE TERM WORKING DAYS OR BUSINESS DAYS IS EXPRESSLY USED.

~~(5)~~ (8) "Department" means the Montana department of ~~social and rehabilitation~~ PUBLIC HEALTH AND HUMAN services.

(6) and (7) remain as proposed in text but are renumbered (9) and (10).

~~(8) "Enrolled recipient" means a medicaid recipient who is eligible for HMO enrollment as provided in [Rule II] and who is enrolled with an HMO that has a contract with the department.~~

(11) "ENROLLEE" MEANS A MEDICAID RECIPIENT WHO HAS BEEN CERTIFIED BY THE DEPARTMENT AS ELIGIBLE TO ENROLL WITH AN HMO, AND WHOSE NAME APPEARS ON THE HMO'S ENROLLMENT INFORMATION THAT THE ADMINISTRATIVE CONTRACTOR FOR MANAGED CARE TRANSMITS TO THE HMO EVERY MONTH AS SPECIFIED IN THE CONTRACT.

~~(9)~~ (12) "Enrollment area" means the county or counties ~~in which~~ THAT an ~~HMO~~ HMO'S ~~is licensed to operate by~~ CERTIFICATE OF AUTHORITY FROM the state of Montana PERMITS IT TO SERVE and in which the HMO has service capability as required by the department and set forth in the contract. ~~An enrollment area must not be less than an entire county.~~ IF A PROPOSED ENROLLMENT AREA IS OTHER THAN AN ENTIRE COUNTY OR COUNTIES, THE PROPOSED ENROLLMENT AREA SHOULD CORRESPOND TO THE NORMAL SERVICE DELIVERY AREA.

(10) and (11) remain as proposed in text but are renumbered (13) and (14).

~~(12)~~ (15) "Health maintenance organization (HMO)" means a ~~public or private organization established and licensed as provided at~~ HEALTH MAINTENANCE ORGANIZATION OR ITS PARENT CORPORATION WITH A CERTIFICATE OF AUTHORITY ISSUED IN ACCORDANCE WITH 33-31-201, et seq., MCA.

(13) remains as proposed in text but is renumbered (16).

~~(14)~~ (1) ~~"Managed health care contractor~~ ADMINISTRATIVE CONTRACTOR FOR MANAGED CARE" means the entity the department contracts with to perform certain administrative functions of the managed health care programs.

~~(15)~~ (17) "Participating provider" means ~~a provider of medical and health services subcontracting with or employed by an HMO~~ ANY PERSON OR ENTITY THAT HAS ENTERED INTO A CONTRACT WITH AN HMO TO PROVIDE MEDICAL CARE.

~~(16)~~ (18) "Primary care provider" means ~~a medical professional directly responsible for the delivery of most routine care and from whom a recipient must gain approval to obtain services from other medical professionals~~ A PHYSICIAN, A CERTIFIED NURSE PRACTITIONER, A CERTIFIED NURSE MIDWIFE, A PHYSICIANS ASSISTANT, A FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC WITH A CONTRACT TO SERVE AN HMO'S ENROLLEES THAT HAS BEEN DESIGNATED BY AN ENROLLEE AS THE PROVIDER THROUGH WHOM THE ENROLLEE OBTAINS HEALTH CARE BENEFITS PROVIDED BY THE HMO. A PRIMARY CARE PROVIDER ATTENDS TO AN ENROLLEE'S ROUTINE MEDICAL CARE, SUPERVISES AND COORDINATES ALL OF THE ENROLLEE'S HEALTH CARE, DETERMINES THE NEED FOR AND INITIATES ALL REFERRALS, DETERMINES THE PROVIDER OF MEDICAL SERVICES AND DETERMINES THE MEDICAL NECESSITY OF THE MEDICAL SERVICES TO BE PERFORMED.

~~(17)~~ (19) "Recipient" means a person who is eligible for medicaid IN ACCORDANCE WITH THE LEGAL AUTHORITIES GOVERNING ELIGIBILITY.

(20) "REGULAR MEDICAID" MEANS THE PROGRAM OF MEDICAID SERVICES FOR MEDICAID RECIPIENTS THAT WOULD HAVE BEEN AVAILABLE TO AN ENROLLEE IF THE ENROLLEE WERE NOT ENROLLED IN AN HMO.

(18) remains as proposed in text but is renumbered (21).

(22) "SCHOOL BASED PROVIDER" MEANS A PROVIDER THAT PROVIDES SERVICES IN A SCHOOL SETTING.

(23) "UPPER PAYMENT LIMIT" MEANS THE COST TO THE DEPARTMENT OF PROVIDING THE SAME SERVICES TO AN ACTUARIALLY EQUIVALENT NON-ENROLLED POPULATION.

(19) remains as proposed in text but is renumbered (24).

(25) "USUAL MANNER" MEANS OBTAINING MEDICAID BENEFITS IN THE MANNER THAT MEDICAID RECIPIENTS OBTAIN THEM THROUGH THE REGULAR MEDICAID PROGRAM.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4804 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY (1) through (1)(b) remain as proposed.

~~(2) A newborn recipient must enroll with an HMO contracting with the department if enrollment with an HMO is available to the recipient.~~

~~(3)~~ (2) A recipient, exempt from required participation in a primary care case management program as provided in ARM 46.12.5003 (2)(a) THROUGH (m), is not eligible to enroll with an HMO contracting with the department.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117 MCA

46.12.4805 HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT (1) Recipient enrollment with an HMO contracting with the department~~, except as otherwise provided in [Rule II]~~, is voluntary.

(2) remains as proposed.

~~(a) A newborn recipient must be enrolled with the mother's HMO effective on the date of birth.~~

(3) remains as proposed.

(4) An eligible recipient who is hospitalized, other than a newborn recipient, may ~~only~~ enroll INITIALLY with an HMO contracting with the department ONLY after the recipient's discharge from the hospital.

(5) Enrollment is requested either by completing a form designated by the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE or by a written or verbal request to the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE.

(a) The form must be available through the county office, the HMO office, the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE, or other locations designated by the department.

(b) An HMO or any entity responsible for making the form available, receiving a form or a request, must forward the form or request IN WRITING to the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE within ~~3~~ three working days.

(6) An HMO must accept without restriction eligible recipients in the order in which they ~~enroll~~ ARE RECEIVED FOR ENROLLMENT BY THE ADMINISTRATIVE CONTRACTOR FOR MANAGED CARE until ~~capacity enrollment~~ THE HMO'S MAXIMUM ENROLLMENT UNDER THE CONTRACT is reached.

(7) The effective date of enrollment for an eligible recipient must be no later than the first day of the second month subsequent to the date on which the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE receives the designated managed health care choice form or written or verbal request. The effective date must be earlier than the second subsequent month if enrollment can be processed before the ~~monthly eligibility deadline~~ LAST FOUR WORKING DAYS OF THE MONTH.

(8) An HMO may issue an appropriate identification card to an ~~enrolled recipient~~ ENROLLEE. A medicaid card is issued to ~~enrolled recipients~~ ENROLLEES BY THE DEPARTMENT.

(9) ENROLLMENT WITH AN HMO IS INDICATED BY THE APPEARANCE OF THE HMO'S NAME AND 24-HOUR TELEPHONE NUMBER ON THE MEDICAID CARD.

(10) AN ENROLLEE MUST OBTAIN COVERED SERVICES AS DEFINED IN 46.12.4810 THROUGH THE HMO.

(11) AN ENROLLEE MAY OBTAIN NON-COVERED SERVICES AS DEFINED IN 46.12.4810 IN THE USUAL MANNER.

~~(9)~~ (12) The total number of ~~enrolled recipients~~ ENROLLEES and Part A and Part B medicare beneficiaries with a non-federally qualified HMO may not exceed 75% of the HMO's total enrollment, as provided in 42 CFR 434.26(a), unless the HMO is the subject of one of the exceptions provided at 42 CFR 434.26(b). The department hereby adopts and incorporates by reference 42 CFR 434.26, dated October 1994. A copy of the incorporated provision may be obtained through the Department of ~~Social and Rehabilitation Services~~ PUBLIC HEALTH AND HUMAN SERVICES, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

~~(10) An eligible recipient, not requesting a particular HMO, must be assigned to, between, or among the contracting managed health care providers. A recipient must first be assigned based on historical usage. If no appropriate historical usage information is available, a random assignment with appropriate consideration of the recipient's age, sex, and location is made. Random assignment alternates between HMO and PASSPORT programs where both are available.~~

~~(11) An eligible recipient, assigned to a managed health care provider, will receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.~~

~~(12) An enrolled recipient, assigned to a managed health care provider, as described in this rule, may request a change to a different available managed health care provider. A change is effective in accordance with effective date provisions in this rule and [Rule IV].~~

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117 MCA

46.12.4806 HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT

(1) An ~~enrolled recipient~~ ENROLLEE may request, without good cause, disenrollment from an HMO at any time.

(2) remains the same.

(3) Disenrollment is requested by either completing a form designated by the managed health care ADMINISTRATIVE contractor FOR MANAGED CARE or by a written or oral request to the ~~managed health care~~ contractor FOR MANAGED CARE.

(3)(a) remains as proposed.

(b) An HMO or any other entity responsible for making the form available upon receiving a form or a request, must forward the form or request to the ~~managed health care~~ ADMINISTRATIVE contractor FOR MANAGED CARE within ~~3~~ THREE working days.

(4)and (4)(a) remain as proposed.

(b) AN ENROLLEE MAY BE TERMINATED FOR GOOD CAUSE IF THE ENROLLEE:

~~(5) An HMO may disenroll an enrolled recipient, subject to the prior approval of the department, if the enrollee:~~

~~(a) has failed to pay required premiums by the end of the grace period;~~

~~(b)~~ (i) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the HMO;

~~(c)~~ (ii) has allowed a nonenrollee to use the HMO certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

~~(d)~~ (iii) has moved outside of the geographical service area of the HMO;

~~(e)~~ (iv) has violated rules of the HMO stated in the evidence of coverage;

~~(f)~~ (v) has violated rules adopted by the commissioner of insurance for enrollment in an HMO; or

~~(g)~~ (vi) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the HMO can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that the enrollee may file a grievance on this matter.

~~(6)~~ (5) Disenrollment takes effect, at the earliest, THE first day of the month after the month in which the ~~department~~ ADMINISTRATIVE CONTRACTOR FOR MANAGED CARE receives the request for ~~enrollment~~ DISENROLLMENT, but no later than the first day of the second calendar month after the month in which the ~~department~~ ADMINISTRATIVE CONTRACT FOR MANAGED CARE receives a request for disenrollment. The ~~enrolled recipient~~ ENROLLEE remains enrolled with the HMO and the HMO is responsible for services covered under the contract until the effective date of disenrollment which is always the first day of a month.

~~(7) An enrolled recipient must be disenrolled from a particular HMO if:~~

(6) THE DEPARTMENT WILL DISENROLL AN ENROLLEE FROM A PARTICULAR HMO IF:

(7)(a) remains as proposed in text but is renumbered (6)(a)

(b) the ~~recipient~~ enrollee permanently moves outside the HMO's enrollment area.

~~(8) An enrolled recipient must be disenrolled if:~~

(7) THE DEPARTMENT WILL DISENROLL AN ENROLLEE FROM AN HMO IF:

(a) the ~~recipient~~ ENROLLEE enters a medicaid eligibility group excluded from HMO enrollment; or

(b) the ~~recipient~~ ENROLLEE becomes ineligible for medicaid.

~~(9)~~ (8) If an ~~enrolled recipient~~ ENROLLEE becomes ineligible for medicaid and is reinstated into medicaid within ~~1~~ ONE month, ~~a recipient~~ THE ENROLLEE may be reenrolled with the SAME HMO.

(9) A RECIPIENT DISENROLLING OR DISENROLLED FROM AN HMO WHO REMAINS MEDICAID ELIGIBLE IS ELIGIBLE FOR REGULAR MEDICAID.

(10) PRIOR TO JULY 1, 1996, THE DATE SSI RECIPIENTS ARE ELIGIBLE TO ENROLL WITH AN HMO, THE DEPARTMENT WILL RETROACTIVELY DISENROLL A NEWBORN ENROLLEE IF THE NEWBORN ENROLLEE IS DETERMINED RETROACTIVELY SSI-ELIGIBLE WITHIN FOUR MONTHS OF BIRTH.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117 MCA

46.12.4810 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) An HMO must provide the following services ~~unless the contract with the department provides otherwise~~ EXCEPT THAT THE HMO NEED NOT PROVIDE AN ASPECT OF ANY OF THESE SERVICES THAT IS SPECIFIED IN (2):

(a) inpatient hospital SERVICES AS DEFINED AT ARM 46.12.503 AND 46.12.504;

(b) outpatient hospital SERVICES AS DEFINED AT ARM 46.12.506 AND 46.12.507;

(c) physician SERVICES AS DEFINED AT ARM 46.12.2001 AND 46.12.2002;

(d) family planning SERVICES AS DEFINED AT ARM 46.12.575 AND 46.12.576;

(e) home health SERVICES AS DEFINED AT ARM 46.12.550 AND 46.12.551;

(f) early periodic screening, diagnosis and treatment SERVICES for individuals under the age of 21 (EPSDT) AS DEFINED AT ARM 46.12.514 AND 46.12.515;

(g) NON-HOSPITAL laboratory and x-ray SERVICES AS DEFINED AT ARM 46.12.2101;

(h) rural health clinic SERVICES AS DEFINED AT ARM 46.12.1601, 46.12.1603 AND 46.12.1605;

(i) ambulance SERVICES AS DEFINED AT ARM 46.12.1021 AND 46.12.1022;

(j) ambulatory surgical center SERVICES AS DEFINED AT ARM 46.12.570, 46.12.571 AND 46.12.572;

(k) chiropractor SERVICES AS DEFINED AT ARM 46.12.516(1)(b);

(l) diagnostic clinic SERVICES AS DEFINED AT ARM 46.12.570 AND 46.12.571;

(m) ~~nutritionist~~ NUTRITION SERVICES AS DEFINED AT ARM 46.12.516(1)(a);

(n) intrauterine monitoring ~~device~~ DEVICES;

(o) federally qualified health center SERVICES AS DEFINED AT ARM 46.12.1701 AND 46.12.1703;

(p) hospice SERVICES AS DEFINED AT ARM 46.12.1819 AND 46.12.1823;

(q) ~~physician assistant~~ MID-LEVEL PRACTITIONER SERVICES AS DEFINED AT ARM 46.12.2010 AND 46.12.2011;

(r) ~~nurse specialist~~ IMMUNIZATIONS RECOMMENDED BY THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES;

(s) occupational therapy SERVICES AS DEFINED AT ARM 46.12.545 AND 46.12.546;

(t) physical therapy SERVICES AS DEFINED AT ARM 46.12.525 AND 46.12.526;

(u) podiatry SERVICES AS DEFINED AT ARM 46.12.520 AND 46.12.521;

(v) private duty nursing SERVICES AS DEFINED AT ARM 46.12.565 AND 46.12.566;

(w) COUNTY public health clinic SERVICES AS DEFINED AT ARM 46.12.570 AND 46.12.571;

(x) respiratory therapy SERVICES AS DEFINED AT ARM 46.12.516(1)(d);

(y) ~~school based services, except occupational therapy, speech therapy, physical therapy, and private duty nursing~~ IMMUNIZATIONS AND WELL CHILD SCREENS PROVIDED BY SCHOOL BASED PROVIDERS;

(z) speech therapy SERVICES AS DEFINED AT ARM 46.12.530 AND 46.12.531;

(aa) targeted case management SERVICES for high risk pregnant women AS DEFINED AT ARM 46.12.1901, 46.12.1902, 46.12.1903, 46.12.1915, 46.12.1916 AND 46.12.1917; and

(ab) transplant SERVICES AS DEFINED AT ARM 46.12.583 AND 46.12.584.

(2) An HMO is not required to provide the following services unless the contract with the department provides otherwise:

(a) nursing facility ~~service~~ SERVICES AS DEFINED AT ARM 46.12.1201 ET SEQ.;

(b) ~~inpatient psychiatric care provided at a state-administered mental health facility~~ INSTITUTIONS FOR MENTAL DISEASE SERVICES AS DEFINED AT ARM 46.12.1107 ET SEQ.;

(c) audiology SERVICES AS DEFINED AT ARM 46.12.535 ET SEQ.;

(d) durable medical equipment and ~~medical~~ PROSTHETIC supplies except for intrauterine monitoring devices AS DEFINED AT ARM 46.12.801 ET SEQ.;

(e) drugs AS DEFINED AT ARM 46.12.702 ET SEQ.;

(f) eyeglasses AS DEFINED AT ARM 46.12.911 ET SEQ.;

(g) free standing dialysis clinic SERVICES AS DEFINED AT ARM 46.12.1501 ET SEQ.;

(h) hearing ~~aids~~ AID SERVICES AS DEFINED AT ARM 46.12.540 ET SEQ.;

(i) home and community-based waiver services AS DEFINED AT ARM 46.12.1401 ET SEQ.;

(j) home dialysis attendant SERVICES AS DEFINED AT ARM 46.12.560 ET SEQ.;

(k) non-emergency transportation AS DEFINED AT ARM 46.12.1001 ET SEQ.;

(l) ~~optometry~~ OPTOMETRIC SERVICES AS DEFINED AT ARM 46.12.901 ET SEQ.;

(m) personal care attendant SERVICES AS DEFINED AT ARM 46.12.555 ET SEQ.;

(n) private duty nursing and occupational, physical, and speech ~~therapies~~ THERAPY SERVICES provided ~~in schools~~ BY SCHOOL BASED PROVIDERS;

(o) targeted case management ~~except for high risk pregnant women~~ SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS AS DEFINED AT ARM 46.12.1925 ET SEQ.; FOR PERSONS AGE 16 AND OVER WITH DEVELOPMENTAL DISABILITIES AS DEFINED AT ARM 46.12.1935 ET SEQ.; AND FOR YOUTH WITH SEVERE EMOTIONAL DISTURBANCE AS DEFINED AT ARM 46.12.1945 ET SEQ.;

(p) inpatient and outpatient mental health services that have as a primary diagnosis one of the following ranges of ICD-9 diagnosis codes: 290-302, 306-314, and 316;

(q) clinical social worker SERVICES AS DEFINED AT ARM 46.12.587 ET SEQ.;

(r) licensed professional counselor SERVICES AS DEFINED AT ARM 46.12.620 ET SEQ.;

(s) psychologist SERVICES AS DEFINED AT ARM 46.12.580 ET SEQ.;

(t) community mental health center SERVICES AS DEFINED AT ARM 46.12.570 ET SEQ.;

(u) residential treatment center SERVICES AS DEFINED AT ARM 46.12.590 ET SEQ.;

(v) therapeutic group home SERVICES AS DEFINED AT ARM 46.12.516 ET SEQ.;

(w) therapeutic foster care SERVICES AS DEFINED AT ARM 46.12.516; ~~and~~

(x) Indian health service clinics on reservations~~.~~;

(y) INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AS DEFINED AT ARM 46.12.1249 ET SEQ.;

(z) MEDICAL AND SURGICAL SERVICES PROVIDED BY A DENTIST AS DEFINED AT ARM 46.12.601 ET SEQ.;

(aa) DENTAL SERVICES AS DEFINED AT ARM 46.12.601 ET SEQ.;

(ab) DENTURE SERVICES AS DEFINED AT ARM 46.12.601 ET SEQ.;

(ac) OUTPATIENT CHEMICAL DEPENDENCY TREATMENT SERVICES AS DEFINED AT ARM 46.12.516 ET SEQ.;

(ad) ABORTION SERVICES; AND

(ae) SWING BED SERVICES AS DEFINED AT ARM 46.12.510.

(3) ~~In addition to covered services, an enrolled recipient may obtain the following services on an as needed basis:~~ AN

ENROLLED RECIPIENT MAY OBTAIN THE FOLLOWING COVERED SERVICES THROUGH SELF-REFERRAL TO A PARTICIPATING OR NON-PARTICIPATING PROVIDER AND THE HMO MUST REIMBURSE THE PROVIDER OF A SERVICE TO WHICH THE ENROLLEE MAY SELF-REFER:

(a) family planning services ~~provided by a family planning provider~~;

(i) REPRODUCTIVE HEALTH EXAMS;

(ii) PATIENT COUNSELING;

(iii) PATIENT EDUCATION;

(iv) LAB TESTS TO DETECT THE PRESENCE OF CONDITIONS AFFECTING REPRODUCTIVE HEALTH, SUCH AS THOSE INVOLVING THE THYROID, CHOLESTEROL/TRIGLYCERIDES, PROLACTIN, PREGNANCY TESTS, AND DIAGNOSIS OF INFERTILITY;

(v) STERILIZATIONS AS DEFINED AT ARM 46.12.2002;

(vi) SCREENING, TESTING, AND TREATMENT OF AND PRE- AND POST-TEST COUNSELING FOR SEXUALLY TRANSMITTED DISEASES AND HIV; AND

(vii) FAMILY PLANNING SUPPLIES PROVIDED BY TITLE X CLINICS.

(4) IF A NON-PARTICIPATING PROVIDER DETECTS A PROBLEM OUTSIDE THE SCOPE OF FAMILY PLANNING SERVICES AS DEFINED ABOVE, SUCH PROVIDER SHALL REFER THE ENROLLEE BACK TO THE HMO.

(5) AN ENROLLEE IS ELIGIBLE FOR ALL NON-COVERED SERVICES AND MAY OBTAIN NON-COVERED SERVICES IN THE USUAL MANNER.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4813 HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES (1) The department may enter into a contract with an HMO ~~licensed~~ WITH A CERTIFICATE OF AUTHORITY under the provisions of 33-31-201, et seq., MCA, to provide any of the services specified in ARM 46.12.4810.

(2) remains as proposed.

(3) A contract for the provision of services through an HMO must meet the requirements of 42 CFR part 434. The department hereby adopts and incorporates by reference 42 CFR part 434, dated October 1994. A copy of the incorporated provisions may be obtained through the Department of ~~Social and Rehabilitation~~ PUBLIC HEALTH AND HUMAN Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(4) and (5) remain as proposed.

(6) An HMO may not in any manner hold ~~enrolled recipients~~ AN ENROLLEE responsible for the debts of the HMO.

