MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 9

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

In the matter of the proposed adoption of rules relating to mailing information on behalf of non-profit organizations.	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On June 22, 1995, the Public Employees' Retirement Board proposes to adopt the following rules pertaining to mailing information to retirement system participants on behalf of an eligible non-profit organizations.

2. The rules as proposed provide as follows:

RULE I MAILING ON BEHALF OF NON-PROFIT ORGANIZATIONS -- ELIGIBILITY AND APPLICATION PROCESS -- PAYMENTS (1) As staff resources permit, the division may mail information on behalf of eligible non-profit organizations to retirees of the retirement systems, to members who request estimates of their retirement benefits, and to any retirement system participant as a part of or in addition to regular newsletters.

(2) Eligible non-profit organizations are limited to those organizations granted tax exempt status under section 501(c)(3) of the Internal Revenue Code and which possess a non-profit organization mailing permit from the U.S. Postal Service in Helena, Montana.

(3) Application forms will be provided by the Division. A non-profit organization must submit a completed application to the division for approval at least one month prior to a proposed bulk mailing or initiation of a program to insert membership recruitment information for mailing along with estimates of the member's retirement benefit. Applications must contain:

(a) a completed application form signed by an officer of the requesting organization;

(b) a copy of the IRS exemption letter provided to non-profit organizations receiving exemption under section 501(c)(3) of the tax code;

(c) a copy of the certification of the appropriate state official of the organization's current incorporation as a non-profit entity;

(d) a copy of the organization's current U.S. postal mailing permit for non-profit organizations for an organization requesting a separate bulk mailing on behalf of the origanization; and

(e) an exact copy of the proposed mailing.

(4) Upon approval, the division will bill the organization for the estimated cost of the mailing and provide a proposed completion date for bulk mailing. Payment of the estimated cost must be made in full at least 10 working days prior to initiation of the mailing.

(5) Upon completion of the mailing, or monthly for insertion mailing, the division will bill the organization for any additional costs incurred by the division to accomplish this service. All charges must be paid in full within 30 days of billing. Thereafter, interest will be assessed at the maximum rate allowed by law from the date of billing.

RULE II ACCEPTABLE DOCUMENTS MAILED ON BEHALF OF NON-PROFIT ORGANIZATIONS (1) The division will approve materials for mailing which conform to the following criteria:

(a) Each piece must be exactly the same as every other piece to be mailed;

(b) Each piece may include an application for membership in the organization and general information about the organization's non-profit activities. No piece may urge or recommend specific actions not within the non-profit nature and scope of the organization (e.g., a non-profit organization may not urge an activity such as voting for a particular individual or joining another organization or affiliated organization).

(2) Each piece approved for insertion with mailing of retirement estimates must be no more than one single page, 8 1/2 inches by 17 inches (or smaller), folded to fit within a regular business envelope (and not stapled or sealed in any manner).

(3) Each piece approved for bulk mailing must meet current postal bulk mailing requirements and must be printed with the organization's non-profit mailing permit from Helena, Montana.

RULE III RIGHT TO BE EXCLUDED -- NON-PROFIT ORGANIZATIONS (1) Any member or other person receiving benefits from a retirement system may request to be excluded from receiving a mailing on behalf of all non-profit organizations by submitting a written request to the division.

(2) Requests for exclusion will become effective no later than 30 days after the division receives the signed written request.

3. The proposed rules are necessary to provide guidance to eligible non-profit organizations desiring to mail membership or other materials to retirees, prospective retirees, and other benefit recipients of the retirement systems administered by this board. The proposed rules are necessary to establish application procedures and to define the requirements to which materials for mailing must comply. The proposed rules also provide a procedure by which retired members may be excluded from all mailings on behalf of non-profit organizations.

4. The authority for the proposed rules is found in 19-2-403, MCA and the proposed rules will implement 2-6-109(8), MCA.

5. Interested persons may present their data, views, or arguments concerning the proposed amendments in writing no later than June 12, 1995 to:

Linda King, Administrator

Public Employees' Retirement Division
P.O. Box 200131
Helena, Montana 59620-0131

6. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, the person must make written request for a hearing and submit this request along with any written comments to the above address. A written request for hearing must be received no later than June 12, 1995.

7. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons directly affected by the proposed action; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 4,384 persons based on January 1995 payroll reports of active and retired members.

By: _____
Berry Teichrow, President
Public Employees' Retirement Board

_____
Dal Smilie, Chief Legal Counsel and
Rule Reviewer

Certified to the Secretary of State on May 1, 1995.

BEFORE THE PUBLIC EMPLOYEES' RETIREMENT BOARD
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 2.43.451 and 2.43.452 pertaining to purchase of service for members who are involuntarily terminated after January 1, 1995 but before July 1, 1997 and limitations on their return to employment within the jurisdiction	NOTICE OF PROPOSED AMENDMENT (NO PUBLIC HEARING CONTEMPLATED)

TO: All Interested Persons.

1. On June 22, 1995, the Public Employees' Retirement Board proposes to amend ARM 2.43.451 and 2.43.452 pertaining to the purchase of additional service as a termination benefit for retirement-eligible members involuntarily terminated due to elimination of the member's position due to privatization, reorganization of an agency, closure of or a reduction in force at an agency, or other actions by the legislature on or after January 1, 1995, but before July 1, 1997.

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

2.43.451 PURCHASE OF ADDITIONAL SERVICE BY EMPLOYERS ~~AS A RETIREMENT INCENTIVE~~ (1) Additional service purchased on behalf of members eligible for the retirement incentive program or members eligible under section 5 of HB 490, 1995 legislature, is limited to three years or restrictions otherwise in place in 19-3-513, MCA and ARM 2.43.432 for purchase of such service. The number of months of active duty military service or service from other public retirement systems purchased by a member after January 1, 1990 will reduce the amount of additional service for which the member is eligible to a combined total of no more than 60 months.

(2) Remains the same.

(3) Potentially eligible members who have been involuntarily terminated must apply for additional service under the retirement incentive program on forms provided by the retirement division on or after May 14, 1993, but prior to January 1, 1994. Potentially eligible members qualifying under section 5, HB 490 must apply after January 1, 1995, but prior to July 1, 1997 on forms provided by the retirement division.

(4) Remains the same.

(5) Each application for additional service will then be forwarded by the retirement division to the member's employer ~~or~~ for certification of termination date; whether the member's termination was voluntary, due to a reduction in force, or for another reason; ~~and~~ whether the member has taken advantage of other termination benefits provided by state law as an alternative benefit to this program; and whether the employee's

position has been eliminated or reclassified.

(6) through (9) Remain the same.

AUTH: 19-2-403 and 19-3-908, MCA
IMP: 19-3-908 MCA and Section 5, HB 490 (1995)

2.43.452 RETURN TO EMPLOYMENT WITHIN SAME JURISDICTION

(1) A member who has received additional service purchased on the member's behalf by their former employer during the window incentive program or because of an involuntary termination as defined in HB 490, 1995 Legislature, may be reemployed within the same jurisdiction for up to 600 hours during any calendar year. A retired member must have both terminated covered employment and have received at least one monthly retirement benefit prior to return to active service. An inactive member who chooses to delay retirement may return to active service within the same jurisdiction after a break in service of at least 5 days.

(2) Remains the same.

(3) The employer of a member who has taken advantage of the retirement incentive or has received retirement benefits due to involuntary termination under the provisions of HB 490, 1995 Legislature, must report all hours worked and all amounts paid to the member after return to employment within the same jurisdiction. It is the employer's responsibility to accurately report each ~~PERS~~ member's active duty service or employment after retirement to the retirement division. If a former employee is employed by an independent contractor (or becomes an independent contractor) engaged in business with the jurisdiction of the member's former employer, the employer will report this information to the retirement division as specified in ARM 2.43.453.

(4) As described in 19-3-908, MCA, all agencies of the state and all units of the university system are considered one and the same jurisdiction for purposes of the restrictions on return to covered employment for members taking advantage of the retirement incentive program. Each individual local government unit with a separate contract for ~~PERS~~ coverage is considered a separate jurisdiction. (For example, a member terminating employment with the department of agriculture may not return to employment for more than 600 hours during any calendar year with any state agency or unit of the university system, but may return to work with the city of Helena, without forfeiting the additional service credit purchased on their behalf by their former employer.)

(5) Remains the same.

AUTH: 19-2-403 and 19-3-908, MCA
IMP: 19-3-908, MCA and Section 5, HB 490 (1995)

3. The amendments are necessary to extend the provisions of these rules in administering the provisions of Section 5 of HB 490, allowing retirement-eligible persons involuntarily terminated due to reductions in force, agency reorganizations, and other actions of the legislature, to have their employers

purchase up to three years of additional service as a severance benefit.

4. Interested persons may present their data, views, or arguments concerning the proposed amendment in writing no later than June 12, 1995 to:

Linda King, Administrator
Public Employees' Retirement Division
P.O. Box 200131
Helena, Montana 59620-0131

5. A person directly affected by the proposed amendment who wishes to express data, views and written or oral arguments at a public hearing must submit a written request for a hearing along with any written comments to the above address. A written request for hearing must be received no later than June 12, 1995.

6. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Those persons directly affected are the members of the retirement systems administered by the Board and ten percent has been determined to be 4,384 persons based on January 1995 payroll reports of active and retired members.

Terry Teichrow, President
Public Employees' Retirement Board

Dal Smilie, Chief Legal Counsel and
Rule Reviewer

Certified to the Secretary of State on May 1, 1995.

BEFORE THE PUBLIC EMPLOYEES' RETIREMENT BOARD
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 2.43.418 pertaining to accrual of membership service and service credit for elected officials) NOTICE OF PROPOSED AMENDMENT) (NO PUBLIC HEARING CONTEMPLATED)

TO: All Interested Persons.

1. On July 27, 1995, the Public Employees' Retirement Board proposes to amend ARM 2.43.418 pertaining to accrual membership service and service credit for elected officials.

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

2.43.418 ELECTED OFFICIALS (1)(a) Any member, other than a legislative member, who holds a covered position by virtue of election to a public office shall accrue membership service ~~years~~ and ~~receive~~ service ~~credits over~~ credit during the entire term for which the member holds elected office and receives a ~~salary for services~~ compensation. The member will be granted membership service and service credit based upon the number of hours for which the member receives compensation. Per diem or other ~~such~~ benefits ~~will~~ are not ~~be considered salary~~ compensation.

(b) A legislator may elect membership in PERS at any time during the term of office. A member may purchase service by self-paying the monthly contributions for any or all months served by the member. A legislator who is a member of the PERS must pay contributions during a legislative session. The legislative member will be granted proportional membership service and service credit for each month or partial month in which contributions are paid. The amount the member must self-pay will be the total contribution required for the months being purchased based on the current statutory salary prescribed in §5-2-301, MCA, less any previous payments of contributions. All self-payments must be remitted to the division no later than the last day of the month preceding the end of the term.

(2) A member ~~who is~~ appointed to fill ~~an elective office to fill~~ an unexpired term will be considered an elected official and has the same rights and privileges as an elected official ~~accrue service years and receive service credits for the fractional portion of such term as the member actually serves~~.

(3) An elected official whose statutory term of office ends prior to the 15th of a month ~~may elect to terminate retirement system membership~~ will be considered to have terminated covered employment effective ~~on~~ the last day of the month preceding the end of the term ~~of office~~.

(4) A member who elects to qualify previous ~~periods of~~ service as an elected official ~~as membership service~~ in the PERS shall qualify that service ~~in the manner~~ as prescribed in 19-3-505, MCA, except the cost ~~to qualify this service~~ will not

include ~~calculations of~~ interest ~~accumulations on employee and employer~~ for any contributions due on service prior to July 1, 1993.

AUTH: 19-2-403 MCA
IMP: 19-2-701, 19-2-702, 19-3-412, 19-3-505, 19-5-301, 19-7-301 MCA

3. The amendment to ARM 2.43.418 is necessary to distinguish between the different statutory pay and membership options for legislative members and other elected officials. Clarification is added that service will be credited based upon hours for which a member is compensated to conform with definitions of full- and part-time service. Additional editorial changes are necessary to make the text more easily understood and comply with the 1993 recodification of retirement statutes.

4. Interested persons may present their data, views, or arguments concerning the proposed amendment in writing no later than June 12, 1995 to:

Linda King, Administrator
Public Employees' Retirement Division
P.O. Box 200131
Helena, Montana 59620-0131

5. A person directly affected by the proposed amendment who wishes to express data, views and written or oral arguments at a public hearing must submit a written request for a hearing along with any written comments to the above address. A written request for hearing must be received no later than June 12, 1995.

6. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Those persons directly affected are the members of the retirement systems administered by the Board and ten percent has been determined to be 4,384 persons based on January 1995 payroll reports of active and retired members.

Terry Telchrow, President
Public Employees' Retirement Board

Dal Smilie, Chief Legal Counsel and
Rule Reviewer

Certified to the Secretary of State on May 1, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.7.313 pertaining the model rate matrix used to determine payment to youth care facilities	NOTICE OF PROPOSED AMENDMENT OF RULE 11.7.313 PERTAINING TO THE MODEL RATE MATRIX USED TO DETERMINE PAYMENT TO YOUTH CARE FACILITIES
	NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 29, 1995, the Department of Family Services proposes to amend Rule 11.7.313 pertaining to the model rate matrix used to determine payment to youth care facilities. The amendment is proposed to be effective on July 1, 1995.

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

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

(6) The department's model rate matrix, effective ~~January 1, 1993,~~ July 1, 1995, is hereby adopted and incorporated by this reference. Copies of the model rate matrix of the department are available upon request from the Administrative Support Division, Department of Family Services, P.O. Box 8005, Helena, Montana 59604. The department shall review and revise its model rate matrix at least once every two years.

(7) remains the same.

AUTH: Sec. 41-3-1103; 52-1-103, MCA, IMP: 41-3-1103; 41-3-1122; 52-1-103, MCA

3. The rate matrix must be changed to implement the rate increase for youth care facilities funded by the 1995 Legislature. The new version of the rate matrix must be referenced in the rule. § 2-4-307, MCA.

4. Interested persons may submit their data, views or arguments to the proposed amendment in writing to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments, to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

6. If the Department of Family Services receives requests

for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be more than 25 based on the large number of persons directly affected by the rate matrix.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson

Hank Hudson, Director

John Melcher

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 1, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.13.101 pertaining to the application of the model rate matrix to basic level therapeutic youth group homes	NOTICE OF PROPOSED AMENDMENT OF RULE 11.13.101 PERTAINING TO THE APPLICATION OF THE MODEL RATE MATRIX TO BASIC LEVEL THERAPEUTIC YOUTH GROUP HOMES NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 29, 1995, the Department of Family Services proposes to amend Rule 11.13.101 pertaining to the application of the model rate matrix to basic level therapeutic youth group homes.

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

11.13.101 THERAPEUTIC YOUTH GROUP HOME, DEFINITIONS

(1) remains the same.

(2) "Basic level" means the supervision and intensity of treatment classified under ARM 11.7.313 as supervision matrix level VI ~~IV, and treatment matrix level II~~.

(3) through (8) remain the same.

AUTH: Sec. 41-3-1103; 52-1-103, MCA, IMP: 41-3-1103; 41-3-1122; 52-1-103, MCA

3. Due to an oversight, the definition of basic level therapeutic youth group homes cited an incorrect supervision level, and included a non-existent treatment level. The amendment is necessary to correctly identify basic level homes within the matrix.

4. Interested persons may submit their data, views or arguments to the proposed amendment in writing to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments, to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

6. If the Department of Family Services receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected

by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. There are currently no operating basic level therapeutic youth group homes. Therefore, the department estimates that there are no persons who are directly affected.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 1, 1995.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.5.1002 pertaining day care rates for state paid day care	NOTICE OF PROPOSED AMENDMENT OF RULE 11.5.1002 PERTAINING TO DAY CARE RATES FOR STATE PAID DAY CARE
	NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 29, 1995, the Department of Family Services proposes to amend Rule 11.5.1002 pertaining to day care rates for state paid day care administered by the department. The effective date of the amended rule is proposed to be July 1, 1995.

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

11.5.1002 DAY CARE RATES (1) Full day care services (six or more hours per day/night) are paid at a rate of ~~$11.25~~12.75 per day/night per child in care in family day care homes. The maximum rate for group day care homes is ~~$11.25~~12.75 per child per day/night of care. The maximum rate for day care centers is ~~$11.00~~14.00 per child per day/night of care. The maximum rate for legally unregistered providers is $11.25 per child per day/night of care. These rates are effective rates for the current fiscal year.

(2) Part-time care (less than six hours per day/night) is paid at a rate of ~~$1.50~~2.00 per hour per child in family day care homes, ~~$1.50~~2.00 per hour per child in group day care homes, ~~and~~ $2.00 per hour per child in all day care centers, and $1.50 per hour per child in all legally unregistered homes up to a maximum of a full day or night care rate.

~~(3) Extra meals are paid at a rate of $1.00 per child per meal, upon the written approval of the department.~~

~~(4)~~(3) Special needs child or exceptional child day care is paid at a rate of ~~$12.00~~13.00 per child per day/night of care in family day care homes, upon approval of the department, or its designated representative. Special needs or exceptional child day care is paid at a rate of ~~$12.00~~13.00 per child per day/night of care in group day care homes, upon approval of the department, or its designated representative. Special needs or exceptional child day care is paid at a rate of ~~$12.15~~14.50 per day/night of care in day care centers, upon approval of the department, or its designated representative. Part-time care (less than six hours per day/ night) for special needs child or exceptional child day care is paid at a rate of ~~$1.75~~2.00 per hour per child in family day care homes, upon approval of the department, or its designated representative, up to a maximum of a full day or night care rate. Part-time care (less than six hours per day/night) for special needs child or exceptional child day care is paid at a rate of ~~$1.75~~2.00 per hour per child in group day care homes,

upon approval of the department, or its designated representative, up to a maximum of a full day or night care rate. Part-time care (less than six hours per day/night) for special needs child or exceptional child day care is paid at a rate of $2.00 per hour per child in day care centers, upon approval of the department, or its designated representative, up to a maximum of the full day or night care rate. No special needs rates are available for care of special needs children in legally unregistered homes.

~~(5)~~(4) The infant care rate may be charged for children under the age of twenty-four months as follows: full day care services (six or more hours per day) are paid at a rate of ~~$12.00~~14.00 per day/night per infant in care in family day care homes. The maximum rate for group day care homes is ~~$12.00~~14.50 per infant per day/night of care. The maximum rate for day care centers is ~~$13.00~~15.00 per infant per day/night of care. The maximum rate for legally unregistered providers is $12.00 per infant per day/night of care. Part-time care (less than six hours per day) is paid at a rate of ~~$1.50~~2.00 per hour per infant in family day care homes, ~~$1.50~~2.00 per hour per infant in group day care homes, ~~and~~ $2.00 per hour per infant in all day care centers, and $1.50 per hour per infant for all legally unregistered providers, up to a maximum of a full day or night care rate, as such rate is calculated for the ~~facility~~ provider.

~~(6)~~(5) Day care operators will be allowed to claim a day's care only when actually provided to the child, unless the ~~child is enrolled in the~~ facility participates in the certified enrollment program.

~~(7)~~(6) The rates set forth in this rule are the maximum rates payable. The rate charged by the day care provider for children whose day care is paid for by the department cannot exceed the rate charged to private paying parents for the same service.

AUTH: Sec. 52-2-704 MCA. IMP: Sec. 52-2-713 MCA.

3. The changes implement rate increases funded by the Legislature in the 1995 session. The results of a market study in 1994 provided data for funding the new rates. The proposed amendments set the rates at the 75th percentile of private rates charged in Montana, as determined by the study. Also based on the study, the amended rule provides for lower rates for legally unregistered providers, and no special-needs rates for legally unregistered providers.

Added language also allows the department to designate a representative for the required approval in (4), and clarifies that a facility is paid for days when a child is not in attendance pursuant to the certified enrollment program. (3) is dropped because the extra-meal program is no longer in existence.

4. Interested persons may submit their data, views or arguments to the proposed amendment in writing to the Office of Legal Affairs, Department of Family Services, 48 North Last

Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

5. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments, to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 12, 1995.

6. If the Department of Family Services receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be more than 25 based on the large number of persons directly affected by state-paid day care.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 1, 1995.

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

In the matter of the amendment of rules 16.20.603, 617, 618, 619, 620, 621, 622, 623, 624, 641, 707, 712, 1003, 1802 concerning surface and groundwater water quality standards, mixing zones, and nondegradation of water quality.	NOTICE OF PROPOSED AMENDMENT OF RULES NO PUBLIC HEARING CONTEMPLATED (Water Quality)

To: All Interested Persons

1. The board proposes to amend the above-captioned rules on June 16, 1995. The rules to be amended contain surface and groundwater water quality standards, mixing zone requirements, and water quality nondegradation requirements. The amendments will incorporate by reference revised numeric water quality standards for carcinogens in state waters and modify the level of nitrogen considered significant under the Montana Water Quality Act.

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

16.20.603 DEFINITIONS In this subchapter the following terms have the meanings indicated below and are supplemental to the definitions given in 75-5-103, MCA:

(1)-(29) Remain the same.

(30) The board hereby adopts and incorporates by reference department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, and other harmful parameters in water. Copies of circular WQB-7 may be obtained from the Water Quality Bureau, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, MT 59620.

(31) Remains the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.617 A-1 CLASSIFICATION (1)-(3) Remain the same.

(4) The board hereby adopts and incorporates ~~herein~~ by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, and other

harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.618 B-1 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.619 B-2 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.620 B-3 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.621 C-1 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.622 C-2 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.623 I CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.624 C-3 CLASSIFICATION (1)-(2) Remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(b)-(c) Remain the same.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.641 RADIOLOGICAL CRITERIA (1) Remains the same.

(2) The board hereby adopts and incorporates by reference department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, and harmful parameters in water. Copies of the circular may be obtained from the Water Quality Bureau, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620.

AUTH: 75-5-201, 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.707 DEFINITIONS Unless the context clearly states otherwise, the following definitions, in addition to those in 75-5-103, MCA, apply throughout this subchapter (Note: 75-5-103, MCA, includes definitions for "degradation", "existing uses", "high quality waters", and "parameter."):

(1)-(23) Remain the same.

(24)(a) The board hereby adopts and incorporates by reference:

(i) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, and harmful parameters in water; and

(ii) Remains the same.

(b) Remains the same.

AUTH: 75-5-301, 75-5-303, MCA; IMP: 75-5-303, MCA

16.20.712 CRITERIA FOR DETERMINING NONSIGNIFICANT CHANGES IN WATER QUALITY (1) The following criteria will be used to determine whether certain activities or classes of activities will result in nonsignificant changes in existing water quality due to their low potential to affect human health or the environment. These criteria consider the quantity and strength of the pollutant, the length of time the changes will occur, and the character of the pollutant. Except as provided in (2) below,

changes in existing surface or ground water quality resulting from the activities that meet all the criteria listed below are nonsignificant, and are not required to undergo review under 75-5-303, MCA:

(a)-(c) Remain the same.

(d) changes in the concentration of nitrogen in ground water which will not impair existing or anticipated beneficial uses, where:

~~(i) the incremental increase of nitrogen from human waste in ground water may not be more than 2.5 mg/l at the boundary of the applicable mixing zone;~~

(~~ii~~ i) the sum of the resulting concentrations of nitrate as nitrogen, outside of any applicable mixing zone, will not exceed the values given in Table I; and~~,~~

(~~iii~~ ii) the change will not result in increases greater than 0.01 milligrams per liter in the nitrogen concentration in any surface water.

