MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 12

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

Page Number

TABLE OF CONTENTS

NOTICE SECTION

Page Number

SPECIAL NOTICE AND TABLE SECTION

BEFORE THE BOARD OF OCCUPATIONAL THERAPISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment, repeal and adoption of rules pertaining to the practice of occupational therapy	)))))	AMENDED NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO THE PRACTICE OF OCCUPATIONAL THERAPY

TO: All Interested Persons:

1. On June 6, 1996, the Board of Occupational Therapists published a notice of public hearing at page 1448, 1996 Montana Administrative Register, issue number 11, to consider the proposed amendment, repeal and adoption of rules pertaining to the practice of occupational therapy. The notice of public hearing is being amended because the comment period did not provide 28 days for public comment. The comment date has been extended to July 18, 1996, to provide the required period of time for public comment.

2. Interested persons may present their data, views or arguments either orally or in writing at the hearing being held on June 27, 1996 at 10:00 a.m., in the conference room of the Professional and Occupational Licensing Bureau, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana. Written data, views or arguments may also be submitted to the Board of Occupational Therapists, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile, number (406) 444-1667, to be received no later than 5:00 p.m., July 18, 1996.

3. A staff attorney for the Professional and Occupational Licensing Bureau has been designated to preside over and conduct the hearing.

BOARD OF OCCUPATIONAL THERAPISTS
LYNN BENSON, 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, June 10, 1996.

BEFORE THE PETROLEUM TANK RELEASE COMPENSATION BOARD
DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the transfer and amendment of rules 16.47.101, 201, 301-311, 314, 317, 323-344, the repeal of rules 16.47.312, 313, 316, 318, 321, 322 and 351, and adoption of new rule I pertaining to the petroleum tank release compensation board.	NOTICE OF PUBLIC HEARING ON PROPOSED TRANSFER, AMENDMENT, REPEAL AND ADOPTION OF RULES (Petroleum Board)

To: All Interested Persons

1. On July 18, 1996 at 10:00 a.m., the board will hold a public hearing in the Lewis Room of the Phoenix Building, 2209 Phoenix, Helena, Montana, to consider the transfer, amendment and repeal of the above-captioned rules.

2. The rules are being transferred pursuant to Chapter 418, Laws of Montana 1995, effective July 1, 1995. In order to implement that legislation, the above-referenced rules are transferred from the Department of Health and Environmental Sciences, ARM 16.47.101 through 16.47.351, to the Department of Environmental Quality, ARM 17.58.101 through 17.58.344.

3. The rules to be repealed can be found at pages 16-4827, 16-4828, 16-4833 through 4835, 16-4843, 16-4844, and 16-4877.

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

~~16.47.101~~ **17.58.101** ORGANIZATION OF BOARD (1) and (2) Remain the same.

(3) Director. The board is allocated to the department of ~~health and~~ environmental ~~sciences~~ quality for administrative purposes only. However, the board has authority to employ its own staff and consultants, and for that purpose, the 7 members of the board exercise the powers of a director of a department.

(4) Functions. The functions of the board are to provide a financial assurance mechanism, ~~to assure the cleanup of petroleum products which leak from storage tanks,~~ and to reimburse the owners or operators of eligible tanks for their expenditures in cleaning up ~~such leaks~~ releases and compensating ~~persons~~ third parties who live or own property near ~~such leaking~~ the tanks for ~~any~~ bodily injury or property damage they may ~~sustain~~ have sustained as a result of the ~~leaks~~ releases. ~~Most of the tanks covered under the major tank or "603" (from House Bill 603, 1989 legislature) program are subject to federal financial responsibility requirements (42 US Code section 6991),~~

~~and the US environmental protection agency has recognized the board's major tank program as an approved financial assurance mechanism. The board's minor tank or "973" (from House Bill 973, 1991 legislature) program covers certain classes of tanks not subject to federal financial responsibility requirements.~~ The board operates in close conjunction with the ~~solid and hazardous waste bureau of the~~ department of ~~health and~~ environmental ~~sciences~~ quality and the department of justice.

(5) Remains the same.

(6) The mailing address of the executive director is as follows:

Executive Director
Petroleum Tank Release Compensation Board
~~1740 N. Montana Ave.~~ PO Box 200902
Helena, MT 59620-0902

(7) Remains the same.

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

~~16.47.201~~ **17.58.201** ATTORNEY GENERAL'S MODEL RULES--INCORPORATION AND SUPPLEMENTATION Remains the same.

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

~~16.47.301~~ **17.58.301** GUIDELINES FOR PUBLIC PARTICIPATION Remains the same.

AUTH: 2-3-103, MCA; IMP: 2-3-103, MCA

~~16.47.302~~ **17.58.302** CONDUCT OF BOARD MEETINGS (1) All meetings of the board, other than contested case hearings, shall be conducted by the ~~chairman~~ presiding officer. In the absence of the ~~chairman~~ presiding officer, the vice-~~chairman~~ presiding officer shall exercise the ~~chairman's~~ presiding officer's powers.

(2) The ~~chairman~~ presiding officer may call any meeting of the board to order, pursuant to notice, when he determines that a quorum is present. A quorum is at least 4 members present, physically or by teleconference media.

(3) The ~~chairman~~ presiding officer may impose time limits on the oral presentation of any person appearing before the board at any meeting other than a contested case hearing.

(4) The ~~chairman~~ presiding officer may appoint a hearing examiner to conduct a contested case hearing within the agenda of a board meeting. A member of the board, including the ~~chairman~~ presiding officer, may question a witness through and by leave of a hearing examiner so appointed.

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.303~~ **17.58.303** OFFICERS; VOTING (1) The board shall elect a ~~chairman~~ presiding officer and a vice-~~chairman~~ presiding officer for terms of 1 year each at its first meeting after October 1 of each year.

(2) and (3) Remain the same.

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.311~~ **17.58.311** DEFINITIONS ~~(1) As used in this~~

~~chapter~~ Unless the context clearly indicates otherwise, the following definitions, in addition to those in 75-11-302, MCA, apply throughout this chapter:

~~(a)~~(1) "Act" means Title 75, chapter 11, part 3, MCA, and 17-7-502, MCA.

(2) "Actually incurred", for purposes of reimbursing claims, means:

(a) invoiced charges for goods received or services performed in furtherance of a department-approved corrective action plan; or

(b) payments made to a third party in compensation for bodily injury or property damage caused by a release.

(3) "Belonging to the federal government", with respect to determining eligibility of a petroleum storage tank, means:

(a) currently under the possession and control of a federal agency, or

(b) located on land held by a federal agency if the tank is operated by a contractor for the primary benefit of a federal agency. However, if the contract binds the operator to hold the federal agency harmless from liability for any release from the tank and the federal agency required its contractor to make this commitment prior to March 31, 1990, the tank is not considered as belonging to the federal government.

~~(b)~~(4) "Bodily injury," as defined in 75-11-302~~(3)~~, MCA, will be measured by the board to include detriment that is currently in existence or certain to occur in the future, based on competent evidence as opposed to conjecture or speculation ~~[27-1-203, MCA; Ewing v. Esterholt, 684 P.2d 1053 (Mont. 1984)]~~.

(5) "Consumptive use" means any use which burns or otherwise consumes heating oil.

~~(c)~~(6) "Consultant" means a professional person or organization of such persons who advise tank owners or operators with respect to planning and implementing corrective action.

~~(d)~~(7) "Day" means a calendar day, including weekends and holidays. Whenever a period of days specified in the Act or this chapter ends on a day state offices are not open for business, the period ends on the next day state offices are open.

(e) "De minimis", as referenced in the definition of "petroleum product" in 75-11-302, MCA, means that amount of a hazardous substance, as defined in this rule, mixed with a petroleum product which does not alter the detectability, effectiveness of corrective action, or toxicity of the petroleum product to any significant degree.

(8) "Farm tank" as defined at ARM 17.56.101.

(9) "Hazardous substance" means:

(a) a substance that is defined as a hazardous substance by section 101(14) of the federal Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), 42 USC 9601(14), as amended;

(b) a substance identified by the administrator of the United States environmental protection agency as a hazardous substance pursuant to section 102 of CERCLA, 42 USC 9602, as amended;

(c) a substance that is defined as a hazardous waste pursuant to section 1004(5) of the Resource Conservation and Recovery Act of 1976, 42 USC 6903(5), as amended, including a substance listed or identified in 40 CFR 261.

(10) "Necessarily incurred", for purposes of reimbursing claims, means:

(a) the work contemplated under a department-approved corrective action plan when that work addresses a release from a petroleum storage tank;

(b) the work not contemplated under an approved corrective action plan, but necessary to respond to an emergency in order to prevent greater damages; and

(c) in the case of third party damages, payment for damages that are a direct and proximate consequence of the release.

~~(f)~~(11) "Property damage," as defined in 75-11-302~~(17)~~, MCA, will be measured by the board in terms of diminution of market value, unless the cost of repairing damage is less than the diminution of market value ~~{Spackman v. Ralph Parsons Co., 147 Mont. 500, 414 P.2d 918 (1966)}~~.

(12) "Reasonably incurred", for purposes of reimbursing claims, means work required under an approved corrective action plan or necessary to respond to an emergency; or provide compensation for bodily injury or property damage caused by a release.

(13) "Residential tank" as defined at ARM 17.56.101.

~~(g)~~(14) "Responsible party" means the person, whether owner or operator, or any subsequent owner of the subject property who accepts responsibility for the release, who undertakes a ~~cleanup plan~~ corrective action after a release from a tank~~, or the representative of such person, and designated on form 5 and filed with the board~~ is discovered.

~~(h)~~(15) "Site/facility" means a complex of tanks under the same ownership on a contiguous piece of property.

(16) "Stored for noncommercial purposes", with respect to motor fuel, means any type of storage, except the following:

(a) storing for resale under license from the weights and measures bureau, department of commerce (82-15-105, MCA); or

(b) storing for later removal to another location where the fuel will be resold.

(17) "Subcontractor" is a person who performs billable labor in association with a corrective action at the release site when that person is under contract with the contractor/-consultant. Subcontractor services do not include delivery or pickup services.

~~(i)~~(18) "Tank," ~~as employed within the definition of~~ is a petroleum storage tank ~~at~~ as defined in 75-11-302~~(16)~~, MCA, and is further defined to mean a stationary device designed to contain an accumulation of petroleum or petroleum products and constructed of non-earthen materials (e.g. concrete, steel, plastic) that provide structural support.

(19) "Vendor" is a person who provides materials necessary for corrective action at the release site or services away from the release site.

~~(2) The Act defines 14 other terms at 75-11-302, MCA.~~
AUTH: 75-11-318, MCA; IMP: 75-11-302 through 75-11-318, MCA

16.47.312 FUEL STORED FOR NONCOMMERCIAL PURPOSES ON FARM OR RESIDENTIAL TO BE REPEALED (See page 16-4827)
AUTH: 75-11-318, MCA; IMP: 75-11-308(2), MCA

16.47.313 BELONGING TO THE FEDERAL GOVERNMENT, CONSTRUED TO BE REPEALED (See page 16-4828)
AUTH: 75-11-318, MCA; IMP: 75-11-308(2), MCA

~~16.47.314~~ **17.58.312** RELEASE DISCOVERED ON OR AFTER APRIL 13, 1989 CONSTRUED/**TANK ELIGIBILITY REQUIREMENTS** (1) ~~A tank~~ Except as otherwise provided in this rule, an owner or operator may be eligible ~~under the 603 program~~ for reimbursement ~~for~~ of eligible costs incurred on or after April 13, 1989, resulting from an accidental release from a petroleum storage tank if the release was discovered on or after April 13, 1989, even though the tank, in place, was out of service on the date of discovery or is presently out of service.

(2) ~~A tank~~ Unless otherwise provided under (3), an owner or operator of a farm or residential tank with a capacity of 1,100 gallons or less that is used for storing motor fuel for noncommercial purposes or a tank storing heating oil for consumptive use on the premises where it is stored may be eligible ~~under the 973 program~~ for reimbursement of eligible ~~expenditures~~ costs incurred after May 14, 1991 if the release was discovered on or after April 13, 1989, even though the tank, in place, was out of service on the date of discovery or is presently out of service.

(3)(a) An owner or operator of a farm or residential tank that was installed on or before April 27, 1995, is not eligible for reimbursement of otherwise eligible costs incurred after that date, unless the tank was voluntarily removed prior to December 31, 1995.

(b) For purposes of (a) above, a tank is:

(i) a farm or residential tank with a capacity of 1,100 gallons or less used for storing motor fuel for noncommercial purposes;

(ii) a farm or residential tank with a capacity of 1,100 gallons or less used for storing heating oil for consumptive use on the premises where it is stored; and

(iii) a farm or residential underground pipe used to contain or to transport motor fuels for noncommercial purposes or heating oil for consumptive use on the premises where it is stored from an aboveground storage tank with a capacity of 1,100 gallons or less.

(4) An owner or operator is not eligible for reimbursement under this rule, if the tank was removed prior to April 13, 1989, or the tank is excluded from eligibility under 75-11-308(2), MCA.
AUTH: 75-11-318, MCA; IMP: 75-11-308, MCA

16.47.316 CRITERIA FOR DECISION--COSTS ACTUALLY,

NECESSARILY, AND REASONABLY INCURRED TO BE REPEALED (See pages 16-4833 through 16-4835)
AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.317~~ **17.58.313** ~~603 TANK PROGRAM AND 973 TANK PROGRAM~~ **APPLICABLE CO-PAYMENTS FOR CO-MINGLED TANK RELEASES** ~~(1) The board has 2 reimbursement programs: the 973 program, which covers heating oil tanks (as defined in the Act) without reference to a maximum size and farm, ranch, and residential petroleum storage tanks (as defined in the Act) holding up to 1,100 gallons, and the 603 program for all covered tanks not clearly eligible under the 973 program. The 603 program covers liability up to $1,000,000 with a potential co-payment amount of $17,500 (half the first $35,000). The 973 program covers liability up to $500,000 with a potential co-payment amount of $5,000 (half the first $10,000).~~

~~(2)~~(1) ~~The board will presume that a petroleum storage tank or group of tanks on a single site which could be eligible under either program is eligible under the 603 program.~~ In the case of co-mingled plumes, for purposes of determining the appropriate percentage of costs covered by the fund for sites that have more than 1 release from separate petroleum storage tanks, the board will presume that the owner or operator may be reimbursed according to the rates and amounts specified in 75-11-307(4)(b)(i), MCA. A person who seeks reimbursement ~~under the 973 program~~ from the fund at a different rate than provided under 75-11-307(4)(b)(i), MCA, must prove that no leaking tank at the site is eligible under ~~the 603 program~~ that section. ~~The 2 programs~~ Different rates of reimbursement provided by the fund may not be combined to reimburse costs or damages incurred from a release at any site.
AUTH: 75-11-318, MCA; IMP: 75-11-307, MCA

16.47.318 HEATING OIL STORED FOR CONSUMPTIVE USE ON THE PREMISES TO BE REPEALED (see page 16-4835)
AUTH: 75-11-318, MCA; IMP: 75-11-307, MCA

16.47.321 ELIGIBLE PERSONS; COMPLIANCE; SUBSTANTIAL VIOLATIONS TO BE REPEALED (see page 16-4843)
AUTH: 75-11-318, MCA; IMP: 75-11-308(1)(e) and (2)(f), MCA

16.47.322 ASSESSMENT OF ENVIRONMENTAL IMPACT TO BE REPEALED (see pages 16-4843 and 16-4844)
AUTH: 2-3-103, 2-4-201, MCA; IMP: 2-3-104, 75-1-201, MCA

~~16.47.323~~ **17.58.323** VOLUNTARY REGISTRATION (1) An owner or operator may register ~~his~~ a tank~~(s)~~ with the board for the purposes of ~~expediting future applications for reimbursement and for procuring a statement of registration~~ determining potential eligibility of the tank for reimbursement under the petroleum tank release cleanup fund.

(2) ~~A person~~ An owner or operator may apply for such registration ~~on form 1~~ by submitting a complete form, referred to as the "Eligibility Checklist and Application for Voluntary

Registration", which must ~~contain the following information:~~

~~(a) the location (street address if available) of each tank;~~

~~(b) the name and address of any insurer covering any risks or liabilities associated with releases from the tank;~~

~~(c) the name and address of the responsible individual; if the entity seeking registration is a sole proprietorship or in a partnership or joint venture among individuals;~~

~~(d) the names and addresses of the resident agent and the chief executive officer if the entity seeking registration is a corporation or a partnership or joint venture including corporations; and~~

~~(e) declarations that, to the best of the declarant's knowledge,~~

~~(i) each tank listed would not be ineligible for possible reimbursement by virtue of its size, ownership, use, or location,~~

~~(ii) each tank listed was not releasing petroleum products on or before April 12, 1989, and~~

~~(iii) that neither the owner nor the operator is ineligible to be reimbursed under the applicable program~~ be signed by the owner or operator. Forms for voluntary registration may be obtained from the board.

~~(3) If the declarant on the application is not the responsible individual listed on the application, the declarant's capacity to speak for and relationship to the responsible individual must be set forth.~~

~~(4)~~(3) The board ~~will not~~ may investigate and consult with other regulatory agencies concerning the information submitted in the forms ~~applications for registration or the declarations therein~~ to confirm the accuracy of the information submitted by the owner or operator. If another regulatory agency has information or the board discovers information that indicates the owner or operator submitted false or inaccurate information, the board may find that the responsible party is ineligible for reimbursement. ~~If the information on the application would, if true, establish potential eligibility for reimbursement, the board will issue a statement to that effect to the applicant.~~

(4) If another regulatory agency has reported non-compliance regarding the operation and management of the tank, the board may find that the responsible party is ineligible for reimbursement.

(5) If the information on the form would, if true, establish potential eligibility and no inaccuracies have been discovered by or reported to the board, the board shall issue a statement to the responsible party indicating potential eligibility for reimbursement.

(6) The board may delegate to the executive director the authority to issue determinations of eligibility for reimbursement when that determination is based on prior board decisions and similar material facts, subject to the responsible party's right to be heard by the board.

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.324~~ **17.58.325** ~~PRE-APPLICATION PROCEDURE;~~ NOTICE OF RELEASE; **ELIGIBILITY DETERMINATION WHEN RELEASE HAS OCCURRED**

(1) When a person notifies the department of a release from a petroleum storage tank, the board ~~will:~~ shall mail the owner or operator a "Document Request Form", which lists all of the forms that the person may need for a determination of eligibility or to receive reimbursement from the board.

~~(a) record the dates of release and notification;~~

~~(b) mail to the responsible party or parties a copy of form 1 to determine their potential eligibility, unless the form is already on file under the voluntary registration procedure as found in ARM 16.47.323);~~

~~(c) mail to parties potentially eligible for reimbursement forms 1 through 5 as applicable.~~

(2) For purposes of determining eligibility of the release, the owner or operator must complete an "Eligibility Checklist and Application for Voluntary Registration Form". Upon receipt of the completed form, the board shall follow the procedures under ARM 17.58.323(3)-(6).

(3) The board may not consider an "Application for Reimbursement" unless the owner and operator has submitted a complete form, referred to as the "Eligibility Checklist and Application for Voluntary Registration".

~~(2)~~(4) Unless the release is clearly ineligible for reimbursement under the Act, the board staff shall ~~monitor the submission and~~ review ~~of~~ the corrective action plan for the purpose of pre-approving rates. ~~The board may authorize its staff to comment on proposed corrective action plans.~~

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.331~~ **17.58.331** ASSENT TO AUDIT (1) Each contractor or subcontractor employed to carry out a corrective action plan in whole or in part shall assent to an audit of the documentation supporting ~~his~~ the contractor's or subcontractor's invoices.

(2) The responsible party shall obtain the ~~contractor's~~ assent on ~~form 2 or shall incorporate language identical to that on the form in his agreement with the contractor~~ an "Assent to Audit Form". A The form may be executed by the contractor, consultant, or subcontractor before or after the work is completed.

(3) Vendors performing delivery services at the site are not required to submit to an audit.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.332~~ **17.58.332** INSURANCE COVERAGE; DISCLOSURE; COORDINATION OF BENEFITS (1) An owner or operator who incurs or may incur eligible costs under the Act must disclose to the board any policy of insurance on the tank or its premises which may cover some or all of the expenses arising from a release of petroleum products from the tank. This disclosure must be made on the "Eligibility Checklist and Application for Voluntary Registration" form ~~1~~ and must contain current information as of the date of a release. A copy of the policy or policies must be

furnished to the board by ~~an applicant~~ the responsible party upon request by the board.

(2) Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.333~~ **17.58.333** DESIGNATION OF REPRESENTATIVE ~~(1) An owner or operator may designate its insurer, contractor, or any other party as its representative to receive reimbursement for expenditures made for eligible costs as determined by the board. The owner or operator must accept responsibility for paying a contractor any amount not recognized by the board as eligible costs.~~

~~(2)~~(1) ~~This designation shall be made on form 5.~~ If an owner or operator wishes to designate another person to receive reimbursement under the Act, the owner or operator shall complete and file with the board a "Designation of Representative" form ~~by a person who has already submitted evidence of eligibility to the board on form 1. A designated representative may execute and file all forms and documents, other than form 1, required by the board~~.

(2) Unless a person is designated to receive reimbursement under (1) of this rule, the board may not consider applications for reimbursement from any person other than the responsible party.

AUTH: 75-11-318, MCA; IMP: 75-11-307(3), MCA

~~16.47.334~~ **17.58.334** APPLICATION PROCEDURE--REIMBURSEMENT AFTER EXPENDITURE (1) Upon completion of any aspect of an approved corrective action plan, the responsible party may apply to the board for reimbursement of expenditures on an "Application for Reimbursement" form ~~3 or 3-6, together with the following attachments:~~

~~(a) Attachment A--a copy of the approved corrective action plan, together with any amendments or modifications approved by the department as the corrective action was being undertaken;~~

~~(b) Attachment B--a copy of each contract made pursuant to the corrective action plan, together with the contractor's invoice, assent to audit (form 2), and backup documentation, as necessary, to verify charges on the invoice;~~

~~(c) Attachment C--where bids or proposals were taken for any work under the corrective action plan, a copy of each bid, proposal, or estimate;~~

~~(d) Attachment D--where third-party damages have been paid, the documents described in ARM 16.47.344~~ , which is available upon request from the board.

(2) and (3) Remain the same.

(4) Charges for work conducted 2 years or more prior to the submittal of the application are ineligible.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.335~~ **17.58.335** APPLICATION FOR GUARANTEE OF REIMBURSEMENT OF FUTURE OR UNAPPROVED EXPENDITURES (1) and (2) Remain the same.

(3) ~~A person~~ An owner or operator shall apply to the board

for this guarantee on the ~~basic application (form 3)~~ "Corrective Action Cost and Completion Schedule Estimate Form", entering "not applicable" where appropriate.

~~(4) The board delegates to the executive director the authority to issue determinations of eligibility for reimbursement when the facts posited are consistent with the facts presented or found in a prior determination, subject to the applicant's right to be heard by the board.~~

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.336~~ 17.58.336 REVIEW AND DETERMINATION (1) The board's staff shall receive all ~~applications~~ claims for reimbursement for corrective action costs. The staff ~~will~~ shall determine if the application for the claim is complete in the initial review, then forward it to the department for its review. The staff ~~will promptly~~ shall advise the ~~applicant~~ responsible party of any incompleteness or deficiency which appears on the application. ~~Further~~ The final review ~~will~~ may be suspended pending the submission of additional information ~~as~~ by the ~~applicant, acknowledging an incomplete or deficient application, agrees to furnish. An applicant who believes any request for additional information by the staff is not authorized by the Act or these rules may request the board to process and consider his application, and the board shall proceed. Following this initial staff review the application will be forwarded to the department for its review~~ responsible party. Any additional information submitted by the responsible party at the request of the board staff may be forwarded to the department for its final review, if the department's review is required to determine whether the work was actual and necessary.

(2) ~~The board will normally consider applications submitted as complete (by staff recommendation or applicant request) up to 60 days preceding a scheduled board meeting. Applications filed and submitted as complete less than 60 days preceding a board meeting will not be considered at that meeting unless, and only to the extent that, expedited review and reimbursement or commitment is necessary to prevent environmental damage which would occur if consideration is held for the following board meeting.~~ Applications that have been reviewed as complete at least 60 days prior to a scheduled board meeting will normally be considered by the board at that meeting. The ~~payment~~ reimbursement of claims for which authority to ~~pay~~ reimburse has been delegated under (3) of this rule~~,~~ is not subject to this procedure. The agenda for consideration of applications at board meetings ~~will~~ must follow the order in which applications were ~~submitted~~ reviewed as complete and which are not ~~paid~~ reimbursed under (3) of this rule.

(3) The board may delegate to the executive director authority to process and order ~~payment~~ reimbursement of specified categories of claims upon receipt and review. The executive director shall report the number of such claims and the amounts obligated ~~to~~ or expended at the next meeting of the board.

(4) Remains the same.

(5) The ~~applicant~~ responsible party may appear before the board and make a statement on ~~his~~ the responsible party's application and on the recommendations. Any other interested party may also make a statement. The board may establish a fair and reasonable limit on the time allowed for oral presentations. The board shall thereafter ~~proceed to~~ consider the application and may grant it in whole, in such part as may to the board seem proper, or may deny the application. Reasons for partial or total denials or disallowed expenses must be stated in the ~~minutes of the meeting~~ claim reimbursement summary contained in the file, and must be mailed to the ~~applicant~~ responsible party within 10 days of the board's decision. The minutes of a board ~~meeting will~~ must reflect the sequence of actions ~~approving~~ taken on applications.

(6) ~~An applicant~~ A responsible party dissatisfied with the denial or disallowance of all or any part of ~~his~~ the application may request a formal hearing. This request, with a specification of the grounds for disagreement with the board's ~~initial~~ decision, must be filed in writing with the board within 15 days of the receipt of the board's determination by the ~~applicant~~ responsible party. Upon receiving such request, the ~~chairman~~ presiding officer of the board may appoint a hearing examiner to supervise any discovery and prehearing matters and to conduct the hearing, either at a subsequent meeting of the board or outside a board meeting, subject to 2-4-621, MCA, as the appointment may specify.

(7) Any time periods specified in this rule may be extended by agreement between the board or its staff and the responsible party.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.337~~ **17.58.341** CONSULTANT LABOR CODES, TITLES, AND DUTIES (1) ~~Consultants must assign to one of the following categories any service time for an individual that is billed to a responsible party and for which reimbursement is claimed, unless the duties of the individual are so unusual that they do not closely approximate any of the following categories:~~

~~Code~~	~~Title~~	~~Duties~~
~~1004~~	~~Clerical Personnel~~	~~Typing reports, copying, running errands, filing, telephone answering.~~
~~1005~~	~~Clerical Administration Accounting Personnel~~	~~All clerical duties described in 1004, plus preparing claims and assembling documentation.~~
~~1007~~	~~Draftsperson~~	~~Drawing maps, using autocad ACAD for mapping and preparing figures.~~
~~1049~~	~~Entry Technician~~	~~Assisting senior personnel on-site; requires supervision.~~
~~1050~~	~~Staff Technician~~	~~Assisting senior personnel with field work, can do field sampling without supervision.~~

~~1051 Senior Technician — Directing entry and staff level technicians. May act as site coordinator for basic field work.~~

~~1014 Staff Engineer/ Geologist/Scientist — Assisting project staff in report writing, or research and background information for the project staff person.~~

~~1015 Project Engineer/ Geologist/Scientist — Managing project, scheduling work, and developing work plans as required for the remediation of a site.~~

~~1016 Senior Engineer/ Geologist/Scientist — Overseeing project staff person, reviewing reports, and assisting with complicated remediation site management.~~

~~1017 Principal Engineer/ Geologist/Scientist — Overseeing complicated projects or work plans if they would require designs which need review by a professional engineer. This individual would not typically be on-site in the field doing basic field work.~~

~~1038 Computer Scientist/ Database Specialist — Set up database tracking, computer modeling, etc.~~

Any services provided by a consultant/contractor, or subcontractor, including services of its employees, for which reimbursement will be claimed, must be categorized by the consultant/contractor/subcontractor according to the type of service contained in the board's "Consultant/Contractor Code List". This requirement does not apply to any service provided by an individual that does not closely approximate one of the categories in the board's list.

(2) A consultant/contractor/subcontractor may file with the board, and amend, not more than once a year (~~absent unusual circumstances~~ unless further amendment is approved by the executive director), the rates at which it bills clients in Montana for the services ~~of its personnel as~~ described in ~~(1)~~ the board's consultant/contractor code list. Rate schedules and amendments must be maintained in confidence by and accessible only to the board staff, as the consultant's expectation of privacy is reasonable and outweighs the merits of public disclosure.

(3)(a) ~~When~~ The board staff shall calculate the industry standard once a year after receipt of rate schedules from companies whose invoices the board frequently reviews and which have been filed in a number sufficient for a meaningful statistical analysis~~,~~. In calculating the industry standard, the board staff shall compute a range of allowable rates for each code listed in ~~(1)~~ the board's consultant/contractor code list, which ~~is~~ will be the mean rate for each code plus the standard deviation, not to exceed 10% of that mean. The board staff shall then notify each filing firm whether its rates exceed the range of allowable rates, and if so, by how much. The amount by which a consultant's rate for a particular code

exceeds the range of allowable rates will be presumed unreasonable.

~~(4)~~(b) Board staff may request a detailed explanation of rate structures when a submitted rate appears to vary significantly from those submitted by other consultants/-contractors/subcontractors for the same code. Board staff ~~reserves the right not~~ may refuse to use rates that significantly vary from similar rates submitted by others ~~consultants~~, rates from ~~consultants~~ persons who have not submitted claims for reimbursement, rates from ~~consultants~~ persons who have not submitted proper documentation for claim reimbursement, and other rates not deemed acceptable by the board.

~~(5)~~(4) A consultant/contractor/subcontractor who has not ~~filing its~~ filed its schedule of rates must submit its invoices for services formatted in accordance with (1) of this rule. Any rates which exceed the range of allowable rates will be presumed unreasonable.

~~(6)~~(5) A responsible party or consultant/contractor, or subcontractor may overcome the presumption that a rate is unreasonable by presenting clear and concise evidence to the board as provided under ARM ~~16.47.336~~ 17.58.336(5) ~~and (6)~~.

(6) Copies of the board's "Fee Schedule List", which establishes categories and codes of consultant/contractor/subcontractor services may be obtained from the executive director of the board.

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.338~~ 17.58.342 OTHER CHARGES ALLOWED OR DISALLOWED (1) The following ~~additional~~ types of charges are eligible for reimbursement, unless listed as disallowed under (2) of this rule. (Other types of charges may be reimbursed if shown to be actually, necessarily, and reasonably incurred in furtherance of the approved corrective action plan):

(a) ~~Long~~ long distance telephone charges specific to the project.;

(b) ~~Computer~~ computer usage for generating ~~figures~~ graphics, maps, wells, logs, etc., that are necessary for reports.;

(c) ~~Supplies~~ supplies and materials directly associated with the project (e.g., equipment purchased or withdrawn from inventory specifically for the corrective action, ~~sample charges~~ laboratory analysis, or well supplies).;

(d) ~~Copies~~ copies and facsimiles, not to exceed ~~10 cents per page~~ the pre-approved rate, unless documentation supports a higher charge paid to an outside entity.;

(e) ~~Mileage~~ mileage, calculated ~~according to~~ utilizing the ~~rental rate blue book~~ "Rental Rate Blue Book", or, for employee-provided transportation, at the actual amount of reimbursement paid the employee, provided that it does not exceed ~~blue book~~ the "Rental Rate Blue Book" values.;

(f) ~~Lodging~~ lodging at actual cost unless ~~clearly~~ excessive. Documentation supporting the cost (lodging invoice) is required; ~~under the circumstances.~~

(g) ~~Meals~~ meals at $20 per full day ($4 for the morning meal, $6 for the midday meal, and $10 for the evening meal) or the appropriate portion of a full day. Computation of time for purposes of determining meal allowances must be made according to 2-18-502(1) and (2), MCA. Exceptions for higher actual costs may be made ~~with a~~ by showing that seasonal or other factors make meals unavailable at the above listed rates ~~such rates not typically available~~ in certain limited areas (receipts will be required)~~.~~;

(h) ~~Vendor and subcontractor materials and/or labor~~ vendor charges at cost ~~unless a markup is allowed under (3)(d) of this rule.~~;

(i) subcontractor charges at cost, unless a markup is allowed under (3)(c) of this rule;

(j) sampling fees at $10 per sample, which includes bottle, ice, cooler, packing, and office-related handling charges.