(7) remains as proposed.

(8) A CONTRACT MAY BE TERMINATED FOR CAUSE, IF THE CONTRACTOR FAILS TO:

(a) PERFORM THE SERVICES WITHIN THE TIME LIMITS SPECIFIED IN THE CONTRACT;

(b) PERFORM ANY REQUIREMENT OF THE CONTRACT;

(c) PERFORM ITS CONTRACTUAL DUTIES OR RESPONSIBILITIES SPECIFIED IN THE STANDARDS OF CONTRACTOR PERFORMANCE DEFINED IN THE CONTRACT;

(d) COMPLY WITH ANY LAW, REGULATION OR LICENSURE AND CERTIFICATION REQUIREMENT; OR

(e) COMPLY WITH THE RESTRICTIONS AND LIMITATIONS PLACED ON CONTRACTOR ACTIVITIES UNDER THE CONTRACT AND ITS ATTACHMENTS.

~~(8)~~ (9) Prior to termination of a contract or withholding of payments for cause, except as provided in ~~(8)~~ (9)(a), a notice to cure will be sent to the HMO, stating the failures in performance and specifying ~~the number of days~~ the HMO has 30 DAYS to correct the failures. The department may proceed with the proposed termination or withholding of payments, if the HMO fails to correct the failures in performance in the specified time period for correction.

(a) A contract with an HMO may be terminated immediately in whole or in part by the department when:

(i) the HMO becomes insolvent; ~~or~~

(ii) THE HMO loses a certificate of authority; ~~or~~

(iii) the department determines that termination is necessary to protect the health of ~~enrolled recipients~~ ENROLLEES;

(iv) THE HMO APPLIES FOR OR CONSENTS TO THE APPOINTMENT OF A RECEIVER, TRUSTEE, OR LIQUIDATION FOR ITSELF OR ANY OF ITS PROPERTY;

(v) THE HMO ADMITS IN WRITING THAT IT IS UNABLE TO PAY ITS DEBTS AS THEY MATURE;

(vi) THE HMO ASSIGNS FOR THE BENEFIT OF CREDITORS;

(vii) THE HMO COMMENCES A PROCEEDING IN BANKRUPTCY, REORGANIZATION, INSOLVENCY, OR READJUSTMENT UNDER A PROVISION OF A FEDERAL OR STATE LAW OR FILES AN ANSWER ADMITTING THE MATERIAL ALLEGATIONS OF A PETITION FILED AGAINST THE CONTRACT IN ANY SUCH PROCEEDING; OR

(viii) THERE IS A COMMENCEMENT OF AN INVOLUNTARY PROCEEDING AGAINST THE HMO UNDER ANY BANKRUPTCY, REORGANIZATION, INSOLVENCY, OR READJUSTMENT IN A PROVISION OF FEDERAL OR STATE LAW THAT IS NOT DISMISSED WITHIN 60 DAYS.

(9) remains as proposed in text but is renumbered (10).

~~(10)~~ (11) An HMO may specify in a contract a limit to the number of ~~enrolled recipients~~ ENROLLEES who can be enrolled with the HMO. If a limit is specified, the HMO must accept the number of voluntarily and assigned ~~enrolled recipients~~ ENROLLEES up to the limit specified in the contract.

(11) remains as proposed in text but is renumbered (12).

~~(12)~~ (13) ~~The department and an HMO may by mutual consent terminate a contract.~~ THE DEPARTMENT OR AN HMO MAY TERMINATE THE CONTRACT WITHOUT CAUSE BY GIVING 60 DAYS WRITTEN NOTICE TO THE OTHER PARTY.

~~(13) The department may terminate a contract for cause. Cause includes, but is not limited to, the following:~~

~~(a) There is an inordinate risk of inadequate or inappropriate medical care to the enrolled recipients;~~

~~(b) The HMO is insolvent;~~

~~(c) The HMO's delivery system is not providing medicaid recipients with adequate access to medical services;~~

~~(d) The HMO's delivery system is not providing for the availability of all services covered under the contract;~~

~~(e) The HMO is not providing proper assurances of financial solvency;~~

~~(f) The HMO is not substantially complying with all provisions of the contract;~~

~~(g) The HMO is discriminating against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, marital status or health status; or~~

~~(h) The HMO is not in compliance with federal or state laws and regulations governing its performance or the provision of services.~~

(14) THE CONTRACT MAY CONTAIN PROPRIETARY INFORMATION. AN HMO ENTERING INTO A CONTRACT WITH THE DEPARTMENT TO PROVIDE HMO COVERED SERVICES DOES NOT CONSTITUTE AN AGREEMENT TO RELEASE INFORMATION, INCLUDING INFORMATION CONCERNING THE PROVIDER'S INFORMATION SYSTEM, WHICH IS PROPRIETARY IN NATURE.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4814 HEALTH MAINTENANCE ORGANIZATIONS; PROVISION OF SERVICES (1)(a) through (1)(b) remain as proposed.

(c) directing an ~~enrolled recipient~~ ENROLLEE to the appropriate level of care for receipt of covered services; and

(d) denial of payment to a provider for services provided to an ~~enrolled recipient~~ ENROLLEE if ~~these~~ THE participation requirements IN THIS SECTION are not met by the enrollee.

(2) An ~~enrolled recipient~~ ENROLLEE must use the participating providers in the ~~enrolled recipient's~~ ENROLLEE'S HMO.

(3) and (3)(a) remain as proposed.

(b) the ~~enrolled recipient~~ ENROLLEE receives a family planning service provided by a family planning provider AS DEFINED IN THE CONTRACT;

(c) the ~~enrolled recipient~~ ENROLLEE receives an immunization or blood lead level testing provided by a public health clinic; or

(d) the ~~enrolled recipient~~ ENROLLEE receives services provided for an urgent condition or emergency OR EMERGENCY ROOM SCREEN.

(4) An HMO must provide COVERED services AS LISTED IN 46.12.4810 to ~~enrolled medicaid recipients~~ ENROLLEES in the same manner as THOSE services are provided to non-medicaid enrollees.

(5) ~~To the maximum extent possible, an~~ AN HMO must MAKE A REASONABLE EFFORT TO inform ~~enrolled recipients~~ ENROLLEES of alternate providers for ~~services not covered by the HMO~~ THE NON-COVERED SERVICES LISTED IN 46.12.4810(2).

(6) An HMO, at a minimum, must provide ~~enrollment recipients~~ ENROLLEES the same AMOUNT, scope AND DURATION for ~~medical procedures~~ COVERED SERVICES as would be available under regular medicaid for those ~~procedures~~ COVERED SERVICES.

(7) An HMO may at its discretion offer services to ~~enrolled recipients~~ ENROLLEES beyond the scope of medicaid as defined in ARM 46.12.501.

~~(8) An HMO may not impose limitations on days of service or length of stay that are more restrictive than regular medicaid.~~

(9) and (9)(a) remain as proposed in text but are renumbered (8) and (8)(a).

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4815 HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS (1) remains as proposed.

(2) ~~An HMO must make a reasonable good faith effort to contract with federally qualified health clinics, rural health clinics and existing providers of targeted case management for high risk pregnant women. The determination of whether or not there has been a good faith effort is made by the department.~~ THE HMO MUST OFFER TO:

(a) MEDICAID-ENROLLED TARGETED CASE MANAGERS FOR HIGH RISK PREGNANT WOMEN WHO SERVE RECIPIENTS IN THE ENROLLMENT AREA, TERMS AND CONDITIONS THAT ARE AT LEAST AS FAVORABLE AS THOSE OFFERED TO OTHER PARTICIPATING PROVIDERS PROVIDING THIS SERVICE; AND

(b) FEDERALLY QUALIFIED HEALTH CENTERS OR RURAL HEALTH CLINICS WHICH SERVE RECIPIENTS IN THE ENROLLMENT AREA, TERMS AND CONDITIONS, EXCLUDING REIMBURSEMENT, THAT ARE AT LEAST AS FAVORABLE AS THOSE OFFERED TO OTHER PRIMARY CARE PROVIDERS, PROVIDING THE FQHC OR RHC SUBSTANTIALLY MEETS THE SAME ACCESS AND CREDENTIALING CRITERIA AS THE HMO'S OTHER PRIMARY CARE PROVIDERS.

(3) An HMO must ~~cooperate~~ MAKE A REASONABLE EFFORT TO COOPERATE, where appropriate and feasible, with community-based organizations in the referral for and delivery of services available through those organizations.

(4) remains as proposed.

(5) ~~An HMO may not employ or contract with a provider that has been sanctioned by the medicaid program.~~ UPON WRITTEN NOTICE BY THE DEPARTMENT, THE HMO MUST EXCLUDE FROM PROVIDING COVERED SERVICES TO MEDICAID ENROLLEES A PROVIDER WHO HAS BEEN TERMINATED BY THE MEDICAID PROGRAM IN ACCORDANCE WITH ARM 46.12.401(1)(a).

(6) remains as proposed.

(7) A participating provider has no right to an administrative hearing as provided in ARM 46.2.201, et seq., 46.12.409 and 46.12.509A for a denial of payment by the HMO TO THE PROVIDER FOR A SERVICE PROVIDED to an ~~enrolled recipient~~ ENROLLEE.

(8) remains as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4816 REIMBURSEMENT OF PROVIDERS (1) ~~An HMO may reimburse a participating provider in the manner and the amounts the HMO determines are appropriate to the provision of services.~~ AN HMO MUST REIMBURSE A FEDERALLY QUALIFIED HEALTH CENTER OR A RURAL HEALTH CLINIC WHICH IS A PARTICIPATING PROVIDER EITHER THE SAME CAPITATION PAYMENTS PER ENROLLEE MADE TO OTHER PRIMARY CARE PROVIDERS OR THE FACILITY SPECIFIC MEDICAID INTERIM RATE FOR EACH ENROLLEE VISIT.

(2) An HMO need not reimburse, except as otherwise provided in this rule, claims for MEDICALLY NECESSARY services provided by non-participating providers if the same service is covered by the HMO under its contract with the department.

(3) An HMO must reimburse MEDICALLY NECESSARY family planning services AS DEFINED BY CONTRACT provided by a non-participating family planning provider to an ~~enrolled recipient~~ ENROLLEE who sought the services without referral.

(4) An HMO must reimburse immunizations and blood lead testing provided by a public health clinic to an ~~enrolled recipient~~ ENROLLEE.

~~(5) An HMO must reimburse a nonparticipating provider for any covered service furnished by the provider that was provided because the service was needed immediately to meet an urgent condition or emergency and the circumstances did not permit a choice of provider.~~

~~(6)~~ (5) An HMO must reimburse nonparticipating providers for services for urgent conditions, emergencies or emergency room screenings provided to an ENROLLEE ~~enrolled recipient while the recipient is temporarily outside the HMO's enrollment area~~.

~~(7)~~ (6) An HMO, owned, controlled or sponsored by or affiliated with a religious organization, must reimburse a covered service received by an ~~enrolled recipient~~ ENROLLEE that the HMO does not make available due to the service constituting a violation of the religious tenets of the organization, to which the HMO is related.

~~(8)~~ (7) An HMO is not responsible for reimbursement of the ~~disportionate~~ disproportionate share payments for inpatient hospital services provided to an ~~enrolled recipient~~ ENROLLEE.

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

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4817 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS (1) In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each ~~enrolled recipient~~ ENROLLEE. This payment is the capitation rate. The capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to each ~~enrolled recipient~~ ENROLLEE under the contract.

(1)(a) through (1)(b)(i) remain as proposed.

(ii) based on services that are reasonably available to the ~~enrolled recipients~~ ENROLLEES of the HMO.

(1)(c) through (1)(e) remain as proposed.

(i) any amounts for the recoupment of losses suffered by an HMO for risks assumed under the contract or any previous risk contract; ~~and~~

(ii) any ~~disportionate~~ disproportionate share payments~~,~~; AND

(iii) ANY PAYMENTS MADE BY THE DEPARTMENT REFLECTING THE DIFFERENCE BETWEEN THE AMOUNTS PAID TO PARTICIPATING FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS BY THE HMO AND THE REASONABLE COST OF PROVIDING SERVICES TO ENROLLEES.

(f) AT A MINIMUM, THE CAPITATION RATE MUST BE 5% LESS THAN THE UPPER PAYMENT LIMIT. THE DEPARTMENT MAY REDUCE THE CAPITATION RATES UNDER THE CONDITIONS SET FORTH IN THE CONTRACT IF THERE IS A FUNDING SHORTFALL.

(2) remains as proposed.

(3) The department reimburses to federally qualified health ~~clinics~~ CENTERS and rural health clinics that are participating providers the difference between the amounts paid to them by the HMO and the reasonable cost of providing services to enrolled recipients.

(a) THE DEPARTMENT RECOUPS FROM FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS THAT ARE PARTICIPATING PROVIDERS ANY EXCESS BETWEEN THE AMOUNTS PAID TO THEM BY THE HMO AND THE REASONABLE COST OF PROVIDING SERVICES TO ENROLLEES, UNLESS THE PROVIDER NOTIFIES BOTH THE HMO AND THE DEPARTMENT IN WRITING THAT IT FORFEITS COST-BASED REIMBURSEMENT FOR ENROLLEES IN FAVOR OF THE REIMBURSEMENT PAID BY THE HMO.

(b) IF AN HMO BECOMES A SUBCONTRACTOR TO A FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC, THE DEPARTMENT IS UNDER NO OBLIGATION TO PAY REASONABLE COSTS TO THE HMO ONLY THE FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC ITSELF REMAINS ELIGIBLE FOR REASONABLE COST SETTLEMENT FOR FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES.

(4) The department reimburses ~~disportionate~~ disproportionate share payments for inpatient hospital services provided to ~~recipients~~ ENROLLEES.

(5) PRIOR TO JULY 1, 1996, THE DATE SSI RECIPIENTS ARE ELIGIBLE TO ENROLL WITH AN HMO, THE DEPARTMENT WILL RECOUP ANY CAPITATION PAYMENTS MADE TO AN HMO FOR A NEWBORN ENROLLEE RETROACTIVELY DISENROLLED PER 46.12.4806(10).

(6) STARTING JULY 1, 1996, THE DATE SSI RECIPIENTS ARE ELIGIBLE TO ENROLL WITH AN HMO, THE DEPARTMENT WILL RECOUP THE AFDC-BASED CAPITATION PAYMENTS MADE FOR A NEWBORN ENROLLEE RETROACTIVELY DETERMINED SSI ELIGIBLE WITHIN FOUR MONTHS OF LIFE AND INSTEAD PAY THE SSI-BASED CAPITATION RATE FOR EACH MONTH OF ENROLLMENT.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4821 HEALTH MAINTENANCE ORGANIZATIONS: ACCESS TO SERVICES (1) An ~~enrolled recipient~~ ENROLLEE must have the opportunity to choose a primary care provider to the extent possible and medically appropriate from any of the participating primary care providers in the ~~recipient's~~ ENROLLEE'S HMO. THE

HMO MAY ASSIGN AN ENROLLEE TO A PRIMARY CARE PROVIDER WHEN AN ENROLLEE FAILS TO CHOSE ONE AFTER BEING NOTIFIED TO DO SO. THE ASSIGNMENT MUST BE APPROPRIATE TO THE ENROLLEE'S AGE, SEX AND RESIDENCE. THE HMO MAY LIMIT AN ENROLLEE'S ABILITY TO CHANGE PRIMARY CARE PROVIDERS WITHOUT CAUSE.

(2) An HMO's medical service delivery ~~site~~ SITES must:

(a) be located within the normal service delivery area of the personal residences of ~~enrolled recipients~~ ENROLLEES;

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

(3) An HMO must have procedures for the scheduling of appointments for ~~enrolled recipients~~ ENROLLEES that are appropriate in relation to the reason for the visit. AT A MINIMUM, THE TIME LIMIT ON APPOINTMENTS MUST BE THOSE SPECIFIED BELOW.

(a) An ~~enrolled recipient~~ ENROLLEE with urgent symptoms must be seen within one day of contacting the participating provider.

(b) Routine visits must be scheduled within 2 to 4 weeks of the date an ~~enrolled recipient~~ ENROLLEE requests an appointment with the participating provider.

(c) Appointments must be scheduled by specific time intervals ~~and not on a block basis~~.

(4) through (4)(d) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4824 HEALTH MAINTENANCE ORGANIZATIONS: GRIEVANCE PROCEDURES (1) An ~~enrolled recipient~~ ENROLLEE has the right of appeal as provided at ARM 46.2.201, et seq.

(2) An HMO must have a written procedure, approved in writing by the department prior to implementation, for resolution of grievances brought by ~~enrolled recipients~~ ENROLLEES either individually or as a class. EXCEPT AS NOTED BELOW, THE HMO'S GRIEVANCE PROCEDURE MUST PROVIDE FOR RESOLUTION OF A GRIEVANCE WITHIN 45 DAYS OF RECEIPT OF THE GRIEVANCE. RESOLUTION MAY BE EXTENDED BEYOND 45 DAYS ONLY WITH THE WRITTEN APPROVAL OF THE DEPARTMENT. IN A SITUATION REQUIRING URGENT CARE OR EMERGENCY CARE, THE DEPARTMENT MAY REQUIRE THE HMO TO EXPEDITE RESOLUTION OF A GRIEVANCE WITHIN A TIMELINE ESTABLISHED BY THE DEPARTMENT.

(3) An ~~enrolled recipient~~ ENROLLEE must exhaust the HMO's grievance procedure before appeal of the matter may be made to the department under the provisions of ARM 46.2.201, et seq.

(4) FOR PURPOSES OF ARM 46.2.202(1)(c), THE 90 DAY APPEAL PERIOD STARTS ON THE DAY THE ENROLLEE FILES A GRIEVANCE WITH THE HMO.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4825 HEALTH MAINTENANCE ORGANIZATIONS: RECORDS AND CONFIDENTIALITY (1) and (2) remain as proposed.

(3) An HMO must have in effect arrangements to provide for an adequate medical record-keeping system which includes a complete medical record for each ~~enrolled recipient~~ ENROLLEE in accordance with provisions set forth in the contract. THE COMPLETE MEDICAL RECORD MAY BE MAINTAINED BY AN HMO'S PARTICIPATING PROVIDER.

(4) and (4)(a) remain as proposed.

(i) The department of social and rehabilitation services' confidentiality policy, adopted October 1, 1988, and published in the Department of Social and Rehabilitation Services Policy Manual ADM 102 is hereby adopted and incorporated by reference. Copies of the policy may be obtained from the Department of ~~Social and Rehabilitation Services~~ PUBLIC HEALTH AND HUMAN SERVICES, Office of Legal Affairs, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(4)(b) remains as proposed.

(i) Consent for release is not required for the transmission of medical record information to participating providers providing services to the ~~enrolled recipient~~ ENROLLEE or to specialty providers who are retained by an HMO to provide services.

(4)(b)(ii) through (4)(c) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

46.12.4826 HEALTH MAINTENANCE ORGANIZATIONS; RECIPIENT EDUCATION ~~(1) An HMO must provide to all applicants and enrolled recipients a written explanation of all fee for service and managed health care plans available to recipients.~~

(1) ~~(2)~~ An HMO must have written instructions for ~~enrolled recipients~~ ENROLLEES in the use of all services provided. The policy must include, but is not limited to, written information on service restrictions and limitations regarding appropriate use of the referral system, grievance procedure, after hours call-in system, provisions for emergency treatment, how the ~~recipient~~ ENROLLEE may obtain services that are the responsibility of the HMO under ARM 46.12.4810 and the contract between the HMO and the department but which are not available through the HMO due to religious objections and how to request a list of providers for the HMO.

~~(3) An HMO must have a written statement of patient rights and responsibilities. The statement must be sent to all new enrolled recipients. The statement must be available to recipients upon request. The right of the recipient to request disenrollment must be stated in the statement.~~

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

ARM 46.12.4827 HEALTH MAINTENANCE ORGANIZATIONS; QUALITY ASSURANCE (1) and (2) remain as proposed.

(a) Copies of 42 CFR 434.34 may be obtained through the Department of ~~Social and Rehabilitation Services~~ PUBLIC HEALTH

AND HUMAN SERVICES, Medicaid Services Division 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: The rules should not be passed until there is an easy mechanism for the department to find out if the enrollees are satisfied with the HMO and not just through disenrollment procedures.

RESPONSE: In addition to tracking the level of disenrollment requests from an HMO, the department will monitor recipient satisfaction with the HMO through quarterly surveys of randomly selected enrollees; quarterly reports submitted by the HMO on the status of all grievances filed; and monitoring calls received on the medicaid hotline.

COMMENT: The rules should not be passed unless the actuarial study is made more clear as to who will do it and who will pay for it and whether there will be annual actuarial studies or not.

RESPONSE: In August, 1994, the department contracted with UNISYS Corporation to develop the HMO program, including the actuarial study and setting of rates. UNISYS subcontracted with Lewin-VHI, a nationally recognized expert in medicaid managed care. Lewin-VHI developed the rates, including the annual update factor. While the department anticipates periodic actuarial studies to update the rates, the studies will not be done annually.

COMMENT: The rules should not be passed unless they state that the department may cut back on the amount of dollars HMO shall receive per enrollee due to shortfalls in the medicaid budget.

RESPONSE: ARM 46.12.4817(1)(f), concerning reimbursement, has been changed to provide for the reduction of the capitation rate in the event of funding shortfalls.

COMMENT: There is no provider appeal mechanism in the rules.

RESPONSE: A non-participating provider of emergency care, urgent care, or emergency room screens (as defined in the HMO rule) would have standing as a third party to the HMO contract should an HMO fail to reimburse these services. Other providers are responsible for addressing and securing appeal rights during contract negotiations with the HMO.

COMMENT: The Deaconess Billings Clinic Health System asks for clarification concerning mental health services. Deaconess

Billings Clinic Health System also provides mental health services, mostly in the area of in-patient services. The System desires clarification of the various rules that are proposing how mental health services will be acquired or contracted for this patient population. For instance, ARM 46.12.4810(2)(p) states that an HMO is not required to provide inpatient and outpatient mental health services within particular ICD-9 diagnosis codes. Those excluded codes appear to cover all of the more intense mental health services while implying that HMOs will be responsible for arranging health care coverage only for learning disabilities and simple alcohol and drug detoxification services. Our principal question in this area then is how will SRS be acquiring and contracting for the other mental health services required by this population. We feel it is essential from a mental health perspective that mental health services be part of HMO networks unless some other suitable arrangement for contracting for those services is being arranged.