Table I. Criteria for determining nonsignificant changes for nitrogen in ground water.
(See next page for Table I)

EXISTING NITROGEN CONCENTRATION IN GROUND WATER AS OF APRIL ~~30~~15, 1995~~5~~	PRIMARY SOURCE OF EXISTING NITROGEN	PREDICTED NITROGEN CONCENTRATION AT THE EDGE OF THE MIXING ZONE AFTER THE PROPOSED ACTIVITY	REQUIREMENTS FOR NONSIGNIFICANCE FOR HUMAN WASTE DISPOSAL	REQUIREMENTS FOR NONSIGNIFICANCE FOR DISPOSAL OF OTHER WASTES
~~< 2.5 MG/L~~	~~HUMAN WASTE~~	~~<2.5 MG/L~~	~~NONE~~	~~NONE~~
		~~2.5 <5.0 MG/L~~	~~LEVEL 2 TREATMENT~~	~~NONE~~
		~~5<7.5~~	~~SIGNIFICANT~~	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~
	~~OTHER~~	~~<5.0 MG/L~~	~~NONE~~	~~NONE~~
		~~5<7.5 MG/L~~	~~LEVEL 2 TREATMENT~~	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~
		~~7.5<10~~	~~SIGNIFICANT~~	~~SIGNIFICANT~~
~~2.5-5.0~~ <5.0 MG/L	~~HUMAN~~ ANY ~~WASTE~~	<5 MG/L	~~LEVEL 2 TREATMENT~~ NONE	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~ NONE
		5.1≤7.5 MG/L	LEVEL 2 TREATMENT	NONE
		~~5<7.5~~ >7.5 MG/L	SIGNIFICANT	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~ SIGNIFICANT
	~~OTHER~~	~~<5~~	~~NONE~~	~~NONE~~
		~~5<7.5~~	~~LEVEL 2 TREATMENT~~	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~
		~~>7.5~~	~~SIGNIFICANT~~	~~SIGNIFICANT~~
5.0-≤7.5	~~HUMAN WASTE~~	~~ANY INCREASE~~	~~SIGNIFICANT~~	~~SIGNIFICANT~~
	OTHER THAN HUMAN WASTE	<≤7.5 MG/L	~~LEVEL 2 TREATMENT~~ NONE	~~SECONDARY TREATMENT AS DEFINED BY THE DEPARTMENT~~ NONE
		≥7.5	SIGNIFICANT	SIGNIFICANT
>7.5	ANY	ANY INCREASE	SIGNIFICANT	SIGNIFICANT
		10 or greater	NOT ALLOWED VIOLATES STANDARDS	NOT ALLOWED VIOLATES STANDARDS
ANY LEVEL	ANY	NO CHANGE	NOT SIGNIFICANT	NOT SIGNIFICANT

(e)-(g) Remains the same.
(2)-(3) Remains the same.
AUTH: 75-5-301, 75-5-303, MCA; IMP: 75-5-303, MCA

16.20.1003 GROUND WATER QUALITY STANDARDS (1) Remains the same.

~~(2) The board hereby adopts and incorporates by reference ARM 16.20.203, 16.20.204, 16.20.206 and 16.20.207 which set forth maximum allowable chemical, radiological and microbiological contaminant levels for drinking water. Copies of ARM 16.20.203, 16.20.204, 16.20.206 and 16.20.207 may be obtained from the Water Quality Bureau, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620.~~

(3) Remains the same but is renumbered (2).

~~(4) Concentrations of dissolved substances in Class I and Class II ground water and in Class III ground water which is used for drinking water supplies may not exceed the human health standards listed in department circular WQB-7.~~

(5) Remains the same but is renumbered (3).

~~(6)~~ (4)(a) The board hereby adopts and incorporates by reference the following:

(i)-(iii) Remain the same.

(iv) Department circular WQB-7, entitled "Montana Numeric Water Quality Standards", (~~1994~~ 1995 edition).

(b) The publications in (a)(i)-(iii) above set forth criteria for ground water quality~~,~~; ~~and~~ department circular WQB-7 establishes limits for toxic, carcinogenic, bioconcentrating, and harmful parameters in water and the human health standards listed in WQB-7 are the standards that apply to Montana ground waters. Copies of the publications listed in (i)-(iv) above are available at the Water Quality Bureau, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620.
AUTH: 75-5-301, MCA; IMP: 75-5-301, MCA

16.20.1802 DEFINITIONS The following definitions, in addition to those in 75-5-103, MCA, and ARM Title 16, chapter 20, subchapters 6 and 7, apply throughout this subchapter:

(1)-(13) Remain the same.

(14) The board hereby adopts and incorporates by reference department circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~1994~~ 1995 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, and harmful parameters in water. Copies of the circular are available from the Water Quality Bureau, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, MT 59620.
AUTH: 75-5-301, MCA; IMP: 75-5-301, MCA

3. These rules are being amended as a result of the passage of Senate Bill 331 by the 1995 legislature. This act established requirements for the adoption of water quality standards and for establishing the significance level of nitrate for purposes of making water quality nondegradation determinations. Senate Bill 331 requires that the water quality

standards for the protection of human health be set at a risk level not to exceed 1 x 10^{-3} for arsenic; for other carcinogens, the risk level must not exceed 1x10^{-5}. The human health standards for carcinogens provided in Department Circular WQB-7, entitled "Montana Numeric Water Quality Standards", have been revised to reflect the risk levels established by the 54th legislature, as specified above, and the revised WQB-7 is being adopted by reference into the water quality standards, mixing zone requirements, and nondegradation rules.

ARM 16.20.1003 is also being amended to clarify that the human health standards adopted in WQB-7 are the state's groundwater standards.

In addition, the nondegradation rules are being amended to reflect the significance levels of nitrate as specified in Senate Bill 331. Due to the extensive amount of public debate during the legislative session regarding the human health standards and nitrate levels adopted by the 54th legislature, no public hearing is contemplated for these rule amendments.

4. A copy of the updated Circular WQB-7 may be obtained by contacting the Water Quality Division, Montana Department of Health and Environmental Sciences, Cogswell Building, P.O. Box 200901, Helena, MT 59620-0901 [(406)444-2406].

5. Interested persons may submit their data, views, or arguments concerning the proposed amendments in writing to Yolanda Fitzsimmons, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620. Any comments must be received no later than 5:00 p.m., June 9, 1995.

6. If a person who is directly affected by the proposed amendments wishes to express his/her data, views, and arguments orally or in writing at a public hearing, s/he must make written request for a hearing and submit this request, along with any written comments s/he has, to Yolanda Fitzsimmons, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620. A written request for hearing must be received no later than 5:00 p.m., June 9, 1995.

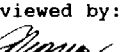
7. If the board receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly 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 number of individuals affected by water quality in Montana.

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

by William J. Cook
for ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995 .

Reviewed by:



Eleanor Parker, DHES Attorney

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

In the matter of the amendment of rules 16.28.101, 201, 202, 203, 204, 305, 605D, 609A, the adoption of new rules I-III, and the repeal of rules 16.28.605C, 606B, 612B, 632, 632A, 632B, and 637 concerning control measures for communicable diseases.	NOTICE OF PROPOSED AMENDMENT OF RULES, ADOPTION OF NEW RULES, AND REPEAL OF RULES NO PUBLIC HEARING CONTEMPLATED (Communicable Diseases)

1. On June 19, 1995, the department proposes to amend ARM 16.28.101, 201, 202, 203, 204, 305, 605D, and 609A, and to adopt new rules I-III regarding control measures for communicable diseases.

2. The department also proposes to repeal ARM 16.28.605C, 606B, 612B, 632, 632A, 632B, and 637. These rules are found on pages 16-1252, 16-1253, 16-1256, and 16-1262 through 16-1264 of the Administrative Rules of Montana.

AUTH: 50-1-202, 50-2-118
IMP: 50-1-202, 50-2-118

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

16.28.101 DEFINITIONS Unless otherwise indicated, the following definitions apply throughout this chapter:

(1)-(13) Remain the same.

(14) "HIV infection" means infection with the human immunodeficiency virus.

(14)-(22) Remain the same, but are renumbered (15)-(23)

~~(23) "Potential AIDS" means the condition in which an individual's blood contains the antibody to the human immunodeficiency virus (HIV).~~

(24)-(28) Remain the same.

(29) "Sexually transmitted disease" means ~~AIDS~~ human immunodeficiency virus (HIV) infection, syphilis, gonococcal infection, chancroid, lymphogranuloma venereum, granuloma inguinale, or chlamydial genital infections.

(30)-(33) Remain the same.

AUTH: 50-1-202, 50-2-116, 50-17-103, MCA;
IMP: 50-1-202, 50-17-103, 50-18-101, MCA

16.28.201 REPORTERS (1) Any person, including but not limited to a physician, dentist, nurse, medical examiner, other health care practitioner, administrator of a health care facility, public or private school administrator, city health officer, or laboratorian who knows or has reason to believe that a case exists shall immediately report:

(a) the information specified in ARM 16.28.204(2) to the department alone, in the case of ~~potential AIDS~~ HIV infection;

(b)-(c) Remain the same.

(2)-(3) Remain the same.

AUTH: 50-1-202, 50-17-103, 50-18-105, MCA;
IMP: 50-1-202, 50-2-118, 50-17-103, 50-18-102, 50-18-106, MCA

16.28.202 REPORTABLE DISEASES (1) The following communicable diseases are reportable:

(a) Acquired immune deficiency syndrome (AIDS), as defined by the centers for disease control, or ~~potential AIDS~~ HIV infection, as indicated by the presence of the human immunodeficiency virus antibody

(b)-(g) Remain the same.

~~(h) Chickenpox~~

(i)-(k) Remain the same but are renumbered (h)-(j).

(~~l~~k) ~~Conjunctivitis epidemic~~ cryptosporidiosis

(m)-(y) Remain the same but are renumbered (l)-(x).

(y) Hemolytic uremic syndrome

(z) Hepatitis A, B, or non-A non-B~~, or unspecified~~

(aa) - (au) Remain the same.

~~(av) Smallpox (including vaccinia)~~

~~(aw) Staphylococcal epidemic~~

~~(ax) Streptococcal epidemic~~

~~(ay) Swimmer's itch (cutaneous larva migrans)~~

(av) Streptococcus pneumoniae invasive disease, drug resistant

(az)-(be) Remain the same but are renumbered (aw)-(bb).

~~(bf) Typhus~~

(bg)-(bj) Remain the same but are renumbered (bc)-(bf).

(2) Remains the same.

AUTH: 50-1-202, 50-17-103, 50-18-105, 50-18-106, MCA;
IMP: 50-1-202, 50-2-118, 50-17-103, 50-18-102, 50-18-106, MCA

16.28.203 REPORTS AND REPORT DEADLINES (1) A county, city-county, or district health officer or ~~his/her~~ the officer's authorized representative must immediately report to the department by telephone the information cited in ARM 16.28.204(1) whenever a case of one of the following diseases is suspected or confirmed:

(a) - (f) Remain the same.

~~(g) Smallpox (including vaccinia)~~

(h) Remains the same but is renumbered (g).

(2) A county, city-county, or district health officer or ~~his/her~~ the officer's authorized representative must mail to the department the information required by ARM 16.28.204(1) for each suspected or confirmed case of one of the following diseases, within the time limit noted for each:

(a) On the same day information about a case of one of the following diseases is received by the county, city-county, or district health officer:

(i)-(x) Remain the same.

(xi) Hemolytic uremic syndrome

(xi)-(xviii) Remain the same but are renumbered (xii)-(xix).

~~(xix) Typhus~~

(xx)-(xxii) Remain the same.

(b) Within 7 calendar days after the date information about a case of one of the following diseases is received by the county, city-county, or district health officer:

(i)-(v) Remain the same

(vi) Cryptosporidiosis

(vi)-(ix) Remain the same but are renumbered (vii)-(x).

(~~x~~xi) Hepatitis, A, B, or non-A non-B~~, or unspecified~~

(xi)-(xxi) Remain the same but are renumbered (xii)-(xxii).

(xxiii) Streptococcus pneumoniae invasive disease, drug resistant

(xxii)-(xxv) Remain the same but are renumbered (xxiv)-(xxvii).

(3) By Friday of each week during which a suspected or confirmed case of one of the diseases listed below is reported to the county, city-county, or district health officer, that officer or ~~his/her~~ the officer's authorized representative must mail to the department the total number of the cases of each such disease reported that week:

~~(a) Chickenpox~~

(b) Remains the same but is renumbered (a).

~~(c) Conjunctivitis epidemic~~

(d) Remains the same but is renumbered (b).

~~(e) Staphylococcal epidemic~~

~~(f) Streptococcal epidemic~~

~~(g) Swimmer's itch (cutaneous larva migrans)~~

(4) Anyone, other than the local health officer, who reports a case of AIDS or ~~potential AIDS~~ HIV infection must submit the report by 5:00 p.m. Friday of the week in which the diagnosis of AIDS is made or the test showing ~~potential AIDS~~ HIV infection is performed.

(5) A laboratorian must submit to the department by the 15th day following each ~~quarter~~ month a report on a form supplied by the department indicating the number of tests with negative or positive results which were done that ~~quarter~~ month for tuberculosis or a sexually transmitted disease.

(6) - (7) Remain the same.

AUTH: 50-1-202, 50-17-103, 50-18-105, MCA;
IMP: 50-1-202, 50-2-118, 50-17-103, 50-18-102, 50-18-106, MCA

16.28.204 REPORT CONTENTS (1) Remains the same.

(2) A report of ~~potential AIDS~~ HIV infection must include:

(a)-(c) Remain the same.

(3)-(4) Remain the same.

(5) The name of any case of AIDS or ~~potential AIDS~~ HIV infection and the name and address of the reporter of any such case are confidential and not open to public inspection.

AUTH: 50-1-202, 50-17-103, 50-18-105, MCA;
IMP: 50-1-202, 50-17-103, 50-18-102, 50-18-106, MCA

16.28.305 CONFIRMATION OF DISEASE (1)(a) Subject to the limitation in (b) below, if a local health officer receives information about a case of any of the following diseases, ~~s/he or his/her~~ the officer or the officer's authorized representative must ensure that a specimen from the case is submitted to the

department, which specimen will be analyzed to confirm the existence or absence of the disease in question:

(i) ~~Amebiasis~~

~~(ii)~~ Anthrax

(~~iii~~ii) Botulism (foodborne) ~~(including infant botulism)~~

~~(iv~~iii) Brucellosis

~~(v) Chancroid~~

(vi)-(viii) Remain the same but are renumbered (iv)-(vi).

~~(ix) Encephalitis~~

~~(x) Escherichia coli 0157:H7 enteritis~~

~~(xi) Gonococcal infection in a person less than 14 years of age~~

~~(xii) Granuloma inguinale~~

~~(xiii) Hansen's disease (leprosy)~~

(~~xiv~~vii) Hantavirus pulmonary syndrome

(~~xv~~viii) Influenza

~~(xvi) Lymphogranuloma venereum~~

(~~xvii~~ix) Measles (rubeola)

~~(xviii) Ornithosis (Psittacosis)~~

(xix)-(xxiii) Remain the same but are renumbered (x)-(xiv).

~~(xxiv) Shigellosis~~

~~(xxv) Smallpox (including vaccinia)~~

(~~xxvi~~xv) Syphilis

~~(xxvii) Tetanus~~

(~~xxviii~~xvi) Trichinosis

(~~xxix~~xxvii) Tuberculosis

~~(xxx) Tularemia~~

(~~xxxi~~xxviii) Typhoid fever

~~(xxxii) Typhus~~

~~(xxxiii) Illness occurring in a traveler from a foreign country~~

(b) Remains the same.

(2) - (3) Remain the same.

~~(4) A physician or laboratorian performing a blood test which shows the presence of the antibody to the human immunodeficiency virus (HIV) must submit to the department laboratory a blood specimen from the person tested in order to confirm the test results.~~

AUTH: 50-1-202, MCA, IMP: 50-1-202, MCA

16.28.605D CHLAMYDIAL GENITAL INFECTION (1) An individual with a chlamydial genital infection must be directed to ~~avoid sexual contact and~~ undergo appropriate antibiotic therapy ~~until discharges from his/her genitourinary tract are found to be noninfectious~~ and to avoid sexual contact until 24 hours have passed after completion of the treatment regimen.

(2) It is recommended that ~~any contact of the case also follow the requirements of (1) above~~ an individual who contracts the infection be interviewed to determine the person's sexual contacts, and that those contacts be examined and receive the medical treatment indicated by clinical and laboratory findings.

AUTH: 50-1-202, 50-2-118, 50-18-105, MCA;
IMP: 50-1-202, 50-2-118, 50-18-102, 50-18-107, MCA

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

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

AUTH: 50-1-202, 50-2-118, 50-18-105, MCA; IMP: 50-1-202, 50-2-118, 50-18-102, 50-18-107, MCA

RULE I CRYPTOSPORIDIOSIS (1) Enteric precautions must be used by a case employed in a sensitive occupation, as described in ARM 16.28.301, until three post-treatment stool specimens collected on 3 successive days test negative.

(2) Sources of infection must be sought, especially in the home, within the family, in food, and in water.

AUTH: 50-1-202, MCA; IMP: 50-1-202, MCA

RULE II HEMOLYTIC UREMIC SYNDROME (1) Enteric precautions must be observed.

(2) The local health officer may not allow an infected person to engage in a sensitive occupation, as described in ARM 16.28.301, until stool specimens are culture-negative for escherichia coli 0157:H7 enteritis.

AUTH: 50-1-202, MCA; IMP: 50-1-202, MCA

RULE III STREPTOCOCCUS PNEUMONIAE INVASIVE DISEASE, DRUG RESISTANT (1) Whenever a case of drug resistant streptococcus pneumonia invasive disease is identified, the following measures must be imposed:

(a) contact isolation for the duration of acute illness; and

(b) concurrent disinfection of discharges from nose and throat.

(2) Surveillance for susceptible contacts must be initiated and immediate immunizations recommended to those identified as high risk for pneumococcal disease, including persons aged 2 years or older with sickle cell disease; functional or anatomic asplenia; nephrotic syndrome or chronic renal failure; immunosuppression, including HIV infection; organ transplantation or cytoreducation therapy; other chronic illnesses; and all persons aged 65 years or older.

(3) Contacts at high risk for whom immunization is not advised or not deemed effective must be evaluated for chemoprophylaxis.

(4) Epidemics or clusters of cases may warrant more liberal use of the pneumococcal vaccine or chemoprophylaxis after consultation with the department.

(5) In the case of meningitis, compliance with ARM 16.28.619 is also required.

AUTH: 50-1-202, MCA; IMP: 50-1-202, MCA

4. The department is proposing the above amendment, repeal, and adoption of rules as necessary to ensure that the communicable disease control measures required by the state are those that are most effective in protection of public health. The department has recently reviewed the list of reportable diseases and the control measures required for them to ensure that they meet criteria developed by the Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE)to be considered of public health importance, such as causing significant morbidity and mortality and being amenable to intervention efforts. Measured against those criteria, certain diseases are being removed based on one or more of the following: (1) they are typically sporadic and uncommon or not usually directly transmissible from person to person; (2) they are of such an epidemiologic nature that there are no special practical measures for control; and/or (3) the information gathered on the disease serves no definite purpose. Other diseases are being added to the reportable disease list because the criteria for public health importance established by CDC and the CSTE indicate they are of public health importance and should be reported.

In addition, the requirement that a blood sample must be submitted to the department for confirmation of results whenever a physician or laboratory diagnoses a person as HIV-positive is deleted because it is not necessary for epidemiological followup. The other diseases deleted from ARM 16.28.305's list for which department confirmation is required were deleted because there is no significant public health need for such confirmation (e.g. because the disease no longer exists, local competency to determine the existence of the disease is high, or the disease is so rare that extensive confirmation occurs before a diagnosis can be made).

The amendment to require laboratories to report results monthly instead of quarterly is necessary to ensure prompt investigation of cases of TB or sexually transmitted diseases.

Finally, the amendment of the reference to "potential AIDS" to read "HIV infection" is necessary to facilitate public understanding, since "HIV infection" is now widely used and "potential AIDS" is not; the reference to AIDS in the definition of "sexually transmitted disease" is necessarily amended to conform closely to the statutory change in that definition by Ch. 71 of the 1993 Laws of Montana.

5. Interested persons may submit their data, views, or arguments concerning the proposed amendments, in writing, to Jim Murphy, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana, 59620, no later than June 9, 1995.

6. If a person who is directly affected by the proposed amendment wishes to express his/her data, views, and arguments orally or in writing at a public hearing, he/she must make written request for a hearing and submit this request along with any written comments he/she has to Jim Murphy, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana, 59620. A written request for hearing must be received no later than June 9, 1995.

7. If the agency receives requests for a public hearing on

the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly 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 persons, based on the number of health officers in the State and the number of persons affected by the reporting requirements, including the control measures, in the State.

/s/ Mary L. Cain for Robert J. Robinson
ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995.

Reviewed by:
/s/ Eleanor J. Parker
Eleanor Parker, DHES Attorney

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

In the matter of the proposed adoption of two new rules and the amendment of ARM 24.21.411, related to apprenticeship programs	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF NEW RULES I AND II, AND AMENDMENT OF ARM 24.21.411

TO ALL INTERESTED PERSONS:

1. On June 2, 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 24.21.411, and the adoption of two new rules related to apprenticeship programs.

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., May 26, 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 24.21.411 as follows: (new matter underlined, deleted matter interlined)

24.21.411 MINIMUM GUIDELINES FOR REGISTRATION OF PROGRAMS

(1) Programs submitted for approval and/or registration by the apprenticeship and training ~~bureau~~ program (registration agency), ~~employment policy division~~ department of labor and industry, ~~will~~ must contain the following:

(a) Provision that the starting age of an apprentice ~~shall~~ may not be less than ~~sixteen (16)~~.

(b) Statement of basic qualifications for apprenticeship: specific and applying equally to all applicants.

(c) Provision for compliance with Title 29 C.F.R. Part 30, which includes the Montana state plan for equal employment opportunity in apprenticeship.

(d) Provision that the term of apprenticeship is consistent with industry practice, but in no case less than 2,000 hours of reasonably continuous employment, which ~~may~~ must include supplementary instruction except as otherwise provided by Montana state law.

(e) A schedule of work processes in which the apprentice will receive work experience and training on the job, and the allocation of the approximate amount of time to be spent in each

major process or division of the trade.

(f) Provision for proper supervision of on-the-job training.

(g) A progressively increasing schedule of wages for apprentices. The entry wage ~~shall~~ must equal or exceed the Montana Minimum Wage Law ~~of~~ or Fair Labor Standards Act minimum where applicable.

(h) Provision for the payment of wages that are consistent with the requirements of RULE II, if the apprenticeship is in a building construction occupation.

~~(h)~~ (i) Provision for organized related and supplemental instruction. This may include supervised correspondence or self-study courses as approved by state law. A minimum of 144 hours each year of apprenticeship is recommended.

~~(i)~~ (j) A statement of the ratio of apprentices to journeymen. The ~~apprenticeship and training bureau~~ registration agency will continue to honor and recognize ratio provisions as established in existing labor/management bargaining agreements or as established by an industry practice. The registration agency may waive ratio standards for apprenticeship sponsors who can demonstrate the need for a waiver due to labor shortages or other reasons deemed sufficient by the registration agency.

~~(j)~~ (k) Provision for periodic evaluation of the apprentice's progress, both in job performance and related instruction; and the maintenance of appropriate progress records.

~~(k)~~ (l) Provision for evaluation of and granting credit for previous experience.

~~(l)~~ (m) Provision for safety training for apprentices, both on the job and in related instruction.

~~(m)~~ (n) Provision that apprentices will be under a written agreement with their employer, or with an employers association, or a joint apprenticeship committee pursuant to state apprenticeship laws and regulations.

~~(n)~~ (o) Identification of the ~~"apprenticeship agency"~~ registration agency by whom apprentices, apprenticeship programs and subsequent amendments thereto will be approved and recorded.

~~(o)~~ (p) Provisions for notifying the ~~"Apprenticeship Agency"~~ registration agency of all actions affecting apprenticeship, such as new hires, completions, suspensions, and cancellations.

~~(p)~~ (q) Provision for employer-employee cooperation where a bargaining agreement exists, except where no participation has been evidenced or practiced by the bargaining agent. Where there is employer and employee participation it may be demonstrated by one or more of the following:

(i) Appropriate provisions in the bargaining agreement.

(ii) Signature to the standards.

(iii) Letter from each indicating agreement to the programs.

(iv) Establishment of a joint apprenticeship committee.

~~(q)~~ (r) Provision for recognition ~~for~~ of successful completion. Recognition is acknowledged by a Certificate of Completion of Apprenticeship.

AUTH: Sec. 39-6-101~~(2)(b)~~ MCA IMP: Sec. 39-6-106 MCA

REASON: There is reasonable necessity for amendment of this rule because the Department has recently received several requests for the proposed substantive amendments from employers that wished to participate in an apprenticeship program, but felt that they could not because of wage or other requirements. There is also reasonable necessity for the technical amendments, in order to correct terminology and conform to usage standards requested by the Secretary of State, Administrative Rules Bureau.

3. The Department of Labor and Industry proposes to adopt new rules as follows:

RULE I GUIDELINES FOR HIRING OF ADDITIONAL APPRENTICES

(1) An apprenticeship sponsor shall make reasonable efforts to encourage apprentices to complete the apprenticeship program.

(2) Before an apprenticeship sponsor may indenture a new apprentice, the sponsor shall offer to rehire any apprentice that had worked for the sponsor, but had been laid off or terminated without good cause.

(a) The registration agency may reject apprenticeship agreements submitted by apprenticeship sponsors who fail to provide proof of having offered to rehire apprentices that were laid off or terminated without good cause.

(b) An apprenticeship sponsor may demonstrate it had good cause for not rehiring a former apprentice. Good cause for not rehiring includes, but is not limited to:

(i) an offer of rehiring that is rejected by the former apprentice, if such offer is reasonable;

(ii) the former apprentice is unavailable for work within a reasonable period of time as determined by the circumstances for the rehiring; or

(iii) the former apprentice cannot be located after a diligent search by the apprenticeship sponsor.