(2) The following list indicates, by way of example and not limitation, types of charges that are not eligible for reimbursement~~.--While these examples may be necessary, they should be built into a firm's general overhead and recovered through the basic rates.~~;

(a) ~~Postage.~~ miscellaneous office postage;

(b) ~~Preparation~~ preparation of billing information and invoices~~.~~;

(c) ~~Computer~~ computer charges for writing reports~~.~~;

(d) ~~Administrative~~ administrative charges for handling payments~~.~~;

(e) ~~Standard~~ standard office supplies~~.~~;

(f) ~~Markups~~ markups, add-ons, or profit added to vendor or subcontractor invoices, except as allowed under (3)(~~d~~c) of this rule~~.~~;

(g) ~~Charges~~ charges for basic telephone service~~.~~;

(h) ~~Interest.~~ interest;

(i) multi-tiered markups;

(j) markups by a person who serves the sole function of providing funding for a corrective action; and

(k) charges incurred prior to release discovery date.

(3) The following ~~charges~~ may be eligible for reimbursement, only if approved by the board staff prior to claim submission:

(a) ~~Rates~~ rates for labor categories not listed in ~~ARM 16.47.337(1),~~ the board's fee schedule list;

(b) ~~Trespass~~ trespass fees~~.~~;

~~(c) Premiums for pollution liability insurance which covers subcontractors (verification of coverage may be required).~~

~~(d)~~ ~~Markups~~ (c) markups, not to exceed 7%, on subcontractor invoices when the subcontractor is furnishing labor (and incidental goods or supplies) on a project as part of the cleanup. Proof of payment by the contractor to the subcontractor ~~will be required~~ must be submitted prior to board approval or executive director approval, authorized under ARM 17.58.336(3). Subcontractor markup is allowed only when the

subcontracted work was preapproved in a corrective action plan.

~~(e) Sampling fees, at $10 per sample, including bottle, ice, packing and handling charges.~~

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.341~~ **17.58.337** THIRD-PARTY DAMAGES: PARTICIPATION IN ACTIONS AND REVIEW OF SETTLEMENTS Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-309(1)(g), MCA

~~16.47.342~~ **17.58.338** REVIEW OF CORRECTIVE ACTION PLAN Remains the same.

AUTH: 75-11-318, MCA; IMP: 75-11-318, MCA

~~16.47.343~~ **17.58.339** CORRECTIVE ACTION EXPENDITURES: DOCUMENTATION (1) ~~Expenditures made~~ Charges claimed by the responsible party pursuant to an approved corrective action plan must be documented as set forth in the instructions for ~~and attachments to~~ the application ~~(form 1)~~ for reimbursement.

(2) The responsible party may also ~~reimburse~~ compensate a third party who undertakes action to mitigate damages to other third parties or their property which would be ~~compensable damages~~ reimbursable under the Act. Corrective action taken by third parties must receive approval by the department and, to the extent necessary, must be reflected in the corrective action plan. ~~The board shall, unless the department has already done so, amend the corrective action plan to reflect the performance of any such work by a third party.~~ The portion of this reimbursement allowed as an eligible cost must meet the actual, necessary, and reasonable standards applied by the board to all expenditures.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

~~16.47.344~~ **17.58.340** THIRD-PARTY DAMAGES: DOCUMENTATION

(1)-(3) Remain the same.

(4) The board may require a third party claiming bodily injuries to be examined by a physician and the physician's report submitted to the board. The board may require a third party claiming property damage to allow a property appraiser or claims adjuster retained by the board to enter upon the property, inspect it, and report to the board. Such examinations are more likely to be required if the ~~applicant~~ responsible party has not kept the board apprised of the course of litigation or settlement negotiations as required under ARM ~~16.47.341~~ 17.58.337. If the responsible party does not keep the board apprised of the course of litigation or settlement negotiations as required under ARM 17.58.337, the board may refuse to reimburse any portion of a settlement or judgment under the actual, necessary and reasonable standards applied by the board to all expenditures.

(5) The board shall require a listing of amounts attributed to compensation for property damage, bodily injury, or any other aspect of damage resulting from a settlement or judgment.

AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

16.47.351 FORMS TO BE REPEALED (See page 16-4877)
AUTH: 2-4-201, MCA; IMP: 75-11-302 through 75-11-318, MCA

NEW RULE I REVIEW AND DETERMINATION OF THIRD PARTY DAMAGE COSTS (1) All "Applications for Reimbursement" of third party damages must be filed with the board. Upon receipt of the application for reimbursement, the board shall determine if the application is complete. The board may forward the claim to the department for its review if the claim is based on environmental damage. The board shall advise the responsible party of any incompleteness or deficiency which appears on the application. The final review may be suspended pending the submission of additional information by the responsible party.

(2) Applications reviewed as complete that are received by the board 90 days preceding a scheduled board meeting will normally be considered by the board. The reimbursement of claims for which authority to reimburse has been delegated under (3) of this rule is not subject to this procedure. The agenda for consideration of applications at board meeting will follow the order in which applications were reviewed as complete and which are not reimbursed under (3) of this rule.

(3) The board may delegate to the executive director authority to process and order reimbursement of specified categories of claims upon receipt and review. The executive director shall report the number of such claims and the amounts obligated or expended at the next meeting of the board.

(4) The recommendations of the board staff, and, if appropriate, the department, must be mailed to each board member and to the responsible party at least 7 days prior to the board meeting that is scheduled to consider the application.

(5) The responsible party may appear before the board and make a statement on the application and on the recommendations. Any other interested party may also make a statement. The board may establish a fair and reasonable limit on the time allowed for oral presentations. The board shall thereafter proceed to consider the application and may grant it in whole, in such part as may seem proper, or may deny the application. Reasons for partial or total denial of disallowed expenses must be mailed to the responsible party within 10 days of the board's decision. The minutes of the board meeting shall reflect the sequence of actions taken on applications.

(6) A responsible party dissatisfied with the denial or disallowance of all or any part of the application may request a formal hearing. This request, with a specification of the grounds for disagreement with the board's decision, must be filed in writing with the board within 15 days of the receipt of the board's determination by the responsible party. Upon receiving such request, the presiding officer of the board may appoint a hearing examiner to supervise any discovery and prehearing matters and to conduct the hearing, either at a subsequent meeting of the board or outside a board meeting, subject to 2-4-621, MCA, as the appointment may specify.

(7) Any time periods specified in this rule may be extended by agreement between the board or its staff and the

responsible party.
AUTH: 75-11-318, MCA; IMP: 75-11-309, MCA

5. The Board is proposing new rule I to establish procedures for an owner or operator to claim reimbursement for third party damages. This rule is necessary in order to implement 75-11-309, MCA, which requires the board to specify the manner in which these claims are submitted.

The Board is proposing to repeal rules 16.47.312, 16.47.313, 16.47.316, and 16.47.318, relating to the board's construction of terms that are used in determining tank eligibility. The repealed rules contained definitions that are more appropriately included with the other definitions under 17.58.311. The terms defined in the repealed rules, which are "actually incurred", "reasonably incurred", "necessarily incurred" (16.47.316), "consumptive use" (16.47.318), "stored for noncommercial purposes" (16.47.312), and "belonging to the federal government" (16.47.313), are now defined in 17.58.311.

The Board is also proposing to repeal rule 16.47.321, regarding the Board's assessment of environmental impacts, because the board is not statutorily responsible for approving corrective action plans that may need such an assessment. In addition, the board is repealing 16.47.322, regarding criteria for determining substantial noncompliance with applicable state and federal tank regulations. This rule is being repealed because it is inconsistent with the provisions of 75-11-308, MCA, which requires compliance with all applicable state and federal regulations and does not provide a "good faith effort" exemption from these requirements.

The proposed amendments are necessary to clarify the Board's procedures governing applications for reimbursement from the Petroleum Tank Release Cleanup Fund. In addition, the amendment of rule 17.58.312 is necessary to clarify the eligibility of tanks that were removed from tank rules with the passage of Chapter 568, Laws of 1995, by the 1995 Legislature (effective April 27, 1995). Section 3 of Chapter 568 also provided that the exempt tanks may be eligible for reimbursement from the fund if voluntary cleanup is conducted in accordance with Title 75, Ch. 10 and 11. (See, 75-11-216, MCA) The amendment clarifies that the tanks that are exempt from tank requirements pursuant to the 1995 legislation may still be eligible for reimbursement if they are removed prior to December 31, 1995, when the provisions of Section 3 of Chapter 568 terminates.

The transfer of rules 16.47.101 through 16.47.351 is necessary because the Department of Health and Environmental Sciences was eliminated by Chapter 418, Laws of Montana 1995. The transfer is effective July 1, 1995.

6. Interested persons may submit their data, views, or arguments concerning the proposed amendments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Jean Riley, Petroleum Tank Release Compensation Board, PO Box 200902, Helena, MT 59620-0902, no later than July 23, 1996.

7. Greg Van Horssen has been designated to preside over and conduct the hearing.

PETROLEUM TANK RELEASE COMPENSATION BOARD
GARY TSCHACHE, PRESIDING OFFICER

BY: JEAN A. RILEY, Executive Director

Certified to the Secretary of State June 10, 1996 .

Reviewed by:

JOHN F. NORTH, Rule Reviewer

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the adoption of proposed rules pertaining to the handling, collection, transportation, sampling and storage of blood samples for DNA Indexing	)))))	NOTICE OF PUBLIC HEARING

TO: All Interested Persons

1. On Thursday, July 11, 1996, at 10:00 a.m., the Forensic Science Division will hold a public hearing in the auditorium of the Scott Hart Building, 303 North Roberts, Helena, Montana, to consider the rules it proposes to adopt pertaining to the handling, collection, transportation, sampling and storage of blood samples taken for DNA identification purposes from persons convicted of certain sexual and violent offenses.

The Department of Justice will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you desire an accommodation, please contact the department no later than Monday, July 1, 1996, to advise it of the nature of the accommodation that you need. Please contact Rob Smith at 215 North Sanders, Helena, Montana 59620; tel. (406) 444-2026.

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

RULE I DEFINITIONS Unless the context requires otherwise, the following definitions apply to this subchapter:

(1) "Blood" means whole blood which contains the cellular components and the serum or plasma of blood.

(2) "CODIS" means the FBI's national DNA identification index system that allows the storage and exchange of DNA records submitted by state and local forensic DNA laboratories. The term "CODIS" is derived from Combined DNA Index System.

(3) "Collection card" means the DNA Database Collection Card prepared by the department and provided with the blood sample collection kit.

(4) "Department" means the Montana Department of Justice.

(5) "DNA" means deoxyribonucleic acid.

(6) "DNA databank" means the repository of DNA samples collected under the provisions of 44-6-101 through 44-6-110, MCA, and this subchapter.

(7) "DNA identification index" means the computerized identification record system adopted by the department for the storage and retrieval of an individual's DNA record.

(8) "DNA record" means DNA identification information stored in the department's DNA database or CODIS.

(9) "DNA sample" means a blood sample or biological specimen.

(10) "EDTA" means the preservative ethylenediaminetetraacetic acid.

(11) "FBI" means the Federal Bureau of Investigation.

(12) "Laboratory" means the State Crime Laboratory of the Division of Forensic Science, of the Montana Department of Justice, or any laboratory that performs forensic DNA analysis on samples or specimens derived from a human body or crime scene.

(13) "Marker" means a genetic trait found in DNA including, but not limited to, the DNA marker D1S80 and the STR loci CSF1PO, THO1, TPOX, vWA (formerly vWF).

(14) "Preservative" means any chemical which inhibits the development of bacterial growth in a collected DNA sample.

(15) "STR" means short tandem repeat.

(16) "Sexual offense" means the offense contained in the definition of that term in 46-23-502, MCA.

(17) "Violent offense" means an offense contained in 45-5-102, 45-5-103, 45-5-202, 45-5-302, 45-5-303, 45-5-401, or 45-6-103, MCA, or an equivalent offense under federal law or the law of another state.

AUTH: 44-6-110, MCA IMP: 44-6-101, MCA

RULE II COLLECTION OF BLOOD SAMPLES FOR DNA ANALYSIS

(1) Following entry of a judgment in district court, or a disposition in youth court, a person convicted of a sexual or violent offense, or a youth found under 41-5-521, MCA, to have committed an act which, if committed by an adult, would constitute a violent or sexual offense, shall provide a blood sample for DNA analysis to a person or entity designated by the county attorney.

(2) A blood sample shall be collected in a medically approved manner by a physician, registered nurse, licensed practical or vocational nurse, licensed clinical laboratory technologist, or any other health care worker who is trained to properly collect blood samples or other specimens.

(3) The laboratory shall provide a reasonable quantity of blood sample collection kits to criminal justice or law enforcement agencies in this state at no cost to that agency. A blood sample collection kit shall consist of a sterile specimen vial, mailing tube and label, DNA database collection card, instructions for collection of blood samples, and other items which may be designated as appropriate by the department.

(4) Failure to use a blood sample collection kit provided by the department will not require the sample to be rejected so long as the collection and submission of the blood sample substantially conforms with the collection and submission of other specimens for diagnostic purposes. Specifically, the blood sample must be deposited in a sterile specimen vial which contains the preservative EDTA (the lavender-topped tube), and labeled with the contributor's name and social security number. The person who draws the blood specimen must seal either the specimen vial or the plastic pouch before returning it to the representative of the submitting agency. To the extent

possible, the submitting agency shall also provide the following information to the department when submitting a blood sample:

(a) subject's name and signature;
(b) subject's social security number;
(c) subject's date of birth;
(d) subject's gender;
(e) subject's race;
(f) subject's SID, FBI and/or juvenile offender number;
(g) subject's qualifying offense or offenses;
(h) subject's left and right thumb prints;
(i) date and time sample was collected;
(j) name and signature of the individual drawing the blood;
(k) name of the submitting agency and phone number;
(l) name of the person preparing the information herein requested; and
(m) record of the chain of custody of the specimen.

(5) A representative of the submitting agency shall witness the collection of the sample in order that he or she may attest to the sample's authenticity.

(6) Unless the record already exists in the DNA Identification System, any person may voluntarily submit a blood sample or other biological specimen to the department for the purpose of creating a DNA record under this subchapter.

AUTH: 44-6-110, MCA IMP: 44-6-103, MCA

RULE III STORAGE OF DNA SAMPLES (1) Before submission to the crime laboratory, the sample should be kept refrigerated. Within seven days after collecting the specimen, the sample should be sent to the crime laboratory.

AUTH: 44-6-110, MCA IMP: 44-6-103, MCA

3. RATIONALE: The 1995 session of the Montana legislature enacted Chapter 251, authorizing the Department of Justice to establish a computerized DNA identification index for the receipt, storage, and exchange of DNA records. Section 7 of Chapter 251 (now 44-6-110, MCA) requires the department to adopt certain rules to implement the act.

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 Rob Smith, Assistant Attorney General, Justice Building, 215 North Sanders, Helena, Montana 59620, and must be received no later than July 20, 1996.

5. Rob Smith, Assistant Attorney General, has been designated to preside over and conduct the hearing.

DEPARTMENT OF JUSTICE

By: Ann D Juuster, Chief Deputy
for Joseph P. Mazurek, Attorney General

Kathy Seeley
Rule Reviewer

Certified to the Secretary of State June 10, 1996.

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

In the matter of the proposed adoption of 5 new rules related to the workers' compensation administrative assessment	) NOTICE OF PUBLIC HEARING ON) THE PROPOSED ADOPTION OF FIVE) NEW RULES))

TO ALL INTERESTED PERSONS:

1. On July 11, 1996, at 10:00 a.m., a public hearing will be held in the auditorium of the Scott Hart Building, 303 North Roberts Street, Helena, Montana, to consider the adoption of rules related to the workers' compensation administrative assessment. If necessary because of the amount of testimony to be offered, the hearing will continue on July 12.

The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 5:00 p.m., July 3, 1996, to advise us of the nature of the accommodation that you need. Please contact the Legal/Centralized Services Division, Attn: Mark Cadwallader, Department of Labor and Industry, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-4493; TTD (406) 444-0532; fax (406) 444-1394. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Mr. Cadwallader.

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

RULE 1 DEFINITIONS For the purpose of this subchapter, the following definitions apply, unless the context of the rule clearly indicates otherwise:

(1) "Administrative assessment" means the workers' compensation administrative assessment provided for by 39-71-201, MCA.

(2) "Associated entities" means governmental bodies, other than the department, which have statutory duties related to workers' compensation and safety matters, and are funded via the administrative assessment. The workers' compensation court is an example of an "associated entity". The term does not include the state fund or the self-insurers guaranty fund.

(3) "Cost allocation base" means the common denominator for systematically linking a cost or group of costs with a cost object.

(4) "Cost object" means any activity for which a separate measurement of costs is desired for, for distribution to the plans.

(5) "Department" means the department of labor and

industry.

(6) "Direct costs" means those costs that can be identified specifically with a particular program.

(7) "Indirect costs" means those costs incurred for a common or joint purpose benefiting more than one program, and which are not readily assignable to the program specifically benefited without effort disproportionate to the results achieved.

(8) "Plans" or "the plans" means all of the different types of plans of workers' compensation insurance provided for by Title 39, chapter 71, MCA. It is distinguished from the phrase "individual plan", which means a particular plan, such as Plan 1, Plan 2, or Plan 3.

(9) "Program" means one or more regulatory, adjudicatory, informational or service functions performed by the department and associated entities in carrying out statutory and policy directives related to workers' compensation and safety matters.

(10) "Year" means a fiscal year, beginning July 1 and ending the following June 30.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-201 MCA

RULE II ADMINISTRATIVE ASSESSMENT METHODOLOGY IN GENERAL

(1) The administrative assessment is established on a yearly basis by apportioning the current year's budget for all programs funded by the administrative assessment to the plans, in the proportion that costs were incurred in the previous year for each individual plan, as provided by RULE III.

(2) The previous year's administrative assessment income, on a plan-by-plan basis, is compared to the total actual plan-by-plan costs incurred in the previous year. Any difference between the income from a plan's administrative assessment and the actual costs for the plan in the previous year is carried forward as an adjustment to the administrative assessment in the current year.

(3) Other income from the previous year is credited to the program from which the income was generated. An example of "other income" is revenue generated by the sale of the workers' compensation "blue book" compilation of statutes and rules.

(4) The administrative assessment by plan is distributed to plan members as required by 39-71-201, MCA.

(5) Following computation of the administrative assessment, the department individually bills each plan member that is liable for a share of the administrative assessment. The bill is the greater of:

(a) the proportionate share of the administrative assessment that is attributable to a plan member, based on the entity's participation in a particular plan during the year; or

(b) the statutory minimum for a plan member.

(6) Payment of the bill for the administrative assessment is due 30 days from the date of the bill.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-201 MCA

RULE III PROPER ACCOUNTING AND COST ALLOCATION PROCEDURES

(1) This rule defines what is meant by the phrase "proper accounting and cost allocation procedures", as that phrase is used in 39-71-201, MCA. This rule applies to the calculation of the administrative assessment for fiscal years beginning on or after July 1, 1991. Because the specific programs or functions funded by the administrative assessment are determined by the law in effect during the year for which the assessment is made, the general principles of assessment and allocation methodology, rather than specific program details, are stated.

(2) The department has determined that accounting and cost allocation procedures are proper when done in accordance with the provisions of (3) and (4), and applying the general methodologies described in RULE II.

(3) Costs are assignable to programs as follows:

(a) direct costs, such as salaries, operating costs, equipment costs, etc., are charged directly to the program or programs receiving benefit of those costs; and

(b) indirect costs for administrative services, centralized services, and other governmental services, are allocated to programs based on a practicable allocation methodology that is consistent with generally accepted accounting principles applicable to governmental entities. Examples of such methodologies are:

(i) use of the square footage for offices used by a program, for rental value of common areas;

(ii) use of the number of full-time equivalent staff for a program, for payroll services costs; and

(iii) use of the number of full-time equivalent staff for a program, for supervision costs at the bureau, division and department level.

(4) Program costs are assignable to the plans as follows:

(a) When, in the department's discretion it is appropriate, employee time in a particular program will be tracked by work performed for or related to a particular plan. The appropriateness of such tracking will be judged on the basis of whether the time spent tracking actual hours by individual plan provides sufficiently greater accuracy to outweigh the increased costs associated with tracking that time.

(b) Where tracking employee time is not appropriate per (4)(a), the department will allocate costs between individual plans by an appropriate cost allocation base, such as number of employers enrolled, number of cases, number of panels, etc.

(c) When no reasonable cost allocation base can be determined, the program will use the same allocation percentages as that used to allocate the cost of administrative services.

(d) The department will use a weighted average technique to allocate the cost of division and bureau administrative services. The weighted average technique is based on the programs for which such administrative services are provided. Programs for which a program specific cost allocation base is not used will not be included in the weighted average allocation.

(5) Costs for associated entities are apportioned to the plans in accordance with the principles described in this rule.
AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-201 MCA

RULE IV RECALCULATION OF ADMINISTRATIVE ASSESSMENTS MADE IN FISCAL YEARS 1992 - 1995 (1) In response to the decision of the workers' compensation court in WCC No. 9309-6893, *Montana Schools Group v. Department of Labor and Industry* (decided June 16, 1995), the department will recalculate the administrative assessment for the years 1992 through 1995, inclusive, using the methodology contained in RULE II and RULE III. The cost allocation bases used to calculate these assessments were those in the actual assessment if no other information was kept at the time and/or no superior cost allocation base could be determined. The cost of administrative services is allocated based on the methodology stated in RULE III.

(2) In the event a particular plan's administrative assessment is changed as a result of the recalculation for fiscal years 1992 through 1995, only those plan members that paid a given year's administrative assessment under protest and exercised the appropriate administrative remedies will have their bill for that year recalculated.

(3) A plan member that has its assessment recalculated will be billed for any net increase in the assessment due for years 1992 through 1995. If there is a net decrease in the assessment due, the plan member may choose to apply the net decrease as a credit toward a future administrative assessment or ask for a refund. A refund will be paid as soon as practicable, from whatever funds the department can properly use to pay such a refund.
AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-201 MCA

RULE V ASSESSMENTS OTHER THAN ADMINISTRATIVE ASSESSMENT (1) In addition to the administrative assessment, the department may levy other assessments on the plans as permitted by law.

(a) As provided by 39-71-902, MCA, the department may make an assessment of not more than 5% of compensation paid in the previous year by each of the plans, for the purpose of funding the subsequent injury fund. The assessment will not be made when, in the judgement of the department, there is no financial need for such an assessment to fund the liabilities and administrative costs of the subsequent injury fund.

(b) As provided by 39-71-1004, MCA, the department may make an assessment of not more than 1% of compensation paid by each plan member, for the purpose of funding the industrial accident rehabilitation account.

(2) The department may combine the billing for any or all of the assessments described in (1) with the billing for the administrative assessment.

(3) Payment of the bill for the assessments described in (1) is due 30 days from the date of the bill.

AUTH: Sec. 39-71-203 MCA
IMP: Sec. 39-71-902 and 39-71-1004 MCA

REASON: There is reasonable necessity to adopt the proposed rules in response to the decision of the Workers' Compensation Court in WCC No. 9309-6893, *Montana Schools Group v. Department of Labor and Industry* (decided June 16, 1995). In that case, the Court ruled that the Department needed to adopt administrative rules in order to prepare and make the assessment required by 39-71-201, MCA.

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

Chuck Hunter, Administrator
Employment Relations Division
Department of Labor and Industry
P.O. Box 8011
Helena, Montana 59604-8011

and must be received by no later than 5:00 p.m., July 19, 1996.

4. The Department proposes to make the new rules effective as soon as feasible. The Department reserves the right to adopt only portions of the rules, or to adopt some or all of the rules at a later date.

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

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

David A. Scott
Rule Reviewer

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

Certified to the Secretary of State: June 10, 1996.

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

In the matter of the amendment of rules 46.8.109, 46.8.202, 46.8.203, 46.8.206, 46.8.207, 46.8.211, 46.8.212, 46.8.705, 46.8.706, 46.8.710 through 46.8.713, 46.8.717, 46.8.720 through 46.8.724, 46.8.1301, 46.8.1302, 46.8.1304, 46.8.1305, 46.8.1307 through 46.8.1309 pertaining to developmental disabilities	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES

TO: All Interested Persons

1. On July 16, 1996 at 2:00 p.m., a public hearing will be held in the auditorium of the Public Health and Human Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.8.109, 46.8.202, 46.8.203, 46.8.206, 46.8.207, 46.8.211, 46.8.212, 46.8.705, 46.8.706, 46.8.710 through 46.8.713, 46.8.717, 46.8.720 through 46.8.724, 46.8.1301, 46.8.1302, 46.8.1304, 46.8.1305, 46.8.1307 through 46.8.1309 pertaining to developmental disabilities.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on July 8, 1996, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.8.109 CERTIFICATION OF PERSONS ASSISTING IN THE ADMINISTRATION OF MEDICATION (1) This rule establishes criteria and procedures under which an employee or an agent of a ~~provider~~ contractor may assist and supervise ~~a client~~ an individual in taking medication. ~~Such~~ aAssistance and supervision may only be given where a medication which is normally self-administered has been prescribed for ~~a client~~ an individual and where the physician who prescribed the medication also prescribed assistance or supervision in the administration of the medication.

(2) For the purposes of this rule, the following definitions apply:

(a) "~~a~~Assistance" means providing any degree of support or aid to ~~a client~~ an individual who independently performs at least one component of medication-taking behavior; and

(b) "~~s~~Supervision" means critically observing and directing ~~a client~~ an individual ~~engaging~~ engaged in medication-taking behavior.

(3) ~~No~~ An agent or employee of a ~~provider~~ contractor, ~~may~~ in order to assist or supervise in the administration of medication to ~~clients unless~~ individuals, must be certified by the department as herein provided unless the agent or employee is otherwise authorized by law to provide such assistance or supervision. ~~Every provider shall maintain a current list of provider employees and agents certified to administer medication on file with the division.~~

(4) To be certified, an employee or agent of a contractor must demonstrate knowledge of seizure disorders and of the use and side effects of medications by achieving a score of at least 90% on a comprehensive test administered by the department.

~~(4)~~ (5) Application for c~~C~~ertification to provide ~~such~~ supervision and assistance in the administration of medication ~~will be determined by the department upon written application~~ is made by providing notification to the Developmental Disabilities ~~Division, Department of Social and Rehabilitation Services,~~ Program, Department of Public Health and Human Services, P. O. Box 4210, Helena, MT 59604. ~~To be certified, an employee or agent of a provider must demonstrate knowledge of epilepsies and of use and side effects of medications by achieving a score of at least 90% on a comprehensive test administered by the department.~~

~~(5)~~ (6) Any ~~provider~~ contractor may receive, free of charge, an instructional and reference aid entitled ~~epilepsies and medications individualized instruction~~ seizure disorders & medications, a self-paced instructional manual~~, which shall have been approved by the board of nursing~~.

~~(6)~~ (7) The department ~~will~~ administers the comprehensive test to a qualified applicant within 30 days of receipt of a ~~written~~ the notification of application for certification.

(8) Notice of certification or noncertification ~~will be~~ is mailed within ~~ten~~ 10 days of the date of testing. The notice ~~will~~ designates an effective date and an expiration date for the certification. Certification is approved for a maximum of 2 years ~~will in no event be longer than for a period of two years~~.

(9) A person may receive consecutive certification by retaking the test as provided in (4) through (7).

(10) A contractor must provide to the developmental disability program of the disabilities services division of the department a current list of employees and agents certified to supervise and administer medication.

~~(7)~~ (11) If an individual has been receiving developmental disabilities services for 30 days and supervision and assistance

is to be administered for more than 10 consecutive days, this activity must be included as an objective in the written individual plan. ~~Any assistance provided under this rule which occurs after the client has been enrolled in the program for 30 days and which must be administered for a longer period than ten consecutive days must be the subject of a written individual habilitation plan.~~ ~~An~~ To address the objective, an individual ~~medication~~ program plan must be prepared which describes a program to train the ~~client~~ individual to self-administer the medication and must specify at least:

(a) the target medication-taking behavior;

(b) the conditions ~~(e.g., times and places) in~~ under which such behavior should occur;

(c) the conditions ~~(e.g., times and places) in~~ under which such behavior will be trained;

(d) ~~criteria~~ the criterion for completion of the individual program plan in accordance with ~~section (9)~~ (13) herein;

(e) the written strategies for training the target behavior;

(f) a data recording system which accounts for each prescribed medication dosage; ; and;

(g) a daily data recording system which specifies progress or lack of progress toward the target behavior ~~on a daily basis~~.

(8) remains the same in text but is renumbered (12).

~~(9)~~ (13) ~~A client~~ An individual is considered to be capable of self-administering medication when it has been documented that the ~~client~~ individual has self-administered all (100%) of prescribed medication dosages for a consecutive 30 day period.

~~(10) (a) The department may revoke certification by notifying the certified person of the reason for revocation in writing at least ten days prior to the effective date of revocation. The certified person may request, in writing, within the ten days prior to revocation, a hearing from the division administrator, who will issue a decision no later than 30 days from the date the request for hearing was received. When a request for a hearing is made, the revocation not effective until the division administrator's decision is made.~~

~~(b) The department may, for cause, suspend a certified person's right to assist or supervise in the administration of medication for a period no longer than 15 days, after which the suspension must be removed or notice of revocation issued. If notice of revocation is issued, suspension may continue until the effective date of revocation or until the division administrator's decision is made.~~

(14) There are two conditions under which an individual program plan to teach self-administration of medication is no longer necessary. They are:

(a) the individual has met the criterion specified in (13), or

(b) the IP team has reviewed the ongoing implementation of the individual program plan and found that the individual has reached the maximum level of independence in the self-administration of medication of which the individual is currently capable. In making this decision, the team must evaluate whether:

(i) the individual has made any progress;

(ii) the program has been consistently implemented;

(iii) a variety of teaching strategies has been employed;

(iv) the decision to discontinue the program will interfere with the individual's ability to be served in a less restrictive environment; and

(v) the program has been in place long enough to make a decision concerning its effectiveness.

(15) If the IP team decides that an individual program plan to teach self-administration of medication is no longer necessary, the requirements concerning the need for certified personnel and recording instances of assistance and supervision must be met.

(16) The feasibility of re-instituting a program to teach self-administration of medication must be examined at subsequent IP meetings by the team. If the individual's situation changes such that there is a possibility of further acquisition of the skill, a program is initiated.

(17) The department may revoke or suspend a certification.

(a) The department may revoke certification by notifying the certified person of the reason for revocation in writing at least 10 days prior to the effective date of revocation. The certified person may request, in writing, within the 10 days prior to revocation, a review by the division administrator. A decision is issued within 30 days from the date the request for review is received. When a request for a review is made, the revocation is not effective until the division administrator's decision is made.

(b) The department may suspend a certified person's right to assist or supervise in the administration of medication for a period no longer than 15 days, after which the suspension must be removed or notice of revocation issued. If notice of revocation is issued, suspension may continue until the effective date of revocation or until the division administrator's decision is made.

AUTH: Sec. 53-20-204, MCA
IMP: Sec. 53-20-204~~(2)~~, MCA

46.8.202 INDIVIDUAL PLAN: IMPLEMENTATION (1) A single, comprehensive individual plan must be developed and maintained by an individual planning team for each recipient of state funded developmental disabilities services. Individual plans are not required for individuals who are only recipients of one or more of the following developmental disabilities services:

(a) family services where an individual family service plan (IFSP) or an annual service agreement exists;
(1)(b) and (1)(c) remain the same.
(d) ~~respite.~~ case management.
(2) and (3) remain the same.

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

46.8.203 INDIVIDUAL PLAN: COMPONENTS (1) Each individual plan must include the following:
(a) any results of comprehensive assessments, both formal and informal, of the ~~person~~ individual receiving services, which identify current abilities and needs. Assessments must include, but are not limited to, the following:
(1)(a)(i) through (1)(a)(iii) remain the same.
(iv) a self assessment; and
(1)(a)(v) through (3) remain the same.