RESPONSE: The department is in the process of seeking a waiver from the federal government to implement a managed care program for all mental health services as defined in ARM 46.12.4810(2)(p). Prior to approval of the waiver, mental health services will be sought by enrollees in the same manner as non-enrolled medicaid recipients. Providers will continue to be reimbursed as they are now. The contractor for the mental health managed care program will be procured through the competitive request for proposals process. Interested parties seeking additional information should contact Randy Poulsen, Medicaid Mental Health Program Specialist, at (406) 444-2706.

COMMENT: Given that FQHC and RHC services are covered services under ARM 46.12.4810, how will these services be handled under an HMO plan?

RESPONSE: All FQHC and rural health clinic services, except for mental health services as defined in ARM 46.12.4810(2)(p), are considered covered services, and must meet criteria established by the HMO.

ARM 46.12.4801

COMMENT: Several terms used in the proposed rules require a definition in order to avoid confusion and/or disagreement. These include "federally qualified health center", "rural health clinic", "county office", "family planning provider" "public health clinic" and "medical service delivery site".

RESPONSE: Federally qualified health center (ARM 46.12.1701, 46.12.1703), rural health clinic (ARM 46.12.1601, 46.12.1603, 46.12.1605), family planning provider (ARM 46.12.575, 46.12.576), and public health clinic (ARM 46.12.571) are already defined elsewhere in ARM subchapter 12, Title 46. Those ARM citations have been added to the covered services listed in ARM 46.12.4810(1).

The department believes the term "medical service delivery site" is self-explanatory and thus does not need to be added to ARM 46.12.4801.

A definition of "County office" has been added to ARM 46.12.4801.

COMMENT: The department has a unique opportunity to assure that definitions and implementing language contained in the HMO contract are consistent with the rule. Given the lack of clarity in the rule and the inconsistencies in definitions between the rule and HMO contract, the current draft contract is of little utility for discussion. What does the department intend to do to eliminate conflicting definitions between the proposed rules and the HMO contract?

RESPONSE: The HMO contract has been finalized, and the terms and definitions in the rules have been conformed with those used in the HMO contract. The definitions of "enrolled recipient", "health maintenance organization", "managed health care contractor", "participating provider", "primary care provider" and "recipient" have been changed.

COMMENT: In view of recent comments from the Office of the Insurance Commissioner regarding fees paid based on age and sex, could SRS provide documented evidence that this methodology is acceptable. An HMO whose contract rates, even those set by other parties such as PHHS, would be reviewed in a compliance examination. If the HMO was out of compliance the HMO would face sanctions by the Commissioner. The department should request that the Insurance Commissioner carefully scrutinize these rules, the draft SRS HMO contract and other HMO administrative processes and make a formal declaration that compliance with SRS rules won't jeopardize HMO compliance with insurance statutes.

RESPONSE: In a recent meeting the department has confirmed with the Insurance Commissioner that medicaid rates may not be based on sex, but may be based on age and eligibility category (i.e. AFDC and SSI). ARM 46.12.4801(1) has been amended by deleting "sex." The staff of the Insurance Commissioner has been provided with the opportunity to review and comment on the proposed rules, the model HMO contract, and the proposed rates.

ARM 46.12.4801(2)

COMMENT: The definition of "community-based organizations" in ARM 46.12.4801(2), does not include a list of the types of organizations that the definition would encompass. Has a list been prepared of potential community-based organizations that SRS believes may be interested in being so designated for purposes of the program? If so, a copy of such list would be appreciated. Because an HMO is required under ARM 46.12.4815(3) to "cooperate, where appropriate and feasible with community-based organizations in the referral for and delivery of services

available through those organizations," it is important that this definition be specific concerning which organizations fit within this category and what specific services are delivered.

RESPONSE: The rule has been amended to list specifically the types of organizations included in this definition. Those organizations include:

local family planning clinics
local Women, Infants, and Children (WIC) projects
local projects of Montana Initiative for the Abatement of Mortality of Infants (MIAMI)
HIV testing, partner notification and early intervention
childhood lead poisoning prevention services
Cherish Our Indian Children
Follow Me programs for special needs children

ARM 46.12.4801(6)

COMMENT: The definition of "emergency care" in ARM 46.12.4801 (6) refers only to inpatient and outpatient hospital services. What about emergency services provided by medical assistance facilities? Also, federal regulations require Federally Qualified Health Centers(FQHC) and Certified Rural Health Clinics(RHC) to provide ". . . medical emergency procedures as a first response to common life-threatening injuries and acute illness . . . "(42 CFR 491.9(3)).

RESPONSE: SB 388, enacted by the recent Legislature, requires the department to define "emergency care." The definition of emergency care in the HMO rule is consistent with that used in medicaid rules at ARM 46.12.102. Medical assistance facilities are a subset of inpatient hospitals, so emergency services provided by them on an inpatient or outpatient basis would meet the definition of emergency care. All FQHC/RHC services, including emergency services, are considered covered services except mental health services as defined in ARM 46.12.4810(2)(p).

ARMA 46.12.4801(7)

COMMENT: The proposed definition of "emergency room screens" in ARM 46.12.4801(7) is not clear concerning the level of care needed in order for reimbursement to be made.

RESPONSE: The definition is consistent with that used in federal COBRA regulations. The level of care required is that required by those same regulations, i.e. whatever is required, within the capacity of the facility, to assess if the patient has an emergent condition or is in active labor, and to stabilize the patient's condition prior to transfer. Both the HMO contract and ARM 46.12.4816(6) and (9) further reflect the SB 388 requirements that HMOs reimburse emergency care, urgent

care, and emergency room screens at rates not less than department rates.

ARM 46.12.4801(9)

COMMENT: The definition of "enrollment area" in proposed ARM 46.12.4801(9) indicates that an "enrollment area" may not be less than an entire county and that an HMO's service capability will be as required by the department and set forth in the HMO contract. There may be circumstances where a provider is licensed in a county, but not have service capacity throughout the county. Further, residents in a county may access their care through medical providers outside their county of residence.

RESPONSE: The department agrees with the comment and has changed the definition of "enrollment area" to reflect the circumstances noted in the comment.

COMMENT: The current draft HMO contract does not contain a definition of "service capability" for purposes of the enrollment area. Will such a definition or formula be added to the HMO contract to ensure that an HMO has sufficient provider capacity for the potential medicaid recipients eligible to enroll in an HMO? Also, how will the department's definition or formula address outlying areas of a county, such as the Augusta or Lincoln areas of Lewis & Clark County?

RESPONSE: In Section 2.10 of Attachment 1 of the HMO contract, the HMO must demonstrate to the department the capability to provide covered services to the maximum number of enrollees it states it can cover in an enrollment area. This must be demonstrated to the department's satisfaction prior to recipients being allowed to enroll with the HMO in that enrollment area. There is no formula used. The determination will be made on a case-by-case basis. Criteria to be examined include primary care provider (PCP) to recipient ratios.

ARM 46.12.4801(12)

COMMENT: In the definition of "health maintenance organization" in proposed ARM 46.12.4801(12) and in other places in the proposed rules there is reference to an HMO's license to operate. The rules should refer to an HMO operating under a "certificate of authority" since that is the term used in 33-31-201(1), MCA.

RESPONSE: In places where it appeared in the proposed rules, the department has replaced "license" with "certificate of authority."

ARM 46.12.4801(13)

COMMENT: The structure of the first sentence in the definition of "managed health care providers" at proposed ARM 46.12.4801 (13) seems to specify that fee for service systems of care are managed health care providers. Is this the intent of the first sentence?

RESPONSE: The definition of "managed health care providers" at ARM 46.12.4801(13) refers to both of the department's managed care programs: HMOs, in which reimbursement is based on capitation rates; or PASSPORT to Health, in which reimbursement is based on fee-for-service or cost-based reimbursement.

COMMENT: Would it be helpful to remove the word "provider" from this definition so as not to confuse the role of actual deliverers of medical services with the role of HMOs as financial intermediaries?

RESPONSE: The department agrees with the comment and has changed the term from "managed health care provider" to "managed health care program."

ARM 46.12.4801(14)

COMMENT: The definition of "managed health care contractor" in proposed ARM 46.12.4801(14) does not clarify which entity is a managed health care contractor. Does the department have a contract with such an entity? If so will that entity be identified in the rules?

RESPONSE: This term "managed health care contractor" has been changed to the term used in the HMO contract, "administrative contractor for managed care." The department has awarded a contract to UNISYS Corporation to be the administrative contractor for managed care through June, 1997. Since this contract will periodically come up for competitive bids, the department has not put the name of the organization in the rules.

ARM 46.1.4801(15)

COMMENT: The proposed rules clearly indicate that the department does not wish to be in privity with any provider of services which has a relationship with an HMO. Consequently, it is recommended that reference in the definition of "participating provider" in proposed ARM 46.12.4801(15) to any subcontract or employment arrangement be stricken and the definition read as follows: " . . . means a provider of medical and services rendering care under an arrangement with an HMO".

RESPONSE: The department does not wish to know every detail of the relationship between the HMO and its participating providers, but does require certain information. Under Section

1.1 of Attachment 1 of the HMO contract, participating providers are considered subcontractors. Section 10.A. of the HMO contract specifies that subcontracts must be approved by the department. Finally, to comply with federal statute, the department reserves the right in Section 13.D. of the HMO contract to inspect any physician incentive plans.

The definition of "participating provider" has been changed to conform with the definition used in the HMO contract.

ARM 46.12.4801(16)

COMMENT: The definition of "primary care provider" of proposed ARM 46.12.4801(16) is significantly different than the definitions included in the current PASSPORT to Health Program rule(ARM 46.12.5002(11)) and the draft HMO contract. Under the current PASSPORT program, physician assistants, nurse practitioners and clinics are allowed to enroll as PASSPORT providers and serve as gatekeepers. Unfortunately, Montana's only currently available state-wide, commercial HMO does not recognize mid-level providers as gatekeepers. The definition of "primary care provider" should be consistent in all three documents and that, at a minimum, any provider eligible to be a primary care provider (gatekeeper) under PASSPORT should be eligible to be a gatekeeper in an HMO.

RESPONSE: The definition has been changed to conform with the HMO contract. The rule allows, but does not require, mid-level practitioners to be primary care providers.

The department is putting an HMO that contracts with it at financial risk for providing certain services. The HMO must have the ability to manage that risk. As a result, the department will not put additional constraints on how the HMO meets its responsibilities to medicaid enrollees. The only exception is for family planning; immunizations and lead testing at public health clinics; and urgent and emergent care.

COMMENT: If the department chooses to leave proposed ARM 46.12.4801(16) unchanged, please address how access to care for the medicaid population will not diminish if an HMO limits their primary care providers/gatekeepers to physicians only?

RESPONSE: Allowing HMOs to limit who can be a primary care provider does not diminish access in the same way that the PASSPORT program's criteria (eg. on 24 hour coverage) do not diminish access. As in PASSPORT, an HMO cannot come up in an area unless the HMO has a sufficient provider network. The PASSPORT program has a smaller number of primary care providers available than would be available without PASSPORT, but it is the providers' commitment to seeing medicaid patients that expands access.

COMMENT: Are current department standards for provider participation in PASSPORT less stringent than standards used by existing licensed HMOs to determine gatekeeper participation?

RESPONSE: It appears that the department's standards for who can be a PASSPORT provider may be less stringent than those of the three HMOs with a certificate of authority to do business in Montana.

COMMENT: Will exclusion of nurse practitioners and physician assistants as gatekeepers at an HMO's discretion promote "the efficient and economical provision of services while protecting the overall integrity of the Medicaid program"?

RESPONSE: The department expects that the imposition of financial risk will promote the efficient and economical provision of services. The PASSPORT program, in which PASSPORT providers are not at financial risk, has already reduced the rate of growth of the Medicaid program. Because of financial risk, HMOs have even more incentive to manage services, and must be given as much freedom as possible to do so without sacrificing quality of care.

ARM 46.12.4801(16)

COMMENT: The Montana Hospital Association (MHA) objects to the definition of "primary care provider" in proposed ARM 46.12.4801(16) by which the department requires that an enrolled recipient "gain approval to obtain services from other medical professionals". MHA suggests that SRS limit the definition of "primary care provider" to identifying who that professional is, and leave the operational consideration of approval for services to the HMO. HMOs in some managed care markets now allow some self referral for specialty care and point of service plans which SRS should not discourage by fiat.

RESPONSE: The department agrees with the comment and has changed the definition of "primary care provider" to conform with the HMO contract. The revised definition allows HMOs to determine policies on how enrollees obtain services.

ARM 46.12.4802(17)

COMMENT: The department should consider an alternative to the term "recipient" in proposed ARM 46.12.4801(17). The department historically differentiates between "eligible" and "recipients" by the actual receipt of medical services. Using the term recipient instead of "medicaid eligible person" or "enrollee" is confusing.

RESPONSE: When discussing budget-related issues, the department does distinguish between recipients and eligibles. However, for all other purposes, including the rest of the medicaid rules, "recipient" refers to someone who has been approved for

medicaid, whether or not the person actually receives medicaid services. To be consistent with the general usage of "recipient," the term is used in the HMO rule as well. A recipient is anyone eligible for medicaid; an enrollee is any recipient actually enrolled in an HMO.

ARM 46.12.4802

COMMENT: While the department has noted that it intends to make HMO enrollment mandatory for "able-bodied adults" next year, the date for such an action is not listed. Clarification is needed concerning when in 1996 this category of recipients will be mandated to enroll in an HMO.

RESPONSE: At this time, welfare reform is scheduled to start being phased in in February, 1996. The rules for that program are scheduled to be promulgated in the fall of 1995. The HMO rule will be amended after the promulgation of those rules to specify who is mandated to enroll in an HMO.

ARM 46.12.4804(2)

COMMENT: The HMO program is supposed to be voluntary, but proposed ARM 46.12.4804(2) would mandate enrollment into HMO for all newborns, whether or not their mothers are in the HMO. Does this mean that the newborn will not be allowed to participate in Passport? What happens if the mother (parent) wishes the newborn to receive care from a provider that is not a participating provider or primary care provider in the HMO? Will they have the option on the date of birth to enroll the newborn with a PASSPORT provider or obtain care from a non-participating provider?

RESPONSE: The department agrees with the comment. The enrollment requirement for newborns has been removed.

ARM 46.12.4804(3)

COMMENT: Proposed ARM 46.12.4804(3) prohibits individuals exempt from participation in the primary care case management program (PASSPORT), as provided in ARM 46.12.5003, from enrolling in the HMO program. ARM 46.12.5003(2)(n) exempts medicaid recipients "enrolled in a health maintenance organization (HMO)" from participation in PASSPORT. Therefore, by reference, an otherwise eligible recipient who voluntarily enrolls in an HMO plan becomes "ineligible" to participate in an HMO contracting with the department. The department clearly needs to eliminate this Catch 22 for medicaid recipients.

RESPONSE: The rule has been amended to provide that people who meet the criteria in ARM 46.12.5003(2)(a) through (m) cannot enroll in the HMO program.

ARM 46.12.4804(3)

COMMENT: Please describe the persons who presently fit the exemption under proposed ARM 46.12.4804(3).

RESPONSE: The categories of persons are: medically needy; subsidized adoption; medicare eligible; nursing home or intermediate care facility for the mentally retarded; medicaid-eligible for less than three months; resident of an area not covered by PASSPORT; only retroactively eligible; lacking a primary care provider who is willing to accept the recipient; already enrolled in managed care under private insurance; exempted by department because of hardship; receiving medicaid home and community-based waiver services for aged or disabled; medicaid restricted card program; or enrolled in a health maintenance organization. In general, the exemption is automatically made by TEAMS, the department's computerized eligibility system. Hardship exemptions are made by the administrative contractor for managed care or department staff. ARM 46.12.5003 provides the specific criteria.

ARM 46.12.4804(3)

COMMENT: MHA suggests the department amend proposed ARM 46.12.4804(3) of this part to allow recipients exempt from required participation in Passport to enroll in HMOs. MHA does not understand why the department would exclude medicaid recipients so inclined from participating in an HMO, unless this exclusion pertains only to institutionalized persons.

RESPONSE: While there are other exemptions besides being institutionalized, all reasons for exemption have in common that it does not make sense for people in those situations to be in a managed care program. This is because enrollment would create a hardship (eg. for a subsidized adoption child living out of state; person retroactively eligible); there is already oversight of the person's care (eg. institutionalized; home and community-based waiver); the bulk of a person's care is paid by someone other than medicaid, and the savings would accrue to the third party (eg. Medicare/medicaid recipients); or the person's eligibility is readily subject to change (i.e. medically needy).

ARM 46.12.4805(2)

COMMENT: ARM 46.12.4805(2) states: "An eligible recipient may request enrollment with a particular HMO." Will HMOs as well as community-based organizations be permitted to advertise for enrollees? If so, will SRS retain the right to review ad copy and promotional materials?

RESPONSE: HMOs will be allowed to advertise to potential HMO enrollees. The HMO contract provides for department approval of marketing materials. While the department can require HMOs signing a contract to coordinate with community-based

organizations, the department has no jurisdiction over those organizations, and so cannot regulate the advertisement of their services to the medicaid population.

ARM 46.12.4805(2)

COMMENT: Proposed ARM 46.12.4805(2) allows an eligible recipient to request enrollment with a particular HMO. It appears that there is no limitation concerning how often (other than once a month) a recipient can change enrollment and thus no limitation concerning how often one can enroll in the same HMO. While HMO shopping will probably be limited, it seems more practical to limit changes to once a year when a new benefit period begins. We encourage the department to apply for the necessary 1115 waiver concerning this issue as soon as possible.

RESPONSE: The ability to change once a month is available in the existing PASSPORT program. Only 4.5% of the people on PASSPORT in a given month request change of PASSPORT provider. Most of those are because they had failed to choose a provider on their own and thus had been mandatorily assigned to a provider they did not want. The department expects this trend of few people changing to continue under HMO. As a result, the department believes HMOs will have the benefit of stability without the department having to restrict a freedom that is not abused.

ARM 46.12.4805(3)

COMMENT: Given the department's current definition of "enrollment area" in proposed ARM 46.12.4801(9), proposed ARM 46.12.4805(3) should be amended to replace "locality" of the recipient's residence with "county". If the department chooses to adopt this rule as proposed, who will determine if the HMO is providing services in the "locality of the recipient's residence"? Will it be acceptable for a recipient residing in Musselshell or Treasure County to enroll with an HMO providing services in Yellowstone County? If not, and a recipient is currently receiving their medical services from a participating provider in Yellowstone County, will they be required to change providers under this rule? Would the department allow enrollment of persons who normally receive their medical care in the HMO's county of operation, but the person resides in an adjoining county?

RESPONSE: As noted in the response to comments on ARM 46.12.4801(9) the last sentence in the definition of "enrollment area," has been replaced with "If a proposed enrollment area is other than an entire county or counties, the proposed enrollment area should reflect the area of the county or counties that correspond to normal service delivery area."

A recipient will be able to enroll with an HMO if the recipient lives in an enrollment area served by the HMO. The HMO may

include in an enrollment area a county in which it has no primary care providers because of unavailability if the residents of that county travel for health care to an adjacent county in which the HMO does have primary care providers.

In the example used in the comment, if the HMO's enrollment area is only Yellowstone county, then only recipients living in Yellowstone county can enroll. Recipients in Musselshell and Treasure counties would be ineligible to enroll in the HMO in Yellowstone county, and would not be required to change from their existing PASSPORT primary care provider under this rule. However, if the HMO's enrollment area is Yellowstone, Musselshell, and Treasure counties, recipients in Musselshell and Treasure counties could choose the HMO and could choose, but would not be required to change, an HMO primary care provider in Yellowstone.

ARM 46.12.4805(4)

The department has amended this rule to clarify that a recipient may not initially enroll with an HMO if the person is hospitalized. This amendment was presented in the department's testimony at the rule hearing on June 14.

COMMENT: The department's testimony and proposed amendments to the rules clarify that under proposed ARM 46.12.4805(4) a person may not initially enroll in an HMO while hospitalized but allows enrollment while hospitalized at other times. Allowing a recipient who is hospitalized or suffering from any acute illness to opt into an HMO opens up the HMO to the risk of cost shifting through the persuasion of seriously ill persons to enroll in an HMO when the illness or hospitalization strikes. Such an action would doom any efforts to privatize medicaid care, in that risk of loss would increase. It is urged that the term of enrollment for a medicaid recipient be for the contract year agreed upon between the department and HMOs unless the recipient is disenrolled for cause or due to loss of recipient's eligibility for the program.

RESPONSE: It appears the first concern expressed is based on a misunderstanding, i.e. that this rule "allows enrollment while hospitalized at any other time." The rule expressly prohibits the start date of a recipient's enrollment from falling in the midst of a hospitalization. This is in accord with a provision in SB 388 enacted by the recent Legislature.

The HMO will be responsible for any subsequent hospitalizations while a person is an enrollee. Inpatient hospital services are a covered service. The cost of inpatient hospital services are included in the capitation rate. HMOs serving commercial clients cover hospitalization, so it is expected HMOs have experience managing this medical service. It is not unreasonable for the department to expect HMOs to bear the risk

for managing this service for medicaid enrollees, whether or not they had been hospitalized prior to enrollment.

Recipients may not be locked into an HMO without a federal waiver. A federal waiver has been requested for certain able-bodied adults who will participate in the upcoming welfare reform program. A six-month lock-in may be requested through a 1915(b) waiver if the HMO is federally qualified (none of the HMOs in Montana have this designation). Mandating recipients into an HMO may also be obtained through a 1915(b) waiver if the recipient is given a choice of two or more HMOs.

A one-year lock-in without choice among two or more HMOs would require an 1115 research and demonstration waiver. These waivers are only granted when states want to demonstrate new systems of delivering medicaid services. A simple lock-in would not meet that criteria.