(c) The following are examples of reasons that do not constitute good cause for not rehiring a former apprentice:

(i) the sponsor's inability to pay the former apprentice at the level which is appropriate for the training and education completed by that apprentice;

(ii) the rejection by the former apprentice of an offer for rehiring that is short term or of limited duration which is not reasonably calculated to provide employment for the former apprentice through the remainder of the apprenticeship program;

(iii) the rejection by the former apprentice of an offer for rehiring having conditions that require violation of the terms of the apprenticeship agreement and/or apprenticeship standards; or

(iv) the rejection by the former apprentice of an offer for rehiring which imposes conditions that require an apprentice to knowingly assist or participate in illegal activity.

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

RULE II 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.

(5) The department will publish the apprentice wage rates provided by (3) and (4). A copy of the wage rate publication is available from the apprenticeship training program, 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 the adoption of proposed new rule I, in order to clarify circumstances when an apprentice can be added, and in order to make sure that sponsors do not take unfair competitive advantage by abusing an apprenticeship program by only using low-paid apprentices. There is reasonable necessity for the adoption of proposed rule II, in order to provide for wage rates for apprenticeships in the building construction trades that balance the interests of union and non-union employers and apprentices, and balance the interests of urban and non-urban employers and apprentices. Rule II also provides a mechanism to recognize certain apprenticeable building trade occupations that are not included in the prevailing wage survey. Proposed rule II will not be effective until the department surveys employers and holds a rule-making hearing on the wage rates payable for apprentices in the non-urban areas. The survey is expected to be completed by September 1, 1995, and a public hearing on the wage rates is expected to be held in October, 1995. The proposed new rules were requested by various interested members of the public and are being proposed in response to those requests. As part of its response to the requests, the Department sought input from those members of the public and other interest parties, who provided advice to the Department on the new rules and the amendments to ARM 24.21.411, above.

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:

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., June 9, 1995.

5. The Department proposes to make the new rules and the amendment effective August 1, 1995. The Department reserves the right to adopt only portions of the proposed rule or proposed amendment, or to adopt some or all of the proposals at a later date.

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

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: May 1, 1995.

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

In the matter of the adoption of a new rule establishing procedures for collecting processing fees for late claims	)))))	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On June 30, 1995, the Department of Natural Resources and Conservation proposes to adopt a rule which establishes procedures for collecting processing fees for late claims.

2. The proposed Rule I provides as follows:

RULE I PAYMENT DATE FOR FILING OF LATE CLAIMS (1) For a statement of claim filed after April 30, 1982, but prior to July 1, 1993, the $150 processing fee must be paid to the department. The department shall give notice of payment due by mailing a billing invoice to the current late claim owner or owners as documented in the department's records. If payment is not received within 30 days the department shall send a second notice by certified mail. If the processing fee is not received within 45 days of the second notice the department shall add a remark to the claim stating: "No processing fee has been received for this claim rendering the claim subject to termination by the Water Court for failure to pay the appropriate processing fee." This remark will also be added to any late claim for which the department is unable to determine a correct address or new owner for a billing invoice that is undeliverable by United States mail. The department will complete its mailing notifications under this rule prior to June 30, 1996.

(2) For a statement of claim filed by a state agency from April 30, 1982 to July 1, 1996, the $150 processing fee must be paid to the department. The department will notify the state agency by billing invoice of the processing fee. The state agency must pay the processing fee to the department by July 30, 1997.

(3) A processing fee is not required for a statement of claim for a right exempt under the provisions of 85-2-222, MCA.

AUTH: 85-2-225, MCA
IMP: 85-2-225, MCA

3. This rule is proposed because chapter 629, L. 1993, requires the Department of Natural Resources and Conservation to establish a rule providing a payment date by which a fee for either a statement of claim filed after April 30, 1982, but prior to July 1, 1993, or a statement of claim filed by a

state agency after April 30, 1982 to July 1, 1996, must be paid.

4. Interested parties may submit their data, views or arguments concerning the proposed rule in writing to Bob Arrington, Department of Natural Resources and Conservation, 1520 E. Sixth Avenue, Helena, MT 59620, on or before June 16, 1995.

5. If a person who is directly affected by the proposed adoption 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 Bob Arrington, Department of Natural Resources and Conservation, 1520 E. Sixth Avenue, Helena, MT 59620. The comments must be received on or before June 16, 1995.

6. 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 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 late claims received by the agency to date.

Mark A. Simonich, Director

Donald D. MacIntyre, Rule Reviewer

Certified to the Secretary of State April 27, 1995

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

In the matter of the amendment of rule 46.12.3803 pertaining to medically needy income standards	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.3803 PERTAINING TO MEDICALLY NEEDY INCOME STANDARDS

TO: All Interested Persons

1. On June 1, 1995, at 10:00 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 rule 46.12.3803 pertaining to medically needy income standards.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.12.3803 MEDICALLY NEEDY INCOME STANDARDS Subsections (1) through (3)(a) remain the same.

(b) Institutionalized recipients must also meet the income criteria of ARM 46.12.4008.

MEDICALLY NEEDY INCOME LEVELS
FOR SSI and AFDC-RELATED INDIVIDUALS
AND FAMILIES

Family Size	One Month Net Income Level	
1	$ ~~446~~	458
2	~~450~~	458
3	~~475~~	485
4	~~499~~	511
5	~~583~~	597
6	~~667~~	684
7	~~750~~	771
8	~~834~~	857
9	~~876~~	900

10	~~915~~	941
11	~~951~~	977
12	~~986~~	1,013
13	~~1,017~~	1,046
14	~~1,046~~	1,076
15	~~1,075~~	1,106
16	~~1,101~~	1,132

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

3. The income standards to determine eligibility for medically needy assistance are based on the standards used in the most closely related cash assistance program, which is the Aid to Families with Dependent Children (AFDC) program. The AFDC payment standards are set at 40.5% of the federal poverty level and are being increased effective July 1, 1995, to reflect recently published increases in the federal poverty levels for 1995. It is therefore necessary to amend ARM 46.12.3803 to increase the medically needy standards also.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rules 46.12.590 through 46.12.593 and 46.12.599 pertaining to medicaid residential treatment services	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.590 THROUGH 46.12.593 AND 46.12.599 PERTAINING TO MEDICAID RESIDENTIAL TREATMENT SERVICES

TO: All Interested Persons

1. On May 31, 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 46.12.590 through 46.12.593 and 46.12.599 pertaining to medicaid residential treatment services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. 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:

46.12.590 RESIDENTIAL TREATMENT SERVICES, PURPOSE AND DEFINITIONS Subsections (1) and (2) remain the same.

(a) "Residential treatment services" means ~~services that are~~ residential psychiatric care provided in accordance with these rules and applicable state and federal requirements, including but not limited to 42 CFR sections 440.160 and 441.150 through 441.156, which provide definitions and program requirements and which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. Residential treatment services are services that meet ~~those provisions~~ the requirements of these rules and the above-cited federal regulations and are provided in a residential treatment facility that is devoted to the provision of residential psychiatric care for persons under the age of 21.

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

~~(h) "Estimated economic life" means the estimated remaining period during which the property is expected to be economically usable by one or more users, with normal repairs~~

~~and maintenance, for the purpose for which it was intended when built.~~

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

(~~j~~i) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility under the direction of a physician, to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity as to require twenty-four hour supervised care to adequately treat or remediate their condition. Residential psychiatric care must be individualized~~,~~ and designed to achieve the patient's discharge to a less restrictive levels of care at the earliest possible time. Residential psychiatric care includes only treatment or services provided in accordance with all applicable licensure, certification and accreditation requirements and these rules.

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

~~(1) Payment for residential treatment services provided outside the state of Montana is subject to the requirements of ARM 46.12.502(3).~~

Subsections (2)(m) and (2)(n) remain the same in text but are renumbered (2)(k) and (2)(l).

(o~~m~~) "Beds available" means the number of residential treatment beds for which the facility has been licensed by the department of health and environmental sciences.

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

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

~~(4) Medicaid reimbursement is not available for services until and unless a complete and accurate certification of need for services, as defined in 42 CFR 441.152(a) and 153, has been completed:~~

~~(a) prior to admission, for an individual who is a recipient of medicaid when admitted to the facility; or~~

~~(b) for individuals applying for medicaid while in the facility, within 14 days after an eligibility determination and covering the entire stay in the facility.~~

~~(5) The provider must notify the department's designated review organization of each admission of a medicaid-eligible individual within 3 working days of the admission, or, if medicaid eligibility is determined after admission, within 14 days after the eligibility determination. If the provider fails to notify the review organization within the time specified in this subsection, the department shall deny reimbursement for the period from admission to the actual date of notification.~~

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-139 and 53-6-141 MCA

46.12.591 RESIDENTIAL TREATMENT SERVICES, PARTICIPATION REQUIREMENTS (1) These requirements are in addition to those contained in ~~ARM 46.12.301 through 46.12.309~~ rule provisions generally applicable to medicaid providers.

(2) ~~Providers of r~~Residential treatment services ~~are eligible for reimbursement under~~ providers, as a condition of participation in the Montana medicaid program ~~if they~~ must meet the following requirements:

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

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-139 and 53-6-141 MCA

46.12.592 RESIDENTIAL TREATMENT SERVICES, REIMBURSEMENT (1) ~~The reimbursement period will be the provider's fiscal year.~~ For residential treatment services, the Montana medicaid program will pay a provider for each patient day the allowable cost incurred, determined on a retrospective basis, subject to an upper limit which will be the lesser of~~:~~

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

~~(b)~~ medicaid allowable costs per patient day as determined in accordance with this section, subject to the ceiling established in this section. The reimbursement period will be the provider's fiscal year.

(a) Medicaid payment is not allowable for treatment or services provided in a residential treatment facility that are not within the definition of residential psychiatric care in ARM 46.12.590 and unless all other applicable requirements are met.

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

(4) Payment for residential treatment services provided outside the state of Montana is subject to the requirements of ARM 46.12.502. Reimbursement for residential treatment services provided to medicaid patients in facilities located outside the state of Montana will be limited to the lesser of:

Subsections (4)(a) and (4)(b) remain the same.

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

Subsections (5)(a) through (5)(c) remain the same.

(d) Base period allowable educational and vocational training costs shall be determined separately from other provider costs. The base period for educational and vocational training costs is the provider's first full 12-month cost reporting period in the Montana medicaid program ending on or after December 21, 1993. A base period educational and vocational training cost per patient day shall be determined by dividing the total allowable ~~medicaid~~ educational and vocational training costs for the base period by the ~~total~~ number of ~~medicaid~~ total patient days in the base period. In cost

reporting years after the base period, reimbursement for educational and vocational training costs shall be subject to a ceiling on the rate of increase in costs per patient day. The ceiling shall be established as provided in subsection (6).

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

(d) Base period and subsequent costs subject to the ceilings as described in this subsection will be determined on a cost per patient day basis. Total Aallowable ~~medicaid~~ costs as defined in subsection (2) will be divided by the ~~total~~ number of ~~medicaid~~ total patient days to determine the cost per patient day.

Subsections (6)(e) through (14) remain the same.

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

46.12.593 RESIDENTIAL TREATMENT SERVICES, COST REPORTING AND AUDITS Subsections (1) through (1)(g) remain the same. ~~(2) A provider may object to audit findings through the administrative review and fair hearing process as provided in ARM 46.12.509A.~~

AUTH: Sec. 2-4-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

46.12.599 ~~INPATIENT PSYCHIATRIC~~ RESIDENTIAL TREATMENT SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW AND CONTROL AND INSPECTIONS OF CARE (1) Prior to admission and as frequently as the department ~~or its designated agent~~ may deem necessary, the department or its ~~designated~~ agents ~~will~~ may evaluate the medical necessity and quality of services for each medicaid recipient. ~~patient, in accordance with 42 CFR sections 441.150 through 441.156, 456.3, 456.150 through 456.245 and 456.600 through 456.614, which are federal regulations which set forth utilization review and control criteria and which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210.~~

(a) In addition to the other requirements of these rules, Tthe provider ~~shall make available~~ must provide to the department or its ~~designated~~ agent upon request any records related to ~~recipients admission and/or~~ services or items provided to a medicaid recipient.

(b) The department may contract with and designate public or private agencies or entities, or a combination of public and private agencies and entities, to perform utilization review, inspections of care and other functions under this section as an agent of the department. Any contracted or designated agent must meet the requirements of this section. The department must give residential treatment services providers advance written

notice of a change in the designated agent. The notice must specify the scope of the agent's duties, the geographical area of the agent's authority and the agent's name, address, telephone number and facsimile number.

(2) Medicaid reimbursement is not available for residential treatment services unless the provider submits to the department's utilization review agent in accordance with these rules a complete and accurate certificate of need for services that complies with the requirements of 42 CFR part 441, subpart D and these rules.

(a) For recipients determined medicaid eligible by the department as of the time of admission to the facility, the certificate of need must:

(i) be completed, signed and dated prior to, but no more than 15 days before, admission; and

(ii) be made by an independent team of health care professionals that includes a physician, that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry and that has knowledge of the recipient's situation, including the recipient's medical condition.

(b) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need must:

(i) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the stay in the facility; or

(B) 90 days after the eligibility determination for recipient's determined eligible after discharge from the facility;

(ii) cover the recipient's stay from admission through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care as specified in 42 CFR 441.155 and 441.156 (1994).

(c) All certificates of need must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(3) Providers must request admission or initial authorization and continued stay authorizations from the department's utilization review agent for each recipient. Medicaid reimbursement is not available for residential treatment services if the portion of the recipient's stay at the facility for which reimbursement is claimed has not been authorized by the department's utilization review agent.

(a) Prior to admission of a medicaid recipient, the provider must submit to the department's utilization review agent a request for admission authorization and must submit the required certificate of need and supporting documentation. The request, certificate of need and supporting documentation must be received by the department's utilization review agent prior to admission.

(b) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the provider must submit to the department's utilization review agent a request for an initial authorization and must submit the certificate of need and supporting documentation. The request, certificate of need and supporting documentation must be received by the department's utilization review agent within 14 days after the department's eligibility determination.

(c) For additional periods of the recipient's stay after the period covered by the initial or admission authorization, the provider must request a continued stay authorization and must submit supporting documentation. The request and supporting documentation must be received no more than 5 and no less than 2 days before the end of the previous authorized span.

(4) The department's utilization review agent must review an admission or initial authorization request or a continued stay authorization request, make a determination on the request and notify the provider and the recipient's parent or guardian of any adverse determination within 3 working days of receipt of a request, unless the provider has not submitted the documentation or information necessary to make a determination. The agent must transmit authorization information regarding authorized spans to the department's fiscal agent within 3 working days of a determination.

(a) If the provider's request is incomplete, the agent must notify the provider, within 1 working day of receipt of an incomplete request, that the request is incomplete and must identify the additional information or documentation necessary to make a determination. Such notification by the agent to the provider is not required if the provider's request indicates that the provider will be sending additional documentation or information to support the request, in which case the burden shall be upon the provider to submit the additional documentation or information or to notify the agent in writing that nothing further will be sent and that the provider requests the agent to make a determination upon the request as submitted.

(5) If the department's utilization review agent in whole or in part denies an admission or initial authorization request or a continued stay authorization request, the provider or the recipient's parent or guardian may within 10 days of the date of the notice request that the department's utilization review agent conduct an informal reconsideration of the determination. The agent may include in the informal reconsideration a peer to peer review and must include a peer to peer review if requested by the provider in its request for informal reconsideration. A peer to peer review must be scheduled by the agent to be held within 10 days of the request for informal reconsideration, but may be scheduled at a later time with the provider's written consent.

(a) The agent may request additional supporting information or documentation. The information and documentation presented by the provider may include only information documented in the recipient's medical record as of the date of admission or end of the most recent previous authorized span.

The agent may not consider information that is not documented in the recipient's medical record.

(b) The agent must make a determination on the informal reconsideration and notify the provider and the recipient's parent or guardian of the determination within 3 working days after the agent has received the written request and supporting documentation, including any additional documentation or information requested by the agent and completed the peer to peer review, if any.

(c) A provider, parent or guardian dissatisfied with the determination on informal reconsideration may request an administrative review according to the provisions of ARM Title 46, chapter 2, subchapter 2. A provider or a recipient's parent or guardian that does not timely request an informal reconsideration will be deemed to have accepted the agent's determination and is not entitled to any further notice or appeal opportunity.

(6) The requests, submissions and notifications required by this section must be made as follows:

(a) Providers must make the required notifications, submissions and requests to the department's utilization review agent by facsimile transmission. Required certificates of need, supporting documentation and similar materials must be submitted by written facsimile transmission or overnight mail.

(b) The department's utilization review agent must notify the provider and the recipient's parent or guardian in writing of any adverse determination on an initial authorization request, a continued stay authorization request, an informal reconsideration request or an administrative review request. A notice must be addressed separately to the provider and to the recipient's parent or guardian. The agent must transmit the provider notice by facsimile and send the original to the provider by U.S. mail. The agent must notify the recipient's parent or guardian by U.S. mail.

(c) A notice under subsection (6)(b) must contain the following:

(i) the recipient's name and medicaid identification number as reported to the agent by the provider;

(ii) a statement of the determination, including the specific dates necessary to identify any period authorized or denied and the date of the determination;

(iii) a short and concise statement of the reasons for the denial, if any;

(iv) a reference to the legal authority supporting the determination; and

(v) an explanation of how to appeal the determination.

(d) If the agent fails to provide notice, or fails to timely provide notice, or if a notice under subsection (6)(b) fails to comply substantially with the requirements of subsection (6)(c), the remedy shall be provision of a new notice which does comply substantially with subsection (6)(c) and a new opportunity to contest the determination specified in the notice. A failure to give adequate or timely notice under subsection (6)(b) shall not entitle the provider or recipient to

an authorization. A provider or recipient is not entitled to an authorization absent a showing and determination of medical necessity.

(7) When required to be submitted under this rule, supporting documentation includes all or any portion of the recipient's medical record as necessary to demonstrate the medical necessity of residential treatment services and where the context allows, includes a certificate of need conforming with the requirements of subsection (2).

(8) Providers must maintain written documentation of authorization requests submitted under this rule, including but not limited to certificates of need, written request letters or memoranda and evidence of submission dates.

(9) Medicaid reimbursement is not available for any portion of a medicaid recipient's stay in a facility that occurs prior to meeting the requirements of subsections (3) through (3)(c).

(10) If the department's utilization review agent fails to timely review a request for authorization or timely make a determination on an authorization or informal reconsideration request, the provider may make written inquiry to the agent regarding the status of the matter. If the provider does not receive a satisfactory response within a reasonable time, the provider may contact the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 for assistance is obtaining a determination.

(11) An authorization by the department or its utilization review agent under this section is not a final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time.

(12) In accordance with 42 CFR part 456, subpart I (1994), the department or its agents may conduct periodic inspections of care in residential treatment facilities participating in the medicaid program.

AUTH: Sec. 2-4-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

3. The proposed changes to the residential treatment services rules are necessary to revise the current rules to specify procedures and requirements for prior authorization of admission to and continued stay in a residential treatment facility for medicaid reimbursement purposes. The changes are also necessary to more clearly and completely reflect department policy and procedures and to more accurately specify the requirements applicable to providers under federal law and regulations.

The proposed changes to ARM 46.12.599 are necessary to specify in detail the procedures and requirements for prior authorization of admission to and continued stay in a

residential treatment facility for medicaid reimbursement purposes. Prior authorization currently is required, but the requirements and procedures are not specifically described in the rule. The proposed rules will assist the department in administering the requirements in this service area and will assist providers in better understanding their responsibilities and what they can expect from the department and its review agents. The department believes that these proposed rules will significantly reduce the number of disputes arising from procedural problems in the prior authorization process.

The proposed changes to ARM 46.12.599(1) would remove the incorporation of certain federal regulations. The list of regulation incorporated includes inapplicable regulations and is also incomplete in not including references to other department rules that may apply. The department does not believe that incorporation of applicable rules and regulations is necessary, because the pertinent authorities are already set forth in rules and regulations that are binding without incorporation by reference. These proposed changes also specify the current department policy that the provider must provide records to the department or its agent upon request, rather than simply making the records available.

Proposed ARM 46.12.599(1)(b) addresses the department's use of contracted entities, including public and private entities, to perform utilization review, including prior authorization and other activities for the department under the rule. The rule reiterates the department's authority to contract, but specifies that any contracted agent must meet the requirements of the section, i.e., the requirements for communicating decisions and notices to providers, the timeframes provided for making decisions and notifying providers and other matters. In addition, the rule specifies that the department must notify providers in writing of any change in the designated agent and provide certain information necessary for the provider to comply with the rule. This rule will address current problems noted by providers in understanding the roles of various entities in the process and in lack of uniform practices in different areas of the state.

Proposed ARM 46.12.599(2) is necessary to specify the requirements applicable to certificates of need which must be submitted in all cases. The proposed rule would incorporate, with revisions, material moved from current ARM 46.12.590(4), the definition section of the rules. The proposed rule specifies that the provider is responsible for submission of a complete and accurate certificate of need. The rule is necessary to specify the time within which the certificate of need must be completed, who must complete it and how it must be signed.

Proposed ARM 46.12.599(3) through (11) are necessary to specify the process for providers to request and obtain the required

prior authorizations. The proposed rules would incorporate, with revisions, material moved from current ARM 46.12.590(5), the definition section of the rules. The proposed rule would specify the method by which a prior authorization must be requested, when it must be requested, the items that must be submitted with the request.

The proposed rule would specify how the request must be handled by the department's review agent, including the time within which the request must be reviewed and determined and the provider and recipient's parent or guardian notified and the time within which prior authorization information must be submitted to the department's fiscal agent. The proposed rule specifies that under certain circumstances the agent must notify providers of incomplete requests and what information is missing. The proposed rule specifies the appeal procedures available to providers, parents and guardians that wish to contest a determination by the agent or the department.

The proposed rule is necessary to specify the methods by which requests, decisions, information and documentation are transmitted between providers and the department's agent. This has been a significant issue and the department believes that the proposed rule will resolve this issue. The rule also provides for retention of certain records, which will assist in resolving any issue as to when a request was made and the contents of the request. The rule specifies the information that must be included in decisions by the agent or department. The proposed rules are necessary to specify the effect of a prior authorization and of failure to comply with certain provisions of the rules.

Proposed ARM 46.12.599(12) is necessary to specify the department's authority to conduct federally required inspections of care in residential treatment facilities.

The proposed changes to ARM 46.12.590 are necessary to more completely and accurately specify the requirements applicable to residential treatment services. In addition to certain federal regulations, other provisions in the department's rules apply to the service. The definition of "estimated economic life" would be removed because federal medicare guidelines incorporated under ARM 46.12.592 more specifically and accurately describe the concept for purposes of allowable depreciation costs. The definition of "residential psychiatric care" would be revised to include the federal requirement of physician direction of services. The definition also would explicitly state the implication already contained in ARM 46.12.591, that the requirements for licensure, certification and/or accreditation mean that the service must be provided in accordance with the requirements for licensure, certification and accreditation. Other proposed changes to this rule are necessary to move items to more appropriate rule sections.

The proposed change to ARM 46.12.593 is necessary to remove an implication in the current rule that audit adjustments are subject to a hearing process separate from the hearing process available for any resulting overpayment or underpayment determination. Under the proposed rule, the provider would be entitled to administrative review and fair hearing, under ARM 46.12.509A, on a determination by the department that the provider was overpaid or if the provider believed that it was entitled to greater amount of payment than determined by the department, including on any issues related to underlying audit adjustments upon which the determination was based. The proposed change would avoid the implication that separate hearings will be held on the adjustments and then on the resulting determination.

The proposed changes to ARM 46.12.591 and 46.12.592 are necessary to revise rule language for clarity, to accurately reflect department policy and practice and to include items moved from other rule sections.

The department does not anticipate that any significant financial impact will result from the proposed changes. The medicaid advisory committee will be informed of the proposed changes on July 20, 1995. Copies of this rule notice may be obtained at local county human services offices.

4. The proposed rules will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rules 46.12.503 through 46.12.509 pertaining to medicaid inpatient and outpatient hospital services	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.503 THROUGH 46.12.509 PERTAINING TO MEDICAID INPATIENT AND OUTPATIENT HOSPITAL SERVICES

TO: All Interested Persons

1. On May 31, 1995, at 1:30 p.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 46.12.503 through 46.12.509 pertaining to medicaid inpatient and outpatient hospital services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. 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:

46.12.503 INPATIENT HOSPITAL SERVICES, DEFINITION

(1) "Inpatient hospital services" means services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, ~~or~~ dentist or other practitioner as permitted by federal law, and that are furnished in an institution that:

Subsection (1)(a) remains the same.