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

46.8.206 INDIVIDUAL PLAN: COMPOSITION OF INDIVIDUAL PLANNING TEAM (1) The individual planning team should include the following persons if available and willing to participate:
(1)(a) through (1)(h) remain the same.
(i) a ~~staff member of the division,~~ field services specialist, if the case manager in (1)(e), herein, is a contracted case manager; and
(j) ~~any~~ professionals such as psychologists, medical personnel and others, ~~professionals~~ as needed.
(2) remains the same.

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

46.8.207 INDIVIDUAL PLAN; STATUS REPORTS AND ANNUAL PLANNING MEETING (1) and (1)(a) remain the same.
(b) A copy of the individual plan status report must be provided to:
(i) the case manager; and
(ii) the ~~regional~~ developmental disabilities ~~division~~ program office, if the case manager is a contracted case manager.
(1)(c) through (2)(d) remain the same.

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

46.8.211 INDIVIDUAL PLAN; DECISION MAKING (1) through (4) remain the same.

(5) At the individual planning meeting held to reconsider a matter upon which there is disagreement, if a consensus is not reached, the unresolved issues must be clearly stated in the meeting summary. The written summary ~~will be~~ is sent to each team member.

(6) Each individual planning team member who wishes to express a viewpoint about issues upon which there is disagreement must submit the reasons for agreement or disagreement in writing to the case manager ~~the reasons for agreement or disagreement~~. The case manager ~~will write~~ must send a cover letter outlining the issues to the regional manager ~~and the regional administrator of the department of family services~~ within ~~ten~~ 10 working days of the previous individual planning meeting. The meeting summary and any written materials submitted by team members are to accompany the letter.

(7) The regional manager ~~and the regional administrator of the department of family services will~~, within ~~ten~~ 10 days of the receipt of a letter from a case manager relating to an appeal, reviews the matter at issue, and after consideration of the meeting summary and any written materials submitted by team members, ~~will~~ arrives at a decision in the matter.

(8) If any individual planning team member is dissatisfied with the decision of the regional manager ~~and the regional administrator of the department of family services~~, the team member must notify the case manager in writing within ~~five~~ 5 working days of receipt of the regional manager's decision. The case manager must refer the appeal immediately to the individual planning appeal committee, as provided for in ARM 46.8.212(3).

(9) In cases where an appeal occurs involving ~~a person~~ an individual who is currently enrolled in public school, the following procedures ~~will~~ apply:

(9)(a) through (10) remain the same.

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

46.8.212 INDIVIDUAL PLAN; INDIVIDUAL PLANNING APPEAL COMMITTEE (1) The individual planning appeal committee is appointed by the administrator of the ~~developmental disabilities~~ disability services division.

(2) The individual planning appeal committee ~~will be~~ is composed of:

(a)~~(i)~~ ~~a person~~ an individual receiving services;

(b)~~(ii)~~ a parent, guardian or advocate;

~~(iii) a representative of the developmental disabilities division;~~

~~(iv)~~ (c) a ~~representative of the department of family services;~~ case manager; and

~~(v)~~ (d) a service provider.

(3) A representative of the developmental disabilities program central office is responsible for coordinating the activities of the appeal committee.

~~(3)~~ (4) The appeal committee ~~will~~ must establish and make available its own operating procedures.

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

46.8.705 RESIDENTIAL FACILITY SCREENING: PURPOSE (1) These rules govern the screening of persons being considered for commitment into residential facilities. The rules provide the procedures and criteria for determining whether a person is seriously developmentally disabled. ~~with developmental disabilities is so severe in condition as to warrant a recommendation to the district court for the person's commitment to a facility.~~

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-102, 53-20-106, 53-20-112, 53-20-116, 53-20-121, 53-20-125, 53-20-127, 53-20-128, 53-20-129, and 53-20-133, MCA

46.8.706 RESIDENTIAL FACILITY SCREENING: DEFINITIONS For the purposes of this rule the following definitions apply:

~~(1) "Accredited program" means a program recognized and accredited by either the accreditation council on services for people with developmental disabilities (ACDD) or by the commission on accreditation of rehabilitation facilities (CARF) for academic and professional preparation programs.~~

~~(2)~~ (1) "Applicant" means a person seeking certification as a developmental disabilities professional ~~person~~.

~~(3)~~ (2) "Certification committee" means, as provided in ARM 46.8.721, the committee with delegated authority to certify developmental disabilities professionals ~~persons~~.

~~(4)~~ (3) "Community-based facilities" or "community-based services" means those services and facilities which are available for the ~~evaluation, treatment, and~~ habilitation of persons with developmental disabilities in a community setting~~, including but not limited to outpatient facilities, special education services, group homes, foster homes, day care facilities, sheltered workshops, and other community based services and facilities~~.

~~(5)~~ (4) "Court" means a district court of the state of Montana.

(5) "Department" means the department of public health and human services (DPHHS).

(6) "Developmental disability" means a disability ~~attributable to mental retardation, cerebral palsy, epilepsy, autism, or any other neurologically handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded persons if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely, and~~

~~constitutes a substantial handicap for the person~~ as defined at 53-20-103(5), MCA.

~~(7) "Professional person" means a person meeting the definition of professional person provided in 53-20-102, MCA and certified by the professional persons certification committee as provided in ARM 46.8.720 through 46.8.724.~~

~~(8) "DCHS" means the department of corrections and human services.~~

(7) "Developmental disabilities professional" means a professional as defined at 53-20-102(4), MCA.

~~(9) "Habilitation" means the process by which a person with a developmental disability is assisted to acquire and maintain those life skills which enable the person to cope more effectively with the demands of the environment and to improve physical, mental, and social efficiency. Habilitation includes but is not limited to formal, structured education and treatment.~~

(10) remains the same in text but is renumbered (8).

~~(11)~~ (9) "Qualified mental retardation professional (QMRP)" means ~~a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is:~~

~~(a) a licensed physician or osteopath;~~

~~(b) a registered nurse; or~~

~~(c)~~ a professional program staff person for the residential facility whom the department ~~of corrections and human services~~ determines meets the professional requirements necessary for federal certification of the facility.

(12) and (13) remain the same in text but are renumbered (10) and (11).

~~(14)~~ (12) "Seriously developmentally disabled" means a person who:

(a) ~~is developmentally disabled;~~ has a developmental disability;

(b) is impaired in cognitive functioning; and

(c) has behaviors that pose an imminent risk of serious harm to self or others, or self-help deficits so severe as to require total care or near total care and, who, because of those behaviors or deficits, cannot safely and effectively be habilitated in community-based services.

~~(15) "SRS" means the department of social and rehabilitation services.~~

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-102, 53-20-106, 53-20-112, 533-20-116, 53-20-121, 53-20-125, 53-20-127, 53-20-128, 53-20-129, and 53-20-133, MCA

46.8.710 RESIDENTIAL FACILITY SCREENING: ADMINISTRATION AND COMPOSITION OF SCREENING TEAM (1) The residential facility screening team is a standing committee ~~administratively assigned to the department of social and rehabilitation services~~.

(2) The residential facility screening team includes the following representatives who are appointed by the director of the department:

(a) a representative from the Montana developmental center;

(b) a representative from the developmental disabilities program;

(c) a representative from an adult services provider agency within the developmental disabilities service system; and

(d) a person representing consumer interests.

~~(a) a department of corrections and human services (DCHS) staff person or designee appointed by the director of DCHS;~~

~~(b) a department of social and rehabilitation services (SRS)/developmental disabilities division (DDD) staff person or designee, appointed by the director of SRS;~~

~~(c) a provider of adult developmental disabilities services appointed jointly by the directors of DCHS and SRS; and~~

~~(d) a consumer interests representative appointed jointly by the directors of DCHS and SRS.~~

(3) The representative from the ~~department of social and rehabilitation services~~ developmental disabilities program ~~will~~ serves as chairperson of the team.

(4) The ~~staff for the~~ residential facility screening team ~~is as follows:~~, as necessary, obtains information and evaluations from the following persons:

(a) ~~a QMRP, or professional person if determined necessary by the residential facility screening team, from the Montana developmental center (MDC)~~ for review of recommitments ~~of all residents of MDC;~~ to the Montana developmental center (MDC) or to the eastmont human services center (EHSC), a QMRP; and

~~(b) a QMRP, or professional person if determined necessary by the residential facility screening team, from eastmont human services center (EHSC) for review of recommitment of residents of EHSC; and~~

~~(c)~~ (b) ~~contracted professional persons who will serve specified geographical areas for review of~~ for individuals residing in communities~~.~~, a developmental disabilities professional.

(5) In a district court hearing for commitment, a member of the residential facility screening team may be required to testify with regard to a determination made by the residential facility screening team.

~~(5)~~ (6) A person serving on the residential facility screening team shall not participate in a determination where that person has a personal conflict. In such circumstances an alternate member ~~will be~~ is selected to serve.

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-133, MCA

46.8.711 RESIDENTIAL FACILITY SCREENING: RESPONSIBILITIES OF DEVELOPMENTAL DISABILITIES PROFESSIONALS ~~PERSONS~~ AND QMRP'S (1) The developmental disabilities professional ~~person assigned by the residential facility screening team to review~~ or QMRP reviewing an individual being considered for commitment or recommitment is responsible for:

(a) gathering and analyzing information about the person;

(b) conducting psychological testing and assessment ~~as needed,~~ when requested by the residential facility screening team or the individual's case manager; and

(c) compiling information and writing reports for the residential facility screening team~~;~~.

~~(d) providing an oral report to the team to assist in the team's recommendation regarding commitment; and~~

~~(e) presenting testimony to the court as required.~~

(2) The ~~QMRP or professional person~~ developmental disabilities professionals, or QMRP's at the residential facilities~~,~~ will:

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

~~(3) The professional person or QMRP may participate in the discussion of the residential facility screening team, but will not be a voting member in determining consensus regarding the commitment or recommitment of an individual.~~

~~(4) The QMRP may not present testimony on behalf of the screening team at a district court commitment hearing.~~

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-112, 53-20-116, 53-20-128, 53-20-129 and 53-20-133, MCA

46.8.712 RESIDENTIAL FACILITY SCREENING: RESPONSIBILITIES OF THE SCREENING TEAM (1) The function of the residential facility screening team is to:

(1)(a) remains the same.

(b) ~~to~~ provide a determination regarding any commitment or recommitment. If commitment or recommitment is recommended, the team ~~will~~ provides that recommendation to the court along with the information considered in making the determination.

(2) The residential facility screening team ~~will~~ initiates a review upon notification that a petition has been filed in court for commitment or recommitment of an individual into a residential facility.

(3) The residential facility screening team ~~will~~ publishes, maintains and disseminates the following information:

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

(c) a handbook describing the operating procedures for the team and guidelines the team ~~will~~ uses in making its decisions, and how non-consensus ~~will be~~ is handled;

(d) identification or development of standardized forms to be used for ~~the two main categories of~~ commitment~~:~~;

~~(i) commitment or contested recommitment; and~~

~~(ii) uncontested recommitment;~~

(e) specific timelines for response to a court after notification of the filing of a petition.

(4) In addition to giving notice of its determination to the court, notice of a team determination ~~will be~~ is mailed or delivered by the screening team to the individual who is being considered for commitment, ~~and as appropriate~~ to the parents or guardian, the responsible person, the next of kin, the attorney for the individual, the advocate for the individual, the county attorney, the residential facility and the attorney for the parents or guardian.

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-125, 53-20-127, 53-20-128, 53-20-129 and 53-20-133, MCA

46.8.713 RESIDENTIAL FACILITY SCREENING: DETERMINATION OF SCREENING TEAM (1) The residential facility screening team, as provided in 53-20-125 and 53-20-133, MCA, determines whether the individual is seriously developmentally disabled and, therefore, may be considered for commitment or recommitment to a residential facility.

(2) The residential facility screening is conducted as follows:

(2)(a) remains the same.

(b) the residential facility screening team completes the assessment process to determine whether the individual meets the definition of seriously developmentally disabled;

(i) if the residential facility screening team determines that the individual meets the definition of seriously developmentally disabled and, therefore, determines that commitment or recommitment to a residential facility is appropriate, the team ~~recommends~~ may recommend to the court that the individual be committed, if the team determines that commitment is appropriate in that particular case; or

(2)(b)(ii) remains the same.

(c) the team ~~will~~ reports its determination to the court.

(3) The residential facility screening team, in making a determination, reviews the following:

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

(d) current status ~~/~~ or situation;

(e) comprehensive medical history ~~and information that must include~~ , including medications history;

(3)(f) through (5) remain the same.

(6) The screening process ~~will only be~~ is initiated when ~~a~~ notice of a properly filed petition has been sent to the residential facility screening team within the required time.

(7) If an individual has been placed by an emergency admission into a residential facility and a petition is not filed within the required timelines, the individual may be returned to the county of origin, in accordance with the residential facility's procedures. If, under these circumstances, the party who brought the individual to the

~~institution~~ residential facility does not come to get the person within 48 hours, ~~institution~~ residential facility staff may return the individual to the county of origin, in accordance with the residential facility's procedures.

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-125, 53-20-127, 53-20-128, 53-20-129 and 53-20-133, MCA

46.8.717 RESIDENTIAL FACILITY SCREENING: APPEAL OF SCREENING TEAM DETERMINATION OR RECOMMENDATION (1) If the residential facility screening team determines that the individual is not seriously developmentally disabled and therefore a commitment or recommitment is not appropriate, the ~~determination will be communicated to the district court and the individual. The~~ individual or the individual's authorized representative may request a fair hearing as provided in ARM 46.2.201 et~~.~~ seq., from the department ~~of social and rehabilitation services~~, within ~~thirty~~ 30 days of the determination that the individual is not seriously developmentally disabled.

(2) remains the same.

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-125, 53-20-127, 53-20-128, 53-20-129 and 53-20-133, MCA

46.8.720 RESIDENTIAL FACILITY SCREENING: CERTIFICATION OF DEVELOPMENTAL DISABILITIES PROFESSIONALS ~~PERSONS~~

(1) Developmental disabilities pProfessionals ~~persons~~ are certified for the following purposes:

(1)(a) remains the same.

(b) to evaluate at the request of the residential facility screening team, as provided in ARM 46.8.711 and 46.8.713, an individual being considered for commitment or recommitment, by gathering information, conducting, as directed by the residential facility screening team or as requested by the individual's case manager, psychological testing and assessment, compiling information, writing reports to the residential facility screening team, and providing a report to the residential facility screening team to assist in the team's ~~recommendation~~ review of the case regarding commitment~~., and presenting testimony on behalf of the screening team to the court as required.~~

AUTH: Sec. 53-20-106 and 53-20-133, MCA
IMP: Sec. 53-20-106, MCA

46.8.721 RESIDENTIAL FACILITY SCREENING: THE CERTIFICATION COMMITTEE FOR DEVELOPMENTAL DIABILITIES PROFESSIONALS (1) ~~Professional persons~~ Developmental disabilities professionals are certified by the ~~professional person~~ certification committee for developmental disabilities professionals.

(2) The purposes of the certification committee are to:

(a) review all applications of persons requesting certification as ~~professional persons~~ developmental disabilities professionals;

(b) certify ~~professional persons~~ developmental disabilities professionals in accordance with these rules; and

(c) perform other duties set forth by these rules or assigned to the certification committee by the ~~directors of SRS and DCHS~~ director of the department.

~~(3) The certification committee functions as the certification committee for professional persons under Title 53, chapter 20, MCA relating to persons with developmental disabilities and under Title 53, chapter 21, MCA relating to persons with mental illness. The rules relating to certification of professional persons for mental health purposes are at ARM 20.14.501 et seq.~~

~~(4)~~ (3) The ~~professional person~~ certification committee for developmental disabilities professionals includes the following members:

(a) a person appointed by the governor;

(b) ~~two~~ four persons appointed by the director of ~~SRS,~~ the department, at least two of whom represent the developmental disabilities program and who are familiar with the roles and responsibilities of developmental disabilities professionals~~, persons; and~~

~~(c) two persons appointed by the director of DCHS, professionals.~~

~~(5)~~ (4) Members of the certification committee shall serve at the convenience of the appointing authority.

~~(6)~~ (5) The person appointed by the governor ~~will~~ serves as chairperson of the committee. Meetings of the certification committee shall be called by the chairperson. The certification committee ~~will~~ meets as needed, but no fewer than four times per year, to review applicants.

AUTH: Sec. 53-20-106 and 53-20-133, MCA
IMP: Sec. 53-20-106, MCA

46.8.722 RESIDENTIAL FACILITY SCREENING; CERTIFICATION PROCEDURES FOR DEVELOPMENTAL DISABILITIES PROFESSIONALS ~~PERSONS~~ (1) The certification procedures for a professional ~~person~~ are the following:

(1)(a) and (1)(b) remain the same.

(c) an issuance or denial of certification or provisional certification of the application by the certification committee;

(i) the certification committee may issue provisional certification that limits the specific services, the conditions under which the developmental disabilities professional ~~person~~ can provide services, or the time period such certification shall be effective, or any combination thereof;

(1)(d) remains the same.

(2) Certification ~~will~~ expires ~~three~~ 3 years from the date of certification.

(3) The certification committee may revoke certification for cause by notifying the certified developmental disabilities professional ~~person~~ in writing of the reasons for revocation at least 10 days prior to the effective date of revocation.

(4) The certification committee ~~will~~ establishes and implements procedures to assure timely and efficient review of applicants.

AUTH: Sec. 53-20-106 and 53-20-133, MCA
IMP: Sec. 53-20-106, MCA

46.8.723 RESIDENTIAL FACILITY SCREENING; QUALIFICATIONS OF DEVELOPMENTAL DISABILITIES PROFESSIONALS ~~PERSONS~~ (1) A ~~professional person must~~ developmental disabilities professional must be:

~~(a) be:~~

~~(i) a physician who is licensed by the state of Montana and is board certified to practice psychiatry;~~

~~(ii) a psychologist licensed by the state of Montana; or~~

~~(iii) a person with a master's degree in psychology from an accredited program;~~

~~(b) have training and experience in psychometric testing and evaluation; and~~

~~(c) document any direct experience involving persons with developmental disabilities, which experience may include:~~

~~(i) evaluation;~~

~~(ii) planning;~~

~~(iii) testing;~~

~~(iv) treatment; and~~

~~(v) consultation.~~

(a) a licensed psychologist;

(b) a licensed psychiatrist; or

(c) a person with a master's degree in psychology, who:

(i) has training and experience in psychometric testing and evaluation; and

(ii) has experience in the field of developmental disabilities.

(2) Experience in the field of developmental disabilities may include:

(a) evaluation;

(b) planning;

(c) testing;

(d) treatment; and

(e) consultation.

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

AUTH: Sec. 53-20-106 and 53-20-133, MCA
IMP: Sec. 53-20-106, MCA

46.8.724 RESIDENTIAL FACILITY SCREENING: RIGHT TO APPEAL CERTIFICATION COMMITTEE DECISIONS (1) Any action of the certification committee concerning certification denial or revocation may be appealed to the department ~~of social and rehabilitation services~~.

(a) The notice of appeal shall be directed to the director of the department ~~of social and rehabilitation services~~.

(b) The appeal shall be in writing ~~setting~~ and shall set forth the nature of the grievance and arguments supporting the grievance and actions desired. The appealing party may also present oral argument.

(1)(c) remains the same.

(2) All findings of the department director or designee ~~will be~~ are binding on the certification committee.

AUTH: Sec. 53-20-106 and 53-20-133, MCA
IMP: Sec. 53-20-106, MCA

46.8.1301 INCIDENT REPORTING AND HANDLING, PURPOSE (1) These rules govern the reporting and handling of incidents which harm or could result in harm to ~~persons~~ individuals with a developmental disability who are recipients of services funded by the developmental disabilities program of the department ~~of social and rehabilitation services~~.

(a) Incidents constituting abuse and neglect of a child as defined in 41-3-102, MCA or abuse, neglect and exploitation of ~~an older~~ a person with a developmental disability as defined in ~~53-5-503~~ 52-3-803, MCA are subject to the statutory and rule provisions governing the reporting, investigation and protection of those persons.

(b) The roles of the department ~~of family services~~ in case management and protective services for persons with a developmental disability, abused and neglected children and abused, neglected and exploited older persons necessitate the provisions of these rules relating to those responsibilities.

(c) Incidents constituting abuse, neglect and exploitation of a person with a developmental disability are to be reported as provided for ~~in~~ at ~~53-20-402~~ 41-3-201 or 52-3-811, MCA, to the protective services programs of the department ~~of family services~~.

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

46.8.1302 INCIDENT REPORTING AND HANDLING, POLICY (1) A ~~provider~~ contractor must have a policy of incident reporting and handling.

(2) An incident handling and reporting policy must assure that incident handling and reporting:

(a) is conducted as provided for in this rule;

(b) provides for the confidentiality of ~~client~~ individual identity and information;

(c) meets any standards, if applicable, for group home licensing at ARM 11.18.199, et seq.;

(d) meets any applicable program standards provided at ARM 46.8.901, et seq.; and

(e) meets any applicable aversive procedure standards provided at ARM 46.8.1201, et seq.

(3) through (3)(d) remain the same.

(4) The policy must provide staff training and orientation on a continuing and consistent basis regarding:

(a) the statutory obligations at 41-3-201 and 52-3-811, MCA to report suspected or alleged abuse and neglect to the protective services programs of the department;

~~(a)~~ (b) the rules on incident reporting at ARM ~~46.8.102~~, 46.8.1301, et seq.;

~~(b)~~ (c) the rules on aversive procedures at ARM 46.8.1201, et seq.;

~~(c)~~ (d) the ~~provider's~~ contractor's policy on client abuse and rights violations;

~~(d)~~ (e) measures necessary to protect the rights and interests of ~~clients~~ individuals who are considered to be "at risk"; and

~~(e)~~ (f) the department ~~of social and rehabilitation services and department of family services~~ procedures for investigating suspected ~~client~~ abuse and neglect in services funded by the ~~division~~ program.

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

46.8.1304 INCIDENT REPORTING AND HANDLING (1) An incident involving a ~~client~~ recipient of developmental disabilities services must be reported in writing and submitted in the format requested by the department to the ~~department of family services'~~ case manager and to ~~the responsible division staff~~ a field services specialist on the first working day following the incident.

~~(2) Verbal notification must be given in suspected abuse and neglect as defined in the client rights policy.~~

~~(3)~~ (2) An incident report must minimally include the ~~client's~~ individual's name and address, the time and date of the incident, a description of the incident, the names of staff and other persons present and responding to the incident, and the response of the staff and others to the incident.

~~(4)~~ (3) Any suspected abuse and neglect of a child or suspected abuse, neglect and exploitation of a person ~~60 years of age or older~~ with a developmental disability must be reported, in accordance with 41-3-201 and 52-3-811, MCA and implementing rules, to the ~~department of family services case manager~~ protective services worker or designee and the county attorney.

AUTH: Sec. 53-20-204, MCA

IMP: Sec. 53-20-205, MCA

46.8.1305 INCIDENT REPORTING AND HANDLING, DEATH, SUICIDE ATTEMPT, UNACCOUNTED FOR ABSENCE, EMERGENCY HOSPITALIZATION OR ~~INCARCERATION~~ LAW ENFORCEMENT INVOLVEMENT (1) The ~~provider~~ contractor must notify the following persons upon ~~the~~ an individual's death, suicide attempt, unaccounted for absence, emergency hospitalization~~,~~; substantial changes in ~~a client's~~ an individual's residential or vocational placement without ~~I.H.P.~~ IP team approval; or alleged unlawful activities by or affecting the individual, including, but not limited to, incarceration of ~~a client~~ the individual:

(a) the case manager or designee;

(b) the ~~division staff~~ field services specialist;

(c) the guardian, if any; ~~and~~

(d) a designated advocate, if any~~.~~ ; and

(e) the next of kin, if any.

(2) Notice must be given, verbally, as follows:

(a) to the guardian or the next of kin, if any, and case manager or their designees as soon as possible but no later than two hours after the incident becomes known; and

(b) to ~~division staff~~ the field services specialist and an advocate within 24 hours of the incident.

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

46.8.1307 INCIDENT REPORTING AND HANDLING, INVESTIGATIONS (1) The department ~~or the department in cooperation with the department of family services~~ may conduct an investigation into any incident, reported or unreported, which involves or appears to involve ~~a person~~ an individual receiving developmental disabilities services.

(2) The contractor must provide the department ~~will have~~ with access to the site and facilities relating to the incident and to any staff ~~or clients~~ who may have knowledge of the matter.

(3) An incident involving suspected abuse and neglect of a child or suspected abuse, neglect and exploitation of a person ~~60 years of age or older~~ with developmental disabilities must be investigated by the department ~~of family services~~ under the statutory and rule provisions governing those investigations. ~~The department will cooperate in investigations as directed by law and participate in the investigation as may be agreed to by the department of family services.~~

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

46.8.1308 INCIDENT REPORTING AND HANDLING, CONFIDENTIALITY (1) remains the same.

(2) An incident report is available to the department, ~~the department of family services and~~ the ~~provider~~ contractor and providers of necessary professional services for use relating to their responsibilities for the care and protection of the ~~client~~ individual and the provision of services to the ~~client~~ individual.

(3) An incident report or information contained therein may be made available to other governmental entities if those entities are responsible for the care and protection of the ~~client and~~ individual or the provision of services to the ~~client~~ individual and the receipt of the incident report or information is necessary to the conduct of those responsibilities.

(4) Information in an incident report concerning ~~a client~~ an individual is available to the ~~client~~ individual, to a legal guardian or legally responsible family member of the ~~client~~ individual, or to an advocate designated by the ~~client~~ individual or legal guardian or legally responsible family member. Information, however, need not be provided to a person who is an alleged or suspected perpetrator.

(5) An incident of abuse and neglect involving a child is subject to the confidentiality provisions of 41-3-205, MCA. An incident of abuse, neglect and exploitation involving ~~an older~~ a person with a developmental disability is subject to the confidentiality provisions of ~~53-5-513~~ 52-3-813, MCA.

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

46.8.1309 INCIDENT REPORTING AND HANDLING, CLIENT ABUSE OR CLIENT PROBLEM BEHAVIOR (1) In a situation where the provisions of either 41-3-101, MCA et seq., relating to child abuse and neglect or ~~53-5-501~~ 52-3-801, MCA et seq., relating to ~~elder~~ abuse, neglect or exploitation of a person with a developmental disability are determined to be applicable, the requirements of these rules may be followed only to the extent that they are not in conflict with the provisions of those laws and rules adopted to effectuate those laws.

(2) Problem behaviors of ~~clients~~ individuals resulting in either harm to self, others or property or the threat of harm to self, others or property are subject to the reporting requirements in ARM 46.8.1304. If staff must use emergency ~~and requiring~~ aversive procedures, as defined and provided in ARM ~~46.8.1204~~ 46.8.1201, et seq., for modification of those behaviors, they must be handled in accord with the aversive procedures in those rules at ARM 46.8.1201, et seq.

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

3. The rules for which amendments are proposed generally implement program requirements governing the delivery of services for the state program of developmental disabilities services administered by the Department of Public Health and Human Services. The specific rules being amended provide program requirements in relation to individual plans, residential facility screening, incident reporting and handling, and certification of persons assisting in the administration of medication.

The Department of Public Health and Human Services delivers developmental disabilities services through contractual agreements with service providers. The rules for which amendments are proposed are generally necessary to provide criteria to govern the delivery of services by the contractual providers.

Proposed Amendment of ARM 46.8.109, Certification of Persons Assisting in the Administration of Medication

The proposed amendments to ARM 46.8.109, certification of persons assisting in the administration of medication, are necessary to provide for the renewal of certification upon expiration, to provide criteria for the individual planning team in determining whether there is a continuing need for medications training objectives, to replace inappropriate references, to conform terminology with current usage, to make appropriate grammatical changes, and to reorganize the rule for clarity. The proposed changes improve the administration of medications by providing further direction for those persons involved in the planning for and provision of medications.

Proposed Amendments of 46.8.202, 46.8.203, 46.8.206, 46.8.207, 46.8.211, and 46.8.212, concerning individual plans for individuals receiving services through the Montana developmental disabilities service system

The proposed amendments, concerning individual plans for individuals receiving services provided through the Montana developmental disabilities service delivery system, are necessary to make appropriate grammatical changes, to replace inappropriate references, to conform terminology with current usage, and to further define service situations where individual plans are not required. The proposed revisions to the decision-making process and the composition of the individual planning appeal committee are necessary to conform with the changes in the administration of services resulting from the reorganization of human services delivery in Montana by the 1995 Legislature in Ch. 546, L. 1995.

Proposed Amendments of ARM 46.8.705, 46.8.706, 46.8.710 through 46.8.713, 46.8.717, 46.8.720 through 46.8.724, concerning residential facility screening

The proposed amendments, concerning residential facility screening are necessary to conform terminology with current usage, to remove terms that are defined elsewhere, to make appropriate grammatical changes, and to replace inappropriate references. The proposed revisions relating to the developmental disabilities professional and to the qualified mental retardation professional are necessary to conform nomenclature with changes enacted by the 1995 Legislature in Ch. 255, L. 1995, to conform the roles with their statutory purposes, and to conform definitional criteria with that enacted by the 1995 Legislature in Ch. 546, L. 1995. The proposed revisions in the composition of the residential facility screening team are necessary to conform this process with the changes in the administration of services resulting from the reorganization of human services delivery in Montana by the 1995 Legislature. The proposed revisions relating to the provision of notice are necessary to conform the parties to whom notice is to be given with changes enacted by the 1995 Legislature in Ch. 255, L. 1995.

Proposed Amendments of ARM 46.8.1301, 46.8.1302, 46.8.1304, 46.8.1305, 46.8.1307 through 46.8.1309, concerning incident reporting and handling for persons receiving services through the Montana developmental disabilities service system

The proposed amendments, concerning incident reporting and handling for persons receiving services through the Montana developmental disabilities service system, are necessary to make appropriate grammatical changes, to replace inappropriate references, to conform terminology with current usage, and to incorporate the provider reporting obligations specified at 41-3-201 and 52-3-811, MCA. The proposed revisions, changing the references from the Departments of Social and Rehabilitation Services and Family Services to the Department of Public Health and Human Services, are necessary to conform this process with the changes in the administration of services resulting from the reorganization of human services delivery in Montana by the 1995 Legislature in Ch. 546, L. 1995.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604, no later than July 18, 1996.

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

Dawn Sliva
Rule Reviewer

Michael S. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the proposed repeal of ARM 2.21.1201 through 2.21.1205 and 2.21.1211 related to adoption of personnel policy	)))))	NOTICE OF THE REPEAL OF ARM 2.21.1201 THROUGH 2.21.1205 AND 2.21.1211 RELATED TO ADOPTION OF PERSONNEL POLICY

TO: All Interested Persons.

1. On April 25, 1996, the Department of Administration published notice of the proposed repeal of ARM 2.21.1201 through 2.21.1205 and 2.21.1211 related to adoption of personnel policy at page 945 of the Montana Administrative Register, issue number 8.

2. The department has repealed the rules as proposed.

3. No comments or testimony were received.

Dal Smilie
Rule Reviewer

Lois Menzies
Director

Certified to the Secretary of State June 10, 1996.

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

In the matter of the amendment of Rules 6.2.103, 6.2.104 and 6.2.107 and the repeal of Rules 6.2.102, 6.2.105, 6.2.106 and 6.2.108 pertaining to the procedural rules of the State Auditor's Office.	) NOTICE OF AMENDMENT AND REPEAL

TO: All Interested Persons.

1. On May 9, 1996, the state auditor and commissioner of insurance of the state of Montana published notice of the proposed amendment of Rules 6.2.103, 6.2.104 and 6.2.107 and the proposed repeal of Rules 6.2.102, 6.2.105, 6.2.106 and 6.2.108 pertaining to the procedural rules of the State Auditor's Office. The notice was published at page 1227 of the 1996 Montana Administrative Register, issue number 9.