ARM 46.12.4805(5)

COMMENT: The provision in proposed ARM 46.12.4805(5) that enrollment be allowed upon receipt of a verbal request by the managed health care contractor creates difficulties. Should the option of a verbal enrollment be eliminated to assure understanding by patients of the consequences of their actions and to eliminate the probability of numerous enrollment changes within short time frames? We suggest that enrollment be by written request only. The process of enrollment as described in this subsection appears cumbersome and could result in increased administrative complexity.

RESPONSE: The enrollment of recipients in PASSPORT to Health via verbal or written requests has reduced paperwork and mailing costs, and made the PASSPORT enrollment system more responsive to recipients. All recipients new to managed care are contacted to make sure they understand the program, and are afforded the opportunity to enroll right then over the phone. This opportunity has increased the number of people who enroll on their own. The department anticipates this experience will continue when HMO is a managed care option.

Recipients retain the right to change PASSPORT providers or between the PASSPORT and HMO programs each month. The option of a verbal request was made to reduce paperwork required to maneuver within the medicaid managed care system. Under PASSPORT, only 4.5% of the population change in any given month.

ARM 46.12.4805(5)

COMMENT: Is there a system in place that will prevent possible duplication in enrollment, i.e., a recipient that may somehow become enrolled in two HMO's at once.

RESPONSE: The three data systems, TEAMS, MMIS, and the managed care enrollment system created by UNISYS Corporation, the administrative contractor for managed care, communicate with one another and verify enrollment data. Consequently, a recipient would not be able to enroll with more than one managed care provider.

ARM 46.12.4805(5)(b)

COMMENT: Under proposed ARM 46.12.4805(5)(a) enrollment will apparently be permitted at other locations designated by the department. Will the enrollment form as well as verbal enrollment elections, if verbal enrollment is retained in the rules, be permitted at the point of service? We feel this should expressly not be permitted to occur.

RESPONSE: The other locations will be able to take written enrollment requests from recipients and forward those requests to the administrative contractor for managed care. The language of the rule has been changed to clearly state this.

ARM 46.12.4805(6)

COMMENT: The concept of first come, first enrolled is acceptable. It is unclear, however if the contractor will determine the order of enrollment or the HMO provider.

RESPONSE: The order of enrollment is the order in which the enrollments are received by the administrative contractor for managed care. The rule has been amended to clarify this.

COMMENT: The proposed rule fixes the number of eligibles as determined in the contract with the HMO. Until this process is better understood, an HMO may only be willing to contract if it is able to stop accepting enrollees when it perceives that it has reached the maximum level of acceptable risk. If, for example the first 20 enrollees have severe medical conditions, the HMO may not be willing to accept further enrollees. An escape clause is important for initial HMO contracts in order that both the HMO and the department understand that a mixture of medicaid eligible be directed to the HMO, not merely eligible persons in need of significant medical care.

RESPONSE: Section 2.10 of Attachment 1 of the HMO contract permits the HMO to set the maximum number of enrollees it will accept in each enrollment area. The HMO may change the maximum enrollment with 30 days notice to the department.

ARM 46.12.4805(6)

COMMENT: The Montana Hospital Association (MHA) seeks clarification of the term "capacity" of the HMO in proposed ARM 46.12.4805(6). Does the department intend to enroll medicaid recipients to the fullest extent the "75/25" ratio allows, or

does the department intend to allow the HMO to limit the percentage or number of enrollees the HMO will accept? Later rule language seems to suggest the latter. Will HMOs be free to limit the percentage of their medicaid enrollment to total lives enrolled?

RESPONSE: The term "capacity enrollment" has been changed to "maximum enrollment as determined by contract." As specified in Section 2.10 of Attachment 1 of the HMO contract, the department intends to allow an HMO to determine what its maximum medicaid enrollment will be, and consequently to allow HMOs to limit the percentage of total enrollment comprised of medicaid enrollees. The department will confirm the HMO has the capability to serve the maximum number, and that the maximum number does not exceed the "75/25" rule unless a waiver has been obtained to do so.

Please note that per CFR 434.26(b), a state can request a waiver of the 75/25 rule for up to three years for a new HMO.

ARM 46.12.4805(7)

COMMENT: Proposed ARM 46.12.4805(7) bases the obligation for enrollment upon the request for enrollment being received by the managed health care contractor, however, it does not require that the managed health care contractor transmit the enrollment information to the HMO by a certain date. In order for an HMO to place an eligible recipient on its system a reasonable time from the date of receipt is necessary.

RESPONSE: The deadline for notifying the HMO of its enrollees is specified in Attachment 5 to the HMO contract. Specifically, the HMO will be notified by the last working day prior to the month of enrollment.

COMMENT: The term "monthly eligibility deadline" used in proposed ARM 46.12.4805(7) is not defined.

RESPONSE: The term "the monthly eligibility deadline" has been replaced with the phrase "the last four working days of the month".

ARM 46.12.4805(8)

COMMENT: Proposed ARM 46.12.4805(8) states that a medicaid card is issued to enrolled recipients. However, an HMO may issue an appropriate identification card also. Providers will have substantial write-offs for services rendered if they deliver services to persons they are not authorized to treat. This is a dilemma in all health care plans and could be significantly alleviated if a single card were produced for a medicaid-covered person. The card should list which HMO network the patient is covered under to assist the provider at time of registration to determine if the patient is staying in or going out of network for services.

RESPONSE: Medicaid will continue to issue a monthly card to all recipients. Currently, the recipient's PASSPORT provider's name and phone number are listed right below the recipient's name. When the HMO program is implemented, a recipient selecting an HMO will have the name and phone number of that HMO listed under the recipient's name. The provider manual for the HMO program will emphasize the need to check the medicaid card itself, even if the patient also has a card issued by the HMO.

ARM 46.12.4805(10)

COMMENT: ARM 46.12.4805(10) conflicts with the concept of a voluntary HMO as specified in proposed ARM 46.12.4805(1) and is outside the authority of the department's pending 1915(b) waiver. Given the department's June 15, 1995 letter to HCFA deleting the request for a mandatory assignment procedure under this waiver, this section should either be dropped entirely or amended to reflect "default assignment" to the PASSPORT program only, if available. If the department proposes to do otherwise, please cite the department's authority to impose such mandatory and/or default assignment.

The Montana Hospital Association (MHA) opposes ARM 46.12.4805 (10). MHA understands that enrollment by medicaid recipients in HMO managed care is voluntary, as stated in proposed ARM 46.12.4805(1). SRS appears to counter this language in proposed 46.12.4805(10).

What is the process for the random assignment? Could one particular HMO become the recipient of adverse selection?

Proposed ARM 46.12.4805(10) provides for alternating enrollment of unassigned persons between the Passport and HMO programs. We suggest that the department make a reasonable effort to steer eligible recipients toward available HMOs from the passport program. Further, alternating assignment may tend to enroll a larger proportion of recipients to smaller HMOs. In order to avoid placing an HMO out of compliance with (9), recipients should be apportioned based upon the number of enrolled persons in the various HMOs.

The proposed rule states patient allocation rules. If further detail has been drafted concerning this rule, it would be appreciated. Suggest "random assignment" be defined or the procedure for assignment be otherwise identified by some examples. In addition, there is no authority to mandate recipients into an HMO in the mandatory assignment process.

RESPONSE: The department agrees with the comment on the department's authority and has removed the provisions allowing mandatory assignment into an HMO for newborns and people who fail to choose a managed care program on their own.

ARM 46.12.4805(11) and (12)

COMMENT: ARM 46.12.4805(11) and (12) will allow an eligible recipient to change HMO or primary care case management programs at will. Such a result limits significantly the ability of a risk taking entity to manage the program. We have found that by limiting choice for changing a primary care provider to an annual one, our insureds' care can be far more intelligently and appropriately managed. By allowing an eligible recipient to move from program to program at will, the department will increase paper work, encourage persons with high usage to migrate to certain programs and off of the non-risk assuming programs and defeat an underlying purpose of an HMO which is to allow the creation of a primary care doctor - patient relationship.

RESPONSE: ARM 46.12.4805(10), (11) and (12) have been deleted, so there is no need to address the mandatory assignment portions of the comment. The response to a comment on ARM 46.12.4805(2) addressed the need to limit a recipient's ability to change managed care programs.

COMMENT: The term "timely fashion" in proposed ARM 46.12.4805 (11) should be defined.

RESPONSE: Due to the deletion of (11), the term has not been defined.

COMMENT: Does proposed ARM 46.12.4805(11) and (12) address the assignment of the recipient to a physician or to a particular managed health care organization, i.e., HMO or Passport?

RESPONSE: Due to the deletion of (11) and (12), there is no need to address the comment.

COMMENT: Given the department's June 15, 1995 letter to HCFA withdrawing the request for a mandatory assignment procedure, proposed ARM 46.12.4805 should be amended to replace the term "managed health care provider", which includes HMOs, with "PASSPORT provider" since a recipient cannot be assigned to the HMO under the department's pending 1915(b) waiver. In addition, the term "PASSPORT provider" should then be added to ARM 46.12.4801 Definitions.

RESPONSE: Due to the deletion of (10), (11) and (12), there is no need to address the comment or define the term "PASSPORT provider."

ARM 46.12.4806

COMMENT: The exact logistics of the disenrollment process in proposed ARM 46.12.4806 need to be more clearly stated. Timing of the transfer of documents is critical. Will all HMOs have

the same cut-off dates for processing new enrollees? More detailed information would be appreciated.

RESPONSE: The manner for a recipient to request disenrollment is as follows. Recipients can request disenrollment from an HMO without cause. The recipient disenrolls by calling the administrative contractor for managed care, by sending a written request to that same contractor, or by filling out a form and requesting the HMO forward it to the contractor. The HMO contract requires the HMO forward a disenrollment request within three working days.

The manner for an HMO to request disenrollment of a recipient is as follows. The HMO can request disenrollment of an enrollee for good cause. The request must be in writing and approved by the department.

The timing involved in disenrollment is as follows. Enrollment is always for a full calendar month. Disenrollment is effective the first of the following month, if possible. If the request is received before the last four working days of the month, it will be effective the first day of the following month. If it is received within the last four working days of the month, it will be effective the first day of the second month after the month in which the request was made.

HMOs will not "process" new enrollees. Recipient enrollment into and disenrollment from an HMO is handled by the administrative contractor for managed care. The HMO will receive a list of its enrollees once a month. The list will be sent by the administrative contractor for managed care, and will arrive no later than the last working day of the month just prior to the month of enrollment.

COMMENT: If a person is disenrolled for whatever reason under proposed ARM 46.12.4806, it is unclear how or if the service will be provided to the individual. Are services completely terminated even though the person qualifies for medicaid?

RESPONSE: Recipients of medicaid remain eligible for medicaid no matter what their managed care status. HMO and PASSPORT put controls on the way recipients obtain a medicaid service, not whether they are eligible for a service. Recipients who opt out of HMO must enroll in the PASSPORT program as required by ARM 46.12.5001. If an HMO disenrolls a recipient, the recipient must choose another managed care option: either enrolling with another HMO or choosing a PASSPORT provider.

(9) has been added to address this.

ARM 46.12.4806(1)

COMMENT: Proposed ARM 46.12.4806(1) allows disenrollment from an HMO without good cause at any time. The result of this

provision could be that of adverse selection. It is submitted that once a person enrolls in an HMO, the enrolled recipient should remain for the contract period so long as that person remains eligible for medicaid. In this way, care can be managed, tracking of health problems can be more efficiently accomplished and recipients will be less likely to "game the system" by moving back and forth among HMOs depending upon the benefits provided.

RESPONSE: Please see the department's responses to the comments of ARM 46.12.4805(2).

ARM 46.12.4806(3)

COMMENT: Disenrollment should only occur upon receipt of a written request. It is important that communication concerning disenrollment be timely communicated and that the time frame for disenrollment be clearly defined.

RESPONSE: The time frames for disenrollment are stated in ARM 46.12.4806(3)(b) and (6). As stated in the response to ARM 46.12.4805(2), oral requests for enrollment and disenrollment have worked admirably.

COMMENT: In the event disenrollment is made retroactive, the HMO should be reimbursed for services rendered between the date of disenrollment and the date of receipt of the notice of disenrollment.

RESPONSE: The language in ARM 46.12.4806 has been changed by creating a new (10) to provide for only one circumstance for retroactive disenrollment. In that instance, the department will recoup the capitation payment from the HMO. The HMO will then recoup payments it made to providers, and instruct the providers to bill medicaid directly. Thus, since the department will be responsible for reimbursing the actual providers of service, the department does not need to reimburse HMOs for these services.

ARM 46.12.4806(4)

COMMENT: In proposed ARM 46.12.4806(4), "and a copy sent to the recipient" should follow "writing". This provides recipients with notice that an adverse action is being taken against them and should provide recipients with an opportunity to present their side of the problem before the department reaches its decision to suspend medical coverage.

RESPONSE: The administrative contractor for managed care will notify the recipient that the person has been disenrolled and why. As a result, sending a copy of the HMO's disenrollment request is unnecessary.

Being disenrolled from an HMO does not mean a person is disenrolled from medicaid. All that happens is that the person is told to select another HMO or a PASSPORT provider. The recipient continues to be eligible to receive medicaid. Language has been included in the rule stating that the recipient continues to be eligible for medicaid.

ARM 46.12.4806(4)(a) and (5)

COMMENT: Is there a definition of "good cause" as used in proposed ARM 46.12.4806?

RESPONSE: Good cause reasons are listed in ARM 46.12.4806(5). These reasons are identical to those in Montana's HMO law.

COMMENT: Proposed ARM 46.12.4806(4) and (5) refer to prior approval of disenrollment for certain specific reasons, however the subsection does not describe the procedure for obtaining prior approval such as when such a request must be made, whether a hearing is allowed etc.

RESPONSE: Section 5.2 of Attachment 1 of the HMO contract requires the HMO request disenrollment of a recipient in writing to the department.

COMMENT: It is not clear whether proposed ARM 46.12.4806(4) is an explanation of what constitutes "good cause" under (4) or whether (4) relates to some other standard.

RESPONSE: The rule has been changed to clarify this. (5) has become (4)(b), and the predicate language modified to read "An enrollee may be terminated for good cause if the enrollee:"

ARM 46.12.4806(5)(a)

COMMENT: Proposed ARM 46.12.4806(5)(a) should be removed since the recipient does not pay premiums.

RESPONSE: The department agrees with the comment and has removed the section.

ARM 46.12.4806(5)(b)

COMMENT: "Verbal abuse" which appears in ARM 46.12.4806(1) is a subjective term which can have several meanings. Given the nature of some mental illnesses this phrase could be applied to discriminate against mentally ill clients. It is recommended the following language be used: "physical and verbal abuse that pose an immediate threat of bodily harm to providers or other enrollees of the health maintenance organization."

RESPONSE: (5) lists verbatim the portion of Montana's HMO law which details when an HMO may request disenrollment of an enrollee. It is unreasonable to require an HMO to serve a

person who is threatening the HMO, its participating providers, or their staff, whether the threat is for "immediate . . . bodily harm" or threats of future harm, bodily or otherwise.

ARM 46.12.4806(5)(c)

COMMENT: The clause in ARM 46.12.4806(5)(c), "knowingly provided fraudulent information in applying for coverage", needs modification. Fraudulent information by its nature is knowingly provided. Misrepresentation should also be included. Is it the department's intent that the acts indicated also include providing false information concerning the services rendered? If so that intent should be clarified.

RESPONSE: This section corresponds with Montana's HMO law.

ARM 46.12.4806(5)(f)

COMMENT: In that enrollment in the HMO will be governed by the department's rules and determined by the managed health care contractor, proposed ARM 46.12.4806(5)(f) does not state an enforceable reason for disenrollment.

RESPONSE: The department believes it has a responsibility to assure that statutory standards are met.

ARM 46.12.4806(5)(g)

COMMENT: It is not clear in proposed ARM 46.12.4806(5)(g) what is referred to in allowing a recipient to file a "grievance".

RESPONSE: Montana's HMO law and the HMO contract require that an HMO have an internal grievance procedure available to all its enrollees. The HMO must inform enrollees of their right to pursue a complaint through an internal grievance procedure.

ARM 46.12.4806(6)

COMMENT: It is recommended that disenrollment, as provided in proposed ARM 46.12.4806(6), take place the last day of the month rather than the first day of the month in order to avoid duplicate enrollment.

RESPONSE: Enrollment is effective a full month at a time. The enrollee is enrolled until the end of the month. As of the first of the following month, the enrollee is no longer enrolled, i.e. disenrollment is effective and the enrollee can be enrolled with a different managed health care program as of the first of the following month.

ARM 46.12.4806(6)

COMMENT: In the third line of proposed ARM 46.12.4806(6) the term "disenrollment" should be used in place of "enrollment."

RESPONSE: The department agrees with the comment and has made the suggested change.

ARM 46.12.4806(7)(b)

COMMENT: Proposed ARM 46.12.4806(7)(b) should be clarified to identify how one determines if an enrolled recipient moves "permanently."

RESPONSE: The department agrees with the comment and has clarified the rule. The provision now states that the department must disenroll recipients who meet the conditions of this subsection. Through its computerized eligibility system, the department is kept informed when recipients change their permanent address. If a recipient moves outside an HMO's enrollment area, disenrollment from that particular HMO will be automatic.

ARM 46.12.4806(8)(a)

COMMENT: How would the HMO be made aware of an enrollee's disenrollment as provided in proposed ARM 46.12.4806(8)(a)?

RESPONSE: The recipient's name will no longer appear on the monthly list of enrollees sent to the HMO by the administrative contractor for managed care. The rule has been clarified to state the department must disenroll a recipient from any HMO if the person meets the criteria of this subsection. The disenrollment will be effective the first of the following month.

ARM 46.12.4806(9)

COMMENT: Is re-enrollment as provided in proposed ARM 46.12.4806(9) into the same HMO?

RESPONSE: Reenrollment is into the same HMO. The rule has been clarified to state this.

ARM 46.12.4806(9)

COMMENT: The Montana Hospital Association (MHA) requests clarification of proposed ARM 46.12.4806(9) which allows for re-enrollment of recipients who become reinstated into medicaid within one month of becoming ineligible. According to the notification of enrollment process explained by SRS, recipients whose eligibility is subject to renewal during a month will be flagged as medicaid eligibility pending. HMOs will presumably continue delivery of managed care services, and be responsible to pay the provider for any care if the person becomes eligible. SRS explained, however, that if a person so flagged loses eligibility, the provider would be exposed to loss, not the HMO.

RESPONSE: The provision to permit reinstatement of an individual to the same HMO if there is a brief lapse of eligibility is meant to enhance continuity of care and reduce the need for re-enrolling someone with a specific HMO. For individuals who are flagged as "pending" on the HMO's monthly enrollment list, the HMO should confirm eligibility prior to arranging for the provision of services. This is the procedure recommended under the current PASSPORT program, where PASSPORT providers get "pending" recipients on their monthly enrollment list. Any provider risks denial of medicaid payment if services are provided to a patient for whom medicaid eligibility has not been confirmed.

If a patient has a department-issued medicaid card, even if issued by the department in error, the department's policy is to reimburse those services delivered by providers who confirmed eligibility by examining the card. Providers should insist on seeing the medicaid card before providing a service to people who indicate they have medicaid coverage.

COMMENT: A concern in relation of proposed ARM 46.12.4806(9) is that eligibility determination can be retroactive for as many as three months. How will the department notify the HMO, when appropriate, and the provider, when appropriate, for the persons who fall into the coverage/eligibility gaps?

RESPONSE: HMOs will be notified on the monthly enrollee list whether someone's eligibility has not been confirmed (i.e., person will be marked as "pending"). Providers can check eligibility by requiring patients to show proof of eligibility (i.e. the medicaid card); via modem and computer to the department's eligibility system; or via the medicaid fiscal intermediary's faxback and voice response system. The latter two are available 24 hours a day, 7 days a week. Eligibility can be retroactive. HMO enrollment cannot be retroactive.

COMMENT: When does the timely claim filing requirement begin for providers who serve recipients showing an HMO medicaid card but whose eligibility is later withdrawn, or retroactively determined beyond the 30 days contemplated in proposed ARM 46.12.4806(9)?

RESPONSE: The start of the 365 day timely filing limit is the day in which eligibility is confirmed or the date of service, whichever is later. For example, if a service is provided on May 1, but eligibility is not determined until June 1, the timely filing limit is 365 days from June 1.

If a patient has a department-issued medicaid card, even if issued by the department in error, the department's policy is to reimburse those services delivered by providers who can prove they confirmed eligibility by examining the card. Providers should insist on seeing the medicaid card before providing a service to people who indicate they have medicaid coverage.

ARM 46.12.4810(1) and (2)

COMMENT: These proposed rules are not consistent with the listing of covered and non-covered services in the draft HMO Contract appendix. This could lead to considerable confusion and disagreement upon implementation. This rule also appears to vary from the services listed in the department's pending 1915(b) waiver. Please explain these inconsistencies and how the department will resolve any conflicts with may arise due to these differences?

RESPONSE: The department agrees with the comment and has conformed the terms in the rule with those used in the HMO contract. Since the terms in the HMO contract are based on terms used in ARM 46.12.501 et seq., which is the basis for the terms used in the PASSPORT 1915(b) waiver request, the department does not anticipate any conflicts.

COMMENT: MHA suggests the department provide clarifying language to match the covered services to the HMO contract, or simply adopt permissive language to allow selection among all services potentially offered by an HMO. The proposed language of the rule does not match the HMO contract. The proposed language includes some conflicts, primarily applicable to EPSDT. ARM 46.12.4810(1)(f) states EPSDT is included in the HMO contract, but several component services of EPSDT are later excluded.

RESPONSE: With respect to EPSDT and similar services, the phrase "except that the HMO need not provide an aspect of any of these services that is specified in (2)" has been added to the lead sentence of ARM 46.12.4810(1).

ARM 46.12.4810(1)

COMMENT: There are a number of services referred to in proposed ARM 46.12.4810(1) which are not contained in ARM 46.12.501 which sets out services provided by medicaid. ARM 46.12.4814, however requires that an HMO provide services in the same manner as those provided medicaid recipients. It is therefore unclear whether those additional services are discretionary with the HMO.

It is also unclear whether those services which are listed in ARM 46.12.501 but not in ARM 46.12.4810 must be provided in order to comply with ARM 46.12.4814.