(b) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located~~.~~; and

(c) except as otherwise permitted by federal law, meets the requirements for participation in medicare as a hospital and has in effect a utilization review plan that meets the requirements of 42 CFR 482.30.

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

(g) medical or surgical services provided by interns or residents-in-training in hospitals with teaching programs approved by the Council on Medical Education of the American Medical Association, the Bureau of Professional Education of the American Osteopathic Association, ~~or~~ the Council on Dental

Education of the American Dental Association or the Council on Podiatry Education of the American Podiatry Association.

(3) "Inpatient" means a ~~patient who is receiving professional services and board and room in a licensed hospital on a 24-hour-a-day basis~~ person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person generally is considered an inpatient if formally admitted as an inpatient with an expectation that the patient will remain more than 24 hours. The physician or other practitioner is responsible for deciding whether the patient should be admitted as an inpatient. Inpatient hospital admissions are subject to retrospective review by the medicaid peer review organization (PRO) to determine whether the inpatient admission was medically necessary for medicaid payment purposes.

(4) "Sole community hospital" is a hospital classified as such by the federal health care financing administration (HCFA) in accordance with 42 CFR 412.92(a) through (d) (1986) and/or hospitals with less than 51 beds.

Subsections (5) through (18) remain the same.

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

46.12.504 INPATIENT HOSPITAL SERVICES, REQUIREMENTS

(1) These requirements are in addition to those contained in ~~ARM 46.12.301 through 46.12.309~~ rule provisions generally applicable to medicaid providers.

(2) Except as otherwise permitted by federal law, ~~I~~inpatient hospital services must be ordered by a physician or dentist licensed under state law.

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

(4) Inpatient hospital services provided outside the borders of the United States will not be reimbursed by the Montana medicaid program.

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

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

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

~~(d) Inpatient hospital services provided outside the borders of the United States will not be reimbursed by the Montana medicaid program.~~

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

(c) The department computes a Montana average base price per case. This average base price per case is ~~$1,887.86~~ $1,944.50, effective beginning July 1, ~~1994~~ 1995.

Subsections (2)(d) through (8)(d) remain the same.

(i) Providers will receive the base DRG payment and any appropriate outlier payments for each catastrophic case through the regular claims payment process, and, subject to settlement

as provided in subsections (ii) and (iii), shall ~~also~~ receive an amount equal to ~~60% of~~ the estimated cost for the inpatient hospital stay less the base DRG payment amount and any applicable outlier payment amounts.

(ii) After the end of the state fiscal year ~~and before the following September 30,~~ the department will determine the total catastrophic case payment to which the provider is entitled as provided in subsection (iii) for each catastrophic case claim submitted during the fiscal year, and shall ~~reimburse providers no later than September 30 for any underpayment, or shall~~ recover any overpayment as provided in ARM 46.12.509(6).

(iii) The total available catastrophic funds, will be apportioned to the eligible cases, except that no payment for any individual case will exceed the maximum payment described in subsection (c). If sufficient catastrophic case funds are not available, the provider ~~may receive an additional~~ payment for each catastrophic case claim submitted for the fiscal year will be adjusted to reduce the payment, so that the provider receives a proportionate share of the remaining available catastrophic funds for each claim, subject to the maximum payment described in subsection (c). Proportionate shares shall be determined so that all claims submitted by providers are reimbursed at the same percentage of the estimated cost for the inpatient stay.

(iv) Based on the estimate of ~~26,844~~ 16,000 DRG discharges in state fiscal year ~~1994~~ 1996, the funds available for catastrophic cases, including the base DRG, add-ons and outlier amounts, is estimated to be ~~$4,441,000~~ $1,800,500. For state fiscal year ~~1995~~ 1997, the estimate is ~~31,676~~ 16,000 DRG discharges and total catastrophic case funds of ~~$5,502,000~~ $1,852,500. Should the number of DRG discharges vary from the estimate, then the available catastrophic funds will vary proportionately. The state is under no obligation to disburse all available catastrophic case funds if there are an insufficient number of claims that qualify for the payments.

Subsections (9) through (13) remain the same.

(14) The Montana medicaid DRG relative weight values, average length of stay (ALOS), outlier thresholds and stop loss thresholds are contained in the DRG table of weights and thresholds (~~1994~~ 1995 edition). The DRG table of weights and thresholds is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the DRG table of weights and thresholds (April ~~1993~~ 1995 edition). Copies may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

Subsections (15) through (17) remain the same.

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

46.12.506 OUTPATIENT HOSPITAL SERVICES, DEFINITION (1) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician, ~~or~~ dentist or other practitioner as permitted by federal law, by an institution that:

(a) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

(b) except as otherwise permitted by federal law, meets the requirements for participation in medicare as a hospital.

(2) "Outpatient" means a ~~patient who is not receiving board and room and professional services on a 24-hour-a-day basis.~~ person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services in the hospital for less than 24 hours, who is registered on the hospital records as an outpatient and who receives outpatient hospital services, other than supplies alone, from the hospital.

(3) "Diagnostic service" means an examination or procedure performed on an outpatient or on materials derived from an outpatient to obtain information to aid in the assessment or identification of a medical condition.

(4) "Imaging service" means diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultra-sound, and other imaging procedures.

(5) "Partial hospitalization services" means partial hospitalization as defined in the Montana medicaid partial hospitalization policy (May 1995 edition). The department adopts and incorporates by reference the Montana medicaid partial hospitalization policy (May 1995 edition). A copy of the policy may be obtained through the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(6) "Full-day partial hospitalization program" means a partial hospitalization program providing services at least 6 hours per day, 5 days per week.

(7) "Half-day partial hospitalization program" means a partial hospitalization program providing services for at least 4 but less than 6 hours per day, at least 4 days per week.

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

46.12.507 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) These requirements of ARM 46.12.506 through 46.12.509 are in addition to those ~~found~~ contained in ~~ARM 46.12.301 through 46.12.309~~ rule provisions generally applicable to medicaid providers.

~~(2) Cardiac rehabilitation exercise programs and other programs primarily educational in nature are not a benefit.~~

(2) Outpatient hospital services do not include:

(a) Services excluded from coverage by the medicaid program under ARM 46.12.502;

(b) exercise programs and programs primarily educational in nature, including but not limited to:

(i) cardiac rehabilitation exercise programs;

(ii) diabetic education and nutritional programs;

(iii) independent exercise programs, such as pool therapy, swim programs, or health club memberships; or

(c) outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy as defined in ARM 46.12.525.

(3) Outpatient hospital services are services that would also be covered by medicaid if provided in a non-hospital setting and are limited to~~:~~ the following diagnostic and therapeutic services furnished by hospitals to outpatients:

~~(a) emergency room services;~~

~~(b) services provided in a hospital that would also be covered by medicaid in a non-hospital setting;~~

(a) diagnostic services, including:

(i) the services of nurses, psychologists and technicians;

(ii) drugs and biologicals;

(iii) laboratory and imaging services;

(iv) psychological tests;

(v) supplies and equipment; and

(vi) other tests to determine the nature and severity of a medical condition;

(b) therapeutic services and supplies, including:

(i) emergency room services;

(ii) clinic services; and

(iii) the use of hospital facilities incident to provision of physician services to the patient where the services and supplies are furnished in the hospital on a physician's order by hospital personnel under the supervision of hospital medical staff;

(c) air transport ambulance services for neonates (age 0 to 28 days, DRGs 385-390) and women with high risk pregnancies (DRGs 370, 372, 375 or 383), as provided in ARM 46.12.1025; ~~and~~

(d) chemical dependency treatment services~~.~~; and

(e) services provided outside the hospital, as follows:

(i) diagnostic services provided by hospital personnel outside the hospital premises with or without direct personal supervision of a physician;

(ii) therapeutic services that are incident to physician services and provided under the direct personal supervision of a physician.

(4) Outpatient hospital services provided outside the borders of the United States will not be covered or reimbursed by the Montana medicaid program.

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

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT (1) The department will reimburse for outpatient hospital services compensable under the Montana medicaid program as ~~follows:~~ provided in this section.

(~~a~~2) Except for the services reimbursed as provided in subsections (3) through (9), Aall facilities will be reimbursed on a retrospective basis. Allowable costs will be determined in accordance with ARM 46.12.509(2) and subject to the limitations specified in ARM 46.12.509(2)(a), (b) and (c). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000 for inpatient and outpatient hospital services provided to Montana medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the department waives retrospective cost settlement, the provider's interim payments for the cost report period shall be the provider's final payment for the period.

~~(b) Outpatient hospital services provided outside the borders of the United States will not be reimbursed by the Montana medicaid program.~~

(~~i~~a) All facilities will be reimbursed for services subject to subsection (2) on an interim basis during the facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the facility's medicare intermediary or by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If a provider fails or refuses to submit the financial information, including the medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 60% of its usual and customary charges.

(3) Except as otherwise specified in these rules, the following outpatient hospital services will be reimbursed under a prospective payment methodology for each service as described in subsections (4) through (9) of this rule.

(4) Clinical diagnostic laboratory services will be reimbursed on a fee basis as follows:

(a) The fee for a clinical diagnostic laboratory service is the lower of the provider's usual and customary charge or the applicable percentage of the medicare fee schedule as follows:

(i) 60% of the prevailing medicare fee schedule where a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are non-hospital patients;

(ii) 62% of the prevailing medicare fee schedule for a hospital designated as a sole community hospital as defined in ARM 46.12.503;

(iii) 60% of the prevailing medicare fee schedule for a hospital that is not designated as a sole community hospital as defined in ARM 46.12.503;

(b) For clinical diagnostic laboratory services where no medicare fee has been assigned, the fee is 60% of usual and customary charges for a hospital designated as a sole community hospital as defined in ARM 46.12.503 or 62% of usual and

customary charges for a hospital that is not designated as a sole community hospital as defined in ARM 46.12.503.

(c) For purposes of subsection (4), clinical diagnostic laboratory services include the laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology, Fourth Edition (CPT-4). Certain tests are exempt from the fee schedule. These tests are listed in the HCFA Pub-45, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology specified in subsection (2).

(d) Specimen collection will be reimbursed separately for drawing a blood sample through venipuncture or for collecting a urine sample by catheterization. The fee for specimen collection is the lower of the provider's usual and customary charges or $3.00 per patient visit, whether or not the specimens are referred to physicians or other laboratories for testing. No more than one collection fee may be allowed for each patient visit, regardless of the number of specimens drawn.

(5) Reimbursement for imaging services will be based on the medicare resource-based relative value scale (RBRVS). The medicaid fees for imaging services are as specified in the medicaid outpatient hospital imaging services fee schedule (May 1995 edition). The imaging services reimbursed under this subsection are the individual imaging services listed in the 7000 series of the Current Procedural Terminology, Fourth Edition (CPT-4). Procedure codes for imaging services subject to this subsection are those listed in Addendum I to Chapter VII, Bill Review, of the Medicare Part A Intermediary Manual, Part 3 (HCFA Pub. 13-3). The medicaid outpatient hospital imaging services fee schedule (May 1995 edition) is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the medicaid outpatient hospital imaging services fee schedule (May 1995 edition). Copies may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(6) Reimbursement for other diagnostic services will be based on the medicare resource-based relative value scale (RBRVS). The medicaid fees for other diagnostic services are as specified in the medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition). The individual diagnostic services reimbursed under this subsection are those listed in the Current Procedural Terminology, Fourth Edition (CPT-4). Procedure codes for other diagnostic services subject to this subsection are listed in Addendum K to Chapter VII, Bill Review, of the Medicare Part A Intermediary Manual, Part 3 (HCFA Pub. 13-3). The medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition) is published by the department of social and rehabilitation services. The department hereby adopts and incorporates by reference the medicaid outpatient hospital other diagnostic services fee schedule (May 1995 edition). Copies may be obtained from the Department of Social and Rehabilitation Services, Medicaid

Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(7) Non-emergent emergency room services provided to a PASSPORT recipient, when the PASSPORT provider has not authorized the services, will be reimbursed a prospective fee of $20 per emergency room visit. The fee is a bundled payment per visit for all outpatient services provided to the patient including, but not limited to, pharmacy, supplies, imaging, clinical diagnostic laboratory and other diagnostic services.

(8) Dialysis visits will be reimbursed at the provider's medicare composite rate for dialysis services determined by medicare under 42 CFR subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department hereby adopts and incorporates herein by reference Pub. 15. A copy of Pub. 15 may be obtained through the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(9) Partial hospitalization services will be reimbursed on a prospective per diem rate basis as follows:

(a) The per diem rate for full-day programs, as defined in ARM 46.12.506, is $196 per day.

(b) The per diem rate for half-day programs, as defined in ARM 46.12.506, is $147 per day.

(c) The per diem rates specified in subsections (9)(a) and (b) are bundled prospective per diem rates for full-day programs and half-day programs, as defined in ARM 46.12.506. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, therapies, nurses, social workers, psychologists, licensed professional counselors and other outpatient services, except as provided in subsection (9)(d).

(d) Physician services, including psychiatrist services, are separately billable according to the applicable department rules governing billing for physician services.

(e) All partial hospitalization services for full-day programs and half-day programs, as defined in ARM 46.12.506, require prior authorization as required in ARM 46.12.509.

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

46.12.509 ALL HOSPITAL REIMBURSEMENT, GENERAL Subsections (1) through (1)(a)(i)(C) remain the same.

(D) services related to organ transplantations covered under ARM 46.12.583 and 46.12.584; or

(E) outpatient partial hospitalization ~~or day treatment services; or~~.

~~(F) outpatient hospital chemical dependency treatment services.~~

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

AUTH: Sec. 2-4-201, 53-2-201, and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141 MCA

3. The proposed changes to the medicaid inpatient and outpatient hospital reimbursement rules are necessary to: (1) implement aggregate legislative funding increases for inpatient hospital reimbursement for state fiscal year 1996; (2) revise the methodology for medicaid reimbursement for selected outpatient hospital services; (3) revise and add definitions for various rule terms; (4) revise department procedures for reimbursement of catastrophic cases and specify funding limits for catastrophic reimbursement for the 1996-97 biennium; (5) update the department's table of DRG weights and thresholds; and (6) delete obsolete provisions and specify department policy affecting reimbursement and provider requirements.

The proposed changes to ARM 46.12.505(2)(c), (13) and (14) are necessary to implement aggregate legislative funding increases for state fiscal year 1996 appropriated under House Bill 2 for increases in medicaid hospital rates. For fiscal year 1996, the department proposes to implement these funding increases by increasing the average DRG base price from $1,887.86 to $1,944.50. This represents a 3% increase in the base price. This increase is consistent with the department's policy to increase rates by a factor that does not exceed the medicare market basket TEFRA update factor.

The proposed changes to ARM 46.12.508 are necessary to revise the current methodology used to reimburse selected outpatient hospital services. The department proposes to adopt prospective payment reimbursement for imaging services, other diagnostic services, emergency room screenings and stabilizations, dialysis services and partial hospitalization services. In addition, the department proposes to simplify its current prospective payment methodology for laboratory services. The proposed changes in the reimbursement methodology were recommended by Abt Associates based upon a study and evaluation of the medicaid outpatient hospital reimbursement system, as authorized by the 1993 Montana Legislature. The proposed payment methodologies, except for the emergency room screen fee and partial hospitalization services, are based upon medicare reimbursement principles. The adoption of proposed ARM 46.12.506(4) through (9) is necessary to define terms used in the proposed prospective reimbursement rules in ARM 46.12.508.

Reimbursement for the emergency room screenings will be a bundled payment of $20 for non-emergent emergency room services, for services provided to a PASSPORT recipient that are not authorized by the recipients' PASSPORT provider. Reimbursement for partial hospitalization services will be a fully bundled prospective per diem rate for full-day and half-day services. All other outpatient hospital services will be reimbursed as provided in current rules under a cost based retrospective payment methodology.

The proposed changes to ARM 46.12.503(1) and (2), 46.12.504(2), 46.12.506(1) and (2), and 46.12.507 are necessary to revise definitions to be consistent with federal medicaid definitions and to specify more clearly the scope of services covered under both the inpatient and outpatient hospital service programs. The department has reviewed the medicare definition of inpatient and outpatient services and proposes to revise these rules to be consistent with medicare definitions. Current medicaid rules establish a strict distinction between inpatient and outpatient based upon receipt of services for a period of more or less than 24 hours. The medicare approach and the proposed rule use the 24-hour basis as a benchmark for the distinction, but recognize that it is primarily the physician's decision to treat a patient as an inpatient or outpatient based upon medial factors, and that a strict 24-hour approach may not be practical or reasonable in all circumstances.

The proposed changes to ARM 46.12.505(8)(i) through (iv) are necessary to revise the department's procedure for reimbursement of catastrophic cases. The current rule provides that providers will receive an interim catastrophic payment of 60% of the catastrophic payment, and requires the department to settle catastrophic case payments after the end of the fiscal year and before the following September 30th. Practice has proven it impossible for the department to comply with the requirement to settle by September 30th. The proposed changes provide for interim reimbursement at 100% of the estimated cost and remove the requirement for settlement by the following September 30th. The proposed rule provides that the catastrophic payments may be adjusted to recover overpayments if the interim amounts exceed available funds, but assures that providers receive payments at an early date. The proposed rule would continue to provide catastrophic case reimbursement as an integral safeguard for providers to protect them from extraordinary cases.

The proposed changes would revise the limits and estimated discharges for the upcoming biennium based upon recent experience and projected information. The estimates for fiscal year 1994 and 1995 were 26,844 and 31,676 DRG discharges, and $4,441,000 and $5,502,000 for the base DRG, add-ons and outlier amounts, respectively. For fiscal year 1994, the department paid for approximately 14,600 DRG admissions (and discharges). The department processed 11 cases for catastrophic case reimbursement for a total of approximately 1.4 million dollars.

The actual experience was significantly different than the estimates drafted for fiscal year 1994. Under the proposed rule, the number of estimated discharges and the available funding levels are revised taking into account this actual experience. The department proposes to set the discharges and funding for purposes of catastrophic reimbursement for 1996 at 16,000 estimated discharges and a funding limit of $1,800,500, and for 1997 at 16,000 estimated discharges and a funding limit of $1,852,500.

The proposed changes to ARM 46.12.509 are necessary to delete outpatient chemical dependency treatment services from the list of outpatient hospital services that must be prior authorized, as this requirement has not proven cost effective for the department.

The estimated financial impact of the proposed changes is approximately $748,000 in fiscal year 1996. Copies of this rule notice may be obtained from local county human services offices.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of Rules 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1241, 46.12.1249, 46.12.1254, 46.12.1260 and 46.12.1265 pertaining to medicaid nursing facility services	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1241, 46.12.1249, 46.12.1254, 46.12.1260 AND 46.12.1265 PERTAINING TO MEDICAID NURSING FACILITY SERVICES

TO: All Interested Persons

1. On June 2, 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 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1241, 46.12.1249, 46.12.1254, 46.12.1260 and 46.12.1265 pertaining to medicaid nursing facility services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. 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:

46.12.1222 DEFINITIONS Subsections (1) through (14)(e)(xxxi)(C) remain the same.

(D) specific therapeutic classes ~~1 and class 6 antacids and laxatives~~ D4B (antacids), D6S (laxatives and cathartics) and Q3S (laxatives, local/rectal) including but not limited to:

Subsections (14)(e)(xxxi)(D)(I) through (20) remain the same.

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

46.12.1223 PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS Subsections (1) through (1)(h) remain the same.

(i) comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 U.S.C. §1396r(b)(5) and 1396r(c) (~~1991~~ 1994 supp.) and implementing regulations, which contain federal ~~laws~~ requirements relating to nursing home reform. The department hereby adopts and incorporates herein by reference 42 U.S.C. §1396r(b)(5) and 1396r(c). A copy of these statutes may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

Subsection (2) remains the same.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal medicaid participation requirements. Department sanctions or actions may include but are not limited to imposition of any remedy or combination of remedies that a state is permitted to impose under federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

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

(4) A provider must mail to the department a copy of each notice of transfer or discharge provided to a resident of the provider's facility pursuant to 42 CFR 483.12(a)(4), (5) and (6). The copy of the notice must be mailed to the department within 3 days after the notice is mailed or provided to the resident. At the same time, the provider must mail to the department a list including the names and addresses of the resident, any responsible party or guardian that acts on the resident's behalf and any known legal counsel representing the resident with respect to the transfer or discharge issue. The notice and list must be mailed to the Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

AUTH: Sec. 53-6-108 [as amended by sec. 14, ch. 354, L. 1995], 53-6-111 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107 [as amended by sec. 13, ch. 354, L. 1995], 53-6-111 and 53-6-113 MCA

46.12.1226 NURSING FACILITY REIMBURSEMENT Subsections (1) through (3)(b) remain the same.

(c) A provider's per diem rate effective July 1 of the rate year shall not exceed the provider's average per diem private pay rate for a semi-private bed, plus the average cost, if any, of items separately billed to private pay residents, in effect on July 1 of the rate year as specified by the provider in the department's survey of private pay rates conducted annually between April 1 and July 1 prior to the rate year. Providers who do not respond to the department's survey by July 1 of the rate year, will be subject to withholding of their medicaid reimbursement in accordance with ARM 46.12.1260. The rate specified by the provider in this survey will be referred to as the reported rate.

Subsection (3)(c)(i) remains the same.

(ii) The medicaid per diem rate will not be increased as a result of increases in private pay rates from the private pay rate in effect on July 1 of the rate year as specified in the department's survey described in subsection (c).

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

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

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

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1993~~ 1995, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1992~~ 1994 and December 31, ~~1992~~ 1994 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

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

(4) The operating cost limit is ~~115%~~ 105% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with subsection (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of 10% of median operating costs or ~~40%~~ 30% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

Subsection (5)(a) remains the same.

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

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

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1993~~ 1995, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1992~~ 1994 and December 31, ~~1992~~ 1994 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

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

(4) The direct nursing personnel cost limit is ~~130%~~ 120% of the statewide median average wage, multiplied by the provider's most recent average patient assessment score, determined in accordance with ARM 46.12.1232.

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

46.12.1237 CALCULATED PROPERTY COST COMPONENT (1) This section specifies the method used by the department to calculate the property cost component for a specific provider for rate years beginning on or after July 1, ~~1994~~ 1995. Such property cost component is expressed in dollars and cents per patient day.

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

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1993~~ 1995, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1992~~ 1994 and December 31, ~~1992~~ 1994 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least 6 months on file with the department before April 1 immediately preceding the rate year.

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

(e) "~~1994~~ 1995 property component" means the provider's calculated property component determined for rate year ~~1994~~ 1995 in accordance with ARM 46.12.1237.

(i) For any provider providing nursing facility services in a facility constructed prior to June 30, 1982 and for whom a calculated property component has not been determined by the department in accordance with ARM 46.12.1237 for rate year ~~1994~~ 1995, the ~~1994~~ 1995 property component shall equal the June 30, 1985 property rate computed for the facility according to the rules in effect as of June 30, 1985 and indexed forward to the 1992 rate year according to the rules in effect for rate year 1992.

(3) For rate years beginning on or after July 1, ~~1994~~ 1995, the provider's calculated property cost component is as follows:

(a) If the provider's ~~1994~~ 1995 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's ~~1994~~ 1995 property component or the property rate cap of $11.00.

(b) If the provider's base year per diem property costs exceed the provider's ~~1994~~ 1995 property component by more than $1.36, then the provider's calculated property cost component is the sum of the provider's ~~1994~~ 1995 property component plus $1.36.

(c) If the provider's base year per diem property costs exceed the provider's ~~1994~~ 1995 property component by $1.36 or less, then the provider's calculated property cost component is the provider's base year per diem property costs.

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

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

46.12.1241 CHANGE IN PROVIDER DEFINED (1) A change in provider will be deemed to have occurred ~~under any one of the following circumstances~~ if the events described in any one of the following subsections (a) through (d) occurs:

~~(a) the addition or substitution of a partner having a 25 or greater percent interest in the partnership as permitted by applicable state law;~~

~~(b) the sale of an unincorporated sole proprietorship or the transfer of title to, or possession of, a facility used in the provision of nursing facility services from the provider to another party or entity;~~

~~(c) the merger of the provider corporation into another corporation or the consolidation of 2 or more corporations. However, the transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of provider under this subsection (c), unless the provider corporation is closely held as defined in ARM 46.12.1222 and stock representing a 25 or greater percent interest in the corporation is transferred from one party or entity to another party or entity; or~~

~~(d) the lease of all or part of a provider-owned facility used in the provision of nursing facility services or the transfer of a lease from the provider to another party or entity.~~

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business.

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain the right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where:

(i) stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated corporation; or

(ii) where the provider corporation is a closely held corporation as defined in ARM 46.12.1222, stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires the provider's title or interest in the nursing facility and the right to control and manage the business of the nursing facility.