2. The agency has amended Rules 6.2.103, 6.2.104, and 6.2.107 as proposed.

3. The agency has repealed Rules 6.2.102, 6.2.105, 6.2.106, and 6.2.108 found on pages 6-9 through 6-12 of the Administrative Rules of Montana.

AUTH: 33-1-313, MCA
IMP: 2-4-201, MCA

4. No written comments were received.

5. Rule 6.2.107 was inadvertently included in the list of rules proposed for repeal in paragraph 3 of the notice of proposed amendment and repeal. As indicated in paragraph 2 above, Rule 6.2.107 is being amended as proposed and not repealed.

Mark O'Keefe
State Auditor and
Commissioner of Insurance

By: 
Claudia Clifford
Assistant State Auditor


Elizabeth O'Halloran
for Gary Spaeth
Rules Reviewer

Certified to the Secretary of State this 10th day of June, 1996.

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

In the matter of the amendment of Rules 6.6.503, 6.6.507, 6.6.507B, 6.6.508, 6.6.508A, 6.6.509, 6.6.510, 6.6.511, 6.6.515, 6.6.517, 6.6.519 and 6.6.521 pertaining to medicare supplement insurance	)	NOTICE OF AMENDMENT

TO: All Interested Persons:

1. On April 25, 1996, the state auditor and commissioner of insurance of the state of Montana published notice of public hearing on the proposed amendment of Rules 6.6.503, 6.6.507, 6.6.507B, 6.6.508, 6.6.508A, 6.6.510, 6.6.515, 6.6.517, 6.6.519 and 6.6.521 pertaining to medicare supplement insurance. The notice was published at page 947 of the 1996 Montana Administrative Register, issue number 8.

2. The agency has amended Rules 6.6.507, 6.6.517 and 6.6.521 exactly as proposed. The agency has amended Rules 6.6.503, 6.6.507B, 6.6.508, 6.6.508A, 6.6.610, 6.6.515 and 6.6.519 as proposed, but with the following changes. Based on comments received, rules 6.6.509 and 6.6.511, which were not proposed for amendment, will also be amended as follows.

6.6.503 APPLICABILITY AND SCOPE (1) Except as otherwise specifically provided in ARM 6.6.507, 6.6.508, 6.6.509, 6.6.515 and 6.6.521, this subchapter shall apply to:

(a) and (b) remain the same.

(2) remains the same as proposed.

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

6.6.507B OPEN ENROLLMENT (1) remains the same as proposed.

(2) This rule must not be construed as preventing the exclusion of benefits under a policy, except as provided in ARM 6.6.522, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective.

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

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) through (3) remain the same as proposed.

(4) For policies issued prior to ~~the effective date of this rule~~September 30, 1993, expected claims in relation to premiums shall meet:

(4)(a) through (10) remain the same as proposed.

Appendix A to Subchapter 5 is being deleted as proposed.

AUTH: 33-1-313, 33-22-904 and 33-22-906, MCA
IMP: 33-15-303 and 33-22-901 through 3-22-924, MCA

6.6.508A FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) through (1)(a) remain the same as proposed.

(b) The policy and certificate must be identified by the proper plan designation letter which must be included anywhere in the form number for the policy.

(2) through (5) remain the same as proposed.

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

6.6.509 REQUIRED DISCLOSURE PROVISIONS

(1) through (5) remain the same.

(6) Issuers of accident and sickness policies or certificates or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, ~~other than incidentally,~~ to persons eligible for medicare ~~by reason of age~~ must provide to such applicants a medicare supplement "buyer's guide~~,~~". This may be the pamphlet entitled "Guide to Health Insurance for People with Medicare~~,~~", developed jointly by the national association of insurance commissioners and the health care financing administration of the U.S. department of health and human services, or any reproduction or official revision of that pamphlet in a type size no smaller than 12 point type. The "buyer's guide" must conform to the language, format, type size, type proportional spacing, bold character, and line spaces as specified in Appendix C of the NAIC Model Regulation, which is incorporated by reference in ARM 6.6.519. Specimen copies may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., or subject to availability of supplies, from the Montana department of insurance. The guide is identified as Department of Health and Human Services/Health Care Financing Administration Form Number HCFA-02110. Delivery of the "buyer's guide" must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgment of receipt of the "buyer's guide" must be obtained by the issuer. Direct response issuers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

(7) through (9) remain the same.

(10) Applications provided to persons eligible for medicare for the health insurance policies or certificates described in this rule shall disclose, using the applicable statement in Appendix C of the NAIC Model Regulation, which was incorporated by reference in ARM 6.6.519, the extent to which the policy duplicates medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

AUTH: 33-1-313, 33-22-904 and 33-22-907, MCA
IMP: 33-15-303 and 33-22-901 through 33-22-924, MCA

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of application, the applicant has another medicare supplement or other health policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements as the following may be used:

(STATEMENTS)

You do not need more than one medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under medicaid and may not need a medicare supplement policy.

The benefits and premiums under your medicare supplement policy ~~will~~can be suspended if requested during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your policy will be reinstated if requested within 90 days of losing medicaid eligibility.

Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning ~~medicaid~~ medical assistance through the state medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(QUESTIONS)

To the best of your knowledge:

(1) Do you have another medicare supplement insurance policy or certificate in force (including health care service

contract, health maintenance contract)?

(2) If the answer to (1) is yes, with which company?

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

(4) If the answer to (3) is yes, with which company?

(5) What kind of policy?

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

(7) Are you covered by the state medicaid program?

(a) As a Low Income Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

(2) through (4) remain the same.

(5) The notice required by (4) for an issuer must be in substantially the same form as below and be in no less than ~~10~~12 point type.

Text of the "NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE" remains the same.

AUTH: 33-1-313, 33-22-904 and 33-22-907, MCA
IMP: 33-15-303 and 33-22-901 through 33-22-924, MCA

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, volume 60, page 53625, 1995, for services furnished in calendar year 1996 under medicare's hospital insurance program (medicare part A), shall apply to the charts for plans A through J in (2)(b) through (2)(k). In each chart, the rule cited in brackets as ARM [6.6.511(1)(a)], [6.6.511(1)(b)], [6.6.511(1)(c)] or [6.6.511(1)(d)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

(a) Inpatient hospital deductible = $736.00;

(b) Daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = $184.00;

(c) Daily coinsurance amount for lifetime reserve days = $368.00;

(d) Daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $92.00.

(1) remains the same but is renumbered (2).

The text of (1)(a) through (1)(k) is renumbered (2)(a) through (2)(k) and remains the same with the exception that each dollar amount in brackets in the charts labeled "Medicare (Part A)" for plans A through J is deleted and replaced with the appropriate cite to (1)(a), (1)(b), (1)(c) or (1)(d).

AUTH: 33-1-313, 33 22 904, and 33-22-907, MCA
IMP: 33-15-303 and 33 22 901 through 33-22-924, MCA

6.6.515 STANDARDS FOR CLAIMS PAYMENT (1) through (1)(d) remain the same as proposed.

(e) Paying user fees for claim notices that are transmitted electronically or otherwise~~; and~~. A~~a~~ny cost may not be passed on to the insured as a separate distinguishable charge and the charge may not be separated from the premium; and

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

AUTH: 33-1-313 and 33-22-904, MCA
IMP: 33-15-303 and 33-22-901 through 33-22-924, MCA

6.6.519 STANDARDS FOR MARKETING

(1) through (1)(b) remain the same as proposed.

(c) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits greater than the benefits under the replaced policy ~~for purposes of triggering first year commissions as authorized in ARM 6.6.517~~.

(1)(d) through (2)(b) remain the same as proposed.

(2)(c) Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an ~~insurer~~insurance producer or ~~insurance company~~issuer.

(3) remains the same as proposed.

AUTH: 33-1-313, 33-18-235 and 33-22-904, MCA
IMP: 33-15-303, 33-18-235, and 33-22-901 through 33-22-924, MCA

3. A public hearing on the proposed rules was held on May 17, 1996. One person attended the hearing. One person at the hearing submitted data, views, and arguments on some of the proposed rules. In addition, there were three written submissions of data, views and arguments. The agency has fully and thoroughly considered all oral and written submissions received respecting the proposed rules and responds as follows:

COMMENT REGARDING RULE 6.6.503(1)

COMMENT: The Omnibus Reconciliation Act of 1990, Public Law 101-508, enacted on November 5, 1990, requires that exceptions to the applicability and scope of the subchapter be specified.

RESPONSE: The agency revises the rule to comply with federal law.

COMMENT REGARDING RULE 6.6.507B(2)

COMMENT: Rule 507B(2) should be amended to comply with the requirement of Public Law 101-508 to specify exceptions for open enrollment of medicare beneficiaries.

RESPONSE: The agency revises the rule to comply with federal law.

COMMENTS REGARDING RULE 6.6.508(4)

COMMENT: Public Law 101-508 requires that the provisions of rule 6.6.508(4) apply to policies issued prior to the 1993 effective date of the rule, which was September 30, 1993.

RESPONSE: The agency revises the rule to comply with federal law.

COMMENT: The agency should include the following language in rule 6.6.508(4): "In meeting the tests in (a), (b), and (c), and for purposes of attaining credibility, an insurer may combine experience under policy forms which provide substantially similar coverage. Once combined form is adopted, the insurer may not separate the experience except with the approval of the commissioner."

RESPONSE: The agency declines to make this change for the reason that it would conflict with 33-22-906, MCA. In addition, the suggested change is not yet approved by the federal government. When a change is approved at the federal level, the commissioner will review the federal regulations and make further rule changes as appropriate. The comment also fails to define what the potential criteria would be for the "combination".

COMMENT REGARDING RULE 6.6.508A

COMMENT: The acceptable format for the form number described in rule 6.6.508A(1)(b) is unclear.

RESPONSE: The requirement to include the plan letter in the form number is for consumer information and administrative clarification and tracking. The letter may be printed anywhere in the form number. The rule is revised to clarify the requirement.

COMMENT REGARDING RULE 6.6.509

COMMENT: Public Law 101-508 requires changes to the language of rule 6.6.509, specifically; the deletion of "other than incidentally" and "by reason of age" in rule 6.6.509(6); language to specify the exact format of the "buyers guide"

described in the rule, and language to conform to the NAIC Model Regulation regarding disclosure of policies which duplicate Medicare.

RESPONSE: The agency revises the rule to comply with federal law.

COMMENTS REGARDING RULE 6.6.510

COMMENT: The language and type size of the "Statements" in rule 6.6.510 must be changed to conform with the requirements of the Social Security Administration Act of 1994, Public Law 103-432. Public Law 101-508 requires that the "Statements" include specific reference to Qualified Medicare Beneficiary and Specified Low Income Beneficiary programs.

RESPONSE: The agency revises the rule to comply with federal law.

COMMENT: The proposed change to the language of the "Statements" in rule 6.6.510 would require changes to the application form. A January 1, 1997, implementation date would allow companies to deplete current supplies of applications.

RESPONSE: Although most companies with multi-state products have made this change, the agency agrees to provide an effective date of January 1, 1997, for this rule to allow companies to deplete current application supplies.

COMMENT REGARDING RULE 6.6.511

COMMENT: The deductible and coinsurance amounts listed in the charts describing plans A through J in rule 6.6.511 must be updated to reflect the new amounts established by federal regulation, effective on January 1, 1996.

RESPONSE: It will be necessary to amend this rule each year when the deductible and coinsurance amounts are updated in the federal register. In order to facilitate the annual amendment of this rule, the rule is revised to list separately the deductible and coinsurance amounts published in the federal register. The charts describing plans A through J are revised to reference the applicable new rule sections, instead of the actual dollar amount. Each referenced rule section should be replaced by the correct dollar amount when printing the chart.

COMMENT REGARDING RULE 6.6.515

COMMENT: The proposed amendment to rule 6.6.515(1)(e) concerning user fees should be clarified.

RESPONSE: The agency concurs and revises the rule accordingly.

COMMENT REGARDING RULE 6.6.517

COMMENT: The effect of the proposed amendment to rule 6.6.517 on agent incentive for sales and other compensation arrangements is of concern.

RESPONSE: Public Law 103-432 requires the amendment, and it protects the consumer against unnecessary policy replacements. Therefore, the agency amends the rule as proposed. However, in order to ease the effect, the change will not be effective until January 1, 1997.

COMMENTS REGARDING RULE 6.6.519

COMMENT: The proposed change to Rule 6.6.519 imposes requirements for new forms. Implementation should be delayed until January 1, 1997.

RESPONSE: The agency agrees to provide an effective date of January 1, 1997, for this rule.

COMMENT: Public Law 103-432 requires language to be deleted in Rule 6.6.519(1)(c).

RESPONSE: The agency revises the rule to comply with federal law.

The language in Rule 6.6.519(2)(c) is changed for consistency.

COMMENT REGARDING RULE 6.6.521

COMMENT: The proposed change to rule 6.6.521 imposes requirements for new forms. Implementation should be delayed until January 1, 1997.

RESPONSE: The agency agrees to provide an effective date of January 1, 1997, for this rule.

4. Rules 6.6.510, 6.6.517. 6.6.519, and 6.6.521 are effective on January 1, 1997.

MARK O'KEEFE, State Auditor
and Commissioner of Securities

By _____ _____
Claudia Clifford
Assistant State Auditor

Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 7th day of June, 1996.

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

In the matter of the adoption of new rules implementing medicare select policies and certificates.	)))	CORRECTED NOTICE OF ADOPTION

TO: All Interested Persons

1. On January 11, 1996, the Department published a notice of public hearing at page 9 of the Montana Administrative Register, Issue No. 1, on the proposed adoption of new rules implementing medicare select policies and certificates. On April 4, 1996, the Department published the notice of adoption at page 907 of the Montana Administrative Register, Issue No. 7.

2. The notice of adoption incorrectly numbered the sections in rule 6.6.613. The corrected rule amendment reads as follows:

(Rule XIII) 6.6.613 PROVISION FOR CONTINUED COVERAGE

(1) through (3) Same as proposed in notice of hearing.

New section (2) remains the same as proposed in the notice of adoption, but is renumbered (4).

AUTH: 33-22-904 and 33-22-905, MCA
IMP: 33-22-901 through 33-22-924, MCA

3. Replacement pages for the corrected notice of adoption will be submitted to the Secretary of State on June 30, 1996.

Mark O'Keefe
State Auditor and
Commissioner of Insurance

By: _____
Frank Cote'
Deputy Insurance Commissioner

_____
Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 7th day of June, 1996.

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

In the matter of the amendment of Rules 6.6.1101 through 6.6.1104 and 6.6.1110 pertaining to Credit Life and Disability Insurance	))))	NOTICE OF AMENDMENT

TO: All Interested Persons.

1. On April 25, 1996, the state auditor and commissioner of insurance of the state of Montana published notice of public hearing on the proposed amendment of Rules 6.6.1101 through 6.6.1104 and 6.6.1110 pertaining to Credit Life and Disability Insurance. The notice was published at page 955 of the 1996 Montana Administrative Register, issue number 8.

2. The agency amends Rule 6.6.1104 exactly as proposed. The agency amends Rules 6.6.1101 through 6.6.1103 and 6.6.1110 with the following changes:

6.6.1101 CREDIT LIFE INSURANCE--ACCEPTABLE RATES

(1) remains exactly as proposed.

(a) ~~For decreasing term credit life insurance, single premium rates per $100 of initial indebtedness repayable in 12 equal monthly installments during the period of coverage:~~ If premiums are payable on a monthly outstanding balance basis the rate is $.80 per month per $1,000 of outstanding insured debt on single life and $1.40 per month per $1,000 of outstanding insured debt on joint life.

~~(i) Single life $.40;~~

~~(ii) Joint life $.60.~~

(b) ~~For decreasing term credit life insurance, monthly premium rates per $1,000 of outstanding balance, where the initial indebtedness is repayable in 12 equal installments during the period of coverage:~~ If the premium is charged on a single premium basis, the rate must be computed according to the following formula or according to a formula approved by the commissioner which produces a rate which is substantially the same as the rate produced by the following formula:

~~(i) Single life $.62;~~

~~(ii) Joint life $.93.~~

$$S_p = \sum_{t=1}^{n} \left(\frac{O_p}{10} \times \frac{I_t}{I_i} \times v^{t-1} \right)$$

$$v = \frac{1}{1+(dis)}$$

S_p = Single premium rate per $100 of initial credit life insurance coverage.

Q_p = $.80, the prima facie credit life insurance premium rate for monthly outstanding balance coverage from (1).

I_t = The scheduled amount of insurance for month t.

I_i = Initial amount of insurance. For a net insurance policy, I_i equals the initial principal balance of the loan.

dis = .0036, representing an annual discount rate of 4% for interest plus 4% for mortality.

n = The number of months in the term of the insurance.

(c) ~~For level term credit life insurance, single premium rates per $100 of initial indebtedness repayable in 12 equal monthly installments during the period of coverage:~~ The premium rate for joint credit life coverage must not exceed 1.75 times the permitted single credit life rate.

~~(i) Single life $.74;~~

~~(ii) Joint life $1.11.~~

(2) remains the same.

~~(3) Single premium rates for indebtedness repayable in installments other than 12 in number shall be 1/12 of the above premium rate multiplied by the number of full months in the period of indebtedness. Premium rates for credit life insurance not covered under (1) of this rule shall be the actuarial equivalent of rates established by that subsection.~~

AUTH: 33-21-111, MCA
IMP: 33-21-205, MCA

6.6.1102 LIMITATION ON PRESUMPTION OF REASONABLENESS

(1) and (2) remain exactly as proposed.

(3) If the policy is issued beyond the age limits established in the policy due to misstatement of age of the debtor, ~~(2) of this rule will apply~~ an equitable adjustment of premiums or of benefits must be made as provided by the policy.

(4) remains exactly as proposed.

AUTH: 33-21-111, MCA
IMP: 33-21-205, MCA

6.6.1103 CREDIT DISABILITY INSURANCE--ACCEPTABLE RATES

(1) and (2) remain the same

The proposed table following (2) is deleted in its entirety and is replaced by the following table.

Number of months in which indebtedness is repayable	Nonretroactive Benefits Elimination Period			Retroactive Benefits Waiting Period		
	7-day	14-day	30-day	7-day	14-day	30-day
6 or less	$1.55	$1.03	$0.41	$2.16	$1.85	$1.34
7	1.61	1.09	0.47	2.22	1.91	1.40
8	1.67	1.15	0.53	2.28	1.97	1.46
9	1.73	1.21	0.59	2.34	2.03	1.52
10	1.79	1.27	0.65	2.40	2.09	1.58
11	1.85	1.33	0.71	2.46	2.15	1.64
12	1.91	1.39	0.77	2.52	2.21	1.70
13	1.96	1.45	0.83	2.58	2.27	1.76
14	2.01	1.51	0.89	2.64	2.33	1.82
15	2.06	1.57	0.95	2.70	2.39	1.88
16	2.11	1.63	1.01	2.76	2.45	1.94
17	2.16	1.69	1.07	2.82	2.51	2.00
18	2.21	1.75	1.13	2.88	2.58	2.06
19	2.27	1.81	1.19	2.94	2.64	2.11
20	2.32	1.87	1.25	3.00	2.70	2.16
21	2.37	1.93	1.31	3.06	2.76	2.21
22	2.42	1.99	1.37	3.12	2.82	2.27
23	2.47	2.05	1.43	3.18	2.88	2.32
24	2.52	2.11	1.49	3.24	2.94	2.37
25	2.58	2.17	1.55	3.30	2.99	2.42
26	2.63	2.23	1.61	3.36	3.04	2.47
27	2.68	2.29	1.67	3.42	3.09	2.52
28	2.73	2.35	1.73	3.48	3.14	2.58
29	2.78	2.41	1.79	3.54	3.19	2.63
30	2.83	2.47	1.85	3.61	3.24	2.68
31	2.88	2.53	1.91	3.66	3.30	2.73
32	2.94	2.59	1.96	3.71	3.35	2.78
33	2.99	2.65	2.01	3.76	3.40	2.83
34	3.04	2.71	2.06	3.81	3.45	2.88
35	3.09	2.77	2.11	3.86	3.50	2.94
36	3.14	2.83	2.16	3.91	3.55	2.99
37	3.19	2.88	2.21	3.96	3.61	3.04
38	3.24	2.94	2.27	4.00	3.66	3.09
39	3.30	2.99	2.32	4.04	3.71	3.14
40	3.35	3.04	2.37	4.09	3.76	3.19
41	3.40	3.09	2.42	4.13	3.81	3.24
42	3.45	3.14	2.47	4.17	3.86	3.30
43	3.49	3.18	2.51	4.21	3.91	3.35
44	3.54	3.23	2.56	4.26	3.95	3.40
45	3.58	3.27	2.60	4.30	3.99	3.45
46	3.62	3.31	2.64	4.34	4.03	3.50

Number of months in which indebtedness is repayable	Nonretroactive Benefits Elimination Period			Retroactive Benefits Waiting Period		
	7-day	14-day	30-day	7-day	14-day	30-day
47	$3.67	$3.36	$2.69	$4.39	$4.08	$3.55
48	3.71	3.40	2.73	4.43	4.12	3.61
49	3.75	3.44	2.77	4.46	4.16	3.65
50	3.79	3.48	2.82	4.50	4.21	3.69
51	3.84	3.53	2.86	4.53	4.25	3.73
52	3.88	3.57	2.90	4.57	4.29	3.78
53	3.92	3.61	2.94	4.60	4.33	3.82
54	3.97	3.66	2.99	4.64	4.38	3.86
55	4.00	3.69	3.02	4.67	4.41	3.91
56	4.04	3.73	3.06	4.70	4.45	3.95
57	4.07	3.76	3.09	4.74	4.48	3.99
58	4.11	3.79	3.12	4.77	4.51	4.03
59	4.15	3.83	3.16	4.81	4.55	4.08
60	4.18	3.86	3.19	4.84	4.58	4.12
61	4.22	3.90	3.23	4.88	4.62	4.15
62	4.26	3.93	3.26	4.91	4.65	4.19
63	4.31	3.97	3.30	4.94	4.69	4.22
64	4.35	4.00	3.33	4.98	4.72	4.26
65	4.39	4.03	3.36	5.01	4.76	4.29
66	4.43	4.07	3.40	5.05	4.79	4.33
67	4.45	4.09	3.43	5.08	4.82	4.35
68	4.48	4.12	3.47	5.12	4.86	4.38
69	4.51	4.15	3.50	5.15	4.89	4.40
70	4.53	4.17	3.54	5.18	4.93	4.43
71	4.56	4.20	3.57	5.22	4.96	4.45
72	4.58	4.22	3.61	5.25	5.00	4.48
73	4.61	4.25	3.63	5.28	5.02	4.51
74	4.64	4.27	3.66	5.30	5.05	4.53
75	4.66	4.30	3.68	5.33	5.07	4.56
76	4.69	4.33	3.71	5.36	5.10	4.58
77	4.71	4.35	3.73	5.38	5.12	4.61
78	4.74	4.38	3.76	5.41	5.15	4.64
79	4.76	4.40	3.79	5.43	5.18	4.66
80	4.79	4.43	3.81	5.46	5.20	4.69
81	4.82	4.45	3.84	5.48	5.23	4.71
82	4.84	4.48	3.86	5.51	5.25	4.74
83	4.87	4.51	3.89	5.54	5.28	4.76
84	4.89	4.53	3.91	5.56	5.30	4.79
85	4.92	4.56	3.94	5.59	5.33	4.82
86	4.94	4.58	3.97	5.61	5.36	4.84
87	4.97	4.61	3.99	5.64	5.38	4.87

Number of months in which indebtedness is repayable	Nonretroactive Benefits Elimination Period			Retroactive Benefits Waiting Period		
	7-day	14-day	30-day	7-day	14-day	30-day
88	$5.00	$4.64	$4.02	$5.67	$5.41	$4.89
89	5.02	4.66	4.04	5.69	5.43	4.92
90	5.05	4.69	4.07	5.72	5.46	4.94
91	5.06	4.71	4.09	5.73	5.48	4.97
92	5.08	4.74	4.10	5.75	5.49	5.00
93	5.10	4.76	4.12	5.77	5.51	5.02
94	5.12	4.79	4.14	5.79	5.53	5.05
95	5.13	4.82	4.15	5.80	5.54	5.07
96	5.15	4.84	4.17	5.82	5.56	5.10
97	5.17	4.86	4.19	5.84	5.58	5.12
98	5.18	4.88	4.21	5.85	5.60	5.13
99	5.20	4.89	4.22	5.87	5.61	5.15
100	5.22	4.91	4.24	5.89	5.63	5.17
101	5.24	4.93	4.26	5.91	5.65	5.18
102	5.25	4.94	4.27	5.92	5.67	5.20
103	5.27	4.96	4.29	5.94	5.68	5.22
104	5.29	4.98	4.31	5.96	5.70	5.24
105	5.30	5.00	4.33	5.97	5.72	5.25
106	5.32	5.01	4.34	5.99	5.73	5.27
107	5.34	5.03	4.36	6.01	5.75	5.29
108	5.36	5.05	4.38	6.03	5.77	5.30
109	5.37	5.06	4.39	6.04	5.79	5.32
110	5.39	5.08	4.41	6.06	5.80	5.34
111	5.41	5.10	4.43	6.08	5.82	5.36
112	5.42	5.12	4.45	6.09	5.84	5.37
113	5.44	5.13	4.46	6.11	5.85	5.39
114	5.46	5.15	4.48	6.13	5.87	5.41
115	5.47	5.16	4.49	6.14	5.88	5.42
116	5.48	5.17	4.50	6.15	5.89	5.42
117	5.48	5.18	4.51	6.15	5.90	5.43
118	5.49	5.18	4.51	6.16	5.91	5.44
119	5.50	5.19	4.52	6.17	5.91	5.45
120	5.51	5.20	4.53	6.18	5.92	5.46

(3) If premiums are paid on the basis of a premium rate per month per $1,000 of outstanding insured gross debt, this premium rate must be computed according to the following formula or according to a formula approved by the commissioner which produces a rate actuarially consistent with the applicable single premium rate in (2):

$$OP_n = \frac{10SP_n}{\sum_{t=1}^{n}\left[v^{t-1} \times \frac{(n-t+1)}{n}\right]}$$

$$v = \frac{1}{1+(dis)}$$

SP_n = Single premium rate per $100 of initial insured debt repayable in n equal monthly installments as shown in (2).

OP_n = Monthly outstanding balance premium rate per $1,000.

n = The number of months in the term of the insurance.

dis = .0033, representing an annual discount rate of 4% for interest.

(~~3~~4) The premium rates for joint credit disability coverage shall not exceed ~~1 2/3~~1.8 times the permitted single credit disability rate.

(~~4~~5) Premiums ~~payable other than~~for credit disability insurance which are payable on a ~~single premium~~ basis not specified in this rule ~~on~~ or ~~for~~ which cover benefits on a basis ~~different than illustrated above,~~not specified in this rule ~~shall~~must be actuarially consistent with the ~~above~~ rates specified in this rule.

(5) remains the same but is renumbered (6).

AUTH: 33-21-111, MCA
IMP: 33-21-205, MCA

6.6.1110 ~~ANTICIPATED LOSS RATIO OF "CLAIMS INCURRED" TO "PREMIUMS EARNED" OF NOT LESS THAN SIXTY PERCENT~~DETERMINATION OF REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED

(1) ~~As a basic test of the reasonableness of the relation of benefits to premium, the anticipated loss ratio of "claims incurred" to "premiums earned" must be at least 60%.~~ Benefits provided by credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may be reasonably expected to develop a loss ratio of not less than the minimum loss ratio required by this rule.

(a) The minimum loss ratio is defined as follows:

(i) Credit disability insurance 55%;

(ii) Credit life insurance 38.5%.

(b) The rates established in this sub-chapter and rates filed and approved pursuant to ARM 6.6.1107 will be presumed to satisfy the loss ratio standards set forth in this rule.

(2) Creditor, agent and general agent compensation must not be more than a combined total of 37.5% of the net written prima facie premium.

(a) For the purpose of (2), prima facie premium means premium using the premium rates set out in ARM 6.6.1101 and 6.6.1103.

(~~2~~3) If ~~the total current expected expenses (including acquisition expenses) exceed 40% of the premium dollar,~~ an insurer's loss ratio is less than the standards set forth in this rule, this will be considered prima facie evidence that the insurer intends to write credit business at a loss ratio not in compliance with these rules. The insurer will then be required to:

(a) Reduce the premium rates as needed to produce an anticipated loss ratio ~~of at least 60%~~ which satisfies the standards in this rule, and file these rates with the commissioner; or

(b) Provide to the commissioner an actuarial justification to demonstrate ~~Show~~ why the premium rates currently filed should not be reduced.

AUTH: 33-21-111, MCA
IMP: 33-21-205, MCA

3. A public hearing on the proposed rules was held on May 15, 1996. Fifteen persons attended the hearing. Eight persons at the hearing submitted data, views, and arguments on some of the proposed rules. In addition, there were thirty-four written submissions of data, views and arguments. The agency has fully and thoroughly considered all oral and written submissions received respecting the proposed rules and responds as follows:

COMMENTS REGARDING 6.6.1101

COMMENT: The single life, single premium credit life insurance prima facie rate should not be reduced from $.60 to $.40 per $100 of initial indebtedness repayable in twelve equal monthly installments. The rate of $.40 per $100, coupled with a 60% loss ratio requirement, would leave only $.16 per $100 per year to cover expenses. Instead, the new rate should be derived through a component-rating approach based on actual and expected claims and expenses.

RESPONSE: The agency concurs, and revises this rule by replacing (1)(a), (b) and (c) with a single life prima facie rate of $.80 per $1,000 of monthly outstanding indebtedness and a formula to convert that prima facie rate into a single premium rate per $100 of initial indebtedness for any type of credit life

insurance, for any term of coverage. This prima facie rate is actuarially equivalent to a single life single premium rate of $.52 per $100 of initial indebtedness repayable in twelve equal monthly installments. $.52 is approximately the rate which would be derived using a component rating calculation assuming an expected claims cost of $.20 per insured, expected general insurer expenses of $.08 per insured, investment income of 5% of premium, taxes of 3% of premium, a limitation of total producer compensation to 37.5% of prima facie premium, and return on equity of 10% of premium. The formula in the revised rule is from the National Association of Insurance Commissioners (NAIC) Consumer Credit Insurance Model Regulation.

COMMENT: Lowering the current credit life prima facie rates could threaten insurer profitability and agents' livelihood. It would result in tighter underwriting and more declinations of coverage, thus reducing the availability of credit insurance to consumers. Therefore, the credit life prima facie rates should not be lowered.

RESPONSE: The agency declines to keep the credit life prima facie rates at the current level, but revises the rule to provide higher prima facie rates, derived from a component rating calculation, than those in the proposed rule. Since the current rules provide insurers the right to file higher rates than the prima facie rates if they can actuarially justify such an action, lower prima facie rates would not threaten insurers, agents, or consumers.

COMMENT: The current credit life insurance premium rate of $.60 per $100 of initial indebtedness repayable in twelve equal monthly installments is fair, and reflects the average of the term life insurance rates from sixteen randomly selected companies. The credit life prima facie rates should not be lowered.

RESPONSE: The agency declines to keep the credit life prima facie rates at the current level, but revises the rules to provide higher prima facie rates than those in the proposed rule. Though the new rates are lower on the scale of the sixteen randomly-selected companies than the rates in the current rules, they are fair based on the component-rating basis through which they were derived.

COMMENT: The current credit life prima facie rates are justified even if other states have lower rates, because the accidental death rate in Montana is higher than in states with large percentages of white collar low risk occupations. They should not be changed.

RESPONSE: The agency disagrees, but revises the rule to provide higher prima facie credit life rates, derived from a component

rating calculation, than those in the proposed rule. Montana's cumulative loss ratio at prima facie rates from 1992 through 1994 for credit life insurance was 32.0%, significantly below the national average of 42.9% during the same time period. This indicates that Montana's credit life experience in relation to the current prima facie rates is much better than the corresponding national experience. The new prima facie rates are expected to result in a loss ratio no higher than 38.5%, which is still better than the national credit life loss ratio.

COMMENT: If the agency feels that prima facie rates should be reduced, the reduction should not be as steep as proposed. Future reductions can be made later if it is deemed necessary.

RESPONSE: The agency concurs, and revises the rule to provide higher prima facie rates, derived from a component-rating calculation, than those in the proposed rule.