RESPONSE: The rule has been amended to make sure each service listed in ARM 46.12.501 et seq. is identified as either a covered or non-covered service.

ARM 46.12.4810(2) has been amended to list additions to the non-covered list, including abortions. Abortions were deleted because a recent District Court ruling requires medicaid to pay

for all medically necessary abortions. Federal matching dollars are only available for a small subset of medically necessary abortions, i.e. in cases of rape, incest, or danger to the life of the mother. The other medically necessary abortions must be paid only with state funds. Because of these funding complications, abortions were removed from the list of HMO covered services and will continue to be provided under regular medicaid.

ARM 46.12.4814(4) has been amended to specify "covered services as listed in ARM 46.12.4810(1)" ARM 46.12.4814(4) has been amended to specify "non-covered services as listed in ARM 46.12.4810(2)."

ARM 46.12.4810(1)(i), (1)(o) and (1)(w)

COMMENT: Are the services listed in proposed ARM 46.12.4810(1)(i), (1)(o) and (1)(w) considered covered services? It would seem that these are facilities that provide covered services. Please consider removing this.

RESPONSE: These services are named for the facilities that provide the services. In order to conform with the way services are defined elsewhere in the ARM, they are specifically listed here.

ARM 46.12.4810(1)(y)

COMMENT: Proposed ARM 46.12.4810(1)(y) refers to "school based services", however those services are not defined.

RESPONSE: The section has been amended to state "immunizations and well-child screens provided by school based providers".

ARM 46.12.4810(2)

COMMENT: Proposed ARM 46.12.4810(2) excludes several services, such as drugs, clinical social workers, psychologists, etc., from HMO coverage which are included in the definition of federally qualified health center services and certified rural health clinic services as defined by federal regulations at 42 CFR Subpart X and 42 CFR 440.20. How will these services, when provided by a FQHC or RHC, be reimbursed? If reimbursed outside the HMO, then how does the HMO meet the mandate as required in ARM 46.12.4810 to cover FQHC and RHC services?

RESPONSE: All services provided by an FQHC, except for mental health, will be a covered service under the HMO program. ARM 46.12.4810(1) has been amended by adding the language "except that the HMO need not provide an aspect of any of these services that is specified in (2):"

ARM 46.12.4810(2)

COMMENT: It is not clear whether an HMO has to provide certain services under proposed ARM 46.12.4810(2). Is the department going to provide these services elsewhere or are they going to cut these services? The department should not pass these rules if they are going to cut these services since they did not ask the Legislature to cut these services and the Legislature did not cut these services. Also, the department may not cut services unless there is a shortfall in funding for medicaid and the department has not said there is.

If the department does cut these services in (2) as mentioned above, are the services supposed to be provided by someone else? If the department is not going to have the HMO provide certain services then who will provide those services and what are the projected savings from not providing those services?

RESPONSE: It is the department's intent that services not covered by the HMO remain available to recipients. ARM 46.12.4810(2) has been amended to clarify that services the HMO does not cover are available to recipients in the usual manner.

In addition, ARM 46.12.4805 has been amended by adding a new (9) that states how enrollment is indicated on the medicaid card; how an enrollee obtains covered services; and how an enrollee may obtain non-covered services from the medicaid program.

COMMENT: It is unclear what happens under these rules what the Montana Medicaid program will provide to SSI recipients.

RESPONSE: SSI recipients, as provided in ARM 46.12.4804(1)(b), will not be eligible for the HMO program until July 1, 1996. Prior to that date, most will be in the PASSPORT program. Starting July 1, 1996, those in areas where HMOs are available will have a choice between PASSPORT and HMO. As provided in ARM 46.12.4804(3), an SSI recipient exempt from PASSPORT is exempt from HMO, and thus these rules will have no impact on them.

ARM 46.12.4810(3)(d)

COMMENT: Proposed ARM 46.12.4810(3)(d) states, "in addition to covered services, an enrolled recipient may obtain the following services on an as needed basis; services for an urgent condition or emergency." Please clarify whether this rule is stating that those services are to be acquired only within the provider network or if they are available from outside the network.

RESPONSE: The rule has been clarified by replacing the lead sentence with the following: "An enrolled recipient may obtain the following covered services through self-referral to a participating or non-participating provider:" The rule has been changed to provide that the HMO must reimburse these particular providers.

ARM 46.12.4810(3)

COMMENT: Proposed ARM 46.12.4810(3) should be clarified to state which family planning services are included.

RESPONSE: This section has been changed to specify to which family planning services an enrollee can self-refer.

ARM 46.12.4813(2)(b) and (2)(p)

COMMENT: ARM 46.12.4813(2)(b) and (2)(p) show an intent to exclude psychiatric care, however, there may be circumstances, given the specificity of the exclusions, under which psychiatric care would be allowed. What happens for an inpatient hospitalization at a non-state administered mental health facility for a diagnosis code which is not listed is covered? It is recommended that the rule be modified to clarify that the exclusion is for all inpatient and outpatient mental health services.

RESPONSE: The mental health services excluded from HMO coverage are those included in the department's waiver request to operate a mental health managed care program. That definition was reached after months of discussion with interested parties, input from the Mental Health Access Advisory Council meetings, and recommendations from a consultant. The exception is intentionally focused on mental health conditions as opposed to chemical dependency and substance abuse. As a result, the department will retain the definition in this rule.

An inpatient admission for an enrollee where the primary diagnosis code is not in ARM 46.12.4813(2)(p) is considered an HMO covered service.

ARM 46.12.4813(2)(x)

COMMENT: Proposed ARM 46.12.4813(2)(x) excludes IHS services if rendered on reservations in an IHS clinic. Are services rendered under contract with IHS off of reservations a benefit?

RESPONSE: If an IHS clinic refers a patient to an off-reservation provider with whom the clinic has a referral contract, that provider bills medicaid directly. As a result, the benefit falls under the service as defined in medicaid, eg. physician or hospital, and is not considered an IHS clinic benefit. It is considered a covered service if it meets the definition of covered service in this rule.

ARM 46.12.4813(4)

COMMENT: In proposed ARM 46.12.4813(4) it is not clear what "or otherwise" means.

RESPONSE: "Otherwise" refers to the stop-loss provisions the department offers as an option for an HMO's SSI enrollees per Attachment 6 of the model HMO contract. This will be available July 1, 1996, the first time SSI recipients are eligible to enroll in an HMO.

ARM 46.12.4813(7)

COMMENT: Proposed ARM 46.12.4813(7) should be clarified to acknowledge that certain information contained in contracts, etc. is proprietary and that entry into an agreement to provide HMO services does not constitute an agreement to release information, including information concerning the provider's information system, which is proprietary in nature.

RESPONSE: The rule has been amended to acknowledge that corporate information may be proprietary.

ARM 46.12.4813(8)

COMMENT: Proposed ARM 46.12.4813(8) should state the period of time within which an entity may cure an alleged breach.

RESPONSE: The rule has been changed to provided for a 30 day period for a contractor to cure an alleged breach.

COMMENT: The rules should explain what termination of a contract "in part" means.

RESPONSE: Termination in part refers to terminating a requirement or requirements contained in the HMO contract or any of its attachments.

COMMENT: The proposed rule should explain what authority exists for a withhold of payments for cause and under what circumstances the department intends to take such an action.

RESPONSE: Sections 7 and 25 of the HMO contract specifically provide for withholding.

ARM 46.12.4813(9)

COMMENT: Proposed ARM 46.12.4813(9), along with the rules generally, seem to leave an HMO with no remedy if it disagrees with a decision of the department.

RESPONSE: Section 28 of the HMO contract provides an HMO with an appeal process.

COMMENT: An appellate process should be provided for disagreements between the department and an HMO or its providers.

RESPONSE: It is the responsibility of participating providers to ensure they have an appeal or dispute resolution mechanism in their contract with the HMO.

ARM 46.12.4813(10)

COMMENT: As previously noted in a comment to proposed ARM 46.12.4805(6), while it is understandable that the department needs certainty concerning the number of persons who will be enrolled in an individual HMO, it is submitted that until all parties have experience with risk based contracts, an HMO should be able to determine that it has accepted as much risk as it deems appropriate and cease accepting new recipients. Such a limitation will allow HMOs to continue to remain financially solvent in the event allocation of recipients results in the enrollment of an extraordinarily large number of persons with high medical expenses.

RESPONSE: Section 2.10 of Attachment 1 of the HMO contract allows the HMO to set the maximum number of enrollees it will accept in each enrollment area. The HMO may change the maximum enrollment with 30 days notice to the department. However, the rules state and the department reiterates the HMO may not disenroll recipients simply because of high medical costs.

ARM 46.12.4813(13)

COMMENT: It is noted that each of the listed causes for termination in proposed ARM 46.12.4813(13) with the exception of (b), (g) and (h) contain subjective language. As has been stated earlier, there appear to be no appeal rights for the HMO. The language should be clarified to define what the department considers a material breach of the HMO contract.

RESPONSE: To conform with the provisions of the HMO contract, this (13) has been deleted. A new (8)(b) has been created under the rule that corresponds with the language of the contract governing termination.

COMMENT: Proposed ARM 46.12.4813(13)(a) should define what "inordinate risk of inadequate or inappropriate medical care" is.

RESPONSE: The provision the comment concerns has not been adopted.

COMMENT: Under proposed ARM 46.12.4813 (13)(c) and (d) what is the basis for determining how the HMO's delivery system is performing?

RESPONSE: The provisions the comment concerns have not been adopted.

COMMENT: Proposed ARM 46.12.4813(13)(a) and (c) provide for termination by the department of an HMO Contract for "inadequate or inappropriate medical care to enrolled recipients" and "the HMO's delivery system is not providing medicaid recipients with adequate access to medical services". Yet no where do these rules define what "adequate" is; how it will be determined; nor who will determine it. Please explain how these determinations will be made.

RESPONSE: The provisions the comment concerns have not been adopted.

COMMENT: "Proper assurances of financial solvency" in proposed ARM 46.12.4813(13)(e) should be defined.

RESPONSE: The provision the comment concerns has not been adopted.

ARM 46.12.4814(1)(a)

COMMENT: Proposed ARM 46.12.4814(1)(a) states "an HMO may impose the following requirements in the provision of services: the use of certain types of providers." Please define what is meant by "certain types of providers" as well as the role of HMOs in specifying providers who patients may seek out for services.

RESPONSE: The HMO may require an enrollee to obtain certain services from a certain type of provider. For example, they may require the enrollee to obtain all routine care from a primary care provider instead of a specialist or an emergency room.

ARM 46.12.4814(1)(a)

COMMENT: Proposed ARM 46.12.4814(1)(a) allows the HMO to impose requirements in the provision of services that specify "the use of certain types of providers". The ability of an HMO to impose restrictions on the use of provider types should be limited by the requirement for the HMO to cover certain services as defined in ARM 46.12.4810. In addition, the HMO should not be allowed to place restrictions on providers inconsistent with any Montana state law which regulates a provider's scope of practice. Finally, the HMO should not be allowed to impose restrictions on the type of providers which may serve as primary care providers/gatekeepers that are more restrictive than those currently used in the PASSPORT program (see ARM 46.12.4801(16) above). To do so, could significantly decrease access to care for eligible medicaid recipients.

RESPONSE: (3) of the rule already defines when the HMO must reimburse certain types of providers, regardless of whether they would otherwise meet the HMO's "certain type of provider" criteria.

As noted in the response to comments on ARM 46.12.4801(16), the department is putting an HMO contracting with it at financial risk for providing certain services. The HMO should have the ability to manage that risk. As a result, the department will not put additional constraints on how the HMO meets its responsibilities to medicaid enrollees. The only exception is for family planning; immunizations and lead testing at public health clinics; and urgent and emergent care.

The department does not interpret increasing access to be the same as simply increasing the number of providers available. For instance, in the PASSPORT program there are some towns in which certain primary care providers do not sign up to be PASSPORT providers. Instead, increased access means enhancing a medicaid recipient's ability to get medically necessary services. This can be done by obtaining commitments from providers to serve medicaid patients and by freeing resources currently devoted to inappropriate or unnecessary care.

ARM 46.12.4814(1)(d)

COMMENT: Proposed ARM 46.12.4814(1)(d) states an HMO may deny payment to a provider who has delivered services if the enrollee has not met participation requirements. Suggest reference to "these participation requirements" be defined or referenced back to specific sections of the rules.

RESPONSE: The department agrees with the comment and has changed the provision to provide specific reference to the requirements of (1).

ARM 46.12.4814(3)(d)

COMMENT: Proposed ARM 46.12.4814(3)(d) contains no method for controlling utilization of emergency care services. If a recipient receives services in an emergency room and the same are later determined not to be an emergency, there is no disincentive for payment.

RESPONSE: Urgent and emergent care are defined in these rules. Not every visit to the emergency room is for urgent or emergent care. For a visit to the emergency room which is later determined not to be urgent or emergent, the HMO is only responsible for reimbursing the emergency room screening. The phrase "or emergency room screen" has been added to the subsection.

ARM 46.12.4814(5)

COMMENT: Proposed ARM 46.12.4814(5) states an HMO must inform enrolled recipients of alternate providers "to the maximum extent possible." The phrase, "to the maximum extent possible," is a phrase that is probably undefinable. Is the phrase necessary?

RESPONSE: The department believes that it is appropriate to require an HMO to make a reasonable effort to inform enrollees of alternate providers. Please see comment and response immediately following.

COMMENT: It is not clear in proposed ARM 46.12.4814(5) what is meant by the requirement to inform to the maximum extent possible. Rather this rule should require that the HMO make a reasonable effort to inform.

RESPONSE: The department agrees with the comment and has changed the provision as suggested in the comment.

ARM 46.12.4814(5)

COMMENT: "Alternate providers" in ARM 46.12.4814(5) is not defined. If the intention is that recipients are to be directed to those providers described in (3)(b) and (c), the proposed rule should say so.

RESPONSE: The intent is to have the HMO provide referrals and assistance in scheduling appointment for enrollees who need non-covered services. The provision has been changed to clarify this intention.

ARM 46.12.4814(6)

COMMENT: Proposed ARM 46.12.4814(6) requires that the HMO provide the same scope of medical procedures as would be available under regular medicaid for those procedures. It is unclear whether the rule is referring to the services described in proposed 46.12.4810 and whether those services are "the same scope". If the intention is to refer to ARM 46.12.501, this rule should be clarified to so indicate.

RESPONSE: The department agrees with the comment and has changed the provisions to provide specific references. ARM 46.12.4814(4) has been changed to specify "covered services as listed in ARM 46.12.4810(1)". ARM 46.12.4814(5) has been changed to specify "non-covered services as listed in ARM 46.12.4810(2)." As noted in the response to comments on ARM 46.12.4810, each covered and non-covered service has been cross-referenced with its specific location in ARM 46.12.501 to make clear where the scope of the services is set forth.

ARM 46.12.4814(8)

COMMENT: Please explain proposed ARM 46.12.4814(8). Is the department in essence setting the length of stay for the HMO patient? This certainly seems to be a disincentive to manage patient care. Would not the HMO manage the care of the medicaid recipient in the same manner as the commercial patient?

RESPONSE: This section has been deleted, so a response to this comment is not needed.

COMMENT: Proposed ARM 46.12.4814(8) would limit significantly the ability of an HMO to provide utilization services through certification review. In addition, because days of service and length of stay determinations are individualized, it is questionable whether an HMO would know if it was in violation of the rule.

RESPONSE: The department does not intend to set the length of stay for a hospital patient. The department has clarified the rule by deleting the section. In addition, (6) has been changed by clarifying that HMO coverage must be for the amount, scope and duration of the services of the regular medicaid program.

ARM 46.12.4814(9)

COMMENT: Proposed ARM 46.12.4814(9) requires the HMO to ensure that services for urgent conditions and emergencies are available on an immediate basis 24 hours a day, 7 days a week. This proposed rule needs explanation. It is not clear what the role is for an HMO in this regard. If the intention is that the HMO have physicians on call 24 hours a day, such an intention should be expressed in that manner. Obviously an HMO cannot make an assurance concerning the availability of services no matter where the recipient is.

RESPONSE: The department's intention is twofold. First, an HMO should, through its contracts with participating providers, assure that 24 hour coverage is available. Coverage means having medical staff available via phone to assist enrollees in determining whether urgent or emergent care is needed. Second, an HMO must have available in the enrollment area participating providers of urgent and emergent care who can provide services 24 hours a day, seven days a week.

The department does not intend that an HMO have participating providers of urgent or emergent care in every possible location outside the enrollment area. Instead, the department anticipates that enrollees who travel out of the enrollment area will still have access to 24 hour phone coverage for guidance on whether to seek urgent or emergent care from the nearest available provider.

ARM 46.12.4815(1)

COMMENT: Proposed ARM 46.12.4815(1) states that an HMO may select providers it wishes. Should this rule be rewritten to be consistent with the opinion produced April 24, 1995, by the staff attorney for the Commissioner of Insurance concerning applicability of The Preferred Provider Agreements Act to HMOs?

RESPONSE: These rules govern the relationship between the HMO and the department. As legal authorities they do not supersede the other statutes governing the operations and performance of HMO's. The department would expect that an HMO would perform in accordance with the HMO contract, these rules, and all other authorities applicable to particular or generic activities of the HMO.

COMMENT: One of the written comments submitted at the rules hearing concerned whether it is necessary for the department to modify proposed ARM 46.12.4815(1) in view of an informal opinion by a staff attorney for the department of Insurance concerning the impact of MCA Title 33, Chapter 22, Part 17, relating to Preferred Provider Arrangements upon HMOs.

It is submitted that no modification to the language proposed is necessary. If an HMO is required to go through a request for proposal process to contract with providers for the delivery of services, the rule is broad enough to allow such an action. The issue of whether such an action is necessary is one which should be determined in a different forum than that of this rule making procedure.

RESPONSE: The department agrees with this analysis.

ARM 46.12.4815(2)

COMMENT: The term "good faith effort" as used in proposed ARM 46.12.4815(2) is insufficient. The determination should not be left until after the fact without any definition or guidance of what minimum good faith effort is. The Primary Care Association proposes the following language be inserted after sentence one of ARM 46.12.4815(2):

"The HMO shall offer such providers terms and conditions at least as favorable as those offered to other providers furnishing similar services to those which the FQHC, RHC, or targeted case management for high risk pregnant women provider is willing and able to provide. The FQHC, RHC, or targeted case management for high risk pregnant women provider must be able to meet substantially the same criteria as other HMO participating providers and primary care providers as defined in ARM 46.12.4801 and/or the contract with the department."

RESPONSE: The department has replaced this section with the language used in Section 2.20 of Attachment 1 of the model HMO contract. This language was developed during negotiations with the Primary Care Association.

COMMENT: This rule should be corrected to reflect the legal terminology and definitions of Federally Qualified Health Centers, Federally Qualified Health Center services, Certified Rural Health Clinics and Certified Rural Health Clinic services found in the federal statute and regulations governing such

entities. ARM 46.12.4810 clearly specifies Federally Qualified Health Centers and Rural Health Clinics as covered services (ARM 46.12.4810(1)(h) and (o)). By definition these services can only be provided by FQHCs and RHCS. Therefore, mandatory contracting with at least 1 FQHC and RHC (if applicable to the enrollment area) will be required if the HMO is to comply with these rules. The language requiring "a reasonable good faith effort to contract" in this rule does not indicate that an HMO without FQHC and RHC contracts will be unable to provide all of the covered services in ARM 46.12.4810. We continue to suggest the alternative wording contained in our June 14, 1995 oral testimony attached.

RESPONSE: The department has amended the rules generally to provide for the appropriate use of the terms "federally qualified health centers" and "rural health clinics" are used correctly throughout these rules. The term "certified rural health clinic" has not been used as it is not used in ARM 46.12.1601.

As noted above, the department has replaced this section with the language used in the contract. That language requires an HMO to offer terms and conditions at least as favorable as those offered to other PCPs. An HMO must have contracts signed with FQHCs and RHCs in the enrollment area or prove the FQHCs and RHCs could not or did not want to meet the terms and conditions offered. Recipients will not be allowed to enroll in the HMO until one of these two criteria is met.

The department interprets the inclusion of FQHC and RHCs in the contract to mean that those services must be managed by an HMO, not that the HMO must have a contract with an FQHC or RHC to serve each enrollment area. If there is an FQHC or RHC in an enrollment area, this rule and the contract compel the HMO to offer the facility the opportunity to become a participating provider. There are also a number of counties in which neither type of facility is available. In these areas the department does not intend that an HMO contract with an FQHC/RHC that is outside the enrollment area and that does not normally serve recipients inside that enrollment area.

COMMENT: Blue Cross and Blue Shield of Montana, HMO Montana questions the proposed amendment of proposed ARM 46.12.4815(20) which was submitted by the Montana Primary Care Association, Inc. The proposed amendment requires an HMO to offer certain listed providers terms and conditions as favorable as those offered to other providers with whom it contracts for the same service, however there is no distinction concerning the level of education and difference in licensure requirements between providers. We support the use of mid-level practitioners and agree that their use, at an appropriate reimbursement level should be encouraged.

RESPONSE: In general it is the department's policy to allow an HMO the latitude to negotiate its own rates with participating providers. However, it is also the department's intent to enhance the viability of certain essential community providers whose primary focus is providing health care to low-income populations. This goal is accomplished by requiring HMOs to offer reimbursement comparable to that offered other providers of the same service. This prevents the possibility of an HMO offering unreasonably low reimbursement rates as a way to keep essential community providers from becoming participating providers.

COMMENT: The second sentence of proposed ARM 46.12.4815(2) should be stricken. The proposed rules do not provide a forum for an HMO to resolve a dispute with the department over this or any other issue.

RESPONSE: This section has been replaced in its entirety and replaced with new language (see response to comment above). While these rules do not provide a forum for HMOs and the department to resolve disputes, Section 28 of the model HMO contract does.

COMMENT: Please define the process for determining "good faith effort" as it applies in proposed ARM 46.12.4815(2).

RESPONSE: This section has been replaced in its entirety, so a response is not needed to this comment.