(2) For purposes of this section:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a spouse, ancestor, descendant, sibling or a spouse of an ancestor, descendant or sibling; or

(ii) a sole proprietorship, partnership or corporation in which a spouse, ancestor, descendant, sibling, uncle, aunt, niece, nephew or a spouse of an ancestor, descendant, sibling uncle, aunt, niece or nephew has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated corporation" means a corporation that is controlled and managed by a board of directors comprised of entirely different persons and by different officers.

Subsections (2) and (3) remain the same in text but are renumbered (3) and (4).

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

46.12.1249 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (1) For intermediate care facility services for the mentally retarded provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with ARM 46.12.1258 and 46.12.1260, divided by the total patient days of service during the rate year, minus the amount of the medicaid recipient's patient contribution, subject to the limits specified in subsections (2)(a) and (b).

Subsection (2) remains the same.

~~(a) For fiscal years ending on or after June 30, 1994, the payment rate will not exceed total allowable costs per day for the previous cost reporting period indexed to June 30 of the rate year by the final medicare market basket index applicable to the rate year.~~

(a) Final per diem payment rates for base years shall be as specified in subsection (1), without application of any further limit. Base years are even-numbered state fiscal years, i.e., state fiscal years 1994, 1996 and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

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

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

46.12.1254 BED HOLD PAYMENTS Subsections (1) through (4) remain the same.

(5) Where the conditions of subsections (1) through (4) are met, providers are required to hold ~~the~~ a bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department's medicaid services division. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill medicaid for the bed hold day until all conditions of billing are met and may not bill the resident under any circumstances.

Subsections (6) through (7) remain the same.

(8) No more than 24 days per resident in each rate year (July 1 through June 30) will be allowed for therapeutic home visits.

Subsections (8) through (10) remain the same.

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

46.12.1260 COST REPORTING, DESK REVIEW AND AUDIT Subsections (1) and (2) remain the same.

(3) Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain the provider's costs of the various services provided. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 (1990 ed.), which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, ~~Department of Social and Rehabilitation Services~~, 111 N. Sanders, P.O. Box 4210, ~~111 Sanders,~~ Helena, Montana 59604-4210. Notwithstanding the above, distinctions between skilled nursing and ~~intermediate~~ nursing facility care need not be made in cost finding.

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

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

46.12.1265 UTILIZATION REVIEW AND QUALITY OF CARE (1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456~~.250 through 456.522~~ subparts E and F (1994), may evaluate the necessity of nursing facility care for each medicaid resident. 42 CFR 456~~.250 through 456.522~~ subparts E and F are federal regulations which specify utilization review criteria for nursing facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456~~.250 through 456.522~~ subparts E and F (1994). A copy of these regulations may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, ~~Department of Social and~~

~~Rehabilitation Services,~~ 111 N. Sanders, P.O. Box 4210, ~~111 Sanders,~~ Helena, Montana 59604-4210.

(2) As frequently as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456~~.600 through 456.614~~ subpart I (1994), may evaluate the quality of medical care provided to each medicaid resident in an intermediate care facility for the mentally retarded ~~or an institution for mental diseases~~. 42 CFR 456~~.600 through 456.614 are~~ subpart I contains federal regulations which specify medical review criteria for nursing facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456~~.600 through 456.614~~ subpart I (1994). A copy of these regulations may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, ~~Department of Social and Rehabilitation Services,~~ 111 N. Sanders, P.O. Box 4210, ~~111 Sanders,~~ Helena, Montana 59604-4210.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142 MCA

3. The proposed changes to the medicaid nursing facility rules are necessary to specify the rate methodology for medicaid reimbursement of nursing facility services provided in the 1996 rate year, to implement various annual updates to the rules, to address issues that have arisen in various program areas and to make miscellaneous revisions to more clearly specify program requirements and processes.

The proposed rule changes are necessary to implement legislative funding increases for medicaid nursing facility reimbursement for state fiscal year 1996. The 1995 Montana legislature appropriated funds under House Bill 2 for increases in aggregate medicaid reimbursement to nursing facilities. Funding continues to be provided from a provider bed fee of $2.80 per patient day on all payers for fiscal year 1996.

The funding appropriated by the 1995 legislature results in fiscal year 1996 nursing facility reimbursement in the average amount of $82.86 per patient day or a total of $120,554,593 of combined state funds, federal funds, and patient contributions. This represents an average increase of $2.71 per patient day over the fiscal year 1995 reimbursement level.

The proposed changes to ARM 46.12.1229, 46.12.1231 and 46.12.1237 are necessary to specify the methodology components under which the fiscal year 1996 funding will be implemented. Under the proposed rules, the department would continue to use the current reimbursement methodology. The rules with the proposed changes would update the operating and direct nursing components by applying the DRI McGraw-Hill Nursing Home market basket index to 1994 base period costs to project costs for rate year 1996 and by adjusting the median rate arrays to set the cost limits for the 1996 rate year.

The department at this time proposes to use an operating cost limit set at 105% of median operating costs and a direct nursing personnel cost limit set at 120% of median direct nursing personnel costs. The department proposes to continue the methodology using cost report information rather than survey information to compute the licensed to non-licensed ratio for the patient assessment system. The proposed rules would reduce the operating incentive to the lesser of 30% of the difference between the provider's indexed cost and the operating cost limit, or 10% of the indexed median operating cost.

The department proposes to continue use of the property cost component as previously adopted with an upper limit of $11.00 per day. The department proposes to modify reimbursement for the property cost component using property reimbursement levels set for 1995 and per diem costs per day as computed from the 1994 medicaid base period cost reports. The proposed property reimbursement methodology would provide for rate increases of up to $1.36 per patient day. Under the proposed rule, providers would either remain at their 1995 property reimbursement level or receive an increase in property reimbursement up to the lower of their cost per day or $1.36 based upon their 1994 cost reports.

Under the proposed rule, the department would continue to limit a provider's medicaid per diem rate to the amount of the provider's private pay rate. The department will survey nursing facilities to determine the private pay rate effective July 1, 1995. The proposed changes to 46.12.1226 are necessary to more clearly state in the rule the department's interpretation of the current rule. The amendment would specify that the private pay limit is the provider's private pay rate in effect on July 1 of the rate year as reported in the survey. The medicaid rate will not be increased after July 1 of the rate year based upon an increase in the provider's private pay rate, even though the provider may have indicated in the survey that the July 1 private pay rate will or may be increased during the rate year.

The proposed changes to ARM 46.12.1249 are necessary to specify the cost reporting periods that would be base periods and the periods that would be subject to ceilings on the rate of increase for rate year 1996 and subsequent rate years for intermediate care facilities for the mentally retarded (ICF/MR's) and to delete provisions relating to rate of increase ceilings applicable to prior rate years.

The proposed changes to ARM 46.12.1222 are necessary to revise the description of certain antacids, laxatives and other items to correspond to changes in the medicaid pharmacy program.

The proposed changes to ARM 46.12.1223(1)(i) and (2)(a) are necessary to update references to federal participation requirements applicable to nursing facilities and to specify that the department may impose sanctions and take actions

against providers that are not in compliance with federal participation requirements.

Proposed ARM 46.12.1223(4) is necessary to specify requirements for facilities to notify the department when notice is given to a resident of a decision to transfer or discharge the resident from a nursing facility. This provision is necessary to allow the department to comply with federal requirements at 42 CFR 431.206(b)(3) to notify residents of certain hearing rights regarding a facility's decision to transfer or discharge the resident.

The proposed amendments to ARM 46.12.1241 are necessary to revise the circumstances that will trigger a change in provider for purposes of the interim rate provisions and a change in the reimbursement rate calculation under ARM 46.12.1243. The current rule was developed for different purposes and was designed to apply broadly to transactions, even though the transactions did not necessarily involve a substantive change in the person or entity controlling the facility. The original purpose of the definition no longer applies. Currently, the change in provider definition serves the purpose of identifying the circumstances in which a new provider will be entitled to the interim rate provision, which under certain circumstances may include use of a more recent cost base for rate calculation. The proposed rule is intended to limit changes in provider to circumstances involving actual changes in the person or entity that controls the business and management of the facility.

The proposed changes to 46.12.1254 are necessary to specify current department policy that when a facility is required to hold a bed for a resident who is temporarily receiving medical services outside the nursing facility, the facility is not required to hold the same bed that the resident was in prior to the bed hold, and that the facility may not bill the resident for a bed hold while the resident is temporarily receiving medical services outside the nursing facility. The proposed amendments are also necessary to specify that the 24 day limit on therapeutic home visits applies to the period July 1 through June 30 of the rate year.

The proposed amendment to ARM 46.12.1260 is necessary to replace the outdated reference to "intermediate care" with the current term "nursing facility care." The proposed amendments to 46.12.1265 are necessary to update the citations to the incorporated federal regulations that apply to utilization review and inspections of care.

The estimated financial impact of the proposed changes is approximately $3,164,320 in state and federal funds in fiscal year 1996. The medicaid advisory committee will be informed of the proposed changes on July 20, 1995. Copies of this rule notice may be obtained from local county human services offices.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rule 46.10.403 pertaining to AFDC assistance standards	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.10.403 PERTAINING TO AFDC ASSISTANCE STANDARDS

TO: All Interested Persons

1. On June 1, 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 rule 46.10.403 pertaining to AFDC assistance standards.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.10.403 TABLE OF ASSISTANCE STANDARDS; METHODS OF COMPUTING PAYMENTS Subsections (1) through (4)(d) remain the same.

(e) Gross monthly income standards to be used when adults are included in the assistance unit are compared with the assistance unit's gross monthly income as defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Persons in Household	With Shelter Obligation Per Month	In Shared Shelter Per Month	Without Shelter Obligation Per Month
1	~~$ 585~~ 594	~~$ 535~~ 544	~~$ 213~~ 216
2	~~783~~ 797	~~733~~ 747	~~344~~ 350
3	~~981~~ 1,001	~~931~~ 951	~~470~~ 481
4	~~1,177~~ 1,204	~~1,127~~ 1,154	~~596~~ 611
5	~~1,375~~ 1,408	~~1,325~~ 1,358	~~712~~ 731
6	~~1,573~~ 1,611	~~1,523~~ 1,561	~~823~~ 844

7	~~1,769~~ 1,817	~~1,719~~ 1,767	~~934~~ 958
8	~~1,967~~ 2,020	~~1,917~~ 1,970	~~1,036~~ 1,064
9	~~2,065~~ 2,120	~~2,015~~ 2,070	~~1,132~~ 1,164
10	~~2,157~~ 2,218	~~2,107~~ 2,168	~~1,227~~ 1,262
11	~~2,240~~ 2,303	~~2,190~~ 2,253	~~1,310~~ 1,347
12	~~2,324~~ 2,388	~~2,274~~ 2,338	~~1,393~~ 1,432
13	~~2,396~~ 2,464	~~2,346~~ 2,414	~~1,465~~ 1,508
14	~~2,466~~ 2,536	~~2,416~~ 2,486	~~1,536~~ 1,580
15	~~2,535~~ 2,607	~~2,485~~ 2,557	~~1,604~~ 1,650
16	~~2,594~~ 2,668	~~2,544~~ 2,618	~~1,663~~ 1,711

(f) Gross monthly income standards to be used when no adults are included in the assistance unit are compared with the assistance unit's gross monthly income as defined in ARM 46.10.505.

GROSS MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Persons in Household	With Shelter Obligation Per Month	~~Without Shelter Obligation Per Month~~
1	$ ~~213~~ 216	$ ~~80~~
2	~~418~~ 426	~~213~~
3	~~627~~ 640	~~344~~
4	~~834~~ 855	~~470~~
5	~~1,042~~ 1,067	~~594~~
6	~~1,251~~ 1,282	~~718~~
7	~~1,460~~ 1,499	~~836~~
8	~~1,665~~ 1,709	~~951~~
9	~~1,765~~ 1,813	~~1,049~~
10	~~1,857~~ 1,909	~~1,143~~
11	~~1,950~~ 2,005	~~1,236~~
12	~~2,037~~ 2,096	~~1,331~~
13	~~2,128~~ 2,189	~~1,412~~
14	~~2,209~~ 2,274	~~1,495~~
15	~~2,292~~ 2,359	~~1,576~~
16	~~2,368~~ 2,436	~~1,652~~

(g) Net monthly income standards to be used when adults are included in the assistance unit are compared with the assistance unit's net monthly income as defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Persons in Household	With Shelter Obligation Per Month	In Shared Shelter Per Month	Without Shelter Obligation Per Month
1	$ ~~316~~ 321	$ ~~266~~ 271	$ ~~115~~ 117
2	~~423~~ 431	~~373~~ 381	~~186~~ 189

3	~~530~~	541	~~480~~	491	~~254~~	260
4	~~636~~	651	~~586~~	601	~~322~~	330
5	~~743~~	761	~~693~~	711	~~385~~	395
6	~~850~~	871	~~800~~	821	~~445~~	456
7	~~956~~	982	~~906~~	932	~~505~~	518
8	~~1,063~~	1,092	~~1,013~~	1,042	~~560~~	575
9	~~1,116~~	1,146	~~1,066~~	1,096	~~612~~	629
10	~~1,166~~	1,199	~~1,116~~	1,149	~~663~~	682
11	~~1,211~~	1,245	~~1,161~~	1,195	~~708~~	728
12	~~1,256~~	1,291	~~1,206~~	1,241	~~753~~	774
13	~~1,295~~	1,332	~~1,245~~	1,282	~~792~~	815
14	~~1,333~~	1,371	~~1,283~~	1,321	~~830~~	854
15	~~1,370~~	1,409	~~1,320~~	1,359	~~867~~	892
16	~~1,402~~	1,442	~~1,352~~	1,392	~~899~~	925

(h) Net monthly income standards to be used when no adults are included in the assistance unit are compared with the assistance unit's net monthly income as defined in ARM 46.10.505.

NET MONTHLY INCOME STANDARDS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	With Shelter Obligation Per Month		~~Without Shelter Obligation Per Month~~
1	$ ~~115~~	117	$ ~~43~~
2	~~226~~	230	~~115~~
3	~~339~~	346	~~186~~
4	~~451~~	462	~~254~~
5	~~563~~	577	~~321~~
6	~~676~~	693	~~388~~
7	~~789~~	810	~~452~~
8	~~900~~	924	~~514~~
9	~~954~~	280	~~567~~
10	~~1,004~~	1,032	~~618~~
11	~~1,054~~	1,084	~~668~~
12	~~1,101~~	1,113	~~714~~
13	~~1,150~~	1,183	~~763~~
14	~~1,194~~	1,229	~~808~~
15	~~1,239~~	1,275	~~852~~
16	~~1,280~~	1,317	~~893~~

Subsections (5) through (6) remain the same.

(a) Maximum payment amounts to be used when adults are included in the assistance unit are compared to the difference between the assistance unit's net monthly income and the net monthly income standard defined in ARM 46.10.505.

MAXIMUM PAYMENT AMOUNTS TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month	In Shared Shelter Per Month
1	$ ~~248~~ 252	$ ~~90~~ 92	$ ~~198~~ 202
2	~~332~~ 338	~~146~~ 148	~~282~~ 288
3	~~416~~ 425	~~199~~ 204	~~366~~ 375
4	~~499~~ 511	~~253~~ 259	~~449~~ 461
5	~~583~~ 597	~~302~~ 310	~~533~~ 547
6	~~667~~ 684	~~349~~ 358	~~617~~ 634
7	~~750~~ 771	~~396~~ 407	~~700~~ 721
8	~~834~~ 857	~~440~~ 451	~~784~~ 807
9	~~876~~ 900	~~480~~ 494	~~826~~ 850
10	~~915~~ 941	~~520~~ 535	~~865~~ 891
11	~~951~~ 977	~~556~~ 571	~~901~~ 927
12	~~986~~ 1,013	~~591~~ 608	~~936~~ 963
13	~~1,017~~ 1,046	~~622~~ 640	~~967~~ 996
14	~~1,046~~ 1,076	~~652~~ 670	~~996~~ 1,026
15	~~1,075~~ 1,106	~~681~~ 700	~~1,025~~ 1,056
16	~~1,101~~ 1,132	~~706~~ 726	~~1,051~~ 1,082

(b) Maximum payment amounts to be used when no adults are included in the assistance unit are compared to the difference between the assistance unit's net monthly income and the net monthly income standard as defined in ARM 46.10.505.

MAXIMUM PAYMENT AMOUNTS TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Persons in Household	With Shelter Obligation Per Month	~~Without Shelter Obligation Per Month~~
1	$ ~~90~~ 92	~~$ 34~~
2	~~177~~ 181	~~90~~
3	~~266~~ 272	~~146~~
4	~~354~~ 363	~~199~~
5	~~442~~ 453	~~252~~
6	~~531~~ 544	~~305~~
7	~~619~~ 636	~~355~~
8	~~707~~ 725	~~403~~
9	~~749~~ 769	~~445~~
10	~~788~~ 810	~~485~~
11	~~827~~ 851	~~524~~
12	~~864~~ 889	~~560~~
13	~~903~~ 929	~~599~~
14	~~937~~ 965	~~634~~
15	~~973~~ 1,001	~~669~~
16	~~1,005~~ 1,034	~~701~~

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

3. House Bill 2 of the 54th Montana Legislature continues payments to recipients of Aid to Families with dependent Children (AFDC) at the current level, which is 40.5% of the federal poverty levels. However, due to recently published increases in the federal poverty levels, ARM 46.10.403 must be amended to increase the AFDC payment amounts. The AFDC gross monthly income standards and net monthly income standards are based on the payment amounts and therefore must also be increased at the same time.

Additionally, the tables of gross and net monthly income standards and payment amounts to be used when there are no adults in the assistance unit and there is no shelter obligation are being deleted. The rule is being amended to conform to the department's current policy of deeming all "child only" assistance units to have a shelter obligation.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rule 46.12.204 pertaining to medicaid recipient co-payments	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.204 PERTAINING TO MEDICAID RECIPIENT CO-PAYMENTS

TO: All Interested Persons

1. On June 1, 1995, at 1:15 p.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 N. Roberts, Helena, Montana to consider the proposed amendment of rule 46.12.204 pertaining to medicaid recipient co-payments.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.12.204 RECIPIENT REQUIREMENTS, CO-PAYMENTS Subsections (1) through (2)(a) remain the same.

(b) pregnant women; and

(c) inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if such individual is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 46.12.4008~~; and~~.

~~(d) health maintenance organization enrollees.~~

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

(b) family planning; ~~or~~

(c) hospice~~.~~; or

(d) services provided by an enrolled medicaid health maintenance organization.

(4) The total co-payment for each medicaid ~~household~~ recipient shall not exceed $200.00 per state fiscal year.

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

3. The proposed amendment to ARM 46.12.204 is necessary in order to provide a more accurate reflection of the actual person incurring the co-payment.

Currently, when the department's computerized tracking system changes a case number for a household, there is no link between the old household case number and the new household case number. Therefore, a co-payment exceeding the intended limits could be applied within a household.

The proposed amendment is necessary in order to allow for the tracking of co-payment through the paid claims system per recipient identification number. This will allow the co-payment amount to stay with the recipient who actually incurred the co-payment. The proposed rule will also negate the time consuming task of department employees manually making adjustments to the computerized co-payment tacking system.

The proposed amendment to ARM 46.12.204 also deletes the exemption of health maintenance organization (HMO) enrolles from co-payments. In this same section, however, services provided by HMO's will be exempt from co-payment charges. This change is necessary in order to encourage medicaid recipients to use less costly medical services provided by HMO's.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to medicaid home health services	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.550, 46.12.551 AND 46.12.552 PERTAINING TO MEDICAID HOME HEALTH SERVICES

TO: All Interested Persons

1. On June 1, 1995, at 1:30 p.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 N. Roberts, Helena, Montana to consider the proposed amendment of rules 46.12.550, 46.12.551 and 46.12.552 pertaining to medicaid home health services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. 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:

46.12.550 HOME HEALTH SERVICES, DEFINITIONS (~~1~~3) "Home health services" ~~are the following~~ means services provided by a licensed home health agency to a recipient considered home-bound in ~~his~~ the recipient's place of residence for the purposes of postponing or preventing institutionalization~~:~~.

(a) Home health services include:

Subsections (1)(a) through (1)f) remain the same in text but are renumbered (3)(a)(i) through (3)(a)(vi).

(b) Home health services do not include:

(i) personal care attendant services; and

(ii) visits made by a registered nurse for evaluating the home health needs of a recipient or to review the provision of home health services by a home health aide or a licensed practical nurse.

(~~2~~6) "Skilled nursing services" means nursing services, as defined in the Montana Nurse Practice Act, provided on an intermittent or part time basis to meet the medical needs of a ~~persons~~ recipient who needs nursing procedures ~~in order to prevent institutionalization~~.

(~~3~~2) "Home health aide services" means ~~assistance~~ services to assist a recipient in the activities of daily living and the

care of the household ~~provided to maintain the person in their home~~.

(~~4~~1) "Homebound status" means either that a recipient is confined ~~to his home~~ for medical reasons and unable to leave home without considerable taxing effort or ~~that~~ the recipient cannot ~~readily~~ reasonably obtain needed medical services other than through a home health agency. The confinement can be ~~of~~ on a part time or intermittent basis.

~~(a) Homebound status must be certified by the attending physician on the physician order sheet.~~

(5) "Place of residence" means the residential setting in which the recipient generally resides.

(a) Place of residence includes a ~~person's~~ recipient's own home, a personal care facility, a foster home, a community home or other residential setting for persons who ~~are developmentally disabled~~ have a developmental disability or ~~physically disabled~~ a physical disability, a rooming house or a retirement home.

(b) Place of residence does not include a hospital or a nursing facility.

(~~6~~4) "A ~~h~~Home health service visit" ~~is~~ means a personal contact in the place of residence of a recipient made for the purpose of providing a covered home health service.

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

46.12.551 HOME HEALTH SERVICES, REQUIREMENTS (1) These requirements are in addition to those ~~contained in ARM 46.12.301 through 46.12.308~~ rule provisions generally applicable to medicaid providers.

(~~a~~2) A home health agency must be:

(a) licensed by the Montana department of health and environmental sciences; ~~and~~

(b) medicare certified~~.~~; and

(c) an enrolled medicaid provider.

~~(b) Home health services are available only through those home health agencies within the borders of the state of Montana that have a contract with the department.~~

~~(c) Home health services meeting the provisions of ARM 46.12.503(3) are available through providers located outside of the borders of the state of Montana by requesting prior authorization on a case by case basis.~~

(3) Home health services may be provided by providers located outside of the borders of the state of Montana only if the service meets the requirements of ARM 46.12.502(3) and the service is prior authorized by the department or the department's designee.

(~~d~~4) Home health services must be:

(a) ~~prescribed~~ ordered by the recipient's attending physician; ~~and be~~

(b) part of a written plan of care~~.~~; and

(~~e~~c) ~~Home health services must be~~ reviewed and renewed by the recipient's attending physician at a minimum of 60 day intervals.

(5) The attending physician must certify in the physician's order that the person is homebound.

Subsection (1)(f) remains the same in text but is renumbered (6).

(~~g~~7) Home health services, except skilled nursing services, are limited to a combined maximum of ~~200~~ 100 visits per recipient per fiscal year. Skilled nursing services are limited to ~~365~~ 75 visits per recipient per fiscal year.

(a) The department may, within its discretion, authorize additional visits in excess of this limit. Any services exceeding this limit must be prior authorized by the department or the department's designee.

(~~h~~8) Skilled nursing services may be provided by contract with a licensed registered nurse in geographic areas not covered by a licensed home health agency. The registered nurse must follow written orders from the recipient's physician and document care and services provided.

(~~i~~9) ~~Limitations upon h~~Home health aide services are subject to the following limitations:

(~~i~~a) Home health aide services must be prior authorized ~~if they exceed 12 visits per recipient in the state fiscal year~~ by the department or the department's designee.

Subsections (1)(i)(ii) and (1)(i)(iii) remain the same in text but are renumbered (9)(b) and (9)(c).

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

46.12.552 HOME HEALTH SERVICES, REIMBURSEMENT (1) Reimbursement fees for home health services ~~will be~~ are as provided for ~~in subsections (2), (3) and (4). For periods between calculations of the reimbursement fees as provided for in subsections (2), (3) and (4),~~ in this rule.

(2) The interim reimbursement for a category of service submitted for reimbursement as provided in subsections (4) or (5) is ~~as provided for in subsection (5)~~ the most current medicare percent of billed charges for each provider.

(3) The provider's final reimbursement ~~will be~~ as provided for in subsections (4) and (5) is calculated when the actual reimbursement fees based on the medicare cost settlements are determined for the period. The medicare cost settlements are derived from an audit of allowable costs conducted for medicare purposes.

(~~2~~4) For home health agencies located within the borders of the state that began providing services before July 1, 1989, the reimbursement fee for a category of service ~~effective~~ after January 1, 1990 and prior to July 1, 1995 is the lowest of:

Subsections (2)(a) through (2)(d)(i)(A) remain the same in text but are renumbered (4)(a) through (4)(d)(i)(A).