COMMENT: The premium rate for joint credit life insurance should be higher than 1.5 times the permitted single credit life premium. One comment was that all joint credit life rates should equal or approach an amount 2 times the single rate. Another comment suggested 1.75 as an actuarially appropriate factor.

RESPONSE: The agency agrees that a factor of 1.5 is too low, and revises the limit on the joint credit life insurance premium to 1.75 times the permitted single credit disability premium. The claims cost for joint coverage is twice that of single coverage, but the general insurer expenses increase only slightly, if at all, for joint coverage compared to single coverage. Doubling the claims cost and adding $.02 to the general insurer expenses in the component-rating formula used to calculate the single life, single-premium credit life rate results in a rate 1.77 times the single rate. Thus, 1.75 is deemed by the agency to be an actuarially appropriate factor to apply to the single rate, and the rule is revised accordingly.

COMMENT: The proposed monthly outstanding balance credit life rates are not actuarially consistent with the single premium credit life rates. They are appropriate for coverage periods of only 13 months, while the average coverage in the credit life market is in the 42-48 month range. Also, they do not take into account the time value of money.

RESPONSE: The agency concurs, and revises the proposed rule to provide prima facie rates, derived from a component-rating calculation, for single and joint coverage on a monthly outstanding balance basis and a formula which must be used to convert these rates to single premium rates for any term of coverage. The formula takes into account both mortality and the time value of money, and will result in actuarially consistent

prima facie rates for any term of coverage. Section 3 is deleted, since adding the formula to the rule makes this section unnecessary.

COMMENT: The proposed level term credit life insurance rates in (1)(c) are low compared to ordinary level term life insurance rates in the Montana marketplace, and should be increased to the average rate charged for comparable coverage. Alternately, they should be increased by 30%.

RESPONSE: The agency agrees that the proposed level term credit life prima facie rates are too low. The rule is revised to replace (1)(a), (b) and (c) with monthly outstanding balance prima facie rates and a formula which must be used to convert monthly outstanding balance rates to single premium rates. This formula will apply to level term credit life insurance as well as to decreasing term insurance, and will result in a rate which is actuarially consistent with the decreasing term credit life insurance rates. For a twelve-month loan, this results in a rate 31% higher than the proposed level term rate.

COMMENT: The proposed language to be added to (1)(b) is unnecessary and confusing, and should not be adopted.

RESPONSE: The agency concurs, and revises the rule to eliminate the proposed language.

COMMENT: When regulators reduce rates while imposing stricter reserve requirements on credit insurance than on term insurance, it sends the message that credit insurance is less risky than term insurance for pricing purposes but more risky for reserving purposes.

RESPONSE: The agency disagrees that lowering the prima facie rates sends a message that credit insurance is less risky than term insurance. Term life insurance rates are not required to be filed for prior approval in Montana; therefore, it is unknown whether term life insurance sold in Montana is truly priced according to the risk. The agency is revising the rule to provide prima facie rates which are derived from a component rating calculation, which does reflect the credit life insurance risk.

COMMENTS REGARDING 6.6.1102

COMMENT: It is unclear what the amendments to (1)(b) are supposed to clarify. They appear to take away the insurer's option to limit eligibility due to age at the time the coverage is elected or as of a scheduled maturity date of the debt. Insurers should be permitted to limit eligibility under either scenario. Also, the language could be rewritten to clarify that insurers may terminate coverage when a borrower reaches a

specific attained age in conjunction with open-end credit transactions, which often don't have a scheduled maturity date.

RESPONSE: The agency declines to revise or eliminate the proposed rule amendments for the reason that the amendments do not take away the insurer's option to limit eligibility. They simply reword the text of the current rules for clarification. Insurers may have an age restriction in the policy as long as the applicable age is no lower than the ages specified in (1)(b). Nothing in the proposed rules prohibits an insurer from limiting eligibility under either scenario. Nothing in the current or proposed rules prohibits insurers from terminating coverage when a borrower reaches a specific attained age in conjunction with open-end credit transactions, since the insurer may define a scheduled maturity date.

COMMENT: Insurers should be able to increase premiums enough to cover the increase in risk if they raise the age eligibility limitations from the minimum age defined in the rule. The limits on the allowable rate increase in the rule are too low for the extra risk incurred, and should be increased.

RESPONSE: The agency declines to revise the proposed rule for the reason that the limits in the rule are appropriate based on the overall expected age distribution of insureds. If an insurer's actual experience demonstrates the prima facie rates adjusted for a raised age eligibility limit to be inadequate, or if the insurer can demonstrate that the age distribution of the insured population justifies a higher rate increase, that insurer has the right to file with the agency a request for an upward deviation in rates.

COMMENT: Proposed new subsection (3) is inconsistent with 33-20-1203, MCA, and would encourage consumer fraud by giving insurers only 60 days to discover misstatement of age.

RESPONSE: The proposed rule is not in conflict with 33-20-1203, MCA, since that statute applies to group life insurance policies which do not provide credit insurance coverage. However, the agency agrees that insurers should not be given a time limit to discover misstatement of age, and revises (3) to conform to the language of 33-20-1203, MCA.

COMMENTS REGARDING 6.6.1103

COMMENT: The credit disability rates should not be changed. The current rates are fair, and lowering them could threaten insurer profitability and agents' livelihood, and reduce the availability of credit insurance to consumers.

RESPONSE: The agency declines to keep the credit disability prima facie rates at the current level, but revises the rule to

provide higher prima facie rates than these in the proposed rule and to revise the slope of the proposed rates to actuarially match the risk to the rate. The agency considers the revised rates to be fairer than the current rates in terms of matching the risk. Since the rules provide insurers the right to file higher rates than the prima facie rates if they can actuarially justify such an action, lower prima facie rates would not threaten insurers, agents, or consumers.

COMMENT: The current credit disability prima facie rates are justified even if other states have lower rates, because Montana occupations have a higher incidence of disability than in states with large percentages of white collar low risk occupations. They should not be changed.

RESPONSE: The agency declines to keep the credit disability prima facie rates at the current level, but revises the rule to provide higher prima facie credit disability rates than those in the proposed rule. Montana's cumulative loss ratio at prima facie rates from 1992 through 1994 for credit life insurance was 51.1%, slightly below the national average of 53.2% during the same time period. This indicates that Montana's credit disability experience in relation to the current prima facie rates is slightly better than the corresponding national experience. The revised prima facie rates are expected to result in a loss ratio approximately equal to that of the national credit disability loss ratio.

COMMENT: The current slope of the credit disability rates should not be changed. The proposed rates maintain a relatively constant ratio between different plans at all durations; this does not reflect the relationship in risk as the coverage period increases. Also, the proposed rate changes are not supported by experience. The current slope better reflects the business exposure. If a rate decrease is imposed, it should be a constant decrease to the rates in the existing rule.

RESPONSE: The agency agrees that the relatively constant ratio by duration in the proposed rules is not appropriate. However, the agency considers the slope of the rate schedules in the existing rules to be inappropriate because the rates increase linearly by duration, except for a slight decrease in linear slope at 36 months duration. The risk does increase with the increase in coverage period, but the slope of the increase in risk is not linear; it tends to level off as the term of coverage increases. Therefore the agency is revising the rates in the proposed rules to reflect decreasing ratios by duration both between plans with different waiting periods and between different kinds of plans with respect to retroactive or nonretroactive benefits, and to reflect the relative risk at the different durations of coverage.

COMMENT: If the agency feels that prima facie rates should be reduced, the reduction should not be as steep as proposed. Future reductions can be made later if it is deemed necessary.

RESPONSE: The agency concurs, and revises the rule to provide higher credit disability prima facie rates than those in the proposed rule. The revised rates are an average of 4.4% lower than the rates in the current rule and an average of 4.8% higher than the rates in the proposed rule.

COMMENT: The premium rate for joint credit disability insurance should be higher than 1 2/3 times the permitted single credit disability premium. Suggestions for an appropriate factor varied from 1.8 to 1.9 to 2.

RESPONSE: The agency concurs, and revises the limit on the joint credit disability insurance premium to 1.8 times the permitted single credit disability premium.

COMMENT: The commissioner's staff recommends that this rule provide monthly outstanding balance credit disability prima facie rates. The prima facie rates in the table are single premium rates per $100 of initial indebtedness. They should be retained, but the rule should also provide prima facie rates per $1,000 of monthly outstanding balance.

RESPONSE: The agency concurs, and revises the rule to include a formula which must be used to convert any single premium rate for credit disability coverage to an actuarially equivalent rate per $1,000 of monthly outstanding balance. The formula is from the NAIC Consumer Credit Insurance Model Regulation. Subsection (4) is renumbered (5) and revised to conform to this change.

COMMENTS REGARDING 6.6.1104

COMMENT: It is unclear what the amendments to (1)(b) are supposed to clarify. They appear to take away the insurer's option to limit eligibility due to age at the time the coverage is elected or as of a scheduled maturity date of the debt. Insurers should be permitted to limit eligibility under either scenario. Also, the language could be rewritten to clarify that insurers may terminate coverage when a borrower reaches a specific attained age in conjunction with open-end credit transactions, which often don't have a scheduled maturity date.

RESPONSE: The agency declines to revise or eliminate the proposed rule amendments for the reason that the amendments do not take away the insurer's option to limit eligibility. They simply reword the text of the current rules for clarification. Insurers may have an age restriction in the policy as long as the applicable age is no lower than the ages specified in (1)(b). Nothing in the proposed rules prohibits an insurer from

limiting eligibility under either scenario. Nothing in the current or proposed rules prohibits insurers from terminating coverage when a borrower reaches a specific attained age in conjunction with open-end credit transactions, since the insurer may define a scheduled maturity date.

COMMENT: Insurers should be able to increase premiums enough to cover the increase in risk if they raise the age eligibility limitations from the minimum age defined in the rule. The limits on the allowable rate increase in the rule are too low for the extra risk incurred, and should be increased.

RESPONSE: The agency declines to revise the proposed rule for the reason that the limits in the rule are appropriate based on the overall expected age distribution of insureds. If an insurer's actual experience demonstrates the prima facie rates adjusted for a raised age eligibility limit to be inadequate, or if the insurer can demonstrate that the age distribution of the insured population justifies a higher rate increase, that insurer has the right to file with the agency a request for an upward deviation in rates.

COMMENTS REGARDING 6.6.1105

COMMENT: No proposal has been made to delete the current exclusion for disabilities due to normal pregnancy. Deletion of the exclusion would have significant premium implications; but any such change would need to be adopted following the full required rule amendment procedure.

RESPONSE: The proposed deletion is beyond the scope of this rulemaking proceeding. However, 33-1-502, MCA, invalidates the portion of the rule which includes pregnancy under allowable exclusions and restrictions of coverage; and any policy with such an exclusion or restriction would be subject to disapproval, in accordance with 33-21-205, MCA. The agency agrees that coverage of normal pregnancy has significant premium implications, and has taken that into consideration in the final determination of the credit disability rates.

COMMENTS REGARDING 6.6.1110

COMMENT: Basing prima facie rates on the loss ratio alone, and increasing the minimum loss ratio from 50% to 60%, will threaten the solvency of insurers whose major line of business is credit insurance, will threaten insurance agents' livelihood, and will reduce the availability of credit insurance to consumers. A component-rating method which reflects actual and expected claim costs and expenses would benefit insurers, agents and consumers.

RESPONSE: The agency agrees to adopt the component-rating method as an actuarially sound method for calculating premium rates for credit life insurance, and revises the rule to replace the 60% required minimum loss ratio with a required minimum loss ratio of 38.5%. The agency is not adopting the component rating

method for credit disability insurance, but revises the rule to replace the 60% required minimum loss ratio with a required minimum loss ratio of 55%.

COMMENT: The limitation of total expenses to 40% of the prima facie rate is too severe. Instead, impose a limitation of 40% on front compensation, and include this limit in a component-rating approach. Change the language to specifically address commissions.

RESPONSE: The agency agrees to revise the proposed rule amendment to eliminate the 40% limit on total expenses, to impose a limitation on compensation for both credit life and credit disability insurance, and to adopt a component-rating method for credit life insurance. The limit on total compensation is 37.5% of the prima facie rate. This provides a more beneficial premium rate for the consumer while allowing for a more generous compensation than would have been allowed with the proposed 60% loss ratio requirement or with the limit of 30% optionally included in the NAIC's Consumer Credit Insurance Model Regulation.

COMMENT: The subsection now numbered (3)(a) would require insurers who do not meet the new loss ratio standard to file for deviated rates, and would have different insurers offering different rates and commissions to the credit granting community. This provision would destabilize the credit insurance industry, and should not be adopted.

RESPONSE: The agency declines to remove the proposed subsection, but revises it to apply to the new loss ratio standards in (1). The agency does not believe that this provision will destabilize the credit insurance industry, since the proposed amendment merely updates and clarifies the current rule.

COMMENT: The commissioner's staff recommends that the subsection now numbered (3)(b) should be more specific as to the filing requirements for an insurer which charges rates exceeding the prima facie rates.

RESPONSE: The agency concurs, and revises the subsection now numbered (3)(b) to require an actuarial justification to show that the insurer is in compliance with the rule.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: _____
Claudia Clifford
Assistant State Auditor

By: _____
Gary B. Spaeth
Rules Reviewer

Certified to the Secretary of State this 7th day of June, 1996.

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

In the matter of the amendment of Rules 6.6.4102 and 6.6.4202 through 6.6.4204, 6.6.4207 and 6.6.4210 and the adoption of new Rules I (6.6.4211) and II (6.6.4212) pertaining to fee schedules and the Continuing Education Program for Insurance Producers and Consultants	NOTICE OF AMENDMENT AND ADOPTION

TO: All Interested Persons.

1. On April 25, 1996, the state auditor and commissioner of insurance of the state of Montana published notice of public hearing on the proposed amendment of Rules 6.6.4102 and 6.6.4202 through 6.6.4204, 6.6.4207 and 6.6.4210 and the adoption of new Rules I and II pertaining to fee schedules and the Continuing Education Program for Insurance Producers and Consultants. The notice was published at page 963 of the 1996 Montana Administrative Register, issue number 8.

2. The agency has amended Rules 6.6.4102, 6.6.4202, 6.6.4207, 6.6.4210, and adopted new Rule I (6.6.4211) and new Rule II (6.6.4212) exactly as proposed.

3. The agency has amended Rules 6.6.4203 and 6.6.4204 with the following changes:

6.6.4203 COURSE SUBMISSIONS (1) through (1)(p) remain the same as proposed.

(q) written notification of additional dates of course offering to the department ~~15~~ days in advance.

(3) through (15) remain the same as proposed.

AUTH: 33-1-313 and 33 17-1206, MCA
IMP: 33-17-1204, MCA

6.6.4204 QUALIFICATIONS FOR INSTRUCTORS (1) through (3)(a) remain the same as proposed.

(b) Has intentionally falsified documents filed with the commissioner;

(c) Has intentionally misrepresented course approval, credit hour assignment, curriculum, or content of a course to students or prospective students;

(3)(d) through (5) remain the same as proposed.

AUTH: 33-1-313 and 33 17-1206, MCA
IMP: 33 17-1203 and 33 17-1204, MCA

4. A public hearing on the proposed rules was held on May 16, 1996. Fourteen persons, including five members of the

Montana Insurance Continuing Education Advisory Council, attended the hearing. Three persons presented data, views, arguments, or written submissions. There were no other written submissions. The agency has fully and thoroughly considered the submissions received on the proposed rules. The following is a summary of the comments received along with the responses of the Advisory Council and the agency to the comments:

COMMENTS REGARDING RULE 6.6.4202

Public Comment

Retain the definition of "hour" in Rule 6.6.4202(7).

Advisory Council Response

The advisory council recommends the rule revision remain as proposed.

Agency Response

The rule is amended as proposed. All references to which the definition referred have been deleted from the administrative rules and therefore there is no need for a definition of "hour".

COMMENTS REGARDING RULE 6.6.4203

Public Comment

Shorten the period of advance notification in Rule 6.6.4203(1)(q) to 3 business days.

Advisory Council Response

The advisory council recommends revising Rule 6.6.4203(1)(q) to read ". . . written notification of additional dates of course offering to the department 3 days in advance."

Agency Response

The agency concurs and revises the rule accordingly.

Public Comment

Amend Rule 6.6.4203(14) to include all sponsoring organizations as defined in ARM 6.6.4102(11).

Advisory Council Response

The advisory council recommends the rule revision remain as proposed.

Agency Response

The rule is amended as proposed. This comment is addressed by amendments to Rules 6.6.4202(11) and 6.6.4203(14)(b).

COMMENTS REGARDING RULE 6.6.4204

Public Comment

Add wording to Rule 6.6.4204(3)(b) and (c) to limit the scope of the rule to intentional action by the instructor.

Advisory Council Response

The advisory council recommends revising (3)(b) and (c) to read " . . .Has intentionally falsified documents . . ." and " . . . Has intentionally misrepresented course approval, . . ."

Agency Response

The agency concurs and revises the rule accordingly.

MARK O'KEEFE
State Auditor and
Commissioner of Insurance

By: _____
Claudia Clifford
Assistant State Auditor

By: _____
Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 7th day of June, 1996.

BEFORE THE BOARD OF ATHLETICS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment, repeal and adoption of rules pertaining to athletic events and participants	))))	NOTICE OF AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO ATHLETIC EVENTS AND PARTICIPANTS

TO: All Interested Persons:

1. On April 25, 1996, the Board of Athletics published a notice of public hearing on the proposed amendment, repeal and adoption of rules pertaining to athletic events and participants at page 969, 1996 Montana Administrative Register, issue number 8.

2. The Board has amended ARM 8.8.2805, 8.8.2901 and 8.8.3301, repealed ARM 8.8.2807, and adopted new rule II (8.8.2906) exactly as proposed. The Board has amended ARM 8.8.2804 and adopted new rule I (8.8.2808) as proposed, but with the following changes: (authority and implementing sections will remain the same as in the original proposed notice)

"8.8.2804 LICENSING REQUIREMENTS (1) will remain the same as proposed.

(2) All licenses shall expire ~~in accordance with ARM 8.2.208~~ on December 31st of each year.

(3) through (15) will remain the same as proposed."

I (8.8.2808) UNPROFESSIONAL CONDUCT In addition to the provisions of 37-1-316, MCA, the board defines "unprofessional conduct" as follows:

(1) through (6) remain the same as proposed.

(i) through (v) remain the same as proposed, but will be renumbered (a) through (e).

(7) through (10) will remain the same as proposed.

3. ARM 8.8.2804 is being amended as shown above because licenses issued by the Board of Athletics are not renewed; licensees apply for licensure each year.

4. No comments or testimony were received.

BOARD OF ATHLETICS
GARY LANGLEY, 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, June 10, 1996.

BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the repeal of rules pertaining to state grants to counties for district court assistance	))))	NOTICE OF REPEAL OF ARM 8.83.401, 8.83.402, 8.83.403, AND 8.83.404 PERTAINING TO STATE GRANTS TO COUNTIES FOR DISTRICT COURT ASSISTANCE

TO: All Interested Persons:

1. On April 25, 1996, the Local Government Assistance Division published a notice of proposed repeal of the above-stated rules at page 988, 1996 Montana Administrative Register, issue number 8.

2. The Division repealed the rules exactly as proposed.

3. No comments or testimony were received.

LOCAL GOVERNMENT ASSISTANCE
DIVISION

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, June 10, 1996.

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the amendment of Teacher Certification	)	NOTICE OF **AMENDMENT OF ARM** 10.57.301 ENDORSEMENT INFORMATION

To: All Interested Persons

1. On **April 25, 1996,** the Board of Public Education **published a notice of** proposed amendment **of** ARM 10.57.301 Endorsement Information on page 990 of the Montana Administrative Register, issue #8.

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

10.57.301 ENDORSEMENT INFORMATION

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

(6) Both elementary and secondary training to include student teaching or appropriate waiver are required for endorsement in any approved ~~K-12~~ P-12 endorsement area.

(a) A class 1 or 2 certificate may be endorsed in special education ~~K-12~~ P-12 with program preparation at the elementary or secondary levels, or a balanced ~~K-12~~ P-12 program of comparable preparation.

(7) through (10) remain the same.

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

3. At the public hearing which was held May 23, 1996 three persons testified as proponents and one person as opponents. Two proponents and one opponent submitted written comments. The proponents stressed the importance of adopting the rule because of the highly skilled professionals that are unable to be endorsed in Special Education. Opponent objections were that the ramifications of such a change was not clear. The board considered all statements and determined that the need for this amendment outweighed the possible problems that might be encountered. In addition, the board adopted the recommendation to change K-12 to P-12 as it relates to special education endorsement.

Wayne Buchanan, Executive Secretary
Board of Public Education

Certified to the Secretary of State on 6/10/96

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

In the matter of the adoption of new RULE I, the amendment of ARM 24.11.315, 24.11.316, 24.11.318, 24.11.325 and 24.11.820; and the repeal of ARM 24.11.332, 24.11.821 and 24.11.825, all related to unemployment insurance case procedures and employment status issues	) NOTICE OF ADOPTION, AMENDMENT) AND REPEAL OF RULES RELATING) TO PROCEDURES IN UNEMPLOYMENT) INSURANCE CASES AND EMPLOYMENT) STATUS (INDEPENDENT CONTRACTOR)) ISSUES))))

TO ALL INTERESTED PERSONS:

1. On April 25, 1996, the Department published notice at pages 1051 through 1055 of the Montana Administrative Register, Issue No. 8, to consider the adoption of new rule I; the proposed amendment of ARM 24.11.315, 24.11.316, 24.11.318, 24.11.325 and 24.11.820; and the proposed repeal of ARM 24.11.332, 24.11.821 and 24.11.825, all related to unemployment insurance procedures and employment status issues.

2. On May 17, 1996, a public hearing was held in Helena concerning the proposed adoption, amendment and repeal of the rules. No oral or written comments, other than those of the Department, were presented at the hearing. No written comments were received prior to the closing date of May 28, 1996.

3. Therefore, the Department has repealed ARM 24.11.332, 24.11.821 and 24.11.825 in their entirety; amended ARM 24.11.315, 24.11.316, 24.11.318, 24.11.325 and 24.11.820 exactly as proposed; and adopted the following rule exactly as proposed.

RULE I (24.11.203) DETERMINATION OF EMPLOYMENT STATUS, INCLUDING THAT OF INDEPENDENT CONTRACTOR

4. The new rule, amended rules and repeals will be effective July 1, 1996.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 10, 1996.

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

In the matter of the adoption of new RULES I, II and III; the amendment of ARM 24.16.7527, 24.16.7531, 24.16.7534 and 24.16.9010; and the repeal of ARM 24.16.1301, 24.16.1302, 24.16.1901 and 24.16.5101, all related to wage claim procedures and employment status issues	) NOTICE OF ADOPTION,) AMENDMENT AND REPEAL OF) RULES RELATING TO THE) WAGE CLAIM PROCESS AND) EMPLOYMENT STATUS) [INDEPENDENT CONTRACTOR]) DETERMINATIONS

TO ALL INTERESTED PERSONS:

1. On April 25, 1996, the Department published notice at pages 1056 through 1060 of the Montana Administrative Register, Issue No. 8, to consider the adoption of new rules I, II and III; the proposed amendment of ARM 24.16.7527, 24.16.7531, 24.16.7534 and 29.16.9010; and the proposed repeal of ARM 24.16.1301, 24.16.1302, 24.16.1901 and 24.16.5101, all related to wage claim procedures and employment status issues.

2. On May 17, 1996, a public hearing was held in Helena concerning the proposed adoption, amendment and repeal of the rules. No oral or written comments were presented at the hearing. No written comments were received prior to the closing date of May 28, 1996.

3. Therefore, the Department has repealed ARM 24.16.1301, 24.16.1302, 24.16.1901 and 24.16.5101 in their entirety; amended ARM 24.16.7527, 24.16.7531, 24.16.7534 and 24.16.9010 exactly as proposed; and adopted the following rules exactly as proposed.

RULE I (24.16.7519) WAGE COMPLAINTS AND INVESTIGATIONS

RULE II (24.16.7535) PAYMENT OF WAGES AND PENALTIES

RULE III (24.16.7520) PROCEDURE FOR ISSUING WAGE CLAIM DETERMINATIONS REGARDING EMPLOYMENT STATUS, INCLUDING THAT OF INDEPENDENT CONTRACTOR

4. The new rules, amended rules and repeals will be effective July 1, 1996.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 10, 1996.

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

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

TO ALL INTERESTED PERSONS:

1. On April 4, 1996, the Department published notice at pages 873 and 874 of the Montana Administrative Register, Issue No. 7, to consider the amendment of the above-captioned rule.

2. On April 25, 1996, a public hearing was held in Helena concerning the proposed amendments at which oral and written comments were received. Additional written comments were received prior to the closing date of May 2, 1996.

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

Comment 1: Rondy Crawford, Business Manager, Boilermakers Local #11, stated that certain rates were improperly calculated because the Department failed to include the amounts paid by the employer for "Annuity" ($1.00 per hour paid) and "Apprenticeship" ($.44 per hour worked), pursuant to a collective bargaining agreement.
Response 1: The Department has included the amount identified as being paid for the category "Annuity" in the applicable rates as part of the pension contribution. The Department's methodology for computation of rates does not include the category "Apprenticeship." Since the Department has not given notice that it is proposing to change its methodology for computing rates, it declines to add another category of benefits to the rates. However, the Department will keep the request of the commenter to include such amounts as part of the rate-setting methodology when it reviews the appropriateness of the methodology in the future.

Comment 2: Mr. Crawford also submitted additional data for boilermakers for the time period October 1995 through March 1996.
Response 2: The Department reviewed this data and determined that work reported was not done during the survey time frame of October 1, 1994 through September 30, 1995. As a result, the data was not used and rates did not increase.

Comment 3: Mike McLaughlin, Bricklayers and Allied Craftsmen Local #1, submitted collective bargaining fringe benefits rates.
Response 3: The Department considered the collective bargaining agreement in setting revised fringe benefit rates, and as a result, the fringe benefit rates increased for bricklayer

occupations in district 3.

Comment 4: Dan Koch, Business Agent, Road Sprinkler Fitters Local #669, commented that the training rate of pay was inaccurately stated in the preliminary rates.
Response 4: The Department reviewed training pay for sprinkler fitters, and as a result, the training rate of pay increased.

Comment 5: Don Herzog, Business Manager, International Brotherhood of Electrical Workers Local #532, commented that preliminary fringe benefit rates for health and welfare and pension were not correct.
Response 5: The Department considered the submitted information, and as a result, the health and welfare rate of pay increased for all districts, and pension rate of pay increased for districts 8 and 10.

Comment 6: Dave Glen, Bricklayers and Allied Craftsmen Local #6, submitted a copy of the collective bargaining agreement.
Response 6: The Department considered the collective bargaining agreement in setting revised fringe benefit rates, and as a result, the fringe benefit rates increased for bricklayer occupations in district 5.

Comment 7: Don Halverson, Plumbers and Pipefitters Local #459, addressed concerns about employers reporting low wage rates, and having that data included to calculate the plumbers and pipefitters preliminary wage rate.
Response 7: The Department reviewed data submitted for plumbers and pipefitters, and the process used for quality review of data. Employers who submit data with low wage rates are contacted and questioned if they reported residential data or commercial data, and if workers are journey-level employees or apprentices or helpers. If employers report residential data or data for apprentices or helpers, data is not used. The Department determined that the wage rate for this occupation was calculated correctly after the quality review was performed. As a result, no change has been made to this wage rate.

Comment 8: Mr. Halverson also commented on the use of "helpers" or "laborers" who assist in the installation of plumbing systems.
Response 8: The Department forwarded a copy of Mr. Halverson's letter to the Department of Commerce's Professional and Occupational Licensing Bureau to address these concerns.

Comment 9: Ron Senger, Sheet Metal Workers Local #103, commented that the travel matrix for sheet metal worker and sheet metal foreperson was incorrect. He submitted information from the collective bargaining agreement showing the correct travel matrix.
Response 9: The Department considered the collective bargaining agreement in setting a revised travel matrix. As a result, the travel matrix changed to reflect the collective bargaining

agreement.

Comment 10: Joe Benson, Operating Engineers Local #400, commented that the pile driver definition on page vi of the preliminary "Montana Prevailing Wage-Building Construction" publication is incorrect. He stated that pile drivers do not operate heavy equipment.
Response 10: The Department reviewed the current description and determined that it adequately represents the work done by pile drivers. The description states that they operate pile drivers mounted to heavy equipment, but does not indicate that they operate the heavy equipment.

Comment 11: Mr. Benson, Operating Engineers Local #400, also commented that wage rates for backhoe operator in district 1 were low.
Response 11: The Department reviewed the wage rate for this occupation and district and determined that it was calculated correctly as a weighted average of the data submitted. As a result, no change has been made to this wage rate.

Comment 12: Ron James, Ironworkers Local #841, commented that wage rates for ironworker-structural steel, rebar placer were low in districts 5 and 8, and that wage rates for ironworker foreperson were low in district 8.
Response 12: The Department reviewed wage rates for these districts and determined that they were calculated correctly as a weighted average of the data submitted. As a result, no change has been made to these wage rates.

Comment 13: G. Bruce Morris, Carpenters and Joiners Local #28, submitted additional data for carpenters in district 2.
Response 13: The Department included the additional data in the calculation of wage rates. As a result, the wage rate for carpenters in district 2 increased.

Comment 14: As noted above, additional data was submitted to the Department by employers and labor groups during the comment period.
Response 14: As a result of the additional data received, prevailing wage rates for certain occupations were raised and others were lowered.

4. After consideration of the comments received on the proposed amendments, the Department has amended the rule exactly as proposed, and the Department adopts and incorporates by reference the prevailing rates of wages entitled "State of Montana Prevailing Wage Rates-Building Construction" for building construction, heavy and highway construction, dated July 1, 1996. The building construction rates are adopted as proposed, but with changes in the standard prevailing rate of wages for following occupations:

Wage increases due to additional data:

Carpenter: District 2
Cement Mason: District 6
General Laborer: District 6
Plumber and Pipefitter: District 4
Sheet Metal Worker: District 4

Wage decreases due to additional data:

Carpenter: District 6
Sheet Metal Worker: District 8

Wage increases-use correct collective bargaining rate:

Communications technician: District 10

Wage decreases-preliminary rates higher than collective bargaining rates:

Bricklayer foreperson: District 3

5. The amendments, including the standard prevailing rate of wages, are effective July 1, 1996.

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

David A. Scott
Rule Reviewer

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

Certified to the Secretary of State: June 10, 1996.

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

In the matter of the adoption of new RULE I, the amendment of ARM 24.2.101, 24.29.201, 24.29.205, 24.29.206, 24.29.207 and 24.29.215; and the repeal of ARM 24.29.202 through 24.29.204 and 24.29.208 through 24.29.210, all related to procedure in workers' compensation matters	) NOTICE OF ADOPTION, AMENDMENT) AND REPEAL OF RULES RELATING) TO WORKERS' COMPENSATION AND) EMPLOYMENT STATUS [INDEPENDENT) CONTRACTOR] ISSUES

TO ALL INTERESTED PERSONS:

1. On April 25, 1996, the Department published notice at pages 1061 through 1069 of the Montana Administrative Register, Issue No. 8, to consider the adoption of new rule I; the proposed amendment of ARM 24.2.101, 24.29.201, 24.29.205, 24.29.206, 24.29.207 and 24.29.215; and the proposed repeal of ARM 24.29.202 through 24.29.204 and 24.29.208 through 24.29.210, all related to procedures in workers' compensation matters.

2. On May 17, 1996, a public hearing was held in Helena concerning the adoption of the proposed rule, amendments and repeals. No oral or written comments have been received from the public. However, agency staff commented on proposed amendments to ARM 24.29.205 and 24.29.206.

3. The Department has repealed ARM 24.29.202 through 24.29.204 and 24.29.208 through 24.29.210 in their entirety; amended ARM 24.2.101, 24.29.201, 24.29.206 and 24.29.215 exactly as proposed; and adopted the following rule exactly as proposed.