ARM 46.12.4815(3)

COMMENT: The proposed rule requires an HMO to "cooperate" with community-based organizations in the referral and delivery of certain services. "Cooperate" is not defined and as a result an HMO has no guidance concerning whether it has complied with this rule. It is suggested that the rule be amended to strike: "must cooperate" and insert in lieu thereof the following: "shall make a reasonable effort."

RESPONSE: The phrase "must cooperate" has been changed to "make a reasonable effort to cooperate." This should alleviate the concern about such organizations using this rule to inappropriately modify a fee structure.

COMMENT: Under this rule an HMO must "cooperate" with community-based organizations in the referral for and delivery of services. Who will determine if the HMO is "cooperating" with these providers and will guidelines be added to the rule to ensure HMOs and community-based organizations know what is expected?

RESPONSE: As noted above, "must cooperate" has been changed to "make a reasonable effort to cooperate." The department will determine if an HMO is making the reasonable effort required.

Guidelines have not been added to the rule. The department makes this determination on a case by case basis.

COMMENT: There is a risk that community-based organizations may see the requirement as an opportunity to modify fee structures to obtain additional payment from at risk HMOs. The proposed language would allow an HMO which finds such an event occurring to negotiate for appropriate charges for its recipients or to cease referrals to such an organization.

RESPONSE: The department believes that the change from "must" to "make a reasonable effort" will eliminate the risk noted in the comment.

ARM 46.12.4815(5)

COMMENT: While the purpose of ARM 46.12.4815(5) is appropriate, it is drawn overbroad. Certainly an HMO should be willing to cease using a provider for HMO medicaid services if the department also ceases using such a provider.

RESPONSE: The department agrees and has changed the language to apply only to providers who are terminated from the medicaid program.

COMMENT: The proposed rule should be clarified to provide that upon receiving notice from medicaid, that a certain provider is no longer certified to provide services for medicaid patients, the HMO will within a reasonable time thereafter cease providing services for medicaid patients through that provider. Certainly with such a restriction, medicaid should be willing in its contracting process to agree to indemnify and hold an HMO harmless from any liability arising out of its cancellation of its contracted services with such a provider.

RESPONSE: The department agrees and has changed the language to apply only to providers who are terminated from the medicaid program, and to provide for written notice from the department. The department does not believe that indemnification of an HMO is necessary for this circumstance.

COMMENT: ARM 46.12.4815(5) should be changed so that the preclusion only extends to recipients enrolled in the HMO and is not intended to compel the HMO to cease to use such a provider for its other enrollees.

RESPONSE: The department agrees with the comment and has changed the language of the rule to limit the preclusion to services provided to enrollee from the medicaid program.

COMMENT: It should be noted that ARM 46.12.4815(5) may well be impacted by Title 33, Chapter 22, Part 17 referred to under (1).

RESPONSE: The department does not believe this subsection is impacted by Title 33, Chapter 22, Part 17, MCA. Criteria and limitations may be established by an HMO as long as they are consistently applied.

Comment: The department should amend ARM 46.12.4815(5) to specify that an HMO may not contract with or employ a provider excluded from the Medicaid program, rather than one subject to sanction. The department may levy sanctions upon providers which may be merely fines or temporary limitations on services. These sanctions should not be considered a sanction which precludes the providers' continued participation in an HMO.

RESPONSE: The department agrees with the comment and has changed the language of the rule to limit the preclusion to providers that have been terminated from the program.

ARM 46.12.4815(6)

COMMENT: The Montana Hospital Association (MHA) opposes ARM 46.12.4815(6) which allows the HMO to establish timely claim filing limits. Providers should be accorded the same filing limit granted by medicaid or by generally accepted insurance practices. HMOs should not be given carte blanche authority to limit consideration of bona fide claims for services.

RESPONSE: An HMO may set its own timely filing limits. Participating providers are responsible for negotiating on this issue with an HMO and need not contract with the HMO if terms are not acceptable.

ARM 46.12.4815(7)

COMMENT: The department should clarify ARM 46.12.4815(7). Under what circumstances would an HMO make a payment to enrolled recipient? What possible appeal considerations is the department attempting to void?

RESPONSE: The department agrees with the comment and has changed the language to clarify that a provider of services under contract with an HMO does not have recourse to the appeal procedures available through the department.

COMMENT: Where does a provider find recourse for denial of payments by an HMO to providers for services rendered to that HMO's enrolled recipients?

RESPONSE: Providers contracting with an HMO are responsible for negotiating appeal rights directly with the HMO.

ARM 46.12.4815(8)

COMMENT: The department should rethink ARM 46.12.4815(8). What enticement is there for a provider to contract with an HMO if

the provider concedes all rights and protections accorded non-contracting providers?

RESPONSE: Providers can negotiate rights and protections when contracting with an HMO. The HMO is free to offer better terms of participation, including protections and reimbursement, than medicaid offers.

ARM 46.12.4816

COMMENT: ARM 46.12.4816 should be clarified to indicate that the HMO is required to reimburse the providers listed only for medically necessary services.

RESPONSE: The department agrees with the comment. The criteria of medically necessary has been added to (1), (2) and (3) of this rule.

ARM 46.12.4816(3) and (4)

COMMENT: It is not clear from ARM 46.12.4816(3) and (4) whether an HMO can reimburse using its negotiated fee schedule or reimburse under the department's cost based methodology.

RESPONSE: While the rule is silent on this issue, Sections 2.4 and 2.5 of Attachment 1 of the HMO contract establish medicaid reimbursement rates as the minimum.

ARM 46.12.4816(5)

COMMENT: ARM 46.12.4816(5) mentions "circumstances" of urgent or emergency care that require an HMO to reimburse a non-participating provider. We believe clarification and examples of the term "circumstances" are needed.

RESPONSE: The section has been deleted from the rule because (6) makes it extraneous. (6) of the rule, however, has been changed so that it now provides that an HMO must reimburse nonparticipating providers for urgent conditions, emergencies or emergency room screenings under any circumstances.

This requirement is needed to comply with SB 388, which requires a managed health care entity to reimburse urgent care, emergency care, and emergency room screens. These terms are defined in ARM 46.12.4801.

ARM 46.12.4817

COMMENT: The rules should not be passed under ARM 46.12.4817 until they state the capitation rate should be at least 5% below the cost of regular medicaid for the same or similar population.

RESPONSE: The department agrees with the comment. The rule has been amended by adding a new section that provides for the capitation rate to be at least 5% less than the projected cost of regular medicaid.

COMMENT: The rules should not be passed under ARM 46.12.4817 if the cost is the same without an HMO since then why even do an HMO. The rules under ARM 46.12.4817 should not be passed unless we have knowledge under a yearly basis of any savings that are realized by the HMO that is less than the capitation rate paid by the dept.

RESPONSE: In accordance with federal regulations, a capitation rate may not exceed the upper payment limit, i.e. the cost per person per month that would have been spent in the absence of an HMO program. States are free to get their capitation at anywhere up to 100% of the upper payment limit. Montana's rates will be 95% of that limit, or a 5% savings over what would have been spent without an HMO.

HMO's are based on the prinicpal of financial risk: they are at risk for providing services within the capitation amount, and are rewarded if they manage services for less than the capitation amount i.e. they can keep the savings. Through the receipt and pricing of encounter data, the department will be able to assess the difference between the capitation payments and what would have been paid if the services were reimbursed directly by medicaid.

ARM 46.12.4817(1)(a)

COMMENT: ARM 46.12.4817(1)(a) states that a capitation rate must be actuarially determined. Is the detail of the actuarial determination of cap rates available to interested parties?

RESPONSE: Interested parties may obtain the capitation rates and methodology by calling Sharon Donovan, medicaid HMO Program Specialist, at (406) 444-4148.

ARM 46.12.4817(1)(c)

COMMENT: ARM 46.12.4817(1)(c) states "The capitation rate may not exceed the cost to the department of providing the same services to an actuarially equivalent non-enrolled population group." Please provide some discussion of how this rule will be applied as well as the background for the rule.

RESPONSE: Federal regulations require that a capitation rate may not exceed the "upper payment limit," i.e. the amount which would have been paid if the person was in fee for service. The rates are determined by examining the experience in the base year (state fiscal year 1994) and projecting it forward. The department will initially set the rates at 95% of the upper payment limit on the assumption that an HMO can manage care more

efficiently and keep costs lower than that provided in the fee for service arena.

ARM 46.12.4817(1)(e)

COMMENT: ARM 46.12.4817(1)(e) provides a listing of payment amounts not included in the capitation rate. We would suggest the following wording be added as ARM 46.12.4817(1)(e)(iii) - "payments made by the department reflecting the difference between the amounts paid to participating FQHCs and RHCs by the HMO and the reasonable cost of providing services to enrolled recipients" consistent with ARM 46.12.4817(3).

RESPONSE: The department agrees with the comment. The recommended language has been added to the section.

ARM 46.12.4821

COMMENT: A reviewer for the Legislative Council requested that the rationale for proposed ARM 46.12.4821 be further developed.

RESPONSE: ARM 46.12.4821 is necessary in order to assure that the medical services provided through enrollment serve to adequately and appropriately meet the medical needs of the medicaid enrollees. The Medicaid program has a responsibility in implementing coverage through HMOs to assure that purposes of the medicaid program are realized for the medicaid recipients enrolled in the program.

The rule assures access for enrollees by providing that services be available on a local area proximity; by having a requirement for adequate professional coverage for the local population of enrollees; by setting minimum standards in relation to need for temporal access to providers; and by providing for 24 hour coverage. The rule assures the delivery of appropriate medical services by requiring that the HMO's providers of medical services meet medicaid participation standards and are in compliance with standards provided by law.

COMMENT: ARM 46.12.4821(2) generally sets out requirements which, while appropriate for a "staff model HMO" which is directly involved in the delivery of services to enrolled recipients, place a significant burden on an "IPA model HMO". Most of the requirements should, if necessary, be made a part of the contract with the HMO rather than as a part of the department's rules.

RESPONSE: To ensure the rule does not create an undue obstacle for IPA model HMOs, the term "site" has been changed to "sites."

The site standards in (2)(d) reference standards on safety, etc. already in effect. The department just wants to make clear it expects medical delivery sites to meet the existing standards. The department intends to reserve the right to monitor

compliance with existing standards, but does not currently certify all medical delivery sites.

COMMENT: ARM 46.12.4821(2) sets out standards for a "medical service delivery site" without a definition concerning what such a site is. If this site is the physician's office or institution where care is rendered, the rule places an extremely difficult burden on an HMO which contracts for delivery of services. It is suggested that if the department is required to ascertain that the site meets medicaid standards and the fire and safety standards are met it should avail the HMO of its process for site certification and agree that such a certification may be relied upon by the HMO as proof of compliance with these standards.

RESPONSE: "Medical delivery site" is the physical site, eg. doctor's office or hospital, where an enrollee receives a covered service. The intent is to ensure the HMO not make unrealistic travel requirements for enrollees to obtain services (eg. requiring recipient to travel several hours for a service which is available in the recipient's town of residence). To ensure the rule does not create an undue obstacle for IPA model HMOs, the term "site" has been changed to "sites."

ARM 46.12.4821(1)

The department has amended (1) of ARM 46.12.4821 to clarify the HMO can assign an enrollee who fails to choose a primary care provider and can restrict the ability to change primary care providers without good cause. This department amendment was offered at the June 14 rule hearing. It is needed to provide the HMO with the authority to assign an enrollee to a primary care provider if the enrollee fails to choose one after being notified to do so.

ARM 46.12.4821(2)(a)

COMMENT: ARM 46.12.4821(2)(a) specifies that the medical service delivery site must "be located within the normal service delivery area of the personal residences of enrolled recipients" but provides no criteria for determining what "within the normal service delivery area" is. Consistent with the department's stated position that "driving distance to the provider will be minimized to improve access" we recommend that the medical service delivery site be no more than 30 miles or 30 minutes of driving time from the personal residence of enrolled recipients.

RESPONSE: The time limit of 30 miles or 30 hours could not be met in certain parts of the state. The department wants to reserve the flexibility to determine service delivery areas based on criteria relevant to the part of the state being covered.

ARM 46.12.4821(3)

COMMENT: Is there under ARM 46.12.4821(3) an expectation that the medicaid recipients would have procedures for the scheduling of appointments that would be different than any other HMO enrollee? Since it seemed that the intent is that once the recipient becomes party of an HMO, they would participate as any other HMO enrollee. Please clarify.

RESPONSE: The department agrees that medicaid recipients should receive appointments in a similar manner as other enrollees. The rule has been changed to provide that the stated criteria are minimum standards.

ARM 46.12.4821(3)(c)

COMMENT: ARM 46.12.4821(3)(c) states "Appointments must be scheduled by specific time intervals and not on a block basis." What is the definition of appointments by block basis? What is the issue SRS wishes to address concerning appointment scheduling?

RESPONSE: The department agrees with the comment. The phrase "block intervals" has been deleted.

ARM 46.12.4824

COMMENT: A reviewer for the Legislative Council requested that the rationale for proposed ARM 46.12.4824 be further developed.

Response: ARM 46.12.4824 is necessary in order to assure that medicaid recipients receiving services through enrollment with an HMO receive the due process protections that are generally accorded to medicaid recipients. The rule is also necessary to encourage resolution of grievances prior to submittal for fair hearing by requiring the HMO to provide an internal grievance procedure and requiring the grieving enrollee to exhaust that procedure before proceeding to fair hearing.

COMMENT: While it is understood that an enrolled recipient has the right to a fair hearing, some qualifications should apply. It is contemplated that an HMO will be operating under a contract with the department, which contract will provide that certain services be rendered using the HMO's medical policies and claims procedures. For those services the HMO receives payment using a capitated reimbursement method. Should the department seek to compel the HMO to rescind or modify medical policy or claims procedures which the HMO has in place as a result of a fair hearing decisions, additional reimbursement to the HMO resulting from such a rescission or modification should be provided for in the HMO contract.

RESPONSE: The department will not provide additional reimbursement to an HMO when a fair hearing decision requires changing of the HMO's policies or procedures. The department does not anticipate significant costs for HMO's due to fair hearing appeals and decisions.

ARM 46.12.4824(2)

The department has amended ARM 46.12.4824(2) to specify the time limits on an HMO's internal grievance procedure. This is necessary to preserve a recipient's right to subsequently appeal to the department. Under regular medicaid, a recipient must appeal to the department within 90 days of being denied a service. If a recipient is an enrollee, the 90 day clock starts when the person initially files a grievance with the HMO.

COMMENT: ARM 46.12.4824(2) requires that the department approve the HMO's grievance procedure prior to implementation. If the intention is to provide a service which is similar to that provided to non-medicaid insureds, the department should allow the HMO to use the same grievance procedure which is filed as a part of the HMO's certificate of authority.

RESPONSE: An HMO may submit as a grievance procedure the grievance procedure approved by the Insurance Commissioner for its commercial population.

ARM 46.12.4825

COMMENT: A reviewer for the Legislative Council requested that the rationale for proposed ARM 46.12.4825 be further developed.

RESPONSE: ARM 46.12.4825 is necessary in order to assure that the medical services delivered to enrollees are appropriate, that the HMO is accountable for the services delivered to the enrollees, and that the privacy interests of the enrollees are appropriately protected.

The maintenance of appropriate and adequate medical records is necessary to assure consistent and knowledgeable delivery of medical services by providers. The rule's requirements in relation to medical records are necessary to assure that appropriate and adequate medical records are maintained and done so in the manner that is necessary for non-HMO medicaid recipients.

The maintenance of medical and business records are necessary to assure that an HMO is accountable fiscally and qualitatively for the delivery of covered services. This protects the health of the enrollees and the financial resources of the program invested in the services available to and provided to enrollees.

Based on constitutional provisions and federal and state laws and regulations, medical and personal information pertaining to

an enrollee which is maintained in medical records and elsewhere by an HMO and its participating providers is private. The confidentiality of this information must be generally maintained. The rule is necessary to provide programmatic authority for the protection of confidentiality and to provide the criteria to govern the protection of confidentiality. The rule provides the criteria that is accorded medicaid recipients who are not enrollees with an HMO.

COMMENT: ARM 46.12.4825(1) through (3) requires the HMO to comply with ARM 46.12.308 concerning the maintenance of records. Unfortunately, the rule is drafted for direct providers of services such as a passport doctor or a staff model HMO. The rule should be clarified that it is acceptable for medical records to be maintained by the providers contracting with the HMO, and that it is not necessary for the HMO to maintain a "complete medical record" of each enrolled recipient.

RESPONSE: The department agrees with the comment. (3) of the rule has been changed to state that the record may be maintained by an HMO's participating provider.

COMMENT: ARM 46.12.4825(4), concerning the confidentiality of records, incorporates the department's confidentiality policy as a part of the guidelines. Because each HMO is required to comply with Title 33, chapter 22, part 19, MCA, "The Insurance Information and Privacy Protection Act", which sets out requirements for insureds' privacy and physicians are also subject to medical records privacy restrictions under Montana law, the rule should reflect that those provisions extend to enrolled recipients and not impose additional administrative requirements.

RESPONSE: While HMOs are governed by other strictures on confidentiality, it is important to apply the department's policy as well. The department's provides for protection of confidentiality in accordance with federal medicaid statutes and regulations as well as state constitutional and statutory provisions.

ARM 46.12.4826

COMMENT: A reviewer for the Legislative Council requested that the rationale for proposed ARM 46.12.4826 be further developed.

RESPONSE: ARM 46.12.4826 is necessary to assure that enrollees can effectively and appropriately use the medical services available to them through an HMO and can actively participate in decisions concerning the delivery of medical services to them. Fully informing enrollees is the best manner to assure that necessary services are sought and obtained and that the financial resources of the program are directed at the most appropriate care.

COMMENT: Does ARM 46.12.4826(1) refer to services provided by the HMO, with which the recipient is enrolled. If the department intends that the HMO describe services rendered under the Passport program and that by other HMOs, the rule should be clarified to so state. If the latter is the department's intent, the department should provide this explanation rather than each HMO.

RESPONSE: (1) has been deleted, since (2) fully expresses the requirement that HMOs must make pertinent information available to enrollees.

COMMENT: ARM 46.12.4826(3) refers to a "written statement of patient rights and responsibilities". This written statement should be clarified. What is required in such a statement? If another rule exists which describes such a statement, reference to the rule should be made. Perhaps the department should suggest a format for such a statement as an exhibit to these rules.

RESPONSE: (3) of this rule has been deleted, since (2) fully expresses the requirement that HMOs must make pertinent information available to enrollees.

ARM 46.12.4827

COMMENT: A reviewer for the Legislative Council requested that the rationale for proposed ARM 46.12.4821 be further developed.

RESPONSE: ARM 46.12.4821 is necessary to assure that the medical services available to enrollees through an HMO are effective, appropriate and properly delivered. The rule is necessary also to adopt the relevant federal medicaid standards for quality assurance in the delivery of services by an HMO. Since delivery of services to enrollees is obtained and managed by the HMO as a third party, the imposition of quality assurance requirements upon the HMO is critical to assuring the enrollees are protected in a degree that is similar to that accorded medicaid recipients who are not enrolled.

ARM 46.12.4828

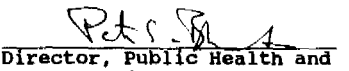
COMMENT: While this rule places the responsibility for investigating third party resources and seeking payment from these sources upon HMOs, it does not grant the authority to the HMO to do so. Montana law makes medicaid payments of last resort. The rule should recite either that the HMO either stands in the position of the department or that the department will adequately enforce an active third party recovery program for, or in cooperation with the HMO.

RESPONSE: The department believes the rule is adequate as a delegation of its authority to pursue third party recoveries.

5. The following is the rule number conversion chart for the adopted rules:

[RULE I]	46.12.4801	HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS
[RULE II]	46.12.4804	HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY
[RULE III]	46.12.4805	HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT
[RULE IV]	46.12.4806	HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT
[RULE V]	46.12.4810	HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES
[RULE VI]	46.12.4813	HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES
[RULE VII]	46.12.4814	HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES
[RULE VIII]	46.12.4815	HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS
[RULE IX]	46.12.4816	REIMBURSEMENT OF PROVIDERS
[RULE X]	46.12.4817	HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS
[RULE XI]	46.12.4821	HEALTH MAINTENANCE ORGANIZATIONS: ACCESS TO SERVICES
[RULE XII]	46.12.4824	HEALTH MAINTENANCE ORGANIZATIONS: GRIEVANCE PROCEDURES
[RULE XIII]	46.12.4825	HEALTH MAINTENANCE ORGANIZATIONS: RECORDS AND CONFIDENTIALITY
[RULE XIV]	46.12.4826	HEALTH MAINTENANCE RECIPIENT EDUCATION
[RULE XV]	46.12.4827	HEALTH MAINTENANCE ORGANIZATIONS: QUALITY ASSURANCE
[RULE XVI]	46.12.4828	HMO, THIRD PARTY

Rule Reviewer



Director, Public Health and Human Services

Certified to the Secretary of State September 18, 1995.

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

In the Matter of Repeal of Existing Rules and Adoption of New Rules Pertaining to Telephone Extended Area Service.	)))))	NOTICE OF REPEAL OF RULES 38.5.1301 THROUGH 38.5.1303 AND ADOPTION OF NEW RULES I THROUGH VI

TO: All Interested Persons

1. On June 15, 1995 the Department of Public Service Regulation published notice of public hearing on the proposed repeal and adoption of rules identified in the above title at pages 1017-1023, issue number 11 of the 1995 Montana Administrative Register.

2. The Commission has repealed rules 38.5.1301 through 38.5.1303 as proposed.

3. The Commission has adopted the following rules as proposed:

RULE I. 38.5.1305 DEFINITIONS
RULE II. 38.5.1307 EAS -- GENERAL

4. The Commission has adopted these rules as proposed, but with the following changes:

RULE III. 38.5.1309 EAS PROCEDURE -- GENERAL (1)(a) No changes.

(b) an application by a ~~commission~~ regulated ~~telephone~~ or unregulated local exchange company; or~~,~~

(c) No change.

(2) The customer petition shall be on a petition form approved by the commission prior to use, which shall include information deemed advisable and informative to the petitioners in the commission's discretion. Qualifying signatures shall be limited to one signature per main billed account and shall be accompanied by information deemed necessary by the commission, such as the account name, the printed name, address, and phone number of each person signing, and like information.