(B) ~~two percent (2%)~~ of the indexed lowest fee. The department hereby adopts and incorporates by reference the HCFA home health DRI market basket rate which is a forecast model of market basket increase factors. The rate and a description of the general methodology and variables used in formulating this

model is available from HCFA, Office of the Actuary, 6325 Security Blvd., Baltimore, MD 21209.

(ii) The state fiscal year 1991 indexed fee for a category of service is the 1990 indexed fee for a category of service increased by ~~two percent (2%)~~.

(~~3~~5) For home health agencies which are located within the borders of the state that began providing services on or after July 1, 1989, the medicaid reimbursement fee for a category of service delivered prior to July 1, 1995 is the lowest of:

Subsections (3)(a) through (3)(d)(i)(A) remain the same in text but are renumbered (5)(a) through (5)(d)(i)(A).

(B) ~~two percent (2%)~~ of the averaged medicaid fee.

(6) For home health agencies located within the borders of the state for services provided on or after July 1, 1995, the reimbursement fee for a home health service is the lower of:

(a) the provider's customary charges; or

(b) 60% of the provider's medicare cost limit for the category of service.

(~~4~~7) For home health agencies located outside the borders of the state, providing a home health service that meets the requirements set forth in ARM 46.12.502(3), the reimbursement fee ~~per~~ for a home health service is the lowest~~r~~ of:

(a) the provider's ~~billed~~ customary charges; or

~~(b) the current adjusted averaged medicaid fee as calculated in (3)(d)(i).~~

(b) the rate established by the medicaid agency in the state in which the agency is located.

~~(5) The interim rate for a category of service is the most current medicare percent of billed charges for each provider.~~

~~(6) A visit made by a registered nurse for the purpose of evaluating the home health needs of a recipient or to review the provision of home health services by a nurse aide or a licensed practical nurse is an administrative function and is not billable as a home health service visit.~~

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

3. Home health services are an array of medical and medically-related services that may be provided to persons in their homes who are medicaid eligible. The purpose of the services is to prevent the institutionalization of persons in more restrictive settings.

The proposed amendments to the home health services rules are generally necessary to conform terminology, to replace archaic terminology, to provide more appropriate definitions of principal words and terminology, to restructure the rules for better comprehension, to remove and add requirements as necessary, and to revise the reimbursement methodology.

The proposed amendments to ARM 46.12.550, definitions, revising definitions, are necessary to improve administration of the

program and comprehension of the rules by providing more appropriate definitions of principal words and terminology.

The proposed amendments to ARM 46.12.551, requirements, are necessary to improve comprehension, to remove an unnecessary requirement for the provider to have a contract with the department, to lower the permissible number of service visits to more appropriate levels, to control usage of home health aide services by removing the availability of home health aide visits without preauthorization, and to allow for extenuating circumstances in service provision by providing for departmental discretion to authorize additional service visits when determined to be appropriate.

The limitations upon home health service visits are necessary to reform the service to set service availability at levels that reflect the characteristics and therefore the service needs of persons for whom home health services are most appropriate. The requirement of preauthorization for use of out of state providers and of home health aides is necessary to reduce inappropriate use of services.

The amendments to ARM 46.12.552, reimbursement, are necessary to simplify the reimbursement methodology. The current reimbursement methodology involves an interim reimbursement followed by an actual cost reimbursement after the costs can be calculated. This methodology is complicated and leads to final resolution of reimbursement long after the service is delivered. The new methodology will provide for reasonable reimbursement immediately after the delivery of the service without any involved complicated process subject to disagreement.

Limitations upon the provision of home health services which are by nature definitional will be deleted from the rule and will be placed into the definition of home health services in ARM 46.12.550.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the adoption of Rule I and the amendment of rules 46.12.555, 46.12.556 and 46.12.557 pertaining to medicaid personal care services	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I AND THE AMENDMENT OF RULES 46.12.555, 46.12.556 AND 46.12.557 PERTAINING TO MEDICAID PERSONAL CARE SERVICES

TO: All Interested Persons

1. On June 1, 1995, at 2:30 p.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 N. Roberts, Helena, Montana to consider the proposed adoption of Rule I and the amendment of rules 46.12.555, 46.12.556 and 46.12.557 pertaining to medicaid personal care services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. 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:

46.12.555 PERSONAL CARE, PURPOSE, SERVICES, ~~DEFINITION~~ PROVIDED, AND LIMITATIONS Subsection (1) remains the same.

~~(2) Personal care services include, but are not limited to, assistance with activities of daily living such as bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medications, meal preparation, escort and household tasks.~~

(2) Personal care includes assistance with the following activities:

(a) activities of daily living;

(b) household tasks; and

(c) escort services.

(3) Activities of daily living are limited to bathing, grooming, transferring, walking, eating dressing, toileting, self-administered medication, and meal preparation.

(a4) Hhousehold tasks are limited to housekeeping activities, provided in accordance with the personal care plan and furnished in conjunction with ~~direct patient care~~ activities of daily living, that are directly related to the recipient's medical needs. Household tasks include only:

~~(i) Household tasks include:~~

Subsections (2)(a)(i)(A) through (2)(a)(i)(D) remain the same in text but are renumbered (4)(a) through (4)(d).

~~(b) Escort services are trips for the purpose of enabling the recipient to receive medical examination or treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are provided by a personal care attendant who accompanies the recipient.~~

(5) Escort services are provided by a personal care attendant who accompanies the recipient. Escort services are limited to accompanying the recipient to a medical examination or treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are available only when the recipient is unable to perform these tasks except with the aid of a personal care attendant.

(~~3~~6) Personal care services ~~do~~ may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA.

(~~4~~7) Personal care services ~~do~~ may not include services which maintain an entire household or family or which are not medically necessary. ~~These~~ Personal care services do not include ~~but are not limited to the following~~:

(a) cleaning floors and furniture in areas recipients do not use or occupy;

Subsections (4)(b) and (4)(c) remain the same in text but are renumbered (7)(b) and (7)(c).

(d) maintenance of ~~pets~~ animals unless the animal is a certified service animal specifically trained to meet the safety needs of the recipient; and

Subsection (4)(e) remains the same in text but is renumbered (7)(e).

(~~5~~8) Personal care provided by a member of the recipient's immediate family is not personal care services for the purposes of the medicaid program ~~and is not subject to the requirements of these rules~~, and is not eligible for reimbursement.

(a) Immediate family member includes the following:

Subsections (5)(a)(i) through (5)(a)(xvi) remain the same in text but are renumbered (8)(a)(i) through (8)(a)(xvi).

AUTH: Sec. 53-6-113 and 53-2-201 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

46.12.556 PERSONAL CARE SERVICES, REQUIREMENTS

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

(4) Personal care services ~~are~~ may not ~~available for~~ be provided to persons who reside in a hospital or long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA.

(5) The recipient, in order to receive personal care services, must be capable of making choices about activities of daily living, understand~~ing~~ the impact of these choices and assum~~ing~~e responsibility for the choices~~,~~ or have someone residing within or outside the household willing to assist the recipient in decision making and to direct their activities.

(6) The type and amount of ~~P~~personal care services must be specified in a plan of care which governs delivery of services. The plan of care for a recipient ~~is~~ must be ordered by a physician and developed by a ~~registered~~ licensed nurse employed by ~~or contracted with the contract~~ a provider. The plan of care shall be delivered based upon the result of the recipient's needs profile as determined by the department.

(7) The delivery of personal care services must be supervised by a ~~registered~~ licensed nurse.

Subsection (8) remains the same.

~~(9) The recipient may not subject the personal care attendant to physical or verbal abuse, threats of physical harm or sexual harassment.~~

Subsection (10) remains the same in text but is renumbered (9).

(~~11~~10) Household tasks may not account for ~~no~~ more than one-third of the total time allocated per week for personal care services. ~~In no case may a personal care plan consist only of household tasks.~~

(~~12~~11) Personal care services must be prescribed in writing at least annually by a physician and must be reviewed at least every ~~120~~ 180 days by a ~~registered~~ licensed nurse.

(~~13~~12) A recipient may receive personal care services through the medicaid home and community based services program for elderly and physically disabled persons, or the medicaid home and community based services program for persons with developmental disabilities, ~~or the medicaid home and community OBRA services for persons with developmental disabilities~~ in addition to the personal care services provided through these rules.

~~(14) The department, except in circumstances meeting the requirements for sole source procurement, contracts with providers chosen through a request for proposals competitive process.~~

(13) Personal care providers must be independent contractors for purposes of federal and state wage and hour laws and workers' compensation laws. Personal care providers are limited to businesses incorporated under the laws of the state of Montana. Personal care providers must demonstrate that they are paying workers' compensation and unemployment insurance premiums.

(14) The department will enroll providers who provide the following documentation:

(a) the provider's articles of incorporation;

(b) a written contingency plan, approved by the department, addressing service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation;

(c) general liability insurance with a minimum coverage of $100,000 per person;

(d) motor vehicle liability insurance with a minimum coverage of $100,000 per person;

(e) current unemployment insurance and worker's compensation coverage; and

(f) financial solvency, to include the ability to make a projected 4 month payroll.

Subsection (15) remains the same.

(16) Personal care services may only be delivered by a personal care attendant employed by an ~~contractor~~ enrolled medicaid provider that has ~~specifically contracted with~~ met the criteria established by the department for the delivery of personal care services.

(17) Personal care services ~~are~~ may not ~~available~~ be provided to relieve a parent of ~~their~~ child caring or other legal responsibilities.

(a) Personal care for disabled children may be appropriate when the parent is unqualified or otherwise unable to provide the personal care ~~or~~ and the child is at risk of institutionalization unless the services are provided.

(18) Personal care services must be delivered in the most efficient manner available.

(19) Personal care services are not available to recipients who live in homes which are not accessible by automobiles.

Subsection (18) remains the same in text but is renumbered (20).

~~(a) the recipient becomes ineligible for medicaid;~~

Subsections (18)(b) and (18)(c) remain the same in text but are renumbered (20)(c) and (20)(d).

~~(d) the recipient leaves the state;~~

~~(e) the recipient dies;~~

~~(f) the recipient is admitted to a nursing facility, intermediate care facility for the mentally retarded, hospital, licensed personal care facility or placement other than a full-time residence;~~

Subsection (18)(g) remains the same in text but is renumbered (20)(b). Subsections (18)(h) and (18)(i) remain the same in text but are renumbered (20)(e) and (20)(f).

(~~j~~a) the recipient or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal sustances or to threats of physical harm; ~~or~~

(~~k~~g) the recipient ~~does not~~ refuses to accept services in accord with the plan of care.

Subsection (19) remains the same in text but is renumbered (21).

(~~2022~~) The ~~department will provide~~ provider shall give at least 10 days advance notice to a recipient when personal care services are terminated for ~~any of the~~ reasons listed in ~~subsections (14)(a) through (e), (h), (i) and (k)~~ subsections (20)(c) through (20)(g).

(23) The provider may immediately but temporarily suspend services for the reasons listed in subsection (20)(f). Following the temporary suspension of services the provider may enter into a contract with the recipient to ensure that the violations of subsection (20)(f) do not reoccur. If the recipient fails to abide by the term of the agreement services may be permanently terminated.

(~~21~~ 24) The department ~~will~~ shall provide written notice to an applicant when personal care services are initially denied to the applicant.

(~~22~~25) A person may request a fair hearing for any adverse determination made by the department ~~with which he is dissatisfied~~. Fair hearings will be conducted as provided for in ARM 46.2.201 et seq.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-6-141 MCA

46.12.557 PERSONAL CARE SERVICES, REIMBURSEMENT

(1) Personal care services ~~are limited to~~ may be provided up to but not more than 40 hours of attendant service per week per recipient as defined by the plan of care. The department may, within its discretion, authorize additional hours in excess of this limit. Any services exceeding this limit must be prior authorized by the department. Prior authorization for excess hours may be authorized if additional assistance is required:

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

(2) Reimbursement for personal care services is ~~based on contracted unit rates~~ $2.64 per 15 minute unit of service. The rates ~~are~~ is for units of attendant and nurse supervision service.

(a) A unit of attendant service is ~~one hour~~ 15 minutes and means an on-site visit specific to a recipient.

(b) A unit of nurse supervision service is ~~one hour~~ 15 minutes and means an on-site recipient visit and related activity specific to that recipient.

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

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

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

[RULE I] PERSONAL CARE SERVICES, PROVIDER COMPLIANCE

(1) Providers of personal care services shall be subject to compliance reviews to provide assurance to the department that services are being provided within the rules and policy of the program.

(2) Compliance reviews shall be conducted by department staff on the provider's premises.

(3) The reviews shall take place:

(a) on an annual basis;

(b) 90 days after the enrollment of a new provider; and

(c) at other times as determined by the department.

(4) The department shall determine compliance in the following service delivery areas:

(a) response to referrals;

(b) service initiation;

(c) physician orders;

(d) recipient needs intake;

(e) service delivery;
(f) attendant orientation to recipient;
(g) supervisory visits;
(h) service breaks;
(i) prior authorization; and
(j) service termination.

(5) The department shall determine compliance in the following administrative areas:
(a) attendant basic training;
(b) attendant in service training;
(c) nurse licensure;
(d) response to complaints;
(e) maintenance of incident reports;
(f) recipient surveys;
(g) attendant pool; and
(h) development of agency manuals and handouts.

(6) The department may choose to review other areas of the program at its discretion.

(7) The department shall examine 15 cases or 5% of the provider's case load for the purpose of the compliance review.

(8) The provider must meet all standards in 90% of the cases to be considered in compliance. If 90% compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM 46.12.402 through 46.12.409.

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

4. The Personal Care Services program provides assistance to medicaid recipients who require help with activities of daily living, escort and household tasks. Policy changes are necessary in order to transition the program from a single contracted agency to a system of multiple providers. This change requires the program to have additional controls to ensure the delivery of appropriate services. Specific changes include limitations on tasks reimbursed by the medicaid program, establishing authorized hours of service through a structured client needs profile, clarifying the role of the nurse supervisor, protecting the worker from abuse by other household members and establishing the requirements for a personal care provider. Other minor changes have been made for ease of administration, clarification of existing rules and grammatical purposes.

The Personal Care Services program has been operational since 1978. The program has grown significantly over the past few years indicating individuals are choosing to stay in their own homes rather than move to institutional settings. From this growth has been an increase in requests to receive services from an agency of their personal choice. The department has chosen to move to a multiple provider system based on this issue.

The notice to recipient provision contained in ARM 46.12.556 is also being changed to recognize current practice and due process requirements. Currently, the department's county offices provide notice if a recipient is determined to be ineligible, has died or leaves the state. Therefore, it is not necessary for the personal care provider to give notice. Thus, this requirement has been deleted from the rule.

5. The proposed changes will become effective July 1, 1995.

6. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the amendment of rules 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 and 46.12.1025 pertaining to medicaid transportation services	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 AND 46.12.1025 PERTAINING TO MEDICAID TRANSPORTATION SERVICES

TO: All Interested Persons

1. On June 2, 1995, at 1:30 p.m., a public hearing will be held in the Haynes Auditorium of the Historical Society of Montana Building, 225 N. Roberts, Helena, Montana to consider the proposed amendment of rules 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1012, 46.12.1015, 46.12.1022 and 46.12.1025 pertaining to medicaid transportation services.

The Department of Social and Rehabilitation 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 May 22, 1995, to advise us of the nature of the accommodation that you need. Providing an interpreter for the deaf or hearing impaired may require more time. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.12.1001 TRANSPORTATION AND PER DIEM, DEFINITION Subsection (1) remains the same.

(a) Transportation service does not include ambulance services or specialized nonemergency medical transportation services for ~~the handicapped~~ persons with disabilities.

(2) Per diem means expenses for a medicaid recipient's cost of meals and lodging enroute to and from ~~medical care~~, and while receiving medically necessary medical care.

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

46.12.1002 TRANSPORTATION AND PER DIEM, REQUIREMENTS ~~(1) Transportation and per diem shall be allowed when medically necessary for a recipient to obtain nonemergency services which are not reasonably available locally or in the state, or the combined total of out-of-state transportation,~~

~~medical services and other related expenses are less costly than in-state services.~~

~~(2) Transportation and per diem will not be reimbursed unless written prior authorization is granted by the department.~~

~~(3) A recipient shall not be directly reimbursed for transportation and/or per diem.~~

~~(a) Reimbursement will be made to the common carrier or a third party chosen by the client.~~

(1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Coverage of transportation and per diem is limited to transportation and per diem necessary to obtain necessary medical services covered by the medicaid program.

(3) Coverage for transportation and per diem is only available for transportation and per diem to the site of medical services nearest to the locality of the recipient.

(a) Transportation and per diem to a site, other than the one nearest to the locality of the recipient, is available if the combined total cost to the medicaid program of medical services and transportation and per diem at the more distant site is less than the total cost to the medicaid program for the provision of the services in the closest location.

(4) Coverage of transportation is limited to mileage fees and does not include any other fees. Reimbursement is not available for other fees.

(5) Coverage of per diem does not include a round trip that can reasonably be made in one day.

(6) Coverage of transportation and per diem must be prior authorized by the department or its designee.

(7) Reimbursement for transportation and per diem is made to the common carrier or lodging facility unless otherwise authorized by the department or its designee.

(~~4~~8) Coverage of ~~T~~transportation ~~shall be by~~ is limited to the least expensive available means suitable to the recipient's medical needs.

(9) Coverage of transportation and per diem are not available for transportation and per diem costs incurred during a retroactive eligibility period.

~~(5) Transportation and per diem are available only for individuals to obtain services from the nearest medicaid providers who are generally available and commonly used by other residents of the community.~~

~~(6) Reimbursement for transportation and per diem to secure medical services not included under the medicaid program shall not be allowed.~~

(10) Coverage of transportation and per diem for an attendant is only available for an attendant that is determined to be medically necessary.

(a) Use of an attendant must be prior authorized by the department or its designee.

(b) Coverage of transportation and per diem for an attendant is limited to the same standards and fees as for a recipient.

(c) An attendant must return home after accompanying the recipient to the destination for provision of medical services unless the department or its designee determine that the cost of the attendant's stay for the recipient's course of treatment will be less than the cost of additional transportation costs resulting from the return to home.

(d) Coverage of per diem and transportation is available for a responsible adult to accompany a minor for whom the responsible adult is necessary to provide legal consent for medical procedures.

~~(7) When a recipient requires an attendant in order to travel for necessary medical care outside his own community, the attendant will be reimbursed per diem for actual expenses up to the limits in ARM 46.12.1005(2). The total per diem reimbursement for an attendant will not exceed the cost of one return round trip to the site of medical care based on the lowest available fares. This maximum limit does not apply to attendants for transplantation candidates/recipients if the presence of the attendant is determined to be medically necessary.~~

~~(a) Prior approval by the department is required for reimbursement of attendants for transplantation candidates/recipients.~~

~~(8) Reimbursement of transportation by pressurized aircraft is only available for the transportation of recipients whose physical health would be endangered if non-pressurized aircraft were used.~~

(9)11) If a recipient dies enroute to or during treatment outside of ~~his~~ the recipient's community, the cost of the recipient's transportation to the medical service ~~will be reimbursed~~ is reimbursable. The cost of returning the body of a deceased recipient ~~will~~ is not ~~be reimbursed~~ reimbursable.

(12) Mileage submitted for travel reimbursement purposes must be rounded to the nearest whole mile.

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

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT

(1) ~~Transportation reimbursement is as follows:~~

~~(a)~~ The department ~~will~~ pays the lowest of the following reimbursement rates for transportation services:

(~~i~~a) the provider's actual submitted charge; or

~~(ii) the amount allowable for the same service under medicare; or~~

(b) the department's fee schedule.

~~(iii) the specified rates for the following services:~~

~~(A) A0170 personal or non-commercial ground vehicle mileage ..... current rate for state employees~~

~~(B) A0150 regularly scheduled, air ..... usual fee~~

~~(C) A0110 regularly scheduled, ground, including taxis and limousine service ..... usual fee~~

~~(D) A0221 pressurized air charter ..... $1.40 per statutory mile, round-trip~~

~~$1.40 per statutory mile, round trip~~

~~(E) A0040 non-pressurized air charter .....~~

~~$1.22 per statutory mile, round trip~~

~~(b) The reimbursement amounts for organ transplant candidates/recipients and attendants may exceed the rates in subsection (1) of this rule if determined by the department to be necessary to provide transportation commensurate with the client's health needs. Any reimbursement amounts in excess of the rates in subsection (1) of this rule must be negotiated with and approved by the department.~~

~~(2) Per diem reimbursement is as follows:~~

(2) The department's fee schedule for transportation is the following:

(a) personal or non-commercial ground vehicle mileage - current rate for state employees for the first 500 miles traveled in a month and $.15 per mile for miles traveled in excess of 500 miles in a month;

(b) regularly scheduled air or air charter - usual fee;

(c) regularly scheduled, ground, including taxis and limousine service for trips up to 16 miles total - usual fee not to exceed a total of $10.07 for a one way trip or not to exceed a total of $17.98 for a round trip;

(d) regularly scheduled ground, including taxis and limousine service for trips exceeding 16 miles - $.63 per mile that a person is a passenger.

(3) The department fee schedule for per diem items is the following:

Subsections (2)(a)(i) through (2)(a)(iv) remain the same in text but are renumbered (3)(a) through (3)(d).

~~(b) The department's per diem reimbursement rates in subsection (a) of this rule may be exceeded to meet actual costs determined medically necessary to preserve the health condition of transplantation candidate/recipient. Those reimbursement amounts for per diem in excess of the rates may be negotiated with and approved by the department but may not exceed the state employee out-of-state per diem reimbursement rates. The state employee out-of-state per diem rates for high cost areas are not applicable in calculating per diem reimbursement.~~

~~(c) Per diem reimbursement for the per diem costs of organ candidates/recipients may be extended for pre-surgical and post-surgical care if the care is determined to be medically necessary by the department.~~

~~(d) Per diem reimbursement for attendants may be extended for pre-surgical and post-surgical care of the organ candidate/recipient if their participation in that care is determined to be medically necessary by the department.~~

(4) No payment is available for travel and per diem costs that total less than $10.00 in a calendar month.

(5) Reimbursement for transportation and per diem may not exceed the reimbursement as calculated and specified by the department in the prior authorization for treatment.

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

46.12.1012 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REQUIREMENTS ~~(1) The service shall be available under the medicaid program only when it is necessary to obtain medical services covered by the medicaid program.~~

~~(a) Individuals receiving this service must have a handicap or physical limitation that causes them to be wheelchair bound and that precludes their use of usual forms of transportation in order to obtain medical services.~~

~~(b) The service may not be used for emergency medical transportation.~~

~~(c) All services must be authorized by the local county director prior to reimbursement.~~

~~(2) No payment will be made for specialized nonemergency medical transportation service in cases where some less costly means of transportation could be utilized without endangering the patient's health, whether or not such transportation is actually available.~~

(1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Coverage of specialized nonemergency medical transportation is limited to transportation of persons with disabilities for the purpose of obtaining nonemergency medical covered by the medicaid program.

(a) The person must be in need of specialized transportation due to the person either being wheelchair-bound or subject to transport by stretcher.

(3) Coverage of specialized nonemergency medical transportation is not available if another mode of transportation is appropriate for the transport of the recipient and is less costly.

(4) Coverage must be prior authorized by the department or its designee.

(5) Coverage of specialized nonemergency medical transportation is not available for costs for the service incurred during a retroactive eligibility period.

(6) Mileage submitted for travel reimbursement purposes must be rounded to the nearest whole mile.

(7) Coverage of specialized nonemergency medical transportation is limited to mileage fees and does not include any other fees. Reimbursement is not available for other fees.

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

46.12.1015 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT (1) The department ~~will~~ pays the lower of the following for specialized nonemergency medical transportation services ~~which are not also covered by medicare~~:

(a) the provider's actual submitted charge for the service not to exceed the rate approved by the public service commission; or

Subsection (1)(b) remains the same.

~~(2) The department will pay the lowest of the following for specialized nonemergency medical transportation services which are also covered by medicare:~~

~~(a) the provider's actual submitted charge for the service;~~

~~(b) the amount allowable for the same service under medicare; or~~

~~(c) the department's fee schedule contained in this rule.~~

~~(3) The provider's rates as approved by the public service commission or the rates allowed by the following specialized nonemergency medical transportation fee schedule.~~

(42) The department's fee schedule for ~~S~~specialized nonemergency medical transportation ~~fee schedule.~~ is the following:

Subsection (4)(a) remains the same in text but is renumbered (2)(a).