RULE I (24.29.213) PROCEDURE FOR ISSUING WORKERS' COMPENSATION DETERMINATIONS REGARDING EMPLOYMENT STATUS, INCLUDING THAT OF INDEPENDENT CONTRACTOR

4. After consideration of the comments received on the proposed amendments, the Department has amended the rules as proposed, with the following changes (new matter underlined, deleted matter interlined):

24.29.205 ISSUING ORDERS (1) through (3) Same as proposed.

(a) Before a party may request a contested case hearing on an order which is issued by either the uninsured employers' fund or the underinsured employers' fund and establishes only the amount of penalty owed and no other issue, the party must first obtain an administrative review of that order.

(4b) Department determinations rendered by the independent contractor central unit regarding employment status issues are not considered department orders for purposes of these rules. These determinations are issued pursuant to ARM 24.35.201, 24.35.202, 24.35.205 through 24.35.207, 24.35.210, 24.35.212 and 24.35.213 and 24.35.301 through 24.35.303.

AUTH: 2-4-201, 39-71-203 and 39-72-203 MCA
IMP: 2-4-201, 2-4-202, 39-71-116, 39-71-120, 39-71-415 and 39-72-203 MCA

24.29.207 CONTESTED CASES (1) through (2)(m) Same as proposed.

(n) disputes regarding department orders that determine occupational disease issues ~~whether a claimant is suffering from an occupational disease, and if so, apportionment under the occupational disease act~~ (Title 39, chapter 72, part 6, MCA).

(2) and (3) Same as proposed.

(4) The workers' compensation court is an appeal court for final orders, other than employment status decisions, made by the department pursuant to ARM 24.29.207(1), (2) and (3). Final decisions regarding employment status issues pursuant to ARM 24.29.207(1)(c), 24.35.201, 24.35.202, 24.35.205 through 24.35.207, 24.35.210, 24.35.212 and 24.35.213 and 24.35.301 through 24.35.303 are appealable to the board of labor appeals pursuant to ARM 24.35.213.

AUTH: 2-4-201, 39-71-203 and 39-72-203 MCA
IMP: Title 2, chapter 6, part 6, 39-71-204, 39-71-415, 39-71-2905, 39-72-611 and 39-72-612 MCA

5. The Department has thoroughly considered the comments and testimony received on the proposed rules. The following is a summary of the comments received, along with the Department's response to these comments:

Comment 1: Agency staff commented that ARM 24.29.205, as proposed for amendment, omits the long-standing requirement that a party request an administrative review of a department order regarding imposition of a penalty by the Uninsured Employers' Fund or the Underinsured Employers' Fund prior to seeking a contested case hearing.

Response 1: The Department agrees that ARM 24.29.205, as proposed for amendment, is ambiguous regarding the process for appealing these penalties. The wording has been changed to clarify the proper procedure.

Comment 2: Agency staff commented that ARM 24.29.207(2)(n), as proposed for amendment, may not be consistent with relevant case law.

Response 2: The Department agrees and has amended that subsection to conform with case law precedent.

6. The new rule, amended rules and repeals will be effective July 1, 1996.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 10, 1996.

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

In the matter of the adoption of new RULES I through XI creating one process for determining all employment status issues, including that of independent contractor	))))))	NOTICE OF ADOPTION OF RULES CREATING ONE PROCESS FOR DETERMINING EMPLOYMENT STATUS [INDEPENDENT CONTRACTOR] ISSUES

TO ALL INTERESTED PERSONS:

1. On April 25, 1996, the Department published notice at pages 1070 through 1077 of the Montana Administrative Register, Issue No. 8, to consider the adoption of new rules I through XI, all related to the creation of a uniform process for determining employment status [independent contractor] issues.

2. On May 17, 1996, a public hearing was held in Helena concerning the adoption of the proposed rules. No oral or written testimony was presented at the hearing. However, written comments were received prior to the closing date of May 28, 1996.

3. After consideration of the comments received on the proposed rules, the Department has adopted the following rules exactly as proposed.

RULE I (24.35.201) DEFINITIONS

RULE IV (24.35.206) APPEAL OF DETERMINATIONS REGARDING EMPLOYMENT STATUS

RULE V (24.35.207) TRANSFER OF FILE TO HEARINGS BUREAU

RULE VII (24.35.212) APPEAL REFEREE'S FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION ON EMPLOYMENT STATUS

RULE IX (24.35.301) DEFINITION OF INDEPENDENT CONTRACTOR

RULE X (24.35.302) DEFINITION OF INDEPENDENT CONTRACTOR--EVIDENCE OF CONTROL

RULE XI (24.35.303) DEFINITION OF INDEPENDENT CONTRACTOR--INDEPENDENTLY ESTABLISHED BUSINESS

4. After consideration of the comments received on the proposed rules, the Department has adopted proposed Rule II, Rule III, Rule VI and Rule VIII with the following changes (new matter underlined, deleted matter interlined):

RULE II (24.35.202) DETERMINATIONS REGARDING EMPLOYMENT STATUS

(1) Same as proposed.

(2) Determinations regarding employment status must comply with the definitions of an independent contractor found at ARM 24.35.301 through 24.35.303, as well as with existing law on partnership, joint ventures and other employment entities.

(3) through (4) Same as proposed.

(5) ICCU determinations regarding employment status are binding on the department and on ~~all~~ any other agency~~ies~~ which elects to be included ~~participate in~~ as a member of the department's ICCU, subject to the limitations contained in ARM 24.35.205(3). This does not include any agency which is merely appearing before the ICCU as a party in an employment status case (for example the state compensation insurance fund), and has not elected to be included as a member of the ICCU.

AUTH: Sec. 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203 MCA

IMP: Sec. 39-3-208, 39-3-209, 39-3-210, 39-51-201, 39-51-203, 39-71-120 and 39-71-415 MCA

RULE III (24.35.205) BINDING NATURE OF DETERMINATIONS REGARDING EMPLOYMENT STATUS (1) Unless appealed pursuant to ARM 24.35.206, w~~W~~ritten determinations issued by the ICCU are binding on all parties with respect to employment status issues under the jurisdiction of the department of labor and industry and the jurisdiction of ~~all~~ any other agency~~ies~~ which elects to be included ~~participate in~~ as a member of the ICCU. These determinations may affect a party's liability in matters related to unemployment insurance, the uninsured employers' fund, the underinsured employers' fund, wage and hour issues, state income tax withholding and old fund liability tax.

(2) Neither the department nor any other agency which elects to be included ~~participate in~~ as a member of the ICCU may appeal the ICCU's employment status determination.

(3) If the ICCU's employment status determination is appealed by a ~~non agency~~ party which has not elected to be included as a member of the ICCU, the determination is not binding on any party until all appeal rights are exhausted.

(4) Nothing in these rules shall be construed to limit the right of any similarly situated individual to a hearing as provided for in ARM 24.35.206.

AUTH: Sec. 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203 MCA

IMP: Sec. 39-3-212, 39-51-1109, 39-71-120 and 39-71-415 MCA

RULE VI (24.35.210) HEARING ON EMPLOYMENT STATUS ISSUE

(1) Same as proposed.

(2) The department and any other agency which has elected to be included as a member of ~~participate in~~ the ICCU may be represented at the hearing by either ICCU staff or the department's legal staff. This does not include any agency which is merely appearing before the ICCU as a party in an employment status case (for example the state compensation

insurance fund), and has not elected to be included as a member of the ICCU.
AUTH: Sec. 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203 MCA
IMP: Sec. 2-4-201, 2-4-611, 39-3-216, 39-51-1109 and 39-71-415 MCA

RULE VIII (24.35.213) APPEAL OF FINDINGS, CONCLUSIONS AND DECISION ON EMPLOYMENT STATUS (1) Unless ARM 24.35.213(4) applies, the findings of fact, conclusions of law and decision of the appeals referee may be appealed to the board of labor appeals.

(2) Notice of appeal to the board must be filed with the hearings bureau within 10 days of notice of the appeals referee's decision.

(a) A party is considered to have been given notice of the appeals referee's decision on the date a written notice is personally delivered or 3 days after a written notice is mailed to the party.

(3) If an appeal is filed, the hearings bureau will notify all parties of record and cause the matter to be brought before the board.

(4) If the appeals referee's findings of fact, conclusions of law and decision concerns a determination regarding ~~workers' compensation benefits,~~ an uninsured employers' fund or underinsured employers' fund penalty issue, the appeal will be to the Montana workers' compensation court, pursuant to 39-71-504~~415(2)~~ and 39-71-532~~2401~~, MCA.

(5) Pursuant to 39-71-415(2), MCA, disputes between an insurer and a claimant regarding the employment status of the claimant may be brought before the workers' compensation judge for resolution following mediation.
AUTH: 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203 MCA
IMP: 2-4-611, 2-4-623, 39-3-216, 39-51-1109, 39-71-415, 39-71-504, 39-71-532 and 39-71-2401 MCA

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

Comment 1: The Administrative Code Committee commented that it is appropriate for the Department to establish one central unit for making independent contractor determinations. The Committee further commented that the Department should ensure that the independent contractor definitions and test are correct with respect to each relevant statute defining independent contractors.
Response 1: The Department appreciates the Committee's approval of its goal. The Department has reviewed the relevant statutes and case law and believes that the administrative definition and tests are consistent with the particular statutes, with one exception. That exception is the reliance certain workers' compensation statutes place on the issuance of an independent

contractor exemption. This exception is noted in Rule IX, subpart (2).

Comment 2: Two commentors found Rules II, III and VI to be confusing with respect to what is meant by "all other agencies which elect to participate in the department's ICCU". Both commentors questioned whether the State Compensation Insurance Fund would be considered such an agency.
Response 2: The Department agrees the language is misleading and has amended these rules in an attempt to further clarify its intent. Currently, the Department of Revenue and the Department of Labor and Industry are the only agencies which have elected to be "members" of the ICCU. This means that audits and decisions regarding employment status questions issued by those agencies are, if contested by any party thereto, subject to review by the ICCU for the purpose of rendering consistent determinations. The Department of Revenue and the Department of Labor and Industry are the only two agencies to which the language "any other agency which elects to be included as a member of the ICCU" currently applies. Other agencies may elect to participate in the future.

However, agencies such as the State Compensation Insurance Fund do not automatically become "members" of the ICCU by virtue of being a party to a proceeding before the ICCU. Thus, those agencies are not bound by the ICCU's determination, may appeal the ICCU's determination and are certainly entitled to be represented by its own attorney in any appeal of an ICCU determination. Nothing in these rules is meant to alter the effect of 39-71-415(1), MCA.

Comment 3: One commentor believes the ten (10) day appeal times contained in proposed Rules IV and VIII are too short and should be extended to either twenty (20) or thirty (30) days.
Response 3: The Department has discussed this time frame at length. The Department believes that by the time the ICCU process has been completed, the parties will have sufficient information to know whether they wish to appeal. The ten (10) day period helps to shorten the time spent in the appeal process.

Comment 4: One commentor noted that Rule VIII(4) purports to permit "appeal" to the Workers' Compensation Court pursuant to 39-71-415(2), MCA, when in fact that statute provides the Worker's Compensation Court with original jurisdiction over benefit disputes which involve an independent contractor issue.
Response 4: The Department agrees and has amended Rule VIII accordingly.

Comment 5: A commentor suggests that changes be made to Rule IX, the definition of Independent Contractor. The commentor finds the definition to be "reasonable", but asks that all agencies, including the State Compensation Insurance Fund, adhere to that definition. The commentor further suggests

reference be made to the federal government's "twenty factor test"; and that the Department consider any simplified definitions of independent contractor adopted by the federal government in the future.
Response 5: The purpose of these rules is to create a uniform procedure for the Department of Labor and Industry's ICCU to use when determining employment status issues. The State Compensation Insurance Fund is not attached to the Department of Labor and Industry.

The Department is not, at this time, adopting substantive rules regarding the definition of independent contractor. The Department discussed referencing the federal government's twenty factor test. However, the Department determined that test to be very similar to the tests found in Rule X and XI, thus unnecessary and perhaps confusing.

The Department is following with great interest the federal government's attempt to simplify the definition of an independent contractor. If the federal government, or any other entity succeeds in this daunting task, the Department will bring the simplified definition to the attention of the Montana legislature.

Comment 6: Another commentor requests that Rule IX reference 39-71-120(2), MCA, regarding the presumption of employee status.
Response 6: The Department believes it unnecessary to include the "statutory presumption of employment" by rule as it is addressed in statutes and case law.

Comment 7: A commentor suggests that the language contained in Rule X(1)(b) is vague and should be replaced with language in 39-71-116(6), MCA, defining "casual employment."
Response 7: The purpose of these rules is to create a uniform procedure for the Department of Labor and Industry's ICCU to use when determining employment status issues. The Department is not, at this time, adopting substantive changes to the definition of independent contractor.

Comment 8: A commentor questions whether Rule X(1)(d) should have an "or" between "frequent" and "recurrent".
Response 8: This language is adopted verbatim from previous ARM 24.11.821. At this time the Department is not adopting substantive changes to the definition of independent contractor.

Comment 9: One commentor listed several concerns which are outside the scope of these rules. Specifically, the commentor offered opinions and suggestions concerning the staffing of the ICCU and suggested that the uniform process extend to the payroll reporting process, taxable wages, auditing, definitions, reporting periods and the payment process.
Response 9: The Department appreciates receiving these comments. The comments will be conveyed to the agency personnel presently working on similar issues and ideas.

6. The new rules will be effective July 1, 1996.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 10, 1996.

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

In the matter of the amendment of rules 46.12.505 and 46.12.507 pertaining to medicaid coverage and reimbursement of inpatient and outpatient hospital services	))))))	NOTICE OF THE AMENDMENT OF RULES

TO: All Interested Persons

1. On April 25, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.505 and 46.12.507 pertaining to medicaid coverage and reimbursement of inpatient and outpatient hospital services at page 1102 of the 1996 Montana Administrative Register, issue number 8.

2. The Department has amended rule 46.12.507 as proposed.

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

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

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

(c) The department computes a Montana average base price per case. This average base price per case is ~~$1,944.50 $2,038.43~~ $1,921.80, effective beginning July 1, ~~1995~~ 1996.

(2)(d) through (13) remain as proposed.

(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 (~~1995 April~~ JUNE 1996 edition). The DRG table of weights and thresholds is published by the department of ~~social and rehabilitation~~ public health and human services. The department hereby adopts and incorporates by reference the DRG table of weights and thresholds (~~April~~ JUNE ~~1995~~ 1996 edition). Copies may be obtained from the Department of Public Health and Human Services, ~~Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210~~ HEALTH POLICY AND SERVICES DIVISION, 1400 BROADWAY, P.O. BOX 202951, HELENA, MT 59620-2951.

(15) through (17) remain as proposed.

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

4. The department did not receive formal comments from hospital providers, the Montana Hospital Association or others, related to the proposed changes to the inpatient hospital rules. In addition, there was no formal testimony, other than the

department's, presented at the rule hearing. This absence of formal comments and testimony is unusual considering the proposed changes to the administrative rules. One reason for the absence of comments and testimony is that the department was working on the proposed changes with an advisory committee, which included staff from the Montana Hospital Association and three Montana hospitals.

At the time of the rule hearing the department and its consultant, Abt Associates, were preparing additional analysis on the DRG recalibration as recommended by the advisory committee. The department notified hospital providers in a letter dated April 30, 1996 that the base price and the table of weights and thresholds was subject to change because the department was still working with the advisory committee on issues relating to obstetric services, split DRG's, and outlier thresholds. This additional analysis led to changes in the proposed table of weights and thresholds and DRG base price.

Bob Olsen from the Montana Hospital Association attended the rule hearing on May 23, 1996. He notified department staff that MHA did not prepare formal comments for the rule hearing because of the additional analysis that was being prepared on the DRG recalibration. He stated that MHA would reserve comments pending the outcome of this additional analysis. The department appreciates the willingness of the Montana Hospital Association to work with the department while we prepared additional information for the DRG recalibration.

On May 28, 1996 the department provided members of the advisory committee a copy of a letter from Abt Associates outlining the changes resulting from the additional analysis recommended by the committee. This information was discussed in a meeting at MHA on May 30, 1996 and it was generally agreed that the changes are a positive step for hospitals. MHA, however, voiced concerns regarding the proposed payment methodology regarding estimated payment as a percentage of costs, cost report settlements, unstable DRG's, outlier pools, and payment for DRG 391(normal newborn). The department appreciates the comments by the Montana Hospital Association and other committee members. In response to their concerns, the department will organize an advisory committee to work on these issues and will modify the reimbursement for DRG 391 so that hospitals continue to receive the current level of payment for that DRG.

Other MHA comments reflected concern over the use of historical data to set future rates. While the department understands this concern, use of such data is unavoidable when implementing changes to prospective payment systems. By revising the payment system this year, the department has ensured that the payment rates will be more up-to-date than if the current rates were simply updated for inflation. Moreover, the department is

implementing rates on July 1, 1996 that reflect claims data up to June 30, 1995. Such a short lag compares very favorably with other payors, especially the medicare program. The department used medicaid cost reports up to state fiscal year 1993 and agrees that more recent cost data would be helpful if it were available. We did supplement the medicaid cost reports with medicare cost reports that provided data as recent as 1995.

As noted above, additional analysis was performed on the DRG recalibration which necessitates changes to the proposed rules. The revised table of weights and thresholds and DRG base price reflect the changes resulting from the exclusion from the recalibration database of cases not paid through the "straight" DRG system. The proposed table of weights and thresholds (dated April 1996) reflects data for 48,574 Medicaid stays in state fiscal years 1993-1995 in referral, medium sized and other DRG hospitals. The department recalculated the weights and thresholds after exclusion of 2,956 cases that would not be paid on a DRG basis, such as catastrophic cases, exempt DRGs, neonate DRGs (385-390) provided by the designated neonate units, and prorated DRGs.

With the exclusion of these cases from the DRG recalibration the average charge per case fell from $4,570.06 to $4,031.17. This difference reflects the fact that the high risk neonatal, catastrophic, and exempt cases are more expensive than average. Since the average charge for most DRGs did not change, the lower denominator translates into a 13% increase in the relative weights for most DRGs, from those we proposed in April 1996. The exceptions are the high risk neonatal DRGs (385-390) for which the relative weights now reflect only those cases handled outside the designated neonatal units. As expected those relative weights have fallen. The weights for various other DRGs have risen or fallen depending on the deletion of individual cases that may have been transfers, catastrophic cases, etc. In addition, the cost and day outlier thresholds were recalculated to reflect the smaller database of cases used in calculating the relative weights. The recalculation resulted in minimal changes to the proposed thresholds provided in April 1996. However, there are substantial changes when compared with the current system. Cost outlier thresholds were originally set so that cost outlier payments would equal 5% of the base DRG payments plus cost outlier payments. That target has now been set at 6%, which will result in increased protection against risk for hospitals. Day outlier thresholds have been similarly liberalized so that target day outlier payments now equal 6% of base DRG payments plus day outlier payments. When a case qualifies for both day and cost outlier payments, the hospital is paid according to whichever calculation is more favorable to it. The revised table of weights and thresholds will be available from the department and will be provided to all hospitals.

One other result of the recalibration as outlined above is a change in the base price from the proposed figure of $2,038.43 to $1,921.80. This change is necessary because a portion of the base price is based upon an update factor for inflation and a casemix adjustment.

When the proposed base price was first calculated in April, the TEFRA rate was estimated to be 3.5%. This percentage recently changed to a forecast of 3.3% based upon information from the Prospective Payment Assessment Commission's recommendation to Congress and the Federal Register for PPS inpatient hospital services for federal fiscal year 1996. The department notified hospital providers in a letter dated April 30, 1996 that this figure was subject to change, and that the department would review this update factor and modify the base price accordingly.

In addition, when we first calculated the relative weights under grouper version 13 DRGs, the department incorporated a $4.28 increase adjustment to the proposed base price to account for the centering of the grouper from changing the DRG grouper version 9 to version 13. This adjustment was necessary to avoid an increase or decrease in total payments due purely to the adoption of the new grouper. Under the proposed (April 1996) relative weights, the average weight changed from 0.9971 under version 9 to 0.9949 under version 13. Therefore, a $4.28 increase to the base price was necessary to maintain neutrality.

Now that we have excluded catastrophic, neonatal ICU, exempt, transfer and prorated cases from our calculations, the average weights have changed. The average version 9 weight for the remaining cases has fallen sightly, to 0.9762 and the average version 13 weight has increased to 1.0318. Therefore, to once again center the groupers against each other, we must reduce the base price by $104.81. The revised 1996-97 base price calculation is as follows:

SFY 1996 Base Price	$1,944.50
Centering of new grouper (v9-v13)	($104.81)
Reduction to finance liberalized outlier thresholds	($16.61)
Increase to reflect previously over-funded catastrophic, outlier and stop loss pools	$37.33
Adjusted base price	$1,860.41
Update for inflation (3.3%)	$61.39
SFY 1997 Base Price	$1,921.80

The revised $1,921.80 base price is not only lower than the proposed $2,038.43 base price but it is also lower than the current $1,944.50 base price. Although the final base price is lower than the current base price, this does not mean that payments rates have been cut. In fact, aggregate payments will increase. This is because the increase in the relative weights outweighs the decrease in the base price. As a result the department estimates that straight DRG payments (base price times the relative weight) are expected to increase by 4.7% from 1996-1997 assuming no change to the volume of cases. This change coupled with the changes in the outlier policy, and the change in the statewide inpatient cost-to-charge ratio will result in increased aggregate payments to hospitals for state fiscal year 1997.

The department received one comment supporting the addition of diabetes education services as a medicaid covered outpatient hospital service. The comment indicated that persons with diabetes provide 95% of their own routine daily care, which largely involves application of complex technology and modification of deeply imbedded lifestyle behaviors. Diabetes education and self-management programs can prevent or delay progression of the disease and complications and result in cost savings. The department appreciates the comment and agrees that the additional coverage is a sound policy decision.

5. The changes will apply to services provided on or after July 1, 1996.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

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

In the matter of the adoption of rules I through IX and the repeal of rules 46.12.525, 46.12.526, 46.12.527, 46.12.530, 46.12.531, 46.12.532, 46.12.535, 46.12.536, 46.12.537, 46.12.545, 46.12.546 and 46.12.547 medicaid coverage and reimbursement of physical therapy, speech therapy, occupational therapy and audiology services	)	NOTICE OF THE ADOPTION AND REPEAL OF RULES

TO: All Interested Persons

1. On April 25, 1996, the Department of Public Health and Human Services published notice of the proposed adoption of rules I through IX and the repeal of rules 46.12.525, 46.12.526, 46.12.527, 46.12.530, 46.12.531, 46.12.532, 46.12.535, 46.12.536, 46.12.537, 46.12.545, 46.12.546 and 46.12.547 medicaid coverage and reimbursement of physical therapy, speech therapy, occupational therapy and audiology services at page 1089 of the 1996 Montana Administrative Register, issue number 8.

2. The Department has repealed rules 46.12.525, 46.12.526, 46.12.527, 46.12.530, 46.12.531, 46.12.532, 46.12.535, 46.12.536, 46.12.537, 46.12.545, 46.12.546 and 46.12.547 as proposed.

3. The Department has adopted [RULE II] 46.12.526A THERAPY SERVICES, PROVIDER REQUIREMENTS; [RULE IV] 46.12.528 THERAPIES, REIMBURSEMENT; [RULE V] 46.12.529 THERAPIES, FEE SCHEDULE; [RULE VIII] 46.12.538 AUDIOLOGY SERVICES, REIMBURSEMENT; and [RULE IX] 46.12.539 AUDIOLOGY SERVICES, FEE SCHEDULE as proposed.

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

[RULE I] 46.12.525A THERAPY SERVICES, DEFINITIONS In ARM 46.12.525A through 46.12.529, the following definitions apply:

(1) through (7) remain as proposed.

(8) "Restorative therapy" means therapy services that are ~~reasonable and medically necessary for treatment of the individual's condition as provided in [Rule III]~~PERFORMED WITH A REASONABLE EXPECTATION THAT THE RECIPIENT'S CONDITION WILL IMPROVE SIGNIFICANTLY IN A REASONABLE AND PREDICTABLE PERIOD OF

TIME, BASED UPON AN ASSESSMENT OF THE RECIPIENT'S RESTORATION POTENTIAL MADE BY A PHYSICIAN OR MID-LEVEL PRACTITIONER IN CONSULTATION, IF NECESSARY, WITH THE LICENSED THERAPIST. THERAPY SERVICES ARE NOT RESTORATIVE THERAPY IF THE RECIPIENT'S EXPECTED RESTORATION POTENTIAL WOULD BE INSIGNIFICANT IN RELATION TO THE EXTENT AND DURATION OF SERVICES REQUIRED. THERAPY SERVICES ARE NO LONGER RESTORATIVE THERAPY IF AT ANY TIME AFTER COMMENCEMENT OF TREATMENT IT IS DETERMINED THAT THE REASONABLE EXPECTATION OF SIGNIFICANT IMPROVEMENT WILL NOT MATERIALIZE.

(9) and (10) remain as proposed.

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

[RULE III] 46.12.527A THERAPY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS (1) and (2) remain as proposed.

(3) Therapy services may be provided to a recipient only upon a current written OR VERBAL order or ~~prescription~~ REFERRAL by a physician or mid-level practitioner. ~~The physician or mid-level practitioner must separately order or prescribe evaluations and treatment services, although the separate orders or prescriptions may be contained in the same document.~~ ALL VERBAL ORDERS OR REFERRALS MUST BE FOLLOWED UP BY A WRITTEN ORDER RECEIVED BY THE PROVIDER WITHIN 30 DAYS OF THE VERBAL ORDER OR REFERRAL.

(a) The provider is not entitled to medicaid reimbursement if services are provided prior to actual receipt of the written OR VERBAL order or ~~prescription~~ REFERRAL. ~~Prescriptions~~ REFERRRALS and orders are valid for medicaid purposes for no more 90 days.

(b) The provider must maintain the ~~prescription~~ REFERRAL or order of the physician or mid-level practitioner and appropriate records that demonstrate compliance with medicaid requirements. The provider must provide copies of these documents at no charge to the department or its agents upon request.

(4) The Montana medicaid program will reimburse restorative therapy services only when the particular restorative therapy services are reasonable and necessary to the treatment of the recipient's condition.

~~(5)~~ As used in this rule, "reasonable and necessary" means:

(a) The services are considered effective treatment for the recipient's specific disorder under generally accepted standards of practice;

(b) The complexity or sophistication of the services or the recipient's condition is such that the required services can be performed effectively only by or under the supervision of a licensed therapist; AND

(c) The amount and frequency of services are within generally accepted standards of practice~~; and~~.

~~(d) There is a reasonable expectation that the recipient's condition will improve significantly in a reasonable and predictable period of time based upon an assessment of the recipient's restoration potential made by a physician or mid-level practitioner in consultation, if necessary, with the licensed therapist. The services are not reasonable and necessary if the recipient's expected restoration potential would be insignificant in relation to the extent and duration of services required. If at any point in the treatment of a condition it is determined that the expectations will not materialize, the services are no longer reasonable and necessary.~~

(4)(e) remains the same in text but is renumbered (5). (6) and (6)(a) remain as proposed.

(7) The Montana medicaid program will reimburse speech therapy service providers for medically necessary augmentative speech devices only if the device has been prior authorized by the department and all other requirements have been met. Requests for prior authorization must be made using the form prescribed by the department and must be submitted to the Department of Public Health and Human Services, Health Policy and Services Divisions, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. Forms are available from the department at the above address.

(8) and (9) remain as proposed.

(10) Medicaid reimbursement for therapy service procedures includes all related supplies and items used in the performance of the service, except that the design, fabrication, fitting and instruction by a licensed ~~occupational therapy practitioner~~ THERAPIST in the use of ~~dynamic and static~~ splints, braces and slings are reimbursable as provided in ARM 46.12.801 through 46.12.806.

(11) through (11)(c) remain as proposed.

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

[RULE VI] 46.12.533 AUDIOLOGY SERVICES, PROVIDER REQUIREMENTS (1) and (2) remain as proposed.

(a) maintain a current audiology license issued by the Montana board of SPEECH-LANGUAGE PATHOLOGISTS AND audiologists, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided;

(2)(b) remains as proposed.

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

[RULE VII] 46.12.534 AUDIOLOGY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS (1) and (2) remain as proposed.

(a) MEDICAID COVERAGE AND REIMBURSEMENT FOR DISPENSING OF HEARING AIDS IS AVAILABLE TO LICENSED HEARING AID DISPENSERS, SUBJECT TO THE REQUIREMENTS OF ARM 46.12.540 THROUGH 46.12.542 AND THE REQUIREMENTS GENERALLY APPLICABLE TO MEDICAID PROVIDERS.

(3) Audiology services may be provided to a recipient only upon a current written OR VERBAL order OR REFERRAL by a physician or mid-level practitioner. ~~The physician or mid-level practitioner must separately order or prescribe evaluations and treatment services, although the separate orders or prescriptions may be contained in the same document.~~ ALL VERBAL ORDERS OR REFERRALS MUST BE FOLLOWED UP BY A WRITTEN ORDER RECEIVED BY THE PROVIDER WITHIN 30 DAYS OF THE VERBAL ORDER OR REFERRAL.

(a) The provider is not entitled to medicaid reimbursement if services are provided prior to actual receipt of the written OR VERBAL order or ~~prescription~~ REFERRAL. ~~Prescriptions~~ REFERRALS and orders are valid for medicaid purposes for no more THAN 90 days.

(b) The provider must maintain the ~~prescription~~ REFERRAL or order of the physician or mid-level practitioner and appropriate records that demonstrate compliance with medicaid requirements. The provider must provide copies of these documents at no charge to the department or its agents upon request.

(4) and (5) remain as proposed.

(6) Basic audio assessments ~~under ear phones must include, at a minimum:~~ MUST INCLUDE FOR EACH EAR UNDER EARPHONES:

(a) PURE TONE AIR CONDUCTION THRESHOLDS AT THE FREQUENCIES OF .5, 1, 2, 3 AND 4 KHZ;

(b) SPEECH RECEPTION THRESHOLD; AND

(c) SPEECH DISCRIMINATION (WORD RECOGNITION) TEST UNDER PB MAX CONDITIONS, AND EITHER PURE TONE BONE CONDUCTION THRESHOLDS AT THE FREQUENCIES SPECIFIED IN (6)(a), OR TYMPANOMETRY, INCLUDING TYMPANOGRAM, ACCOUSTIC REFLEXES AND STATIC COMPLIANCE.

~~(a) a speech discrimination test;~~

~~(b) a speech reception threshold;~~

~~(c) a pure tone air threshold; and~~

~~(d) either a pure tone bone threshold or one of the following: a tympanogram, acoustic reflex, tympanometry for tubal function or static compliance.~~

~~(7) A hearing aid evaluation must be conducted in a sound attenuated room in a free field setting to determine those acoustical specifications most appropriate for the recipient's hearing loss. A hearing aid evaluation must include at least one follow up visit.~~ A HEARING AID FITTING MUST INCLUDE EITHER SOUND FIELD TESTING IN AN APPROPRIATE ACCOUSTIC ENVIRONMENT OR REAL EAR MEASUREMENTS TO DETERMINE ADEQUACY OF FIT OF THE HEARING AID FOR THE RECIPIENT'S NEEDS. A HEARING AID FITTING MUST INCLUDE AT LEAST ONE FOLLOWUP VISIT AND WARRANTY COVERAGE FOR THE HEARING AID FOR A PERIOD OF AT LEAST 2 YEARS.

(8) remains as proposed.

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

5. The Department has thoroughly considered all commentary received:

General Comments

COMMENT #1: The department is commended for eliminating the physician prescription requirement.

RESPONSE: The department has not removed the physician prescription requirement. Rather, in compliance with federal law, the department has changed the rule to allow referral or order by either a physician or a mid-level practitioner.

COMMENT #2: In Rule I(2) and (7)(ARM 46.12.525A), the language "particular category of therapy services provided" should be changed to "particular category of therapy services enumerated." This change would clarify that the category of therapy services referenced are to those therapies enumerated in the applicable statutory provisions.

RESPONSE: The department will not adopt this suggested change. The proposed language referred to in the comment is intended to require that the practitioner be licensed for the particular category of therapy services provided to the recipient. In other words, the provider of physical therapy services to a recipient must be licensed as a physical therapist. A person licensed only as a physical therapist cannot receive reimbursement under the medicaid program for speech therapy services. We believe that the language as proposed better reflects the department's intent.