(3) EAS proceedings will be conducted in two phases, as described in ARM 38.5.1313 and 38.5.1315, below, and, when required pursuant to the rules, as contested cases under Title 2, chapter 4, MCA (MAPA) and ARM Title 38, chapter 2 (commission procedural rules).

(4) - (5)(b) No changes. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-3-301, MCA

RULE IV. 38.5.1311 EAS PROCEDURE -- REGIONS (1)-(1)(c) No changes.

(2) The designation of an area as a region may also be considered on petition signed by at least 30 percent of the customers within any petitioning exchange or an application by a ~~commission~~-regulated or unregulated ~~telephone~~ local exchange company.

(3)-(5) No changes. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-3-301, MCA

RULE V. 38.5.1313 EAS PROCEDURE -- PHASE I, COMMUNITY OF INTEREST DETERMINATION (1) Phase I shall be for determining whether a qualifying community of interest exists between or among exchanges. Upon receipt of proper application or proper findings following a commission investigation, the commission will order the regulated telephone company (or companies) and request any unregulated company (or companies) in the exchanges involved to initiate a call usage study, which shall be for the most recent three months for which data is available, to determine calling patterns between or among exchanges (if there is good reason to believe that one or more of the designated three months is an inaccurate representative month, the next most recent month or months for which data are available shall be included). The study must be completed and filed with the commission within 45 days of the commission order (an extension of time may be granted for good cause). In the event that a ~~commission~~-regulated or unregulated local exchange ~~telephone~~ company applies for EAS the call usage study may be submitted with the application.

(2)-(2)(b) No changes.

(3) If the study demonstrates a sufficient indication of community of interest its filing shall be accompanied by a statement of the company's (or companies') position on the requested EAS, with rationale for that position, and shall be followed by a commission notice to interested persons with an opportunity to object and an opportunity to request a hearing.

(4) If the study demonstrates no sufficient indication of community of interest its filing may be accompanied by a statement of the company's (or companies') position and shall be followed by notice to interested persons with an opportunity to object and an opportunity to request a hearing.

(5) If a proposed EAS arrangement does not qualify using the calling patterns in (2), above, the applicant can attempt to establish, through economic, demographic, or other evidence, that a community of interest does exist for the majority of the affected customers. For the determination of community of interest in the absence of qualifying calling criteria, the evidence and argument must be clear and convincing. In this regard the commission ~~may consider evidence such as location (relative to exchange boundaries) of schools; medical and emergency services; local government entities; police and fire protection; shopping and service centers; churches; agricultural and civic organizations; and employment centers.~~ will focus its consideration on factors such as local calling for

law enforcement, fire protection, medical, and other emergency services. Other factors such as local calling to schools, local government agencies, churches, shopping and service centers, agricultural and civic organizations, and employment centers can also be considered, but may be of secondary importance. In addition argument may be made that the call usage study, although not meeting the threshold criteria, establishes community of interest from another standpoint (e.g., the two-way pattern is significant). If this option to establish community of interest is pursued, the applicant must file a notice of intent to establish community of interest by the time fixed for objecting in response to the commission notice referenced in (4), above.

(6)-(7)(a) No changes.

(b) a sufficient community of interest exists to justify the consideration of EAS between the exchanges (in which case phase II will commence as provided in ARM 38.5.1315).

(8) For purposes of this rule and related rules, qualifying calls in "calls per main billed account" and "call usage study" shall be limited to 1+ and 0+ calls. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-3-301, MCA

RULE VI. 38.5.1315 EAS PROCEDURE -- PHASE II, COST ANALYSIS AND RATE DESIGN (1) Phase II shall be for determining cost and revenue impacts and for rate design. When the commission determines that a sufficient community of interest exists to warrant further consideration of EAS, the affected regulated local exchange company (or companies) shall be directed, and unregulated local exchange companies shall be requested, to perform an impact analysis. The company (or companies) shall submit the results of the impact analysis along with rate design proposals to the commission within 90 days after the commission order commencing phase II (an extension of time may be granted for good cause), accompanied by all necessary company prefiled testimony, including an estimated implementation plan and schedule.

(2)-(2)(b) No changes.

(c) net changes in operating and other expenses;

(d) ~~changes in interstate division of revenue settlements~~ cost shifts from the interstate jurisdiction to the intrastate jurisdiction resulting from the new EAS arrangement;

~~(e) changes in Bell independent settlements;~~

~~(f)~~ (e) losses in switched and special access revenues;

~~(g)~~ (f) ~~losses~~ net changes in billing and collection revenues; and

~~(h)~~ (g) changes in switched access allocations.

(3) Proposed EAS rates shall be designed so that EAS implementation is revenue-neutral to the affected local exchange company (or companies). EAS rate design will ~~have both flat and usage sensitive options~~ include a flat rate option and at least one lower cost usage sensitive option. Additional rate design proposals are not precluded (and are encouraged, to provide additional customer choices). Except when there is a substantial basis for shifting the cost to

others, the rates shall be designed to recover the costs of EAS from those customers who directly benefit from EAS. The rate proposals should include a detailed description of the costs considered, how the proposed rates recover the costs of EAS implementation, the extent to which these costs are recovered from the customers who directly benefit, and the extent to which these costs are shifted to other customers.

(4) No change.

(5) Following receipt of the company's (or companies') ~~analysis~~ analyses and prefiled testimony the commission will issue notices as might then be required, providing an opportunity for hearing and a contested case procedural order and schedule.

(6) and (7) No changes. AUTH: Sec. 69-3-103, MCA; IMP, Sec. 69-3-301, MCA

5. The PSC has received written comments from the public and the parties to a related case (Docket No. 94.2.5) wherein the PSC is investigating EAS. The PSC has received oral comments at satellite hearings in communities throughout the state and at its technical hearing on the proposed rules. Comments received and responses by the Commission are as follows:

a. COMMENT: Comments from the public fall within three general categories: those favoring EAS without any great concern about possible increased rates; those generally favoring EAS, but wanting to know the effects on rates before committing; and those opposed to EAS as a free ride to some, paid for by others. Comments from the parties also fall within several general categories: US West Communications (USW), Montana Independent Telecommunications Systems, Inc. (MITS), Northwestern Telephone Systems, Inc., dba PTI Communications (PTI), and the Montana Consumer Counsel (MCC) generally support EAS and the proposed rules; Citizens Telecommunications Company of Montana (CTC), and Montana Telephone Association (MTA) generally support EAS, but offer substantial amendments to the proposed rules; AT&T Communications of the Mountain States, Inc. (AT&T), and MCI Telecommunications Corporation (MCI) do not favor EAS, suggesting that it is not compatible with the trend toward competition and the customer choices, technical innovations, efficient pricing, and quality service that accompany competition. AT&T and MCI offer extensive amendments in the event that the PSC proceeds with the rules.

RESPONSE: These general comments are valuable as they reinforce the PSC's expectation that the approach to EAS must be a cautious one, permitting adequate consideration of all factors and effects involved, but also allowing for a realistic chance at obtaining EAS and implementing it when and where determined to be preferred and appropriate. Therefore, the PSC will proceed with the rules, incorporating suggested amendments to the rules where those are convincing. Throughout AT&T's and MCI's comments it is asserted that EAS is anti-competitive. Generally, it is difficult to consider these assertions as presently justified when effective competition

simply has not yet come to the areas that might be EAS compatible. In these areas EAS is a reasonable means of filling a present need in the public interest.

b. COMMENT: AT&T and MCI comment that Rule I's reference to EAS as local service is inappropriate, as EAS is interexchange and therefore a toll service.

RESPONSE: Converting what is now toll calling to what is, in effect and for all practical purposes, local calling is at the core of EAS. The PSC does not disagree that, as earlier EAS comments might allude, EAS might actually be a hybrid service with elements of both local and toll service. However, EAS is seven digit calling (i.e., local) extending beyond existing local exchange boundaries. In this context, referring to this service or calling as "local" is not inappropriate.

c. COMMENT: MTA suggests that Rule III(1)(b)'s designation of who can apply for EAS should include unregulated cooperatives, as most EAS involving cooperatives will involve an exchange served by a regulated company. MTA comments that the same applies in Rule IV (regions).

RESPONSE: The PSC agrees and has amended the referenced rules and related rules as might be necessary to include unregulated local exchange companies in the process to the extent that such is possible.

d. COMMENT: MTA comments that the petition form, Rule III(2), should specifically include the need for local rate adjustments so that petitioners are made aware that local rate increases could result. MTA also suggests that the petition include an account name and phone number if the account is under a name other than the person signing. AT&T comments that the petition should be only by residential customers and should be by at least 51 percent of them.

RESPONSE: The PSC has amended the rule slightly to allow for flexibility in the personal information necessary from the individuals petitioning. However, it chooses not to prescribe that information or the contents of the petition, preferring flexibility and discretion, especially while gaining experience which might better demonstrate what should be included. However, the PSC will take MTA's comments into consideration when approving petition forms. In regard to AT&T's suggestion, the PSC determines that business and residential accounts should carry the same weight at the petition stage. Also, the PSC determines that 30 percent produces a satisfactory indication of interest and that the additional burden accompanying a 51 percent requirement would be excessive.

e. COMMENT: USW proposes that the PSC, rather than limiting the number of pending EAS petitions and prioritizing them as proposed in Rule III(5)(a) and (b), consider a consolidation of EAS petitions into an annual docket, as this might allow for efficiencies in analyses and ease administrative burdens.

RESPONSE: The PSC overrules this suggestion, although the PSC does not believe that it is necessarily restricted from following the proposal under the present rule.

Limitation and prioritization of EAS is optional and might not become necessary at all. If the PSC decides to limit and prioritize, to the extent practical it will attempt to allow for efficiencies in analyses and ease administrative burdens.

f. COMMENT: AT&T comments that Rule IV's regions should be deleted as there is no public interest served through regional EAS and regions merely expand the anti-competitive effects of EAS. AT&T suggests that exchange by exchange EAS will fully protect consumers and ensure that EAS is justified. AT&T comments that the arbitrage (bridging) problem which regions are purportedly designed to solve will not be solved by regions. MCI also supports elimination of regions, but suggests that regions be approached with caution if the PSC believes that they are necessary. MCI comments that bridging is not significant enough to remonopolize an area. MTA comments that Rule IV's regions may be necessary in some instances, but may cause larger than necessary rate impacts through elimination of toll routes in areas where volume is low and will likely involve complex local compensation arrangements among more than two companies. MTA suggests that the rules be amended to reflect that regions are the exception, reserved only for instances when problems are apparent and it has been clearly shown why regions are the only workable solution. PTI suggests that the PSC consider requiring at Rule IV(4) that a regional petitioning exchange exhibit calling greater than eight calls per main billed account within the region as a whole.

RESPONSE: The PSC disagrees with the suggestions on eliminating the rules allowing for regions. However, it agrees that regions should be approached with caution. The PSC determines that under certain circumstances regions may be in the public interest and may be more efficiently implemented than multiple exchange-by-exchange EAS. Rule IV provides an option to consider and implement in such case. The PSC determines that the rule as proposed allows consideration of MTA's concerns. Regions can produce the problems identified, however regions can resolve others. Regions are not a simple matter, but should remain an option available for consideration. The analyses prescribed in the EAS rules should indicate the level of rate impacts resulting from proposed EAS regions. Affected customers will be given ample opportunity to indicate whether or not they would accept the resulting rates. If rate impacts are "larger than necessary" for reasons identified by MTA or others, it will become apparent and likely result in no region. MTA's referenced complex local compensation arrangements may occur and, again, regions present these kinds of problems, but they also resolve others. The PSC overrules PTI's suggestion on more than eight calls, as there is no compelling basis for it.

g. COMMENT: PTI suggests that what actually qualifies for Rule V's "calls" in "calls per main billed account" and "call usage study" should be specifically identified (i.e., state whether it includes things like FX, 10XXX, cellular, coin, etc.).

RESPONSE: The PSC agrees and has amended the rule.

h. COMMENT: MTA comments that the Rule V(1)'s three months of data requirement should be accompanied by an allowance for exception when factors disclose that one or more of the particular months may be an inaccurate representative. AT&T suggests six months be the period required, as it will account for seasonal variations and produce a more accurate average.

RESPONSE: The PSC agrees with MTA and has amended the rule accordingly. AT&T's concern may be partially eliminated by the MTA amendment, otherwise the PSC disagrees, as the three month study, in context, is sufficient.

i. COMMENT: MTA suggests that Rule V(2)(a)'s eight calls be increased to fifteen, in harmony with its overall position that EAS only be pursued where a very strong community of interest exists (MTA's concern here is higher local rates and the effect on universal service). AT&T comments that EAS should be implemented in rare instances, only in clear cases of residential need. AT&T suggests that community of interest should be based on residential calling patterns, as business calling can skew the determination and businesses have service options available.

RESPONSE: The PSC determines that the eight call criterion is a sufficient indication of a strong community of interest with business calls factored in. The two call requirement will mitigate effects of skewing. EAS will likely not be a realistic option if the criteria is raised substantially.

j. COMMENT: AT&T proposes that Rule V(2)(b)'s two calls be three to help ensure that a community of interest truly exists and that EAS is important, not merely a convenience to those with high volumes. MCI agrees and states that it be by 51 percent of the customers.

RESPONSE: The PSC determines that the two call criterion is a sufficient indication of a strong community of interest. EAS will likely not be a realistic option if the criteria is raised substantially.

k. COMMENT: AT&T comments that Rule V(5) be revised to consider only essential services, such as police, medical, and emergency. To AT&T the others are not essential and cannot create a community of interest in the absence of the required volume of calls. MCI agrees and adds that the availability of 911 or 1-800 calling for essential services should also be considered.

RESPONSE: The PSC agrees in part that emergency services should be the important concern and the others might be only secondary in the context of community of interest. Therefore, although the PSC determines that the rule generally should be left as is on the identified criteria, it has amended the rule slightly, including to clarify that the existence of alternative proof on community of interest for EAS does not automatically establish it. Overall, there must be convincing evidence and argument accompanying the alternative proof.

l. COMMENT: CTC notes that Rule V(1)'s 45 day period for a call usage study allows for an extension of time for good cause, but Rule VI(1)'s 90 day time for a cost impact analysis and rate design proposal does not. It comments that, under some circumstances, the analysis and rate design is likely to take longer than 90 days and extensions of time should be permitted. It also suggests that the rules note that extensions will be liberally granted.

RESPONSE: The PSC agrees that an extension of time should be available for the analysis and rate design. However, it determines that the good cause standard should remain the standard. The rule has been amended accordingly.

m. COMMENT: MTA suggests some changes in Rule VI(2) to be consistent with today's environment. In this regard it states that sub-part "(d)" should read "cost shifts from the interstate jurisdiction to the intrastate jurisdiction resulting from the new EAS arrangement" and sub-part "(e)" should be eliminated as settlements no longer exist. It also suggests that consideration should be given to lost toll and savings in carrier access charge expenses.

RESPONSE: The PSC agrees and has amended the rule.

n. COMMENT: USW comments that Rule VI(2)(g)'s inclusion of losses in billing and collection revenues should be accompanied by savings in associated expenses.

RESPONSE: Although the rule can be viewed as referencing "net" changes, it has been amended or clarified accordingly and in a fashion that extends the same to other revenues and expenses where necessary.

o. COMMENT: In context of flexibility in EAS rate design, CTC comments that Rule II(2)'s designation of EAS as mandatory and Rule VI(3)'s requirement of both flat and usage sensitive options are inconsistent, conclusory, and pre-judge the type of EAS offering that the PSC could approve. CTC suggests that Rule II(2)'s mandatory requirement be eliminated and Rule VI(3) be modified to state that EAS rates shall apply to all customers in the affected exchange or region, but may include both flat and usage sensitive options. AT&T and MCI also comment that EAS should not be mandatory, primarily because of its effect on customer choice and competition. In addition AT&T disagrees that EAS should be two-way, asserting that absent community of interest there will be no customer confusion and asserting that two-way is not a wise solution to code calling.

RESPONSE: The rule's designation of EAS as mandatory and the rule's allowance for rate options are not inconsistent. Mandatory simply means that EAS itself is not optional. EAS can include optional rate designs and remain mandatory. Without being mandatory EAS revenues would be uncertain, required EAS network engineering would be uncertain, and customer confusion and problems in billing could result. However, the rule is not intended to preclude innovation in rate design or additional rate design proposals. It is intended to require that there be a flat rate option and at least one lower cost usage sensitive option. Nevertheless, the rule has

been amended to clarify this. The two-way requirement will remain, as code calling and customer confusion are valid and significant concerns. AT&T provides no compelling support for its assertion to the contrary.

p. COMMENT: AT&T and MCI comment that Rule VI(3)'s requirement for revenue neutrality be eliminated, as the burden should be on the local carrier to demonstrate the reasonableness of its rates. To AT&T, guaranteed revenue neutrality insulates a carrier from the effects of competition. AT&T also argues for a price floor comprised of the imputed price of the LEC's switched access service plus other costs attributable to EAS.

RESPONSE: The PSC disagrees. The effect that EAS has on competition is not materially influenced by revenue neutrality. As the PSC has earlier indicated competition has not effectively responded to the demand for EAS. Imputation of the price for switched access should already occur under revenue neutrality.

q. COMMENT: CTC comments that Rule VI(4)'s requirement that interconnection and compensation arrangements be presented to the PSC be changed to allow carriers freedom to make arrangements without PSC involvement unless agreement cannot be reached. MTA comments that new interconnection arrangements will likely exist in EAS and, if the carriers are unable to agree, the PSC could resolve the matter.

RESPONSE: The PSC encourages agreement on such arrangements, but determines that it must be involved in approving them, as the arrangements will likely affect EAS rates.

r. COMMENT: For Rule VI, MTA suggests an additional rule allowing PSC consideration of discount toll plans as a solution to customer needs in cases where the resulting rates under EAS are unreasonable.

RESPONSE: The PSC agrees that discount toll plans could be an alternative where EAS is desired but found not workable because of price or any other reason. However, that alternative already exists without including it in the EAS rules. The PSC encourages companies to explore this alternative.

s. COMMENT: CTC comments on community of interest and implementation of EAS that it is impossible for customers to know whether they will be willing to pay the increased rates associated with EAS until after the rates are determined. It suggests that the customer survey (balloting) in Rule VI(6) be the general rule, not an option, unless it is clearly demonstrated as unnecessary. It also comments that Rule VI(6) should specify the level of support necessary to justify EAS. It recommends the rules be changed to specify substantial support for EAS be found first through appropriate methods, including survey or public hearing. AT&T and MCI propose that at least 51 percent of the customers approve an EAS arrangement (including rates) prior to implementation. They also suggest non-responses to balloting be a "no." They also comment that the survey should clearly include the estimated price and the rules should specify this requirement.

RESPONSE: The PSC generally disagrees. Balloting is a tool to help the PSC ascertain customer acceptance of a proposed EAS arrangement. The PSC will use balloting when deemed necessary. A specified level of support is inappropriate because balloting is only one factor to be weighed with others. Not responding to a survey could mean many things, not necessarily a vote against EAS. It is already anticipated that a survey, if used, will include all relevant information, including price.

t. COMMENT: USW comments that Rule VI(3)'s mandate that the costs of EAS shall be recovered from customers who directly benefit should be changed to allow more flexibility through alternative methods (e.g., allow for some company wide averaging) fitting within the rate structure of each company.

RESPONSE: The PSC overrules this comment. The rules allow for exception when there is a substantial basis for it.

u. COMMENT: AT&T and MCI propose additional requirements to promote competition: unrestricted and non-discriminatory resale of EAS by the other carriers; and dialing parity or, to compensate customers for dialing inconvenience, an LEC offering of the EAS price additive at a discount to resellers until the LEC is willing and able to provide dialing parity.

RESPONSE: The PSC agrees that these may be important issues that might need to be addressed eventually, but not at this time. Resolution of these issues is not essential to implementation of EAS.

NANCY McCAFFREE, Chair

CERTIFIED TO THE SECRETARY OF STATE SEPTEMBER 18, 1995.

Reviewed By Robin A. McHugh

**BEFORE THE COMMISSIONER
OF POLITICAL PRACTICES
OF THE
STATE OF MONTANA**

In the matter of the adoption of new Rules I through IV pertaining to campaign contribution limitations and surplus campaign funds, and the amendment of Rule 44.10.331	))))))	**NOTICE OF ADOPTION OF RULES I THROUGH IV AND AMENDMENT OF RULE 44.10.331**

TO: All Interested Persons.

1. On July 13, 1995, the Commissioner of Political Practices published notice of the proposed adoption of new Rules I through IV and the amendment of Rule 44.10.331 pertaining to campaign contribution limitations and surplus campaign funds, at page 1298 of the 1995 Montana Administrative Register, issue number 13.

2. The Commissioner has adopted the new rules I (44.10.332), and II (44.10.333), and amended Rule 44.10.331 as proposed.

3. The Commissioner has adopted new Rules III (44.10.334), and IV (44.10.335) with the following changes (added language is underlined and deleted language is interlined).

RULE III (44.10.334) ELECTIONS TO WHICH AGGREGATE CONTRIBUTION LIMITS APPLY (1) For purposes of the limitations on contributions established in section 13-37-216, MCA, and these rules, the term "election" is defined in section 13-37-216(5), MCA.

(2) The term "contested primary", as used in section 13-37-216(5), MCA, means a primary election in which two or more candidates compete for the same nomination ~~or nominations~~.

(a) In partisan primary elections, if two or more candidates compete for one party's nomination, but only one candidate seeks a different party's nomination, it is a "contested primary", resulting in two elections to which the contribution limits in section 13-37-216, MCA, apply ~~only~~ with respect to the primary for which two or more candidates compete for the party's nomination. For example, if two candidates seek Party A's nomination in the primary election for a public office, ~~but only one candidate seeks the Party B's nomination for the same public office, it is a contested primary.~~ it is a contested primary with respect to Party A's nomination. If only one candidate seeks Party B's nomination for the same public office, it is not a contested primary with respect to Party B's nomination.