~~(b) There shall be no charge for usual passenger baggage which is not cargo.~~

~~(c) Children under six years of age accompanied by an adult paying passenger shall be carried free.~~

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

46.12.1022 AMBULANCE SERVICES, REQUIREMENTS (1) These requirements are in addition to those ~~contained in ARM 46.12.301 through 46.12.310~~ rule provisions generally applicable to medicaid providers.

(~~1~~2) ~~Medicaid payment for a~~Ambulance services ~~will be made only when~~ must be provided by a licensed ambulance provider.

(~~2~~3) ~~Medicaid payment for~~ Coverage of ambulance services ~~will be made only for~~ is limited to transportation ~~to~~ necessary to obtain medically necessary services from the nearest appropriate facility.

(~~3~~4) ~~No payment will be made~~ Coverage for ambulance services ~~in cases~~ is not available where ~~some means of~~ transportation by a mode other than the ambulance could be utilized without endangering the patient's health, whether or not such other transportation is actually available.

(45) Ground ambulance service is covered ~~if~~ when the patient's medical condition requires transportation by ambulance. The following are examples of circumstances which may be considered in determining the medical need for ground ambulance service. However, the presence or absence of any one or more of the following does not necessarily establish the medical need for the service:

Subsections (4)(a) through (4)(d) remain the same in text but are renumbered (5)(a) through (5)(d).

(e) the patient sustains an acute stroke or myocardial infarction; ~~and~~/or

Subsection (4)(f) remains the same but is renumbered (5)(f).

~~(5)~~(6) Air ambulance service is covered ~~if~~ when:

Subsections (5)(a) through (5)(c) remain the same but are renumbered (6)(a) through (6)(c).

(7) Nonemergency scheduled ambulance services must be prior authorized by the department or its designee.

Subsection (6) remains the same in text but is renumbered (8).

(9) Emergency ambulance services must be reported to the department's designee within 30 days of the emergency transport.

(~~7~~10) Ambulance claims ~~will be~~ for emergency services are screened for medical necessity and appropriateness by the designated review organization prior to payment.

(11) Coverage of ambulance services is not available for costs for the service incurred during a retroactive eligibility period.

(12) Mileage submitted for travel reimbursement purposes must be rounded to the nearest whole mile.

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

46.12.1025 AMBULANCE SERVICES, REIMBURSEMENT (1) Except as provided in subsection (9), the department ~~will~~ pays the lowest of the following for ambulance services:

Subsections (1)(a) and (1)(b) remain the same.

(c) the department's fees as provided in this section.

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

(3) The department may reimburse providers for ambulance services to transport patients to out-of-state facilities at negotiated fees where the department or its designee in its discretion determines that the in-state reimbursement rates are inadequate to assure that the recipient will receive medically necessary services.

Subsection (4) remains the same.

(a) The fee ~~will be~~ is adjusted as necessary so that the fees in the aggregate are in accord with adjustments authorized for the particular fiscal year by the legislative appropriation process for that fiscal year.

Subsections (5) through (7) remain the same.

(8) Copies of the pricing manual, billing codes and HCPCS may be obtained from the ~~Medicaid Services Division,~~ Department of Social and Rehabilitation Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, Montana 59604-4210.

(9) Air transport ambulance services to the nearest appropriate facility for neonates (age 0 to 28 days) identified as meeting any one of the diagnosis related group (DRG) codes 385-390 and for pregnant women identified as meeting any one of the DRG codes 370, 372, 375 or 383 may be billed by an outpatient hospital service provider and reimbursed by medicaid as outpatient hospital services, according to the provisions of ARM 46.12.506 through ~~509~~ 46.12.509. ~~Such services must be provided by a licensed ambulance service provider.~~

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

3. The Department of Social and Rehabilitation Services provides coverage through the medicaid program for

transportation and per diem, specialized nonemergency medical transportation, and ambulance services. These services allow medicaid recipients to access necessary medical and medically-related services covered by the medicaid program.

The proposed rule amendments are generally necessary to conform terminology, to restructure the rules for better comprehension, to remove and add requirements as necessary, to revise coverages and to revise the reimbursement methodology.

The proposed amendments to ARM 46.12.1001, transportation and per diem, definition, revising definitions, are necessary to conform terminology in the definition of transportation and to further define per diem.

The proposed amendments to ARM 46.12.1002, transportation and per diem, requirements, are generally necessary to improve comprehension, to state coverage requirements with more specificity and to revise coverage of transportation and per diem to incur program savings. Removing county directors, as agents of the department in the matter of providing authorizations will improve administration of the program by allowing for a centralized clearinghouse to handle inquiries, reporting and authorizations. The limitation of coverage for per diem to trips of more than one day will reduce expenditures in a reasonable manner since a person traveling on a day trip may bring their own meals. The limitation of coverage for transportation to mileage fees is necessary to preclude providers from seeking further reimbursement through ancillary fees. Precluding coverage of transportation and per diem incurred during a retroactive eligibility period will improve administration of the program, will reduce expenditures and will not result in loss of access to medical services since the services were provided prior to the determination that the person is eligible for medicaid. The criteria for coverage of transportation and per diem for attendants is necessary to bring the rule into conformity with current practices.

The proposed amendments to ARM 46.12.1005, transportation and per diem, reimbursement, are necessary to improve comprehension, to improve administration of the reimbursement and to revise reimbursement for transportation and per diem to incur program savings. The removal of special reimbursement rates will simplify administration of the reimbursement and reduce program expenditures.

The proposed amendments to ARM 46.12.1012, specialized nonemergency medical transportation, requirements, are necessary to improve comprehension, to state coverage requirements with more specificity, to remove county directors as agents of the department in the matter of providing authorizations and to revise coverage of transportation and per diem to incur program savings.

Removing county directors, as agents of the department, in the matter of providing authorizations will improve administration of the program by allowing for a centralized clearinghouse to handle inquiries, reporting and authorizations. The limitation of coverage for transportation to mileage fees is necessary to preclude providers from seeking further reimbursement through ancillary fees. Precluding coverage of transportation and per diem incurred during a retroactive eligibility period will improve administration of the program, will reduce expenditures and will not result in loss of access to medical services since the services were provided prior to the determination that the person is eligible for medicaid.

The proposed amendments to ARM 46.12.1015, transportation and per diem, reimbursement, are necessary to improve comprehension. The preclusion of charges for passenger baggage is being removed since the rule on requirements will preclude the imposition of fees other than mileage fees. The preclusion of charges for children under 6 is being removed since this limitation is inappropriate.

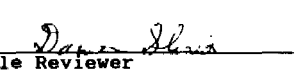
The proposed amendments to ARM 46.12.1022, ambulance services, requirements, are necessary to improve comprehension, to state coverage requirements with more specificity and to revise coverage of transportation and per diem to incur program savings. The requirement that nonemergency services be prior authorized and that use of ambulance services for emergencies be reported will provide for better administrative oversight to service usage without jeopardizing the health of the recipients. The limitation of coverage for transportation to mileage fees is necessary to preclude providers from seeking further reimbursement through ancillary fees. Precluding coverage of transportation and per diem incurred during a retroactive eligibility period will improve administration of the program, will reduce expenditures and will not result in loss of access to medical services since the services were provided prior to the determination that the person is eligible for medicaid.

The proposed amendments to ARM 46.12.1022, ambulance services, reimbursement, are necessary to improve comprehension and to remove a requirement that will be placed in the requirements rule.

4. The proposed changes will become effective July 1, 1995.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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



Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

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

In the matter of the adoption of Rule I and the amendment of rules 46.10.404, 46.10.408, 46.10.409 and 46.10.410 pertaining to AFDC child care services and at-risk child care services	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULE I AND THE AMENDMENT OF RULES 46.10.404, 46.10.408, 46.10.409 AND 46.10.410 PERTAINING TO AFDC CHILD CARE SERVICES AND AT-RISK CHILD CARE SERVICES

TO: All Interested Persons

1. On June 1, 1995, at 10:00 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 adoption of Rule I and the amendment of rules 46.10.404, 46.10.408, 46.10.409 and 46.10.410 pertaining to AFDC child care services and at-risk child care services.

The Department of Social and Rehabilitation 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 May 22, 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 rule as proposed to be adopted provides as follows:

[RULE I] JOBS CHILD CARE (1) Subject to the requirements of subsection (2) of this rule, the department must provide child care assistance to AFDC recipients who are enrolled in the JOBS program, a tribal JOBS program or the families achieving independence in Montana employment and training demonstration project and need child care in order to participate in approved activities of the program, including training.

(a) Training includes high school, GED and adult basic education programs, programs at vocational or technical schools, business colleges, junior colleges or universities and special classes which provide employment-related training.

(b) The child for whom the care is provided must be:

(i) under the age of 13 years; or

(ii) age 13 to 18 and a full-time student expected to complete the child's school program by age 19, providing that the child requires care because the child is either:

(A) physically or mentally incapacitated as determined by a physician or licensed or certified psychologist; or

(B) is under the supervision of a court.

(2) The department shall make child care payments in accordance with the requirements and payment amounts set forth in ARM 46.10.404.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

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

46.10.404 TITLE IV-A ~~DAY~~ CHILD CARE, ~~FOR CHILDREN OF RECIPIENTS IN TRAINING OR IN NEED OF PROTECTIVE SERVICES~~ REQUIREMENTS AND PAYMENT RATES ~~(1) Unless otherwise provided, in addition to the basic AFDC grant, day care payment will be provided for children of recipients who are attending employment-related training or for children in need of protective services day care. AFDC recipients who attend JOBS training shall be referred for JOBS-related day care. AFDC recipients who are employed shall have their day care expenses deducted from earned income when testing net monthly income and when determining grant amount as provided in ARM 46.10.512.~~

(1) The provisions of this rule regarding requirements and payment rates for Title IV-A child care apply to child care assistance provided to AFDC recipients participating in the JOBS program (including tribal JOBS program and the employment and training demonstration project for recipients participating in the families achieving independence in Montana project), to recipients pursuing self-initiated education or training and to families under the transitional child care and at-risk child care programs.

Subsection (2) remains the same.

(a) "full-day care" means care provided for a continuous period of ~~six~~ 6 hours or more per day;

(b) "part-time care" means care provided for a continuous period of less than ~~six~~ 6 hours per day;

(c) "day care home" means a private residence in which ~~day~~ child care is provided for ~~one~~ 1 to ~~six~~ 6 children on a regular basis;

(d) "group day care home" means a private residence in which ~~day~~ child care is provided for 7 to 12 children on a regular basis; and

(e) "day care center" means a place in which ~~day~~ child care is provided for 13 or more children on a regular basis~~; and~~.

~~(f) "extra meal" means meals as defined in ARM 11.14.101(6)(e).~~

(3) ~~Limitations to~~ Title IV-A ~~day~~ child care requirements:

~~(a) Title IV-A day care payments are made for children of parents who are AFDC recipients in training on a full- or part-time basis. Training includes, but is not limited to: vocational-technical schools, business colleges, junior colleges, universities, or special classes which may be classified as "employment-related training." Students who are working to support their education are included under this rule.~~

~~(b) Determination as to whether a child is in need of protective services day care shall be made by the county social worker.~~

(~~a~~) Title IV-A ~~day~~ child care payment may be made through a vendor or two-party payment.

(~~d~~b) Title IV-A ~~day~~ child care payment will be made upon evidence of actual charge or cost. Evidence of actual charge or cost includes verification from the provider of day care services. Verification includes the signature of the individual provider or his designee, the month of service, and names of children served.

(c) Title IV-A child care is available only for care provided by licensed or registered day care facilities or by a child care provider who is legally operating pursuant to Montana law as set forth in 52-2-703 and 52-2-721, MCA. Title IV-A payments are available for in-home care furnished by a provider who is licensed or registered or is not required to be licensed or registered, including care provided by a person related to the child by blood or marriage. However, no payments shall be made to any person who is living in the same house as the child for whom care is being provided or to the child's parent or to any person who is not 18 years of age or older.

(d) Families must recertify with their district resource and referral agency as required in order to continue receiving child care assistance.

(e) The provider must allow the children's parents unlimited access to the children whenever they are in the care of the provider.

(f) The provider may not discriminate against children on the basis of race, national origin, ethnic background, sex, religion or handicap.

(4) Payment rates are as follows:

(~~e~~a) The maximum rate for full-day care in day care homes is ~~$11.25~~ $12.75 per day per child for children 24 months of age or older and ~~$12.00~~ $14.00 per day per child for infants under 24 months of age. The maximum rate for full-day care in group day care homes is ~~$11.25~~ $12.75 per child per day for children 24 months of age or older and ~~$12.00~~ $14.50 per child per day for infants under 24 months of age. The maximum rate for full-day care in day care centers is ~~$11.00~~ $14.00 per child per day for children 24 months of age or older and ~~$13.00~~ $15.00 per child per day for infants under 24 months of age. The maximum rate for full-day care provided by legally unlicensed and unregistered providers is $11.25 per day per child for children 24 months of age or older and $12.00 per day per child for infants under 24 months.

(~~f~~b) The maximum rate for part-time care in day care homes is ~~$1.50~~ $2.00 per hour per child. The maximum rate for part-time care in group day care homes is ~~$1.50~~ $2.00 per hour per child. The maximum rate for part-time care in day care centers is $2.00 per hour per child. The maximum rate for part-time care provided by legally unlicensed and unregistered providers is $1.50 per hour per child. Part-time care payments may not exceed the full-day or night care rate.

~~(g) Upon written approval of the department, the following services are also eligible for payment under Title IV-A day care:~~

~~(i) extra meals at a rate of $1.00 per meal per child; and~~

(~~i~~ic) ~~exceptional~~ Upon written approval of the department payment shall be made for special needs child care, as defined in ARM 11.14.101~~(6)(d)~~, at a maximum of ~~$12.00~~ $13.00 per day per child for full-time care or ~~$1.75~~ $2.00 per hour per child for part-time care in day care homes or group day care homes and ~~$12.15~~ $14.50 per day per child for full-time care and $2.00 per hour per child for part-time care in day care centers.

~~(h) Title IV-A day care is available only for care provided by licensed or registered day care facilities or by a day care provider who is legally operating pursuant to Montana law as set forth in 52-2-703(2)(a) and (b) and 52-2-721(1)(a) and (b), MCA. Title IV-A payments are available for in-home care furnished by a provider who is licensed or registered or is not required to be licensed or registered, including care provided by a person related to the child by blood or marriage. However, no payments shall be made to any person who is living in the same house as the child for whom care is being provided.~~

(~~i~~5) The recipient shall choose his day care provider, subject to the limitations set forth in subsection (3)(c) of this rule. Additionally, if the provider chosen by the parent is legally unlicensed or unregistered, the provider must complete an application at the local office of the department of family services in order to receive payment.

AUTH: Sec. 53-4-212 and 53-4-503 MCA
IMP: Sec. 53-4-211, 53-4-514 and 53-4-716 MCA

46.10.408 TRANSITIONAL CHILD CARE, REQUIREMENTS

~~(1) A family which is no longer eligible for AFDC qualifies for transitional child care assistance if:~~

~~(a) a qualifying child as defined in subsection (2) of this rule is present in the home;~~

~~(b) the family meets the requirements of subsection (3) of this rule;~~

~~(c) the family's income does not exceed the maximum income specified for that size family in the sliding fee scale contained in ARM 46.10.409;~~

~~(d) child care is necessary in order for a member of the family to accept or retain employment; and~~

~~(e) the family requests assistance and provides verification of income necessary to determine eligibility.~~

~~(2) A qualifying child is one who meets the definition of a dependent child in ARM 46.10.110 except that the child is not needy and is:~~

(1) Transitional child care, if necessary to permit a member of the AFDC family to accept or retain employment, and if requested, shall be provided to needy families with dependent children:

Subsection (2)(a) remains the same in text but is renumbered (1)(a).

(b) age 13 ~~or older if~~ to 18, or if 18, a full-time student expected to complete their school program by age 19; and

(i) the child is physically or mentally incapable of caring for himself or herself, as determined by a physician or licensed or certified psychologist; or

(ii) under the supervision of the court; or ~~and would be a dependent child except for the receipt of supplemental security income benefits under Title XVI or foster care benefits under Title IV-E of the Social Security Act.~~

(iii) who would be a dependent child except for the receipt of benefits under supplemental security income (SSI) under Title XVI or foster care under Title IV-E of the Social Security Act.

(~~3~~2) ~~To be~~ The family is eligible for transitional child care if ~~assistance, a family must~~:

(a) ~~have~~ the family ceased to be eligible for AFDC because of either:

(i) the loss of the ~~$30 plus~~ 1/3 disregard at the end of 4 months;

(ii) the loss of the $30 disregard at the end of ~~8~~ 12 months; or

(iii) increased income from employment or increased hours of employment; ~~and~~

(b) ~~have~~ the family received AFDC in at least 3 of the 6 months immediately preceding the first month of ineligibility~~.~~, and at least 1 of the 3 months of AFDC receipt was in Montana; and

(c) the family requests transitional child care benefits, provides required information and meets income standards.

(~~4~~3) Eligibility for transitional child care begins with the first month which the family is ineligible for AFDC ~~due to~~ for reasons ~~specified~~ included in subsection (~~3~~2)(a)(i), (ii) or (iii) and continues for a period of 12 consecutive months unless the caretaker relative:

(a) ~~the caretaker relative~~ terminates employment without good cause;

~~(b) the caretaker relative fails to cooperate with child support requirements;~~

~~(c) the child is no longer deprived of parental care or support, except in the case of a family which qualified for AFDC based on the unemployment of the parent; or~~

~~(d) the caretaker relative fails to pay the child care provider the family's co-payment.~~

(b) fails to cooperate in establishing and enforcing child support obligations;

(c) has countable gross family income exceeding the guidelines of the sliding fee scale; or

(d) fails to recertify every 3 months with their district resource and referral agency.

(~~5~~4) If the caretaker relative loses a job without good cause, and then finds another job, the family may qualify for the remaining portion of the 12 month eligibility period. If the child care arrangements during breaks in employment would

otherwise be lost, up to 30 days of child care may be provided during breaks in employment.

(a) If the family reestablishes eligibility for AFDC, a new 12 month period of eligibility for transitional child care may be established if the family meets the conditions of eligibility found in subsections (1)~~,~~ and (2) ~~and (3)~~ above.

(5) Families must report changes of income, changes in household composition or address changes (within 10 days). Failure to report any of these changes could result in an overpayment of benefits. When a family receives transitional child care assistance for which it is not eligible or in an amount larger than that to which it is entitled:

(a) the family must repay the department 100% of the amount which the family was overpaid if the overpayment occurred because the family assistance was continued pending a hearing decision as provided in ARM 46.2.206 and the hearing decision sustains the department's action to terminate or reduce the family's assistance;

(b) the family must repay the department 125% of the amount which the family was overpaid if the family obtained assistance to which it was not entitled through fraudulent means. A willfully false statement, representation or impersonation or other fraudulent device will be considered fraudulent means.

(6) The family is required to repay the department 100% of the amount which the family was overpaid if an overpayment caused by the department's error or in the family's non-fraudulent error.

(7) The amount which the family is required to repay under subsections (5)(a)(b) and (6) of this rule is a debt due to the state until fully repaid.

(8) All adult members of the family residing in the household at the time an overpayment occurs shall be jointly and severally liable for the amount which the family is required to repay.

(9) A family which is dissatisfied with an action taken on its application for transitional child care assistance or the continuation of such assistance is entitled to a fair hearing as provided in ARM 46.2.202.

(a) The family is entitled to a fair hearing with regard to the issues of:

(i) the family's eligibility for assistance;

(ii) the amount of the family's co-payment;

(iii) whether the family was in violation of the requirements of subsection (2) of this rule; and

(iv) whether an overpayment of transitional child care assistance has occurred and the amount of such overpayment, if any.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

46.10.409 SLIDING FEE SCALE FOR TRANSITIONAL CHILD CARE

(1) The following is a sliding fee scale which indicates the amount the family will contribute towards child care costs. The number of household members which contribute to the sliding fee scale family size will be determined by using AFDC rules for determining household members. The amount of countable gross family income will be determined according to AFDC rules for counting income except that:

(a) Step-parent income is not deemed; it is counted in full.

(b) Earned income of children in the household is not counted.

(ac) ~~SLIDING FEE SCALE FOR TRANSITIONAL CHILD CARE (TCC) October 16, 1992~~

133% OF POVERTY SLIDING FEE SCALE

Family Size	Gross Monthly Income	Co-payment (1 child)	Co-payment (2 children)*
2	0 - ~~766~~ 700	$ ~~0~~ 7	
	~~767 - 866~~ 701 - 800	~~17~~ 16	
	~~867 - 966~~ 801 - 900	~~29~~ 27	
	~~967 - 1066~~ 901 - 1000	~~43~~ 40	
	~~1067 - 1166~~ 1001 - 1112	~~58~~ 56	
	~~1167 - 1266~~	~~76~~	
	~~1267 - 1366~~	~~96~~	
	~~1367 - 1440~~	~~115~~	
	~~1441~~ 1113+- ineligible		
3	0 - ~~964~~ 900	$ ~~10~~ 9	$ ~~13~~ 14
	~~965 - 1064~~ 901 - 1000	~~21~~ 20	~~28~~ 25
	~~1065 - 1164~~ 1001 - 1100	~~35~~ 33	~~46~~ 39
	~~1165 - 1264~~ 1101 - 1200	~~51~~ 48	~~67~~ 54
	~~1265 - 1364~~ 1201 - 1395	~~68~~ 70	~~89~~ 77
	~~1365 - 1464~~	~~88~~	~~115~~
	~~1465 - 1564~~	~~109~~	~~143~~
	~~1565 - 1664~~	~~133~~	~~174~~
	~~1665 - 1779~~	~~142~~	~~186~~
	~~1780~~ 1396+- ineligible		
4	0 - ~~1163~~ 1100	$ ~~12~~ 11	$ ~~16~~ 17
	~~1164 - 1263~~ 1101 - 1200	~~25~~ 24	~~33~~ 30
	~~1264 - 1363~~ 1201 - 1300	~~41~~ 39	~~54~~ 46
	~~1364 - 1463~~ 1301 - 1400	~~59~~ 56	~~77~~ 63
	~~1464 - 1563~~ 1401 - 1500	~~78~~ 75	~~102~~ 83
	~~1564 - 1663~~ 1501 - 1679	~~100~~ 101	~~131~~ 109
	~~1664 - 1763~~	~~123~~	~~161~~
	~~1764 - 1863~~	~~149~~	~~195~~
	~~1864 - 1963~~	~~157~~	~~206~~
	~~1964 - 2063~~	~~186~~	~~244~~
	~~2064 - 2118~~	~~191~~	~~250~~
	~~2119~~ 1680+- ineligible		

5	0 - ~~1361~~ 1300 ~~1362 - 1461~~ 1301 - 1400 ~~1462 - 1561~~ 1401 - 1500 ~~1562 - 1661~~ 1501 - 1600 ~~1662 - 1761~~ 1601 - 1700 ~~1762 - 1861~~ 1701 - 1800 ~~1862 - 1961~~ 1801 - 1963 ~~1962 - 2061~~ ~~2062 - 2161~~ ~~2162 - 2261~~ ~~2262 - 2361~~ ~~2362 - 2456~~ ~~2457~~ 1964+- ineligible	$ ~~14~~ 13 ~~29~~ 28 ~~47~~ 45 ~~66~~ 64 ~~88~~ 85 ~~112~~ 108 ~~137~~ 137 ~~166~~ ~~173~~ ~~203~~ ~~213~~ ~~246~~	$ ~~18~~ 20 ~~38~~ 35 ~~62~~ 53 ~~86~~ 72 ~~115~~ 94 ~~147~~ 117 ~~179~~ 147 ~~216~~ ~~227~~ ~~266~~ ~~278~~ ~~322~~
6	0 - ~~1559~~ 1500 ~~1560 - 1659~~ 1501 - 1600 ~~1660 - 1759~~ 1601 - 1700 ~~1760 - 1859~~ 1701 - 1800 ~~1860 - 1959~~ 1801 - 1900 ~~1960 - 2059~~ 1901 - 2000 ~~2060 - 2159~~ 2001 - 2100 ~~2160 - 2259~~ 2101 - 2247 ~~2260 - 2359~~ ~~2360 - 2459~~ ~~2460 - 2559~~ ~~2560 - 2659~~ ~~2660 - 2795~~ ~~2796~~ 2248+- ineligible	$ ~~16~~ 15 ~~33~~ 32 ~~53~~ 51 ~~74~~ 72 ~~98~~ 95 ~~124~~ 120 ~~151~~ 147 ~~181~~ 180 ~~189~~ ~~221~~ ~~230~~ ~~266~~ ~~280~~	$ ~~21~~ 23 ~~43~~ 40 ~~69~~ 60 ~~97~~ 81 ~~128~~ 105 ~~162~~ 130 ~~198~~ 158 ~~237~~ 191 ~~248~~ ~~290~~ ~~301~~ ~~348~~ ~~367~~
7 or more	0 - ~~1758~~ 1700 ~~1759 - 1858~~ 1701 - 1800 ~~1859 - 1958~~ 1801 - 1900 ~~1959 - 2058~~ 1901 - 2000 ~~2059 - 2158~~ 2001 - 2100 ~~2159 - 2258~~ 2101 - 2200 ~~2259 - 2358~~ 2201 - 2300 ~~2359 - 2458~~ 2301 - 2400 ~~2459 - 2558~~ 2401 - 2530 ~~2559 - 2658~~ ~~2659 - 2758~~ ~~2759 - 2859~~ ~~2860~~ 2531+- ineligible	$ ~~18~~ 17 ~~37~~ 36 ~~59~~ 57 ~~82~~ 80 ~~108~~ 105 ~~135~~ 132 ~~165~~ 161 ~~197~~ 192 ~~205~~ 227 ~~239~~ ~~248~~ ~~286~~	$ ~~24~~ 26 ~~48~~ 45 ~~77~~ 67 ~~107~~ 90 ~~141~~ 116 ~~177~~ 143 ~~216~~ 173 ~~258~~ 204 ~~269~~ 240 ~~313~~ ~~325~~ ~~376~~

* Note: There will be no additional charge if a family places more than 2 children in child care; the maximum fee will be the 2 children rate.