COMMENT #3: In proposed Rule III(3)(ARM 46.12.527A), the language should be revised to allow services to be provided on verbal orders or referrals, as long as the verbal order or referral is followed up with a written order within 30 days. The overwhelming majority of orders and referrals are verbal. Verbal orders allow for a more rapid intervention, which has been shown to reduce the duration and ultimate cost of treatment. The use of verbal orders is necessary to provide effective evaluation and treatment. Further, it is standard practice for therapists to receive referrals from physicians to both evaluate and treat in a single order or referral. Requiring separate orders for evaluations and treatment prior to service is inconsistent with current practice, would delay required treatment and would create additional and unnecessary hassles. The references to "prescribe" and "prescription"

should be deleted and the words "orders" and "referrals" should be used, as they reflect current practice.

RESPONSE: The department agrees and will adopt the rule with the suggested changes, and will also adopt the same changes in Rule VII (ARM 46.12.534) for audiologists.

COMMENT #4: In proposed Rule III(3)(a)(ARM 46.12.527A), the first sentence should be deleted entirely to conform with the changes suggested in Rule III(3)(ARM 46.12.527A).

RESPONSE: The department will keep the first sentence of Rule III(3)(a)(ARM 46.12.527A), but will modify it to permit reimbursement for services provided after receipt of either the written or verbal order or referral.

COMMENT #5: The department should eliminate the last sentence of Rule III(3)(b)(ARM 46.12.527A), which requires the provision of copies of written orders to the department or its agents at no charge. The department should recognize that this requirement is costly, and reimbursement should reflect this added expense. Medicare currently recognizes this as an overhead cost in its resource based value system. Further, the rule should specify how long a provider is required to maintain these documents.

RESPONSE: The proposed rule is intended to reflect current department policy for all medicaid providers, which requires provision of records without a separate copy charge. The costs of providing copies is minimal and is reflected in the providers' charges upon which fees or rates are based. The department believes that provision of such copies is included in the overall service reimbursed by the fees specified in the rules. ARM 46.12.308 requires that providers maintain the required records for a period of at least three years after the date of service.

COMMENT #6: "Restorative therapy" needs to be further defined. It does not help to have the definition language repeated in the service requirement rule. How is restorative therapy different than maintenance therapy? The definition should demonstrate these differences.

RESPONSE: The department believes that the language of the proposed rule defines restorative therapy and differentiates it from maintenance therapy. However, the department agrees that the proposed rule is not well organized in separating the definition from the service requirements. The department will revise the rule to more clearly specify the definition and separate the definition from the service requirements.

COMMENT #7: The department should delete the provision in proposed Rule III(11)(ARM 46.12.527A) that requires prior

authorization for up to an additional 30 hours per fiscal year above the first 70 hours. The department has not developed an efficient pre-authorization process that does not delay treatment. When such a process is developed it must be described in the rule. This would benefit both providers and medicaid staff. Requiring pre-authorization without any description of the process will only cause confusion, delay and utilization of different processes at the department. An attempt to develop such a process several years ago led to abandonment of the attempt and a decrease in the number of reimbursable hours. Therapy should be limited to 100 hours without prior authorization.

RESPONSE: The prior authorization requirements in proposed Rule III(11)(a), (b) and (c) (ARM 46.12.527A) are already in effect currently and have been for several years. See current ARM 46.12.526(7), 46.12.531(6) and 46.12.546(7). The department believes that the proposed prior authorization requirement for services over 70 hours is a reasonable device for limiting additional hours of therapy services to cases where the additional hours are necessary. The department will adopt the rule as proposed. The prior authorization process developed by the department will be clearly defined in the respective provider manuals.

COMMENT #8: How did the department arrive at the 100 hour yearly limitation for each service category?

RESPONSE: The 100 hour limit is not a new rule, but has been in effect for many years. This limit was arrived at by the department working with providers and provider associations.

COMMENT #9: Do the 100 hour limitations apply to EPSDT recipients? Is there a separate procedure for granting prior authorization to EPSDT recipients who need over 100 hours? States can place tentative limits on services, but such utilization controls must be consistent with the preventative thrust of EPSDT. Utilization controls cannot unreasonably delay the recipient of services nor can they cause recipients to go without needed care. There must be an expeditious process in place to allow children to obtain treatment services beyond the tentative limits.

RESPONSE: The issues raised in the comment are addressed in the rules for the EPSDT program, found at ARM 46.12.514 through 46.12.517. ARM 46.12.514(2) states that limitations on the amount or duration of medicaid services which apply generally to particular services, as specified in the rules applicable to such services, do not apply to such services when provided to medicaid recipients under age 21, unless specifically provided in the EPSDT rules. The 100 hour limit for PT, OT and ST services do not apply to EPSDT recipients.

COMMENT #10: The rates paid to providers may be too low to elicit enough providers to provide the services covered. If this were the case or if this becomes the case in the future, the department would be in violation of the amount, duration and scope requirements of federal law.

RESPONSE: The department believes the rates are adequate to enlist providers to provide recipients adequate access to the services, and that the program complies with the applicable requirements of federal law.

COMMENT #11: Once the rate is set under the proposed rule, does this mean that only the legislature can make adjustments to insure that coverage is available? If over time the rates become too low because of inflation and services are not being provided because the legislature declines to increase rates, this would clearly violate the amount, scope and duration requirements. How were rates set in the past? Did the department always rely upon the legislature or did the department have the discretion to implement certain rate increases or decreases within the legislative allotment?

RESPONSE: Under both the current and the proposed rules, rate increases will be granted only as authorized or directed by the legislature. If the department believed that it were necessary to increase rates, however, it could amend the rule as deemed appropriate and to the extent authorized by state statute and within existing budgets. The department believes that section 53-6-113, MCA authorizes the department to set reimbursement rates, although the department must consider the availability of appropriated funds, among other factors listed in the statute. The availability of services is another factor listed in the statute.

COMMENT #12: Medicaid reimbursement currently is extremely low. We currently receive about 50% reimbursement on our charges. The proposed methodology would allow us to receive 65.2%, but that is based upon the aggregate average of all providers. One provider's reimbursement should not be tied to another provider's charges when each provider's overhead costs may be entirely different. Also, the proposed rule appears to indicate that charges for PT, OT and ST services will be pooled for this purpose. This creates problems with the reimbursement system. The department should consider adopting for medicaid a system similar to the resource based relative value system (RBRVS) developed by HCFA over the last 4 or 5 years. The department should revalue the modalities and procedures for reimbursement purposes. Medicaid's reimbursement priorities are in opposition to those of other payers, particularly medicare. Clinical expertise reasonably should be reimbursed at a greater rate than passive modalities. The reimbursement is very low, and is very close to not being even a break even point for many providers

and services. This may lead to providers opting out of the medicaid program.

RESPONSE: The department believes that the proposed fee methodology is a reasonable and adequate method of reimbursement. Fees are developed based upon an averaging of charges from various providers. Charges are pooled for a particular procedure only among the individual categories of therapy providers, i.e., PT charges are pooled separately from OT charges for this purpose. This method does not reimburse the full cost of the highest cost providers, which encourages a more cost effective approach to providing services. Nonetheless, we appreciate the concern expressed in the comments. The department is undertaking a study of the medicare RBRVS system for possible future use in medicaid reimbursement of therapy and other services. This study should address any disparities between rates paid for the various services.

Physical Therapy Comments

COMMENT #1: Physical therapists should be reimbursed for the fabrication and instruction in splints and braces, and this should be made clear in the rule. The proposed language in Rule III(10)(ARM 46.12.527A) is unclear as to how the physical therapist is reimbursed.

RESPONSE: The department is modifying Rule III(10)(ARM 46.12.527A) to apply to all licensed therapists, not just occupational therapists, and to remove the language "dynamic and static" and clarify reimbursement.

COMMENT #2: The removal of the specific medical necessity criteria for augmentative speech devices suggests that the department may be pulling away from funding augmentative speech devices. Not having specific criteria for such devices will lead to an increased tendency to deny the services. Although the department states that it will follow medical necessity definitions contained in the ARM, it is well known that the department keeps separate policies apart from the regulations about what it will fund. The department will still have criteria but those criteria will not be available for public review and comment. The department should adopt the policies under MAPA procedures to eliminate these separate policies and provide adequate due process through the review and comment procedures set out in statute.

RESPONSE: The removal of the specific criteria does not indicate any change in medicaid policy regarding augmentative speech devices. The department does not agree that there will be an increased tendency to deny these services. The items that were listed may still be considered under the medical necessity definition that remains in the rules. Other relevant criteria

may also be considered. The department believes that the rule was redundant and unnecessary, and that the department has an obligation under HJR 5 to review and eliminate unnecessary administrative rules. Moreover, the applicable rules that govern medical necessity have been adopted under MAPA and remain in the ARM. Given the vast number of specific applications of the medical necessity rule, the department indeed must interpret the rule based upon the particular circumstances of each case. However, the department cannot and is not required to adopt as rule a statement covering every possible application of the rule. Due process is assured by the notice and hearing rights granted by federal and state law as to application of the rule in a particular case. However, the department will address particular interpretations in the provider manuals for the respective programs.

Audiology Comments

COMMENT #1: The definitions of "licensed therapist" and "practitioner" in Rule I (ARM 46.12.525A) should include audiologists, and the definition of "therapy services" in Rule I (ARM 46.12.525A) should include audiological therapy. Most audiologists are trained not only to test hearing and fit hearing aids, but also to provide therapy such as speech reading, auditory perceptual testing, language development, etc. Some audiologists provide only therapeutic services. These providers need to be able to practice their profession and bill for services.

RESPONSE: The definitions of "licensed therapist," "practitioner" and "therapy services" in proposed Rule I (ARM 46.12.525A) apply only to physical therapy, occupational therapy and speech therapy services. These definitions do not apply to or address the scope of audiology services covered or reimbursable by the Montana Medicaid program. Proposed Rules I through V (ARM 46.12 525A through 46.12.529) apply to physical therapy, occupational therapy and speech therapy services. Proposed Rules VI through IX (ARM 46.12.533 through 46.12.539) apply to audiology services. Montana medicaid reimbursement of audiology services currently is limited to hearing aid evaluations and basic audio assessments provided within the scope of practice authorized by state law, and the Montana Medicaid program currently does not cover or reimburse audiologists for the therapy services described in the comment.

COMMENT #2: Proposed Rule VI(2)(a)(ARM 46.12.533) refers to the "Montana board of audiologists." The rule should be revised to reflect the correct title, which is the board of speech-language pathologists and audiologists.

RESPONSE: The department agrees and has revised the language accordingly.

COMMENT #3: The actual fitting of hearing aids requires that the dispenser be licensed by the Montana Board of Hearing Aid Dispensers. The department should add a sentence in Rule VII(2)(ARM 46.12.534) to specify this requirement.

RESPONSE: The department agrees that the actual fitting of hearing aids requires that the dispenser be licensed by the Montana Board of Hearing Aid Dispensers. The department's rules for reimbursement of hearing aid dispensers includes this requirement, at ARM 46.12.541. We agree that additional language in the audiology rules may be helpful to make this point clear, and we have added such language to the rule.

COMMENT #4: Proposed Rule VII(7) (ARM 46.12.534) requires that hearing aid evaluations be conducted in a sound attenuated room in a free field setting. In many cases this is an impossible requirement. Many recipients are bound to their home or rest home environment and cannot be tested in a sound treated environment. The last sentence of proposed Rule VII(7) (ARM 46.12.534) should more appropriately read "a hearing aid fitting" rather than "evaluation." This language is more consistent with current laws and rules of the board of speech-language pathologists and audiologists and the board of hearing aid dispensers. Moreover, the language of proposed Rule VII(6) and (7)(ARM 46.12.534) should be revised for clarity and specificity, and for consistency with current professional practice standards. The comment suggested specific language.

RESPONSE: The department agrees and has made the suggested changes and adopted substantially the same language suggested in the comment.

Miscellaneous Comments

COMMENT #1: In proposed Rule III(7)(ARM 46.12.527A), the word "Divisions" should be "Division".

RESPONSE: The department has corrected this error.

6. The adopted rules will be applied effective July 1, 1996. The rules permitting mid-level practitioners to order or refer for physical therapy, occupational therapy, speech therapy and audiology services will apply to services provided on or after May 22, 1995, the effective date of the implemented federal regulations.

Dave Ehm
Rule Reviewer

Michael S. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

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

In the matter of the amendment of rules 46.12.1222, 46.12.1223, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1245 and 46.12.1254 pertaining to nursing facilities	)))))))	NOTICE OF THE AMENDMENT OF RULES

TO: All Interested Persons

1. On April 25, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.12.1222, 46.12.1223, 46.12.1229, 46.12.1231, 46.12.1237, 46.12.1245 and 46.12.1254 pertaining to nursing facilities at page 1081 of the 1996 Montana Administrative Register, issue number 8.

2. The Department has amended rules 46.12.1222, 46.12.1223, 46.12.1231, 46.12.1245 and 46.12.1254 as proposed.

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

46.12.1229 OPERATING COST COMPONENT (1) through (4) remain as proposed.

(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 ~~30%~~ 33% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

(5)(a) remains as proposed.

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 (1) through (2)(d) remain the same.

(i) For rate years beginning on or after July 1, ~~1994~~ 1996, the property rate cap is ~~$11.00~~ $11.50.

(2)(e) through (3) remain as proposed.

(a) If the provider's ~~1995~~ 1996 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 ~~1995~~ 1996 property component or the property rate cap of ~~$11.00~~ $11.50.

(b) If the provider's base year per diem property costs exceed the provider's ~~1995~~ 1996 property component by more than ~~$1.36~~ $1.86, then the provider's calculated property cost

component is the sum of the provider's ~~1995~~ 1996 property component plus ~~$1.36~~ $1.86.

(c) If the provider's base year per diem property costs exceed the provider's ~~1995~~ 1996 property component by ~~$1.36~~ $1.86 or less, then the provider's calculated property cost component is the provider's base year per diem property costs.

(4) remains as proposed.

(a) the adjusted component shall be the lesser of ~~$11.00~~ $11.50 or a blended rate determined by dividing the sum of the product of pre-construction square footage and the provider's July 1 calculated property cost component and the product of the additional constructed square footage and ~~$11.00~~ $11.50, by the total square footage after construction.

(5) remains as proposed.

(a) the adjusted component shall be the lesser of ~~$11.00~~ $11.50 or the existing component plus a per diem amount determined by amortizing 80% of the amount derived by dividing the total allowable remodeling cost by the number of licensed beds after remodeling. Such amount shall be amortized over 360 months at 12% per annum. A per diem amount shall be determined by multiplying the monthly amortization amount by 12 months and dividing the result by 365.

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

4. The Department has thoroughly considered all commentary received:

COMMENT #1: We support the increases in the operating, nursing, incentive, and property components of the rate setting methodology. We note, however, that each of these caps remain below the pre-FY 96 cuts and below levels previously agreed to by the department as being appropriate and necessary to properly fund nursing facilities. Rates generated by this formula continue to be, according to your own calculations an average of over $5 per patient day below actual costs experienced by facilities; and 58 of 98 facilities (nearly 60%), according to your spreadsheet, receive rates lower than their actual costs.

COMMENT #2: One commentor supports the move to a 106% of the median operating cost cap and reluctantly supports the department's decision to again increase the incentive payment with extra dollars. This commentor expects that any dollars remaining, after the private pay limits are calculated, will be used to further raise the cap. Further, if the private pay limit reduces available funds below those needed to fund the proposed rule, the commentor recommends that the department first reduce the incentive factor, then the property cost component before reducing the operating cost cap.

RESPONSE FOR #1 and #2: The department continues to further the basic goals of the reimbursement methodology to maximize reimbursement of nursing services and nursing costs while providing an incentive to operate efficiently and contain costs. These adjustments in percentages have been set with these reimbursement goals in mind and in conjunction with the adjustment of the reimbursement components to incorporate inflationary trends, patient assessment information, new median cost computations, adequacy of the reimbursement levels through the department's findings processes and appropriation levels. The department has continued to update the information in the rate spreadsheet from the first notice of the rule and, based on the updated information, we will adopt a direct nursing personnel cost limit median of 117%, an operating cost limit median of 106%, an incentive upper limit of 33%, and a property cap of $11.50. Reimbursement rates must be considered as a whole to determine the adequacy of reimbursement levels and not isolated to one component of reimbursement. Percentages have previously been adjusted in order to provide for the maximum amount of reimbursement to be distributed in the most appropriate manner to all facilities participating in the program. These percentages have been adjusted upward in some instances but can be adjusted downward in conjunction with the other reimbursement components in order to maximize the system of reimbursement as a whole.

The department believes that the proposed medicaid rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards, and assures continued access to medicaid services.

The operating incentive is discretionary from the department's standpoint as it reimburses providers for costs not incurred, it provides an incentive for providers to consider how to incur facility operation costs in an efficient manner and provides a mechanism for facilities to be recognized for cost containment while still meeting participation requirements.

The department notes that neither the Boren Amendment nor any state or federal regulation requires that any particular number or percentage of facilities receive rates that equal or exceed actual costs, and that courts have recognized that there is no requirement that all costs be reimbursed. Moreover, such a percentage test is not the standard adopted by the department by which to assess compliance with Boren Amendment requirements. The department believes that based on our findings process that the level of reimbursement is reasonable and adequate to meet the cost that must be incurred by efficiently and economically operated nursing facilities in Montana.

As stated at the rule hearing, the department will leave some funds undistributed through the rate spreadsheet on July 1, in order to accommodate rate adjustments during the year. Some of these undistributed funds will be the result of private pay savings while others will represent undistributed appropriations prior to any private pay savings.

COMMENT #3: We believe that rebasing the system utilizing calendar year 1995 cost reports, instead of using an inflationary index, is the best way to account for cost increases reflected by facilities. Facilities' continuing efforts to comply with federal regulations (the interpretation of which never stops evolving), including adding staff to assure compliance, means that our facilities are experiencing cost increases beyond "inflation" which should be recognized by the Medicaid program.

RESPONSE: The rate system was rebased in fiscal year 1996 to use 1994 cost report information. For fiscal year 1997, the department continues to utilize the 1994 cost reports as the base period costs, and provides for indexing these costs forward to the mid point of the rate year utilizing the DRI skilled nursing index. The department does not believe that annual rebasing is necessary to reasonably and adequately reimburse nursing facilities. The DRI-SNF inflationary component has proven to be an accurate index of aggregate cost increases in Montana. The DRI index is applied to all of the facilities' operating and direct nursing costs. The adequacy of the DRI index must be measured by comparing it to the total cost increases in all cost areas. The adequacy of the index cannot be measured by comparing the DRI percentage with the rates of increase for individual cost items in individual facilities. Not every specific cost increase will be projected in the inflationary adjustment, but the department believes that in the aggregate all necessary cost increases are met or exceeded by application of the DRI index. Moreover, the fact that any particular facility actually incurs costs at a certain rate of increase does not mean that all of such costs need be incurred by an economically and efficiently operated facility or that the costs must be reimbursed. The system is not a cost based system and is not intended to reimburse all of the costs incurred at each facility. Because the department believes that the use of the 1994 cost base and the DRI index adequately recognizes all necessary cost increases, the department disagrees with the comment that suggests current costs are not accounted for in the rates.

COMMENT #4: We believe the rule should be changed to reflect a minimum wage increase "pass through" in the event the federal government increases the minimum wage during FY97. This is looking more and more likely and is a contingency we should be prepared for. "Savings" from the private pay limit and other

reserved contingency funds could be used to fund this contingency.

RESPONSE: The department will undertake a survey of all facilities to determine the impact of any changes that would be made in the minimum wage during the next fiscal year and the estimated impact that will result based on the proposed increases. In reviewing the licensed to non-licensed ratio spreadsheet the impact of increases in the minimum wage do not appear to be significant in the nursing area, as they were the last time that the minimum wage was increased, and a pass through reimbursement system was developed. The areas that most likely will be impacted will be the non-direct care areas such as dietary and housekeeping. The impact of any increases in minimum wage will be considered based on the survey information that the department receives and any resulting increases will be considered based on this analysis.

COMMENT #5: We continue to be concerned about the way the nursing wage is calculated and the relationship between the patient assessment score and actual staffing. The department has previously agreed to further analyze and study this issue but has not done so. The department is also discussing moving away from the use of the patient assessment abstract in reimbursement in favor of the MDS, which we do support.

RESPONSE: The department believes that the use of the PAS, which is a measurement of the relative acuity and care needs of residents served by facilities is a reasonable approach to determining efficient and economical nursing costs. Moreover, we believe that the mix of information used in the current calculation will tend to encourage providers to staff carefully based upon resident needs rather than reimbursement impacts, because understaffing or overstaffing will have a balanced rate result under the methodology. The department does agree that this approach does not in every case provide a precise indication of staffing needs during the corresponding period, and that further consideration is warranted to determine whether an approach could be developed that would achieve better results. The department will consider the changes in the case mix adjustment factor in conjunction with computerization of the minimum data set and its use as an assessment tool during the upcoming fiscal year. The department has asked for funding in the next biennium to contract with a consultant to develop a case mix adjustment system from the MDS data. The computerization requirement and the transmission of MDS information will assist the department in converting to a new acuity measure for reimbursement which will use MDS information and eliminate duplication of requirements for providers that exist under the present system. The development and implementation of such a system may also provide additional

options to address the concerns that have been raised regarding the nursing wage computation.

COMMENT #6: There has been discussion and agreement by the department for a number of years with respect to develop a system for reimbursement of property that more accurately reflects the value of the use of the property. We continue to urge the department to work with providers to develop such a system.

RESPONSE: For fiscal year 1997 the department has proposed to increase the property cap to $11.50 or up to a $1.86 increase over fiscal year 1996 reimbursement rates. Providers will remain at their 1996 rate if that rate already exceeded their costs, or otherwise would receive the lower of an increase up to their cost per day or an increase of $1.86, subject to the $11.50 cap.

The department made a commitment to form working groups to work toward property system changes. The department has not committed to a fair rental value system or any specific property methodology for the future. The department will continue to look at the property reimbursement system and to work with providers in developing a new system of property reimbursement.

There continue to be providers that have completed remodeling and new construction projects within the current reimbursement limits and qualify for rate adjustments under these rule provisions. It still is unclear to the department based on this continued building and expansion why providers believe that there is no incentive to renovate and add beds when there continue to be providers that in fact are doing exactly this very thing.

COMMENT #7: The department, at proposed ARM 46.12.1223(1)(g), directs a nursing facility to return any remaining personal funds of a deceased resident who received medicaid benefits at any time to the department's third party liability unit. Does the rule apply to a resident who received any benefits at any time, or received nursing facility benefits at any time? Certainly, some residents may have received medical assistance at some point in their lives, and not be medicaid eligible at the time of their death. A nursing facility would not know of the past medicaid eligibility or assistance, and therefore could not comply with the rules.

This commentor also questions if the rule applies to those persons eligible for care, or for those persons who actually have received services paid for by medicaid. Finally, we question whether this policy would apply to any medicaid eligible person, or only to those persons where Montana medicaid benefits are at question.

The commentor recommends the department clarify these issues in the response to the comments, and, if necessary, modify the rule language as needed. At a minimum, the department should clarify the rule that applies to situations where the facility has the information necessary for compliance. Further, facilities who return personal funds to a resident's estate or heirs, but whose funds should have been returned to the state should not become responsible to pay those dollars on behalf of the resident. The state should state in the rule that they will recover from the responsible party who actually holds the funds in question.

RESPONSE: Montana law at 53-6-168, MCA requires that under certain circumstances nursing facilities must pay the funds of deceased residents to the department. If a nursing facility or a person, other than a financial institution, is holding personal funds of a deceased nursing facility resident who received Medicaid benefits at any time shall, within 30 days following the resident's death, pay those funds to the department's third party liability unit. Funds paid to the department under this statute are not considered to be property of the deceased resident's estate, and do not apply to recovery of the funds by the department. The department's intent in adding the proposed subsection was merely to include a reference to this new section of law in the list of facility responsibilities contained in ARM 46.12.1223. The department's intent is not to adopt detailed rules to interpret the statute at this time.

We believe that the statute speaks for itself in addressing the questions raised in the comment. The statute applies to a nursing facility resident that received medicaid benefits at any time. The statute does not restrict the type of medicaid benefits received to nursing facility benefits only, but applies to any medicaid benefits received at any time. The statute would not apply, however, if the recipient had been medicaid eligible but no medicaid benefits had been paid or claimed on the recipient's behalf. The statute creates an enforceable legal obligation on facilities, and failure to comply could result in liability to the facility. Therefore, facilities should exercise care before disposing of personal funds after a resident's death.

In most instances a resident who has been medicaid eligible in the community will continue to be eligible in the nursing facility. In many communities the facility does know if the recipient is or has been medicaid eligible. However, if there is any doubt or a provider wants to know whether or not the individual received medicaid benefits, they can call the department's third party liability unit and obtain this information prior to disposing of any resident funds on deposit with the facility.

COMMENT #8: Commentors again object to the department's policy to utilize the private pay rate in place on July 1, 1996 to limit medicaid payments for the entire state fiscal year. Providers are, in some cases, forced to raise private pay rates sooner than needed to avoid the medicaid limit. Providers with fiscal year ends in December, March and April are especially impacted by this policy. Budgeting for those providers' upcoming fiscal years has not yet begun. Providers don't know what medicare payment policies will look like, and how changes in input costs, like minimum wages, might affect them down the road. The department's stand on this issue creates a perverse incentive to raise rates paid by private paying patients. We recommend that the department amend this policy to accommodate rate changes by providers with other than June 30 year ends, and who change their rates during the state fiscal year.

RESPONSE: The department has responded to this comment in prior years. The department was directed to implement the private pay limit as part of a legislative cost containment provision that is included in House Bill 2, the general appropriations bill, during the 1993 legislative session. The legislative language limits a facility's medicaid rate to no more than the facility's private pay rate. The department will survey nursing facilities to determine the private pay rate effective July 1, 1996. If the private pay rate is less than the July 1, medicaid rate computed under the reimbursement formula, then the facility's medicaid reimbursement is limited to the facility private pay rate for the entire year. The private pay limit will be based upon the private pay rate effective July 1 and rates will not be adjusted upward for private pay rate increases occurring during the year. To monitor private pay rates and to continually adjust rates would be costly and is not administratively feasible. Each facility needs to evaluate the cost of providing nursing facility care and compare this to the private pay charges in order to determine if the private pay rate is reflective of the cost of providing care for the year beginning July 1. Based on this analysis, some private pay rates may need to be raised, not because of the limit on the medicaid rate but because the cost of providing this care is greater than what is being charged to the private paying resident for this care. This continues to be the policy that the department adopted in the fiscal year 1994 rules and is not a new interpretation in how the department has applied the private pay limit. There will be no adjustments to the computed medicaid rate established on July 1 if the facilities who are limited increase their private pay rates during the year.

COMMENT #9: One commentor suggests the department rethink the policies which limit the time a resident may spend away from the facility for therapeutic home visits. The policy adopted by the department conflicts with the spirit of OBRA reforms which mandate the facility consider the patient's room as their home,

and to provide treatment and services to the greatest benefit of the resident. The 72 consecutive hour limit policy appears to make work for government officials, rather than serve any purpose to promote well being for the resident. The department already has a maximum number of days for which a bed can be paid for, protecting its fiscal interest. Perhaps doling out time away for each resident might be a bit overbearing. The policy is arguably out of step of the department's own mission to improve one's health status.

RESPONSE: This proposed rule does not change existing department policy or practice but clarifies that a provider must call in to the department to obtain an extension on a therapeutic home visit if something unforseen occurs and a resident is out of the facility longer than expected. Obtaining prior approval guarantees that it is medically appropriate for a resident to be absent from the facility for that duration, because such absences must be physician approved. This provision does not deter the resident from leaving the facility at any time but will allow for monitoring of days up to the twenty-four that are reimbursable by the medicaid program during the fiscal year. Days utilized under the 72 hour limit do not require prior approval but do require submission of a form to the department to track day utilization. The department disagrees this is a labor intensive process. The department believes that the controls imposed are reasonable, especially considering that the medicaid program will be paying the full rate for these days, even though the resident is physically absent from the facility.

COMMENT #10: One commentor felt that 10 days is not an adequate amount of time to prepare testimony in person on proposed changes from the date of receipt of the proposed information to the date of the public hearing. This time period is insufficient to allow analysis of the data. For all practical purposes the period is so short that it appears the department is not interested or concerned about meaningful provider input.

RESPONSE: The department mailed two draft spreadsheets on May 8th to all nursing facilities. One spreadsheet contained rates as proposed in the first rule notice and one increased the property and incentive limits. The public hearing for the first notice of the proposed ARM rules for FY 1997 was scheduled for May 23th with written comments accepted through May 29th. This allows approximately three weeks for a nursing facility to respond to the draft spreadsheets and the proposed rules for FY 1997. The department believes that all providers have been given adequate notice of changes being proposed and have been given opportunity to comment on these changes. In addition, the department discussed the proposed changes with association representatives at an earlier date and has carefully considered

the comments received from providers and associations as a result of this rule process.

COMMENT #11: We have a continuing requirement under ARM 46.12.1223(1)(g)(3) that a provider provide the department with thirty days notice of termination of participation in the program. On the other hand, I do not know what my medicaid rate will be for the period beginning July 1, which is a little over 33 days from now. I cannot analyze the fiscal position of the nursing home and its position in the medicaid program because I do not have rates for the period beginning July 1. In other words, I am forced to accept the rate computed by the department for a minimum of one month even if I was to find the rate unacceptable and decide to withdraw from the program because of that rate. I feel that the department should set the current period fiscal rate at least 60 days in advance so that facilities have an opportunity to analyze the impact of that rate on current operations.

RESPONSE: The department agrees that the new rates should be determined as far in advance of the rate year as reasonably possible. However, the department believes that it is in fact completing the rate setting process as early as possible in light of the dates when the necessary cost and other rate setting information is available. As stated in a previous response, the department believes that providers have had adequate time to review the draft spreadsheets and have a reasonable idea what their facility's rate will be beginning July 1. The department has consistently followed this time line in establishing reimbursement rules and rates. Rate setting coincides with the July 1 date where new appropriation levels, established by the legislature, are available for provider rate increases. If the provider truly wishes to terminate participation in the medicaid program based upon the specific rate set under this process, the department will make every effort to accommodate a quicker withdrawal from the program, bearing in mind that the orderly transfer of residents to appropriate placements is the primary concern.

COMMENT #12: The logic behind using assessments of patient and costs incurred in calendar year 1994 to determine reimbursement for services North Valley Health Care Center is going to provide over a year from now in 1997 totally escapes me. One-third of the PAS in the base period include a time period that is not covered by the base period cost report. The fiscal year end of the nursing home is November 30th and the base period PAS includes scores from October and November. At the very least these scores should be in the base period. I do not think it is necessary for the department to use a sample selection of PAS to determine the base score when in fact they have access to a full fiscal years scores for each provider. These twelve months'

scores could be used to compute an average PAS for the nursing facility.

The use of PAS is more in line with larger metropolitan area hospitals that use nurse registry with their inherent inflated wage cost. Nurses are brought in and assigned to areas as the need arises. This may be adequate for short term stays associated with hospitals but is completely contrary to the philosophy of the long term care industry whose goal is to provide a continuity of care. The nursing facility is the home of the residents and a shifting staff is very disruptive to them.

A change in PAS does not cause a change in staff because in a rural area, trained licensed and non-licensed staff is not hired or discharged based on PAS. They are an asset of the nursing facility and cannot easily be replaced. These costs which are treated as a totally variable cost in the rate formula are essentially fixed costs for most facilities therefore PAS should not be included in the rate calculation.