(b) In judicial and other nonpartisan primary elections, if two or more candidates compete for nomination, it is a "contested primary", resulting in two elections to which the contribution limits in section 13-37-216, MCA apply. For example, if two candidates seek nomination in the primary election for the office of district judge, it is a contested primary even though both candidates will advance to the general election pursuant to section 13-14-117, MCA. (c) When an incumbent judicial officer is the only candidate who files a declaration for nomination in the primary election, and subsequently faces a vote, pursuant to section 13-14-212, MCA for or against retention in the general election, there is no "contested primary", and there is only one election to which the contribution limits in section 13-37-216, MCA apply.

AUTH: Section 13-37-114, MCA
IMP: Section 13-37-216, MCA

RULE IV (44.10.335) DISPOSAL OF SURPLUS CAMPAIGN FUNDS

(1) Candidates shall dispose of surplus campaign funds within 120 days of filing the closing campaign report required by section 13-37-228, MCA.

(a) The candidate's closing report shall be filed whenever all debts and obligations are extinguished and no further contributions or expenditures will be received or made which relate to the campaign.

(b) No closing report needs to be filed following a primary election campaign if the candidate will advance to the general election.

(2) "Surplus campaign funds" are those campaign funds remaining when all debts and other obligations of the campaign have been paid or settled, no further campaign contributions will be received, and no further campaign expenditures will be made.

(3) Surplus campaign funds will be considered to have been "disposed of" on the date payment is made by the candidate or the candidate's committee to a permissible person, entity, or account.

(4) Payment of surplus campaign funds shall be evidenced by a receipt from the recipient containing the following information:

(a) The full name and mailing address of the recipient;

(b) The date the funds were received;

(c) The full name of the candidate from whose campaign the funds were received, and;

(d) The exact amount of funds received.

The candidate shall be responsible for obtaining a receipt containing the requisite information from all recipients of any surplus campaign funds.

(5) Those candidates with surplus campaign funds shall file a supplement to the closing campaign report, on a form prescribed by the Commissioner, showing the disposition of surplus campaign funds. The report shall be accompanied by copies of all receipts required by subsection (4) of this rule.

The supplement shall be filed within 135 days after the closing report is filed.

(6) A candidate shall abide by the prohibitions on the use of surplus campaign funds specified in section 13-37-240, MCA.

(a) For purposes of the restrictions on the disposal of surplus campaign funds set forth in section 13-37-240, MCA, "personal benefit" is defined in section 13-37-240(2), MCA. For purposes of this definition, a candidate's "immediate family" includes the candidate's spouse and minor children only, pursuant to the definition of this term in section 5-7-213, MCA.

(b) For purposes of the restrictions on the disposal of surplus campaign funds set forth in section 13-37-240, MCA, "campaign" means any organized effort to secure or prevent the nomination or election of a candidate for public office, or secure or prevent passage of a ballot issue.

(c) The following are examples of permissible uses of surplus campaign funds:

(i) Return of the funds to the contributor, so long as the funds will not result in personal benefit or a contribution to a campaign;

(ii) Donation of the funds to any organization or entity, so long as the use of the funds will not result in personal benefit or a contribution to a campaign;

(iii) Upon election, use of the funds to establish an account to serve a public purpose related to the officeholder's public duties, so long as the funds will not result in personal benefit or a contribution to a campaign.

(7) A candidate shall not contribute surplus campaign funds to a political committee, including a leadership political committee maintained by a political officeholder. However, nothing in this subsection shall be construed as prohibiting contribution of surplus campaign funds to a political party or a political party committee, so long as the funds are not earmarked for a specific campaign.

(8) Upon a determination that a candidate made a prohibited disposal of surplus campaign funds, the Commissioner may employ any enforcement measures within his or her jurisdiction.

AUTH: Section 13-37-114, MCA
IMP: Section 13-37-240, MCA

4. A public hearing on the proposed rules and the amendment was held on August 3, 1995. The Commissioner has thoroughly considered all commentary received:

RULE III (44.10.334) ELECTIONS TO WHICH AGGREGATE CONTRIBUTION LIMITS APPLY

COMMENT:

An accounting section should be added to this rule to make it clear that in cases of contested primaries any funds received after the date of the primary election count

toward the general election limits and not the primary election limits.

RESPONSE:

The Commissioner has reviewed this comment and makes no change. While the Commissioner agrees that it is important to keep track of the separate contribution limits for primary and general elections, he believes that it is not necessary to set forth any internal accounting procedure in an administrative rule.

COMMENT:

Subsection (2), which applies the primary campaign contribution limits to candidates of both parties, so long as one party has a contested primary race, is inconsistent with the language of Mont. Code Ann. § 13-37-216, as amended by Initiative 118.

RESPONSE:

This comment is well taken and the rule is changed to harmonize it with the language of the statute.

RULE IV (44.10.335) DISPOSAL OF SURPLUS CAMPAIGN FUNDS

COMMENT:

Subsection (7) could be construed as prohibiting contribution of surplus campaign funds to a political party.

RESPONSE:

Language has been added to subsection (7) to clarify that contribution of surplus campaign funds to political parties is not prohibited so long as the money is not earmarked for a specific campaign.

Rule Reviewer

JAMES M. SCHEIER

Commissioner of Political Practices

ED ARGENBRIGHT, Ed.D.

Certified to the Secretary of State September 15, 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 June 30, 1995. This table includes those rules adopted during the period July 1, 1995 through September 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 June 30, 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 Registers.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number. These will fall alphabetically after department rulemaking actions. Accumulative Table entries will be listed with the department name under which they were proposed, e.g., Department of Health and Environmental Sciences as opposed to Department of Environmental Quality.

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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 August, 1995, appear. Vacancies scheduled to appear from October 1, 1995, through December 31, 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 September 7, 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 AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Apprenticeship Training Council (Corrections)			
Mr. Gary Curtis Helena Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Ms. Ingrid Danielson Helena Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Rick Day Helena Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Ray Fitz Deer Lodge Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Riley Johnson Helena Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Alan Kuoppala Deer Lodge Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Ed Leipheimner Anaconda Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Mr. Ray Lincoln Butte Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Apprenticeship Training Council (Corrections) cont.			
Ms. Candyce Neubauer	Director	not listed	8/1/1995
Deer Lodge			8/1/1997
Qualifications (if required): none specified			
Mr. Jack Powers	Director	not listed	8/1/1995
Deer Lodge			8/1/1997
Qualifications (if required): none specified			
Judge Michael C. Prezeau	Director	not listed	8/1/1995
Missoula			8/1/1997
Qualifications (if required): none specified			
Mr. David Watkins	Director	not listed	8/1/1995
Deer Lodge			8/1/1997
Qualifications (if required): none specified			
Board of Directors of State Compensation Insurance Fund (Administration)			
Mr. Tom Horn	Governor	Hirsch	8/7/1995
Cohagen			4/28/1999
Qualifications (if required): representing state fund policyholders			
Mr. Dale Mahlum	Governor	Holman	8/7/1995
Bigfork			4/28/1999
Qualifications (if required): representing private enterprise			
Board of Physical Therapy Examiners (Commerce)			
Ms. Cheryl Glasser	Governor	Meagher	8/7/1995
Glendive			7/1/1998
Qualifications (if required): physical therapist			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Veterans' Affairs (Military Affairs)			
Ms. Barbara Ellestad	Governor	Opp	8/17/1995
Gallatin Gateway			5/18/1998
Qualifications (if required): veteran			
Montana Public Health Improvement Task Force (Public Health and Human Services)			
Ms. Lil Anderson	Governor	not listed	8/17/1995
Billings			9/30/1996
Qualifications (if required): representing county health officers from large cities			
Mr. Peter Blouke	Governor	not listed	8/17/1995
Helena			9/30/1996
Qualifications (if required): Director of the Department of Public Health and Human Services			
Mr. Curt Chisholm	Governor	not listed	8/17/1995
Helena			9/30/1996
Qualifications (if required): representing the Department of Environmental Quality			
Mr. Peter Frazier	Governor	not listed	8/17/1995
Great Falls			9/30/1996
Qualifications (if required): representing local health departments from large cities			
Ms. Ruth Haugland	Governor	not listed	8/17/1995
Dillon			9/30/1996
Qualifications (if required): representing local boards from rural counties over 5000			
Ms. Karen Hinick	Governor	not listed	8/17/1995
Butte			9/30/1996
Qualifications (if required): representing local health departments from large cities			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Public Health Improvement Task Force (Public Health and Human Services) cont.			
Mr. Kyle Hopstad Lewistown Qualifications (if required): representing health care providers	Governor	not listed	8/17/1995 9/30/1996
Ms. Sandra Kinsey Baker Qualifications (if required): public health representative from a county under 5000	Governor	not listed	8/17/1995 9/30/1996
Ms. Ellen Leahy Missoula Qualifications (if required): representing county health officers from large cities	Governor	not listed	8/17/1995 9/30/1996
Ms. Cynthia Lewis Helena Qualifications (if required): representing the Health Care Advisory Council	Governor	not listed	8/17/1995 9/30/1996
Ms. Cindy Morgan Thompson Falls Qualifications (if required): representing local boards from rural counties over 5000	Governor	not listed	8/17/1995 9/30/1996
Ms. Jean Ruppert Butte Qualifications (if required): representing citizens concerned with public health	Governor	not listed	8/17/1995 9/30/1996
Dr. Kermit Smith Billings Qualifications (if required): representing the Indian Health Service or Indian Tribes	Governor	not listed	8/17/1995 9/30/1996
Rep. Bill Tash Dillon Qualifications (if required): representing the House of Representatives	Governor	not listed	8/17/1995 9/30/1996

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Public Health Improvement Task Force (Public Health and Human Services) cont.			
Sen. Mignon Waterman Helena	Governor	not listed	8/17/1995 9/30/1996
Qualifications (if required): representing the Montana Senate			
Montana Wheat and Barley Committee (Agriculture)			
Mr. Fred Elling Rudyard	Governor	reappointed	8/20/1995 8/20/1998
Qualifications (if required): is a Republican from District II			
Ms. Judy Vermulum Cut Bank	Governor	reappointed	8/20/1995 8/20/1998
Qualifications (if required): is a Democrat from District III			
Regional Correctional Facility Advisory Council (Corrections)			
Mr. Robert W. Anderson Helena	Governor	not listed	8/1/1995 8/1/1997
Qualifications (if required): none specified			
Mr. Myron Beeson Deer Lodge	Governor	not listed	8/1/1995 8/1/1997
Qualifications (if required): none specified			
Rep. Ernest Bergsagel Malta	Governor	not listed	8/1/1995 8/1/1997
Qualifications (if required): none specified			
Lieutenant Jim Cashell Bozeman	Governor	not listed	8/1/1995 8/1/1997
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Regional Correctional Facility Advisory Council (Corrections) cont.			
Mr. Ralph DeCunzo	Governor	not listed	8/1/1995
Helena			8/1/1997
Qualifications (if required): none specified			
Mr. John DeVore	Governor	not listed	8/1/1995
Missoula			8/1/1997
Qualifications (if required): none specified			
Ms. Ginger Faber	Governor	not listed	8/1/1995
Havre			8/1/1997
Qualifications (if required): none specified			
Mr. Mike Gersack	Governor	not listed	8/1/1995
Great Falls			8/1/1997
Qualifications (if required): none specified			
Mr. John E. Kahl	Governor	not listed	8/1/1995
Glendive			8/1/1997
Qualifications (if required): none specified			
Captain Dennis McCabe	Governor	not listed	8/1/1995
Billings			8/1/1997
Qualifications (if required): none specified			
Captain Mike O'Hara	Governor	not listed	8/1/1995
Missoula			8/1/1997
Qualifications (if required): none specified			
Mr. John Strandell	Governor	not listed	8/1/1995
Great Falls			8/1/1997
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
State Banking Board (Commerce)			
Ms. Shirley Gierke	Governor	Rebal	8/7/1995
Miles City			7/1/1998
Qualifications (if required): public member			
Mr. Douglas Morton	Governor	reappointed	8/7/1995
Kalispell			7/1/1998
Qualifications (if required): national bank officer			
State Emergency Response Commission (Military Affairs)			
Mr. Steve Barry	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing state law enforcement			
Mr. Pat Brannon	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing the Department of Transportation			
Sheriff Cliff Brophy	Governor	not listed	8/10/1995
Columbus			8/10/1999
Qualifications (if required): representing local law enforcement			
Ms. Judy Browning	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing the Governor's Office			
Dr. Drew Dawson	Governor	not listed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing state medical response			
Mr. Thomas Ellerhoff	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing the Department of Environmental Quality			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Ms. Beate Galda	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing the Department of Fish, Wildlife and Parks			
Mr. Bill Gianoulias	Governor	not listed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing the Department of Administration			
Mr. Jim Greene	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing Disaster and Emergency Services			
Mr. Gary Hindoien	Governor	not listed	8/10/1995
Clancy			8/10/1999
Qualifications (if required): representing the Montana National Guard			
Mr. Lloyd Jackson	Governor	not listed	8/10/1995
Pablo			8/10/1999
Qualifications (if required): representing Native Americans			
Mr. Marv Jochems	Governor	reappointed	8/10/1995
Billings			8/10/1999
Qualifications (if required): representing local fire organizations			
Mr. Pat Keim	Governor	reappointed	8/10/1995
Helena			8/10/1999
Qualifications (if required): representing Burlington Railroad			
Ms. Yvonne Kobasziar	Governor	reappointed	8/10/1995
Great Falls			8/10/1999
Qualifications (if required): representing the United States Air Force			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Mr. Curt Laingen Helena Qualifications (if required): representing motor carriers	Governor	reappointed	8/10/1995 8/10/1999
Mr. Tim Murphy Missoula Qualifications (if required): representing the Department of Natural Resources and Conservation	Governor	not listed	8/10/1995 8/10/1999
Mr. Bill Rhoads Butte Qualifications (if required): representing a Montana utility company	Governor	reappointed	8/10/1995 8/10/1999
Mr. Paul Spengler Helena Qualifications (if required): representing a local emergency planning committee	Governor	reappointed	8/10/1995 8/10/1999
Mr. Bruce Suenram Helena Qualifications (if required): representing the Department of Justice	Governor	reappointed	8/10/1995 8/10/1999
Mr. Seldon Weedon Great Falls Qualifications (if required): representing a state fire organization	Governor	reappointed	8/10/1995 8/10/1999
Ms. Linda Williams Fort Benton Qualifications (if required): representing local medical response	Governor	not listed	8/10/1995 8/10/1999

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
State Historical Preservation Officer (Historical Society)			
Mr. Paul Putz	Governor	not listed	8/9/1995
Vermillion			0/0/0
Qualifications (if required): not specified			
Swan River Correctional Training Center Advisory Council (Corrections)			
Ms. Nancy Brosten	Director	not listed	8/1/1995
Swan Lake			8/1/1997
Qualifications (if required): none specified			
Mr. George Field	Director	not listed	8/1/1995
Bigfork			8/1/1997
Qualifications (if required): none specified			
Mr. Grant Holle	Director	not listed	8/1/1995
Bigfork			8/1/1997
Qualifications (if required): none specified			
Mr. Jefferson Jones	Director	not listed	8/1/1995
Swan Lake			8/1/1997
Qualifications (if required): none specified			
Rep. Bob Keenan	Director	not listed	8/1/1995
Bigfork			8/1/1997
Qualifications (if required): none specified			
Ms. Terry McLeod	Director	not listed	8/1/1995
Swan Lake			8/1/1997
Qualifications (if required): none specified			
Mr. Robert Parcell	Director	not listed	8/1/1995
Condon			8/1/1997
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM AUGUST, 1995

Appointee	Appointed by	Succeeds	Appointment/End Date
Swan River Correctional Training Center Advisory Council (Corrections) cont.			
Ms. June Smith Swan Lake Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997
Ms. Diane Tripp Missoula Qualifications (if required): none specified	Director	not listed	8/1/1995 8/1/1997

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
Alfalfa Seed Committee (Agriculture)		
Mr. Durl Heiken, Billings	Governor	12/21/1995
Qualifications (if required): public member		
Mr. Keith Reynolds, Winnett	Governor	12/21/1995
Qualifications (if required): public member		
Board of Outfitters (Commerce)		
Mr. Jack Billingsley, Glasgow	Governor	10/1/1995
Qualifications (if required): licensed outfitter from District 4		
Mr. R. Craig Madsen, Great Falls	Governor	10/1/1995
Qualifications (if required): licensed outfitter from District 3		
Capitol Restoration Commission (Administration)		
Ms. Iva Kolstad, Ledger	State Auditor	12/3/1995
Qualifications (if required): none specified		
Ms. Jeanne Michael, Billings	Lt. Governor	12/3/1995
Qualifications (if required): member appointed by Lieutenant Governor		
Mr. Walter (Howdie) S. Murfitt, Helena	Governor	12/3/1995
Qualifications (if required): public member		
Mr. E.V. "Sonny" Omholt, Helena	Governor	12/3/1995
Qualifications (if required): public member		
Ms. Pat Regan, Billings	Secretary of State	12/3/1995
Qualifications (if required): none specified		
Mr. Ernie Richards, Butte	Secretary of State	12/3/1995
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
Capitol Restoration Commission (Administration) cont.		
Mr. Loren Smith, Great Falls	Lt. Governor	12/3/1995
Qualifications (if required): member appointed by Lieutenant Governor		
Classification and Rating Committee (State Auditor)		
Mr. Robert Carlson, Portland, OR	Insurance Comr.	9/30/1995
Qualifications (if required): involved in workers' compensation market		
Mr. James Davis, Boise, ID	Insurance Comr.	9/30/1995
Qualifications (if required): involved in workers' compensation market		
Continuing Education Advisory Council (State Auditor)		
Mr. John Bebee, Great Falls	Insurance Comr.	9/30/1995
Qualifications (if required): at-large insurance		
Mr. Ted Clark, Billings	Insurance Comr.	9/30/1995
Qualifications (if required): public member		
Historic Preservation Review Board (Historical Society)		
Mr. Dale Herbort, Helena	Governor	10/1/1995
Qualifications (if required): archeologist		
Mr. David Johns, Butte	Governor	10/1/1995
Qualifications (if required): public member		
Mr. Don Wetzel, Harlem	Governor	10/1/1995
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
Independent Living Advisory Council (Social and Rehabilitation Services)		
Ms. Ellen Alweis, Billings Qualifications (if required): none specified	Director	10/1/1995
Ms. June Hermanson, Polson Qualifications (if required): none specified	Director	10/1/1995
Ms. Jan LaValley-Miller, Great Falls Qualifications (if required): none specified	Director	10/1/1995
Mr. Mike Mayer, Missoula Qualifications (if required): none specified	Director	10/1/1995
Local Government Records Committee (Secretary of State)		
Ms. Peggy Lamberson Bourne, Great Falls Qualifications (if required): none specified	Secretary of State	10/1/1995
Ms. Marcia Porter, Missoula Qualifications (if required): none specified	Secretary of State	10/1/1995
Ms. Bonnie Ramey, Boulder Qualifications (if required): none specified	Secretary of State	10/1/1995
Ms. Lorraine Van Ausdol, Helena Qualifications (if required): none specified	Secretary of State	10/1/1995
MT Comprehensive Health Association Board (State Auditor)		
new appointment Qualifications (if required): public member	Insurance Comr.	
new appointment Qualifications (if required): public member	Insurance Comr.	

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
MT Insurance Guaranty Association (State Auditor)		
new appointment	Insurance Comr.	
Qualifications (if required): public member		
new appointment	Insurance Comr.	
Qualifications (if required): public member		
MT Life and Health Insurance Guaranty Association (State Auditor)		
new appointment	Insurance Comr.	
Qualifications (if required): public member		
new appointment	Insurance Comr.	
Qualifications (if required): public member		
Resource Conservation Advisory Council (Natural Resources and Conservation)		
Mr. Sever Enkerud, Glasgow	Director	11/30/1995
Qualifications (if required): none specified		
Mr. Ellis Hagen, Westby	Director	11/30/1995
Qualifications (if required): none specified		
Ms. Marieanne Hanser, Billings	Director	11/30/1995
Qualifications (if required): none specified		
Mr. Don Iverson, Fairview	Director	11/30/1995
Qualifications (if required): none specified		
Mr. Ken Minnie, Roundup	Director	11/30/1995
Qualifications (if required): none specified		
Mr. Bob Schroeder, Florence	Director	11/30/1995
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
Resource Conservation Advisory Council (Natural Resources and Conservation) cont.		
Mr. Tom Stelling, Fort Shaw	Director	11/30/1995
Qualifications (if required): none specified		
Water Pollution Control Advisory Council (Health and Environmental Sciences)		
Mr. Donald L. Burnham, Helena	Governor	11/7/1995
Qualifications (if required): livestock feeder		
Mr. Gary Fritz, Helena	Governor	11/7/1995
Qualifications (if required): administrator of the water resources of Department of Natural Resources and Conservation		
Mr. Leo Giacometto, Helena	Governor	11/7/1995
Qualifications (if required): represents Department of Agriculture		
Mr. Pat Graham, Helena	Governor	11/7/1995
Qualifications (if required): represents Department of Fish, Wildlife & Parks		
Mr. Robert Dennis Greenlief, Butte	Governor	11/7/1995
Qualifications (if required): representative of labor		
Mr. Don Jenkins, Whitehall	Governor	11/7/1995
Qualifications (if required): representative of industry concerned with inorganic waste		
Ms. Barbara J. Morgan, Eureka	Governor	11/7/1995
Qualifications (if required): municipal government representative		
Mr. Douglas Parker, Missoula	Governor	11/7/1995
Qualifications (if required): representative of inorganic industry		
Mr. Doug Richardson, Billings	Governor	11/7/1995
Qualifications (if required): representative of industry concerned with organic waste		

VACANCIES ON BOARDS AND COUNCILS -- October 1, 1995 through December 31, 1995

Board/current position holder	Appointed by	Term end
Water Pollution Control Advisory Council (Health and Environmental Sciences) cont.		
Mr. Keith Ward, Missoula	Governor	11/7/1995
Qualifications (if required): representative of an organization concerned with fishing for sport		
Mr. Robert E. Willems, Harlowton	Governor	11/7/1995
Qualifications (if required): supervisor of a soil and water conservation district		
Water and Wastewater Operators Advisory Council (Health and Environmental Sciences)		
Mr. Steven Ruhd, Conrad	Governor	10/16/1995
Qualifications (if required): water treatment operator		