(~~b~~d) The co-payment for families using less than 20 hours per week of child care will be ~~one-half~~ 1/2 of the co-payment shown in the tables in subsection (1)(a).

(2) The department will pay the portion of the family's child care costs, based on the established reimbursement rates for the appropriate type of care, which the family is not required to pay pursuant to subsection (1) of this rule. ~~If an overpayment occurs for any reason, the family is required to repay to the department the amount which was overpaid.~~

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-4-701 and 53-4-716 MCA

46.10.410 AT-RISK CHILD CARE SERVICES Subsection (1) remains the same.

(2) Families are eligible for at-risk child care if all eligibility requirements set forth in subsections (2)(a), (2)(a)(i), (2)(b) through (f)(i), and (3) are met. There will be a limited number of slots available based on funding and the average cost of child care per family paid by the department. Priority for ~~A~~at-risk child care assistance will be given ~~on a first come, first served basis. In the event that two or more families apply for assistance at the same time, priority will be given as follows~~ as follows: first priority will be given to parents whose ~~earned~~ income is below ~~34%~~ 100% of ~~the state median income~~ the federal poverty level; second priority will be given to families whose ~~earned~~ income is at or below ~~75%~~ 133% of ~~the state median income~~ the federal poverty law but above ~~34%~~ 100% of ~~the state median income~~ the federal poverty level. In each of these income categories, priority will be given to any family which has lost eligibility for transitional child care ~~in the 24 months immediately~~ prior to their application for at-risk child care. In the event 2 families have equal priority, at-risk child care assistance will be given on a first come, first served basis.

Subsection (2)(a) remains the same.

(i) A family is at risk and is income-eligible for assistance if its gross income is at or below the maximum income for a family of its size set forth in the tables in ARM 46.10.409. All ~~E~~education income from scholarships, grants, loans ~~and work study~~ will be excluded as well as earned income tax credits, tribal per capita payments, VISTA volunteer stipends, independent living individual needs criteria (INC) payments for youth, food stamp benefits, and foster care payments. All supplemental security income, state supplemental income, in-kind income, earned income of dependent children living in the household, training related reimbursement, AFDC recoupment amount, Alien sponsor deemed income, child support arrearage, earned income tax credit, housing subsidy, irregular or infrequent income of $20 or less and valid loans are exempt. All other gross family income will be counted.

(b) If ~~the~~ a family member also attends school, the child care needed for the time the family member is in school must be paid for from another source. At-risk child care is only for employment or ~~e~~employment-related ~~child care~~ reasons.

(c) If anyone in the immediate family receives either regular AFDC or AFDC-unemployed parent grants, the family is not eligible for at-risk child care.

(d) All children living in the home, who need to be cared for in order for a family member to work, are eligible under this funding source. ~~They~~ The children must be under age 13 or if age 13 or older but less than 18 years of age, or if over 18, expected to graduate from their school program by age 19, physically or mentally incapable of self-care or under court supervision. The children do not have to meet AFDC dependent child deprivation criteria. Children in common, step-children, supplemental security income (SSI) or Title IV-E foster care children are eligible.

Subsections (2)(e) through (2)(f)(iii) remain the same.

(iv) Families must report ~~income~~ any increases or decreases ~~of $100 or more~~ in income.

~~(g) Families may choose any legally operating child care provider to care for their children, as long as the person is age 18 or over and is not the parent or a person who resides in the same household. If not already licensed or registered, the provider must register with the local office of the department of family services in order to receive payment.~~

~~(h) The provider must allow unlimited parental access to the parent's children whenever they are in the care of the provider. The provider may not discriminate against children on the basis of race, national origin, ethnic background, sex, religion or handicap.~~

Subsection (2)(i) remains the same in text but is renumbered (2)(g). Subsections (3) and (4) remain the same.

(5) When a family receives at-risk child care assistance for which it is not eligible or in an ~~larger~~ amount larger than that to which it is entitled:

Subsections (5)(a) and (5)(b) remain the same.

(i) "Fraudulent means" is ~~defined as~~ considered to be a willfully false statement, representation or impersonation or other fraudulent device.

(6) The family is not required to repay ~~an overpayment caused~~ the department 100% of the amount which the family was overpaid if an overpayment was caused by the department's error or the family's non-fraudulent error.

(7) The amount which the family is required to repay under subsections (5)(a)(b) and ~~or (5)(b)~~ (6) of this rule is a debt due to the state until fully repaid.

Subsections (8) through (9)(a)(iii) remain the same.

(iv) whether an overpayment of at-risk child care assistance has occurred and/~~or~~ the amount of such overpayment, if any.

AUTH: Sec. 53-2-201 and 53-4-212 MCA
IMP: Sec. 53-2-108, 53-2-201, 53-2-606, 53-4-212 and 53-4-231 MCA

4. The amendment of ARM 46.10.404 is necessary to increase the rates the department pays for child care for recipients of Aid to Families with Dependent children (AFDC) who are in the JOBS program or in self-initiated training or education or who receive child care assistance in the at-risk or transitional child care programs. The rates are being raised to implement increased appropriations by the 54th Montana Legislature in House Bill 2 which will bring payment rates to 75% of the market rate for child care. Additionally, provisions of 46.10.404 relating solely to JOBS participants are being moved to a new rule in Title 46, chapter 10, subchapter 8, which contains rules pertaining to the JOBS program. The new rule specifies when the department must provide child care assistance to JOBS participants.

In House Bill 245 the 54th Montana Legislature mandated that at-risk child care assistance be provided only to families whose income does not exceed 133% of the federal poverty level. The at-risk program is a federally funded program for families not currently receiving AFDC who need care in order to work and who are at risk of becoming eligible for AFDC without assistance. The states are allowed to set their own eligibility rules for the at-risk program, and currently Montana's rules allow families with incomes greater than 133% of poverty to receive at-risk assistance. The amendment of ARM 46.10.410 is therefore necessary to limit eligibility to families whose income does not exceed 133% of poverty. Changes are also being made to the rule to specify in more detail what income is counted and what income excluded for purposes of determining eligibility, and provisions are being added regarding repayment of benefits erroneously received under the at-risk child care program.

ARM 46.10.408 and 46.10.409 govern the transitional child care (TCC) program, for persons who have recently lost eligibility for AFDC due to increased income. The amendment of ARM 46.10.408 and 46.10.409 is necessary to keep the income requirements for the TCC program consistent with those governing the at-risk program. In accordance with federal mandates, the department has tried to make its federally funded child care programs "seamless," that is, having rules for the different programs which are as consistent as possible. This makes the rules of the programs less confusing to the families they serve and makes administration of the programs easier and less error-prone. Currently the same income limits and sliding fees scales apply to both the TCC and at-risk programs. ARM 46.10.408 and 46.10.409 therefore must be amended to keep the rules of the two programs regarding eligibility, co-payments and certain other requirements consistent.

Changes are also being made in the wording and organization of ARM 46.10.404, 46.10.408, 46.409, and 46.10.410 which do not affect the substance of those rule but are made for purposes of style and clarity.

5. The proposed changes will become effective July 1, 1995.

6. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 8, 1995.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 1, 1995.

BEFORE THE BOARD OF HORSE RACING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to licenses for parimutuel wagering and general requirements	)))))	NOTICE OF AMENDMENT OF 8.22.502 LICENSES ISSUED FOR CONDUCTING PARIMUTUEL WAGERING ON HORSE RACING MEETINGS AND 8.22.801 GENERAL REQUIREMENTS

TO: All Interested Persons:

1. On March 30, 1995, the Board of Horse Racing published a notice of proposed amendment of the above-stated rules at page 426, 1995 Montana Administrative Register, issue number 6.

2. The Board has amended 8.22.502 exactly as proposed and has amended 8.22.801 as proposed, but with the following changes:

"8.22.801 GENERAL REQUIREMENTS (1) through (27) will remain the same as proposed.

(28) NO MAIDEN 7 YEARS OLD OR OLDER SHALL BE ELIGIBLE TO ENTER OR START IN ANY RACE. FOR PURPOSES OF THIS RULE ONLY, A MAIDEN IS A HORSE WHICH AT THE TIME OF STARTING HAS NEVER WON A RACE ON THE FLAT IN ANY COUNTRY.

(28) through (37)(b) will remain the same as proposed, but will be renumbered (29) through (38)(b).

(c) Lease arrangements shall reflect both lessor's (owner) and lessee's name in the racing program, ~~and identical lessor and/or owner names, along with identical trainer names, shall cause the horses or mules to be deemed an entry~~ AND HORSES OR MULES SHOWING THE SAME OR PARTIALLY THE SAME OWNERSHIP (WHETHER INDIVIDUALLY OR THROUGH A PARTNERSHIP OR CORPORATION) SHALL BE DEEMED A HARD ENTRY.

(38) through (68)(a) will remain the same as proposed, but will be renumbered (39) through (69)(a)."

Auth: Sec. 23-4-104, 23-4-202, MCA; IMP, Sec. 23-4-104, 23-4-202, 23-4-301, MCA

3. The Board accepted written comments through April 27, 1995. The Board has thoroughly considered all comments and testimony received. Those comments, in summary form, and the Board's responses are as follows:

COMMENT: One comment was received stating the change to 8.22.801(28) was an excellent rule change and should be implemented immediately to allow more horses to compete in 1995.

RESPONSE: The Board acknowledges receipt of the comment in support. The Board will implement the rule change for the 1995 season, but will change the proposed language to allow maidens up to seven years old, rather than with no age limit whatsoever. The Board expressed concern over allowing horses to race in maiden races with no upper age limit, as this might

encourage inappropriate entries of horses which should not be racing.

COMMENT: One comment was received stating the proposed language of 8.22.801(37)(c) was not accurate in that it states "identical" owner and trainer names would create a hard entry, but some ownership arrangements through partnerships or corporations might not use identical names. The comment suggested the language be amended to read "Lease arrangements shall reflect both lessor (owner) and lessee names in the racing program, and horses or mules showing the same or partially the same ownership (whether individual or through partnership or a corporation) shall be deemed a hard entry."

RESPONSE: The Board concurs with the comment and will amend the rule as shown above.

COMMENT: One comment was received stating the proposed change to 8.22.502 is not necessary, as the Board already has the authority to fine a track or individual if warranted, and the proposed change would only duplicate authority already in place.

RESPONSE: The Board stated it is aware of its existing authority over track licensees, but this has not solved the problem of tracks continuing to submit stakes conditions after the stated deadline. The Board will implement this rule change to put all track licensees on notice that this is the penalty they face for non-compliance with the rule, in an attempt to achieve compliance where other existing methods have failed.

BOARD OF HORSE RACING
JAMES SCOTT, DVM, CHAIRMAN

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 1, 1995.

BEFORE THE BOARD OF FUNERAL SERVICE
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to reciprocity, fees, definitions, continuing education, and sponsors; repeal of rules pertaining to standards for approval, prior approval of activities, post approval of activities, review of programs, hearings, attendance record report, disability or illness, hardship exception and other exceptions; and adoption of rules pertaining to crematory operators and technicians	NOTICE OF AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO THE FUNERAL SERVICE INDUSTRY

TO: All Interested Persons:

1. On March 16, 1995, the Board of Funeral Service published a notice of proposed amendment of ARM 8.30.404, 8.30.407, 8.30.501, 8.30.502 and 8.30.504; repeal of ARM 8.30.503, 8.30.505 through 8.30.509, and 8.30.511 through 8.30.513; and adoption of new rules pertaining to the funeral service industry, at page 322, 1995 Montana Administrative Register, issue number 5.

2. The Board has amended 8.30.404, 8.30.407, 8.30.501 and 8.30.502; repealed 8.30.503, 8.30.505 through 8.30.509 and 8.30.511 through 8.30.513; and adopted new rules I (8.30.807), II (8.30.808) and III (8.30.809) exactly as proposed. The Board has amended 8.30.504 as proposed, but with the following changes:

"8.30.504 SPONSORS (1) The board will recognize courses, programs or other continuing education activities sponsored by Montana funeral directors association (MFDA), national selected morticians (NSM), national funeral directors association (NFDA), independent funeral directors association (IFA), federated funeral directors of America, NATIONAL FOUNDATION OF FUNERAL SERVICE, Montana coroner's association, order of golden rule, Montana department of justice coroner's training programs and funeral industry supplier programs. All other programs must meet the criteria established in ARM 8.30.502."

Auth: Sec. 37-19-202, 37-19-316, MCA; IMP, Sec. 37-19-316, MCA

3. The Board accepted written comments through April 13, 1995. The Board has thoroughly considered all comments and testimony received. Those comments, in summary form, and the Board's responses are as follows:

COMMENT: One comment was received stating that some funeral homes within the state are owned by unlicensed persons, who receive monies from the business, but have never been required to comply with the continuing education rules and obtain six credits per year. The requirements should be changed to issue mortuary licenses only to corporations whose personnel meet the six continuing education credit hours each year.

RESPONSE: The Board noted that the proposed rules do not address the licensing of owners of funeral homes, but rules do exist which require a licensed mortician as a manager of the funeral homes. The licensed mortician managers are, of course, required to obtain six continuing education credits each year. No rule change is therefore necessary at this time.

COMMENT: One comment was received stating inspections of funeral homes may soon be done by unlicensed morticians, which would not be appropriate.

RESPONSE: The Board noted that this was not a comment on the proposed rule, and no response was therefore necessary.

COMMENT: One comment was received stating the proposed amendment to ARM 8.30.504(1) should include the National Foundation of Funeral Service as a recognized provider of continuing education courses.

RESPONSE: The Board concurs with the comment and will amend the rule to include the National Foundation of Funeral Service, as noted above.

COMMENT: One comment was received stating the requirements for establishing a crematory, especially a new facility not owned by an existing funeral home, should be stricter.

RESPONSE: The Board noted that crematory requirements are set by statute, and this comment is not therefore a comment on the proposed rules, so no response by the Board is necessary.

BOARD OF FUNERAL SERVICE
JOHN MICHELOTTI, CHAIRMAN

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

Annie M Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 1, 1995.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to non-disciplinary track, admission criteria and educational requirements	))))	NOTICE OF AMENDMENT OF 8.32.1606 NON-DISCIPLINARY TRACK, 8.32.1607 ADMISSION CRITERIA AND 8.32.305 EDUCATIONAL REQUIREMENTS

TO: All Interested Persons:

1. On December 8, 1995, the Board of Nursing published a notice of public hearing on the proposed amendment of the above-stated rules at page 3065, 1995 Montana Administrative Register, issue number 23.

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

3. No comments or testimony were received.

BOARD OF NURSING
NANCY HEYER, RN, CNA, PRESIDENT

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 1, 1995.

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

In the matter of the amendment of rules 16.8.401, 16.8.403 and 16.8.404, regarding emergency procedures, 16.8.807, regarding ambient air monitoring, 16.8.1001-16.8.1003, 16.8.1006 and 16.8.1008, regarding visibility impact assessment, 16.8.1102, 16.8.1107 and 16.8.1119, regarding preconstruction permits, 16.8.1204 and 16.8.1206, regarding stack heights and dispersion techniques, 16.8.1302 and 16.8.1307, regarding open burning, 16.8.1803 and 16.8.1804, regarding preconstruction permits for major stationary sources or major modifications located within attainment or unclassified areas, 16.8.1903 and 16.8.1905, regarding operating and permit application fees, 16.8.2002-16.8.2004, 16.8.2113, 16.8.2021 and 16.8.2025, regarding operating permits, and the adoption of new rule I, regarding acid rain permits.	CORRECTED NOTICE OF AMENDMENT AND ADOPTION (Air Quality)

To: All Interested Persons

1. On December 8, 1994, the board published a notice proposing the amendment and adoption of the above-captioned rules on page 3070 of the 1994 Administrative Register, Issue No. 23. On April 13, 1995, the final notice of adoption and amendment of those rules was published on page 535 of the 1995 Administrative Rules of Montana, Issue No. 7. Subsequently, it became apparent that both notices, through oversight, omitted a reference to paragraphs (28) through (33) of ARM 16.8.2002, which contains definitions. The following indicates the status of ARM 16.8.2002 as amended by the board:

16.8.2002 DEFINITIONS (1)-(26) Remain the same.
(27) Same as proposed.
(28)-(33) Remain the same.

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

by _____
ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995.

Reviewed by:
_____
Eleanor Parker, DHES Attorney

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

In the matter of the amendment of rule 16.29.103 regarding the transportation of dead human bodies)	NOTICE OF AMENDMENT OF RULES (Dead Human Bodies)

To: All Interested Persons

1. On March 30, 1995, the department published notice of the proposed amendment of the above-captioned rule at page 431 of the 1995 Montana Administrative Register, Issue No. 6.

2. The rule was amended as proposed with no changes.

3. No written or oral comments were received.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

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

In the matter of the amendment of rules 16.32.375, 425, and 426 regarding construction standards for hospices and specialty mental health care facilities	)))))	NOTICE OF AMENDMENT OF RULES (Health Care Facilities)

To: All Interested Persons

1. On March 30, 1995, the department published notice of the proposed amendment of the above-captioned rules at page 437 of the 1995 Montana Administrative Register, Issue No. 6.

2. The rules were amended as proposed with no changes.

3. No written or oral comments were received.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995 .

Reviewed by:

Eleanor Parker, DHES Attorney

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

In the matter of the adoption of a rule regarding the application of other licensure rules to personal care facilities.	NOTICE OF ADOPTION OF RULE (Personal Care Facilities)

To: All Interested Persons

1. On March 30, 1995, the department published notice of the proposed adoption of the above-captioned rule at page 435 of the 1995 Montana Administrative Register, Issue No. 6.

2. The rule was adopted as proposed with no changes.

RULE I (16.32.901A) APPLICATION OF OTHER RULES

3. No written or oral comments were received.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995.

Reviewed by:

Eleanor Parker, DHES Attorney

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

In the matter of the adoption of a rule regarding the application of other licensure rules to adult day care centers.	NOTICE OF ADOPTION OF RULE (Adult Day Care Centers)

To: All Interested Persons

1. On March 30, 1995, the department published notice of the proposed adoption of the above-captioned rule at page 433 of the 1995 Montana Administrative Register, Issue No. 6.

2. The rule was adopted as proposed with no changes.

RULE I (16.32.1012) APPLICATION OF OTHER RULES

3. No written or oral comments were received.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 1, 1995 .

Reviewed by:
Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the adoption of the proposed amendments and repeal of rules concerning the location of utilities in highway right-of-way	)))))))	NOTICE OF AMENDMENT OF RULES 18.7.201 THROUGH 18.7.204, 18.7.206, 18.7.211, 18.7.222 THROUGH 18.7.224, 18.7.226, 18.7.227, AND 18.7.229 THROUGH 18.7.232; AND THE REPEAL OF RULE 18.7.241

TO: All Interested Persons.

1. On February 23, 1995, the Department of Transportation published notice of public hearing on the above-stated proposed amendments, and repeal, at page 258 of the 1995 Montana Administrative Register, issue number 4.

2. No written comments were received. At the hearing on March 22, 1995, there were no comments in opposition to the proposed changes. There were, however, the following questions, which were fully considered:

(a) Do the proposed amendments apply to existing facilities? Answer: No. The existing facilities are "grandfathered," so long as they are not physically altered. The proposed amendments only apply prospectively.

(b) How do the rules affect reimbursements for relocations? Answer: Such reimbursements are not changed by these rules.

(c) Is it possible to provide training to the utilities regarding the environmental requirements? Answer: The Department's districts will provide guidance. Perhaps the Department can offer workshops.

(d) Is raptor protection required on all facilities regardless of the absence of reported problems? Answer: Every new facility installed within the highway right-of-way must be raptor proofed.

(e) What about highway construction where there are existing underground facilities? Answer: The Department will exercise discretion regarding the impact of construction. Some utilities have complained about minor projects with little impact on buried utilities, such as asphalt shoulder work. Utilities need to recognize that highways expand and could affect underground utilities. The Department recognizes that in some cases the highway construction will require relocation of the utility.

3. The Department has repealed rule 18.7.241 as proposed.

4. Except for rule 18.7.231, the Department has amended the rules listed above as proposed.

5. The Department has amended rule 18.7.231 with the following changes:

18.7.231 General Considerations (1)(a) - (1)(o) Same as proposed.

(p) The utility company shall comply with the Montana Environmental Policy Act, sections 75-1-101, et seq., MCA; the ~~Threatened and~~ Endangered Species Act, 16 U.S.C. § 1531, et seq.; the Migratory Bird Treaty Act, 16 U.S.C. § 701, et seq.; the Bald and Golden Eagle Protection Act, 16 U.S.C. § 668, et seq.; and all other applicable environmental laws, regulations or provisions.

(1)(q) Same as proposed.

This change was made because the Department determined that the reference to the Act should be "Endangered Species Act."

6. AUTH: 60-3-101, and 60-4-402, MCA.
IMP: 60-3-101, and 60-4-402, MCA.

MONTANA DEPARTMENT OF TRANSPORTATION

By: _____
MARVIN DYE, Director

_____
Lyle Manley, Rule Reviewer

Certified to the Secretary of State April 27, 1995.

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

In the matter of the adoption of rules related to the workers' compensation data base system and amendment of the attorney fee rule	) CORRECTED NOTICE OF ADOPTION) AND AMENDMENT)))

TO ALL INTERESTED PERSONS:

1. On April 27, 1995, the Department published notice at pages 675 through 679 of the Montana Administrative Register, Issue No. 8, of the adoption of new rules II through IV and the amendment of ARM 24.29.3802, related to the workers' compensation data base system.

2. The notice of adoption incorrectly stated that RULE IV (24.29.4336) was being adopted exactly as proposed, when the notice should have stated that the rule was being adopted with a change related to the timing of when reporting was to occur. The change clarifies the timing of the report and makes the language consistent with similar language in ARM 24.29.4332. The corrected rule adoption reads as follows:

24.29.4336 IN-HOUSE COUNSEL COST ALLOCATION (1) Same as proposed.

(2) The purpose of this cost allocation rule is to obtain a figure that reasonably reflects the per-claim cost of having in-house counsel. The insurer shall report annually ~~to~~ upon request by the department:

(a) and (b) Same as proposed.

AUTH: Sec. 39-71-203 MCA IMP: Sec. 39-71-225 MCA

3. Replacement pages for the corrected notice of adoption will be filed with the Secretary of State by not later than June 30, 1995.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: May 1, 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 EMERGENCY AMENDMENT

TO: All Interested Persons:

1. The Department is required by law to mail tax assessments to taxpayers who are owners of industrial machinery and equipment prior to May 31, 1995, for tax year ending January 1, 1995. In reviewing the amendments made to ARM 42.22.1311 on December 23, 1994, the Department has determined there were three errors to the table found in (1) entitled "1995 Industrial Machinery & Equipment Trend Factors."

Therefore, the Department intends to amend that rule through the emergency process so that the tax assessments for tax year ending January 1, 1995, will correctly reflect the proper life for trending the property.

2. The emergency rule will be effective May 11, 1995.

3. The text of the emergency rule is 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
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(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
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(21)	Stone Products	15
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(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.

4. The rationale for the emergency rule is stated in paragraph 1.

5. A standard rulemaking procedure will be undertaken prior to the expiration of this emergency rule.

6. Interested parties are encouraged to submit their comments during the upcoming standard rulemaking process. If interested persons wish to be personally notified of that rulemaking process, they should submit their names and addresses to:

Cleo Anderson
Department of Revenue
Office of Legal Affairs
P.O. Box 202701
Helena, Montana 59620-2701

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State May 1, 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 December 31, 1994. This table includes those rules adopted during the period January 1, 1995 through March 31, 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 December 31, 1994, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1994 and 1995 Montana Administrative Register.

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