RESPONSE: Currently the PAS is a part of the rate calculation as provided in the Administrative Rules of Montana for medicaid nursing facilities. The department believes that the use of the PAS, which is a measurement of the relative acuity and care needs of residents served by facilities is a reasonable approach to determining efficient and economical nursing costs. Moreover, we believe that the mix of information used in the current calculation will tend to encourage providers to staff carefully based upon resident needs rather than reimbursement impacts, because understaffing or overstaffing will have a balanced rate result under the methodology. The department does agree that this approach does not in every case provide a precise indication of staffing needs during the corresponding period, and that further consideration is warranted to determine whether an approach could be developed that would achieve better results. The department will consider the changes in the case mix adjustment factor in conjunction with computerization of the minimum data set and its use as an assessment tool in the 1998 fiscal year. The computerization requirement will assist the department in converting to a new acuity measure for reimbursement which will use MDS information and eliminate duplication of requirements for providers that exist under the present system. The development and implementation of such a system may also provide additional options to address the concerns that have been raised regarding the nursing wage computation.

The department at the request of providers specified, in the fiscal year 1995 rules, the 6 month period that will be used to compute the patient assessment average for all providers. This 6 month average is taken from the period October through March

preceding the rate period. This allows the department to use the most current patient assessment information available in the calculation of the direct nursing component. The use of any other time period is not under consideration by the department. The most current information available at the time that reimbursement is established is used in this computation. Variations occur from month to month, but when averaged over the six month period this is reflective of the care being provided in facilities. The nursing hourly wage is calculated by taking base period nursing costs and dividing by the product of occupied days during the cost reporting period and the PAS that most closely corresponds to the base period. The resulting cost per hour is then inflated to the midpoint of the rate period and is compared to the median upper limit. The current PAS average is then applied to the cost per hour to compute the total direct nursing component. Under this computation, the base period components that most closely correspond to each other are used to calculate the nursing hourly wage, that wage is inflated forward and then multiplied by the current PAS. The department believes that this methodology projects nursing costs with reasonable accuracy and results in reasonable and adequate reimbursement. The department will continue to use this computation for the nursing component in fiscal year 1997 rate setting.

COMMENT #13: The department should use the most current information at its disposal. Inflation factors do not take into account internal changes in the operations of a specific nursing home. Nursing homes with high costs in the base period will have those costs inflated and continue to receive a high rate. The inflation factor inflates old cost. It does not reflect current cost of operating a nursing home. The economic climate in Montana is very volatile. Licensed and non-licensed nursing wages have increase substantially and nursing homes have had to meet these requirements to remain competitive in the labor market place. I do not feel that the incentive factor can replace the information presented in the 1995 cost reports.

RESPONSE: The rate system was rebased in fiscal year 1996 to use 1994 cost report information. The department does not believe that annual rebasing is necessary to reasonably and adequately reimburse nursing facilities. The DRI-SNF inflationary component has proven to be an accurate index of aggregate cost increases in Montana. The DRI index is applied to all of the facilities' operating and direct nursing costs. The adequacy of the DRI index must be measured by comparing it to the total cost increases in all cost areas. The adequacy of the index cannot be measured by comparing the DRI percentage with the rates of increase for individual cost items in individual facilities. Not every specific cost increase will be projected in the inflationary adjustment, but the department believes that in the aggregate all necessary cost increases are met or

exceeded by application of the DRI index. Moreover, the fact that any particular facility actually incurs costs at a certain rate of increase does not mean that all of such costs need be incurred by an economically and efficiently operated facility or that the costs must be reimbursed. The system is not a cost based system and is not intended to reimburse all of the costs incurred at each facility. Because the department believes that the use of the 1994 cost base and the DRI index adequately recognizes all necessary cost increases, the department disagrees with the comment that suggests current costs are not accounted for in the rates.

COMMENT #14: One commentor wonders if the current rate formula meets the intent of the legislature. An analysis of the current year rates for the two nursing homes in Whitefish, North Valley Hospital and Colonial Manor, will illustrate my point. These nursing homes operating within a few miles of each other draw employees from the same labor pool and operate in the same economy. To the best of my knowledge both of these nursing homes have been able to maintain their state license. The property rate of each facility is similar. There the similarities end. The indexed operating cost per diem with fee of the combined facility, North Valley Hospital, of $55.20 is approximately $20.00 per patient day higher than Colonial Manor, a free standing facility, of $32.80. The calculated direct nursing care wage at North Valley Hospital is $57.54 while Colonial Manor's is $31.49, a difference of approximately $26.00. Under the proposed rates, the operating cost of North Valley Hospital was limited to $42.06 while the nursing cost was limited to $48.07. The proposed medicaid rate is $96.79 while Colonial Manor, which received a $2.78 operating incentive, is $73.26, a difference of $23.53 per patient day. In looking at these differences a person has to wonder what type of allocation of cost is happening between the hospital portion of the operation and the nursing facility portion. In the case of the Northern Montana Long Term Care facility located in Havre they are reporting an operating cost of over $74.00 per patient day. This would seem almost inconceivable when the median for the state is only $39.68. What method of cost allocation is happening to result in these gigantic differences. Somehow what is called operating cost in Havre must not bear any resemblance to what the rest of the state calls operating cost.

The conclusion that must be reached from the above rate difference is that the combined hospital-nursing home is receiving a (based on average patient medicaid days) subsidy of about $350,000 per year. To my knowledge there has never been anything in the legislative history to indicate that they intended funds from the medicaid budget to be directed this way. It may be in the public interest to fund communities that need a small combined facility. However, if the legislature deems it in the public benefit to provide funding for them it would

appear they would do it directly rather than have the funds distributed through the medicaid long term care appropriation.

RESPONSE: North Valley Hospital and Northern Montana Long Term Care were capped at $42.06 for their operating rate component ($39.68 median x 106%). North Valley Hospital had more nursing costs than Colonial Manor which in the rate calculation resulted in the higher rate of $96.79 for North Valley Hospital. In accordance with ARM 46.12.1221(4), the purpose of the department's rules relating to medicaid reimbursement of nursing facility services is to provide, as required by federal law, for payment for nursing facility services through rates which are reasonable and adequate to meet the costs, including the costs of services required to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each medicaid recipient, which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

The department continues to further the basic goals of the reimbursement methodology to maximize reimbursement of nursing services and nursing costs while providing an incentive to operate efficiently and contain costs. All of the reimbursement factors must be considered as a whole to determine the adequacy of reimbursement levels and not isolate to one component of reimbursement. The department continues to believe that this methodology projects cost with reasonable accuracy and results in reasonable and adequate reimbursement levels.

We also believe that the current system appropriately recognizes a degree of differences in the operating environments faced by different providers and provider types within the state, rather than in effect mandating a one-size-fits-all approach to providing services. We believe that this system is a vast improvement over the previous system. That system set rates primarily on an averaging of costs and allowed low cost facilities to benefit from the higher cost of other facilities, by paying a rate much higher than their own costs without holding them accountable to spend the difference on improving patient care. We recognize that there are some providers that reaped large profits from the old system and that continue to complain in effect that the high profit opportunities of the old system do not remain available. The department believes that the quality of patient care is a more important goal than profitability, especially under a publicly funded welfare program, and the system has been adjusted to reflect that priority. We do believe, however, that the current system provides a fair opportunity for all providers to receive a reasonable return for their efforts.

5. The rule amendments will apply to nursing facility services provided on or after July 1, 1996.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

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

In the matter of the amendment of rule 46.14.401 pertaining to the low income weatherization program	))))	NOTICE OF THE AMENDMENT OF A RULE

TO: All Interested Persons

1. On March 21, 1996, the Department of Public Health and Human Services published notice of the proposed amendment of rule 46.14.401 pertaining to the low income weatherization program at page 731 of the 1996 Montana Administrative Register, issue number 6.

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

46.14.401 ~~PRIORITIZATION~~ ELIGIBILITY FOR SERVICE, PRIORITIES (1) Dwellings which have been weatherized after September 30, 1985, with U.S. department of energy funds or with LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP) WEATHERIATION OR MONTANA POWER COMPANY FREE WEATHERIZATION funds ~~from sources other than the U.S. department of energy~~ after January 1, ~~1996~~ 1995 are not eligible for weatherization services.

(2)(a) through (6) remain as proposed.

3. No written comments or testimony were received.

4. The Department has noted that one of the dates in ARM 46.14.401(1) as proposed to be amended is incorrect. The rule should state that dwellings which have been weatherized with funds from sources other than the U.S. Department of Energy after January 1, 1995, rather than January 1, 1996, are ineligible for weatherization services. Subsection (1) is being changed to state the correct date.

Additionally, the Department has noted that the phrase "with funds from sources other than the U.S. department of energy after January 1, 1995" is too broad. The Department does not intend to make dwellings weatherized after January 1, 1995 with funds from any source other than Department of Energy ineligible for weatherization services. The intent is to make only dwellings weatherized with Low Income Energy Assistance Program (LIEAP) or Montana Power Company weatherization funds after that date ineligible. The language of subsection (1) is therefore being changed accordingly.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

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

In the matter of the amendment of rules 46.30.507, 46.30.701 and 46.30.1605 pertaining to child support enforcement distribution of collections and non-AFDC services	))))))	NOTICE OF AMENDMENT OF RULES

TO: All Interested Persons

1. On December 21, 1995, the Department of Public Health and Human Services published notice of the proposed amendment of rules 46.30.507, 46.30.701 and 46.30.1605 pertaining to child support enforcement distribution of collections and non-AFDC services at page 2765 of the 1995 Montana Administrative Register, issue number 24.

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

46.30.507 DISTRIBUTION OF COLLECTIONS (1) Except as provided in (2), AND (6), ~~(7) and (8),~~ ~~when the CSED is enforcing a support order,~~ collections OF SUPPORT from all sources including but not limited to the proceeds from writs of execution, support liens and lump sum settlements will be distributed, to the extent the collection is sufficient, in the following sequence:

(1)(a) remains as proposed.

~~(b) to satisfy accounts receivable owed by the obligor for recoupment of excess refunds, returns, reimbursements and other payments previously made to the obligee by the CSED because of error or mistake of fact;~~

(c) to satisfy fees awarded under 40-5-210, MCA which are owed by the obligor; and

(b) ~~(d)~~ to satisfy any arrears owing to the state of Montana by reason of 40-5-202, 40-5-221 and 53-2-613, MCA. If there are no arrears owing to the state of Montana or if the collection exceeds the arrears owed to the state, to satisfy arrears owed to the obligee; ~~and~~

~~(e)~~(d) to satisfy fines awarded under 40-5-208 or 40-5-226, MCA which are owed by the obligor.

(2) When the CSED is collecting support arrears only, amounts shall be distributed to open CSED cases according to (1)(b) through (1)~~(e)~~(d).

(3) After a distribution of SUPPORT collections to the obligee is determined appropriate but before actual distribution is made, the CSED may:

(3)(a) and (3)(b) remain as proposed.

(4) When the CSED is providing services to two or more obligees of the same obligor:

(4)(a) remains as proposed.

(b) a collection of SUPPORT arrears owed under (1)~~(d)~~ (b) shall be distributed equally among the obligor's cases, provided however, that the amount distributed shall not exceed the arrears owed; and

(4)(c) remains as proposed.

(5) Notwithstanding the provisions of (4) above:

(a) if a particular SUPPORT collection is made through an order to withhold income, any amount distributed from that collection must be distributed only to the obligor's cases that currently have an order to withhold income in place;

(b) a SUPPORT payment by personal check, money order or like form of payment which is made payable only to a particular obligee, will be distributed only to that obligee's case;

(c) a SUPPORT collection resulting from a writ of execution or similar case-specific remedy must be distributed to the specific obligee's case;

(d) a SUPPORT payment received by an obligee directly from the obligor and turned over to the CSED for distribution under this section will not be distributed to any other obligee's case; and

(e) SUPPORT collections made through a clerk of court or other public or private child support enforcement authority, who forwards the collection to the CSED, shall be distributed only to the obligor's case designated by the clerk of court or other authority. If the forwarded collection fails to include a designated specific case, the distribution provisions of (4) will apply.

~~(6) A payment made by personal check, cashier's check or teller's check which is directed or restricted by a writing on the check to the payment of a particular debt, account or fund, will be distributed only to that particular debt, account or fund.~~

~~(7) A payment made in consideration of an agreement with the CSED, including an agreement to prepay costs and fees, will only be distributed according to the terms of the agreement.~~

~~(8)~~ (6) SUPPORT ~~c~~collections resulting from federal and state tax offsets will be distributed only to THOSE arrears CERTIFIED TO THE TAX AUTHORITIES AS PAST DUE, AND TO THE EXTENT APPLICABLE as provided under (1)~~(d)~~ (b) and, if appropriate, (4)(b).

~~(9)~~ (7) Except as provided in ~~(11)~~ (9) below, the CSED shall not distribute collections or any part of collections towards future support, even though the obligor may so direct, until all appropriate distributions under (1) and, if appropriate, (4) are made first.

~~(10)~~ (8) In the absence of a support order, voluntary payments OF SUPPORT made by an obligor shall be distributed ~~to the extent the payment is sufficient, in the following sequence~~ AS FOLLOWS:

(a) WHENEVER THERE IS A WRITTEN OR ORAL AGREEMENT AND THE AGREEMENT SPECIFIES A SUPPORT AMOUNT AND THE FREQUENCY OF

PAYMENT. PAYMENTS SHALL BE DISTRIBUTED AS PROVIDED IN (1); OR ~~to satisfy any fees owed by the obligor under 40-5-210, MCA;~~

(b) IF THERE IS NO AGREEMENT, THE TOTAL AMOUNT RECEIVED IN A GIVEN MONTH WILL BE COUNTED AS THAT MONTH'S CURRENT SUPPORT OBLIGATION. ~~to reimburse public assistance payments made to the obligee; and~~

~~(c) the excess amount, if any, shall be distributed equally among all of the obligees of the same obligor.~~

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

(a) For collections made under an order to withhold income, the date of collection is the day the payor withholds the collection from the obligor's income. If the collection is paid by check, the date of collection is the date specifically reported by the payor in documentation accompanying the payment. ~~If no date of collection is specifically reported, the date of collection is presumed to be the date shown on the check. This presumption may be overcome by credible evidence that the collection was withheld on another date. If credible evidence is received that a collection under an order to withhold is based on an advance payment to the obligor, the date of collection is presumed to occur in the future pay period represented by the advance.~~

(b) Except as provided in ~~(11)~~ (9)(c), when a collection is received in the mail directly from the obligor, the date of collection is the postmark date. If the postmark is illegible or missing, the postmark date is presumed to be 3 days prior to receipt, if posted in the state of Montana, and 5 days prior to receipt if posted outside the state.

(11)(c) and (11)(d) remain the same in text but are renumbered (9)(c) and (9)(d).

~~(12)~~ (10) Under this rule, collections characteristic of past due support, may be distributed THE SAME as collections identified as current support. However, for purposes other than distribution, these collections will be accounted for as past due support.

~~(13)~~ (11) For the purposes of determining statutes of limitations, arrears, interest on arrears, collection remedies and similar uses, all SUPPORT collections, without regard to date of distribution, will be applied to satisfy the oldest unpaid installment of support due under the support order.

AUTH: Sec. ~~17-4-105,~~ 40-5-202 ~~and 40-5-405~~, MCA
IMP: Sec. 17-4-105, ~~40-5-201 through 40-5-264 and 40-5-401 through 40-5-434~~ and 40-5-202, MCA

46.30.701 TERMS AND CONDITIONS (1) through (3)(i) remain as proposed.

(4) THE CSED MAY COLLECT ANY FEES INCURRED AND OWING BY A CUSTOMER UNDER 40-5-210, MCA, BY OFFSETTING THE FEES AGAINST ANY FUNDS WHICH MAY BE DISTRIBUTABLE TO THE CUSTOMER. HOWEVER, IF THE AMOUNT BEING DISTRIBUTED IS A CURRENT SUPPORT PAYMENT, THE OFFSET WILL NOT EXCEED 10% OF THE PAYMENT.

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

~~(3)~~ ~~(5)~~ (7) Except as provided in ~~subsection (6)~~ ~~(7)~~ (9)of this rule, a customer cannot specify which of the CSED services that customer may want to receive. ~~the~~ The CSED will determine which services are appropriate and the ~~type,~~ timing and ~~extent~~ duration of those services in accordance with Title IV-D of the Social Security Act, and the regulations promulgated thereunder.

(6) Because support orders are often expressed in terms other than in monthly payments and because they often provide for varying and inconsistent payment due dates, to simplify monitoring of payments and payment accounting, the CSED may elect to annualize the obligations. When the obligation is annualized, the total support payments due for a 1 year period are divided into 12 equal monthly installments.

(6) through (9)(e) remain the same in text but are renumbered (8) through (11)(e).

~~(10)~~ (12) The CSED will notify the customer in writing 60 calendar days prior to termination of services under (11) ~~(8)~~(b) through (e) of this rule, of the CSED's intent to terminate services. The CSED will not terminate services if the customer, within the notice period, reestablishes contact with the CSED, supplies the requested information, documents or materials or begins to cooperate with the CSED, whichever is appropriate. The CSED's decision to terminate services is final and not subject to protest except as may otherwise be provided by law.

(10)(a) remains the same in text but is renumbered (12)(a). (11) remains the same in text but is renumbered (13).

AUTH: Sec. 40-5-202, MCA
IMP: Sec. 40-5-203 and 40-5-210, MCA

46.30.1605 *FEE SCHEDULE* (1) through (5) remain as proposed.

(6) Other fees assessed to the party or entity requesting the service are:

(a) for parent locate services, a fee of $11.00;

(b) for each intercept of federal and state income tax refunds AND STATE DEBT OFFSETS in non public assistance cases, a standardized fee of $25.00 or actual costs if less than the standardized fee; and

(c) for photocopies of CSED files, records and other materials, for each page, a fee of $.25.

(7) In no case may a fee authorized under this rule be charged to or collected from a person while that person is a recipient of AFDC unless federal regulations pertaining to operation of the IV-D program allow the charging or collection of that fee.

AUTH: Sec. 40-5-202 and 40-5-210, MCA
IMP: Sec. 40-5-210, MCA

3. The Department has thoroughly considered all commentary received:

Rule 46.30.507 DISTRIBUTION OF COLLECTIONS

COMMENT #1: One commentor did not think the rule sufficiently distinguished between distribution of support collections and collections of other monies. For example, penalties may be assessed against employers who fail to honor income withholding orders. Sanctions may be imposed against a party for failure to cooperate with discovery orders. These and other non-support debts are collected and distributed by the same staff who distribute support collections. Therefore, to one who is not aware of CSED procedures, the rule appears to apply these other collections to support, or conversely, to permit support to be distributed to one of these other accounts. The latter situation would be contrary to the federal regulations which apply to Title IV-D programs.

RESPONSE: The CSED agrees with the comments. To show that the rule is intended to apply only to distribution of support collections, several of the subsections are amended to include the word "support". (1)(b) did apply to non-support collections, consequently, that subsection is removed from the proposed rule. Likewise, (7) is removed from the proposed rule because it does not pertain to collections of support. With the removal of (7), subsequent subsections are renumbered accordingly.

Comment #2: One commentor expressed problems with subsection (1)(c). The first mentioned problem is that this subsection appears to apply to both AFDC cases and non-AFDC cases. In AFDC cases, federal regulations do not permit distribution of support collections to fees before distribution to arrears. The subsequent subsection (1)(d) provides for distribution to arrears. The second problem is that even if the subsection applied only to non- AFDC cases, it would not be practical or equitable to create distinctions between the two types of cases.

Response: The CSED agrees that it is not clear that (1)(c) was intended to apply only to non-AFDC cases. The CSED also agrees with the commentor that it would not be practical or equitable to create distinctions between AFDC and non-AFDC cases. Therefore, rather than clarify (1)(c) to show it was intended to only apply to non-AFDC cases and not to AFDC cases, the CSED decided it is the better policy to apply the rule equally to all cases. Because federal regulations do not allow collection to be distributed to fees before arrears, (1)(d) is renumbered to (1)(b) so that distribution to arrears comes before distribution to fees.

COMMENT #3: One comment was made that the provisions of (6) are covered by other law and therefore are redundant and, as such, need not be included in the rule.

RESPONSE: The CSED agrees with the commentor. The law applicable to checks and the endorsement of checks is well established in the Montana codes. Consequently, there is no need to restate those laws in this subsection. (6) is removed from the proposed rule and subsequent subsections are renumbered accordingly.

COMMENT #4: One commentor suggested that new language be added to the now renumbered (6) -- previously subsection (8) -- to make the rule more consistent with federal regulations pertaining to federal intercepts of obligor tax returns.

RESPONSE: The CSED drafted the proposed subsection broadly to allow for the differences between the federal and state tax return intercept programs. However, after considering the comment, the CSED believes the subsection to be drafted too broadly. Therefore, additional language is added to more closely align the subsection with federal regulations.

Comment #5: One commentor claimed the now renumbered (8) -- previously (10) -- was inconsistent with federal policy interpretation as set out in PIQ-81-09.

Response: Federal policy interpretations are just that, interpretations as to what the drafter believes a particular federal regulation means. There is room for other interpretation of the same regulations. Consequently, it cannot be said that the proposed subsection is contrary to federal regulations. However, to avoid possible conflict, the CSED agrees to amend (8) to conform with PIQ-81-09.

COMMENT #6: One commentor pointed out that some words appear to have been inadvertently left out of the now renumbered subsection (10) -- previously (12). The first sentence reads: "Under this rule, collections characteristic of past due support, may be distributed as collections identified as current support." The commentor suggested that the words "the same" should be inserted into the sentence immediately preceding the words "as collections identified".

RESPONSE: The CSED agrees with the commentor and the words " the same" are now included in the sentence as suggested.

COMMENT #7: The statutes cited by the department for amending ARM 46.12.507 are too broad and should be changed to reflect the correct rule authorizing and implementation sections.

RESPONSE: The department agrees with the suggestion to review and modify the statutory references. Authority for the department to adopt this rule is 40-5-202, MCA. The rule implements 17-4-105 and 40-5-202, MCA. All other cites are therefore being removed from the rule history.

Rule 46.30.701 TERMS AND CONDITIONS

COMMENT #1: (4) sets a cap of 10% on the amount which can be withheld from funds distributions of support to satisfy recoupment accounts. One commentor suggested the rule might also want to consider a similar cap on withholdings to satisfy fee accounts.

RESPONSE: The CSED found the comment to have merit. A new (4) is added to the rule providing a cap of 10% on withholdings to satisfy fees. Subsequent subsections are renumbered accordingly.

COMMENT #2: One comment was received which requested the addition of a new subsection informing customers of the CSED's policy for reconciling support orders which provide for other than monthly payments of support or which have varying and inconsistent payment due dates.

RESPONSE: The CSED considered this request to be a reasonable method for informing customers of CSED policy. A new (6) is added to the rule stating the CSED's policy for annualizing support orders which are not uniform in payment intervals or payment due dates. Subsequent subsections are renumbered accordingly.

COMMENT #3: One commentor expressed agreement with the provisions requiring cooperation by the customer and with the provision reserving to the CSED the right to determine how to handle the case. The same commentor also expressed special agreement with the provision allowing up to 10% to be withheld to pay back overpayments. The commentor stated she had considerable problems in the past trying to recover overpayments and this rule should make it much easier.

RESPONSE: The department agrees and thanks the commentor for her statement.

Rule 46.30.1605 FEE SCHEDULE

COMMENT #1: While the commentor understood that the CSED is precluded by federal regulations from charging certain fees in AFDC cases, the commentor suggested clarification of this issue be added to the rule.

RESPONSE: The rule itself does not expressly state the fees will not be charged in AFDC cases. CSED policy in those cases is to not request assessment of fees. However, to avoid any possible misunderstanding, the CSED agrees with the commentor that clarification should be added to the rule. A new subsection (7) is added to the end of the rule.

COMMENT #2: One comment was received with regard to (6)(b). The state agency which administers the state tax refund intercept program also administers the state debt offset program. Under this program, monies owed to a person by any other state agency is intercepted and used to offset accounts owing by that person to the CSED. The fees charged to the CSED for this service are the same fees charged for tax refund intercepts. Therefore, the commentor suggested that the debt offset fees be included in (6)(b) with the refund intercept fee.

RESPONSE: One of the purposes of this rule is to allow the CSED to recoup fees paid by it for services provided by other agencies. Recoupment is accomplished by charging the fee back to the person receiving the tax return or offset funds. In short, this fee should have been in the original proposed rule and its omission was inadvertent. Consequently, (6)(b) is amended to include the debt offset fees.

COMMENT #3: One commentor suggested that fees for review and modification of support orders should only be charged if a party objects to the findings of the review.

RESPONSE: The rule already accomplishes this suggestion. Under (4), a fee is not charged when there is a determination that a review is not appropriate. Nor is a fee charged if the parties consent to a modification prior to contested case activities. A contested case begins when the parties cannot agree on the modification. Once it becomes a contested case, fees are assessed.

COMMENT #4: One commentor wondered whether the CSED is going to charge application fees to persons if they are not on public assistance.

RESPONSE: No application fees are under consideration at this time.

Dawn Sliva
Rule Reviewer

Michael G. Billings for
Director, Public Health and Human Services

Certified to the Secretary of State June 10, 1996.

VOLUME NO. 46 OPINION NO. 17

INSURANCE - Uniform health benefit plans;
STATUTORY CONSTRUCTION - In determining intent, unambiguous statutes require no reference to other statements;
STATUTORY CONSTRUCTION - In harmonizing statutes, newly-enacted specific statutes control earlier, more general provisions;
MONTANA CODE ANNOTATED - Title 33, chapter 22; sections 1-2-101, -102; 33-1-311, -501; 33-22-245, -522, -1521(2); 33-31-322;
MONTANA LAWS OF 1995 - Chapter 527.

HELD: Uniform health benefit plans, authorized by 1995 Montana Laws chapter 527, must include coverage for the services and articles specifically referred to in sections 33-22-245 and -522 and the mandated benefit provisions of title 33, chapter 22.

June 3, 1996

Mr. Mark O'Keefe
State Auditor
Mitchell Building, Room 270
P.O. Box 200301
Helena, MT 59620-0301

Dear Mr. O'Keefe:

You have requested my opinion on the following issue:

> Must uniform health benefit plans authorized by 1995 Montana Laws chapter 527 include benefits not specified in chapter 527, but mandated by other provisions of the Montana Insurance Code?

In 1995, the Montana legislature passed an act relating to health benefit plans. 1995 Mont. Laws ch. 527. The Act is titled as follows:

> AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES; AMENDING SECTIONS 33-22-101, 33-22-508, AND 33-30-1007, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE.

1995 Mont. Laws ch. 527, at 2672-73.

Your question deals with the portion of this Act relating to "uniform health benefit plans." These plans were newly created by 1995 Montana Laws chapter 527 and are codified in Mont. Code Ann. §§ 33-22-245 (regarding individuals) and 33-22-522 (regarding groups). The only other mention in the Act of a "uniform health benefit plan" is codified in Mont. Code Ann. § 33-31-322, which requires that health maintenance organizations offer a uniform health benefit plan, comparable to that set out in Mont. Code Ann. § 33-22-245(2).

Thus, the statutory provisions regarding this new type of insurance plan are not extensive. They are as follows:

33-22-245. Uniform health benefit plan - individual. (1) Each insurer or health service corporation delivering or issuing for delivery in this state a health benefit plan, as defined in 33-22-243, to an individual shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

33-22-522. Uniform health benefit plan - group. (1) Each insurer or health service corporation delivering or issuing for delivery in this state a health benefit plan, as defined in 33-22-243, to a group shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

As stated above, the only other mention of "uniform health benefit plan" is in Mont. Code Ann. § 33-31-322.

Your question is whether this new type of insurance plan is subject to the numerous provisions of title 33 which require that all insurance plans provide coverage for services such as mammography examinations, well child care, mental illness, and home health care. These provisions are referred to as "mandated benefits." As Commissioner of Insurance, you are required to review all medical insurance policies sold in this state to determine whether they include coverage of these mandated benefits. Mont. Code Ann. §§ 33-1-311 and -501. You therefore are seeking my opinion as to whether the mandated benefit provisions of title 33 apply to the new uniform health benefit plans.

Your question is resolved by reference to a number of rules of statutory construction. First, the intention of the legislature, in passing a statute, is to be discerned from the plain meaning of the words used. Mont. Code Ann. § 1-2-102; Gulbrandson v. Carey, 272 Mont. 494, 500, 901 P.2d 573, 577 (1995); Lovell v. State Comp. Mutual Ins. Fund, 260 Mont. 279, 285, 860 P.2d 95, 99 (1993); State ex rel. Roberts v. Public Serv. Comm'n, 242 Mont. 242, 246, 790 P.2d 489, 492 (1990); Thiel v. Taurus Drilling Ltd., 218 Mont. 201, 205, 710 P.2d 33, 35 (1985).

Second, when several statutory provisions are pertinent to a subject, the provisions are to be harmonized and considered together so that all are given effect. Mont. Code Ann. § 1-2-101; Matter of WJH, 226 Mont. 479, 483-84, 736 P.2d 484, 486-87 (1987); Darby Star Ltd. v. Department of Rev., 217 Mont. 376, 705 P.2d 111 (1985); McClanahan v. Smith, 186 Mont. 56, 606 P.2d 507 (1980).

It is clear that the 1995 legislature intended to create uniform health benefit plans which must contain coverage for the "services and articles" listed in Mont. Code Ann. § 33-22-1521(2). There is no ambiguity in the language of sections 33-22-245 and -522 regarding the coverages listed in section 33-22-1521(2). Where no ambiguity exists, a court need not look beyond the language of a statute to determine the legislative intent. Gulbrandson, supra; State v. Mummey, 264 Mont. 272, 277, 871 P.2d 868, 871 (1994); Lovell, supra.

Similarly, there is no ambiguity in the statutes requiring all disability insurance plans to have certain types of coverage. These statutes are generally referred to as mandated benefit provisions. See, e.g., Mont. Code Ann. §§ 33-22-111, -114, -130, -131, -132, -303, -512, -703, -1002, -301, -504, -304, and -506. They unambiguously require the inclusion of certain coverages in group and individual insurance policies. Your question concerns the relationship between this type of statute and sections 33-22-245 and -522.

The codification instruction passed as part of chapter 527 leaves no question regarding the placement of the new statutes, as it provides:

> (3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8]
>
> (4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

1995 Mont. Laws ch. 527, at 2679 (brackets in original). Thus, the legislature expressly placed the uniform health benefit plans with other insurance plans and the mandated benefit provisions spread throughout title 33, chapter 22. It did so without any language restricting application of the mandated benefits provisions.

The legislature is presumed to act with full knowledge of existing laws. Thiel v. Taurus Drilling Ltd., 1980-II, 218 Mont. 201, 207, 710 P.2d 33, 36 (1985). Harmonizing the new Act with the existing statutes leads to the conclusion that the mandated benefit provisions apply to uniform health benefit plans.

There is some overlap between the mandated benefits and the services listed in section 33-22-1521(2). See §§ 33-22-1521(2)(p) and -504, regarding coverage of newborns. Where there is such an overlap, the reference to section 33-22-1521(2) in section 33-22-255 must control. For where "a general and particular provision are inconsistent, the latter is paramount to the former." Mont. Code Ann. § 1-2-102. The statutes enacted in 1995 are clearly specific to uniform health benefit plans. Also, later statutes control earlier statutes. Wiley v. District Ct., 118 Mont. 50, 55, 164 P.2d 358, 361 (1945). Application of these rules allows harmony between the statutes so that all have effect.

It has been suggested that the legislative history of chapter 527 indicates an intention not to require application of the mandated benefit provisions to the newly-created uniform

health benefit plans. In a similar vein, statements have been provided to me by various persons involved in the passage of chapter 527 indicating their views of the intention of the drafters of the legislation. Even if I assume the intention of the drafters and persons advancing this health benefit plan was to exclude mandated benefits, the language of the legislation must provide that. The law does not allow me to consider these matters in deciding the question you pose and then to place into the statute what is not there. Only the legislature has that authority. Even if I assume the intention of the drafters and persons advancing the uniform health benefit plans was to exclude mandated benefits, the language of the legislation does not so provide. Only the legislature has the authority to add such language; I am precluded by law from such action.

The function of one construing a statute is to declare what the statute means, relying if possible on the language of the statute alone. Resort to extrinsic materials such as legislative history documents is appropriate only where an ambiguity exists in the statutory language itself. The extrinsic materials cannot be used to create an ambiguity that does not exist in the plain statutory language. In Fulton v. Farmers Union Grain Terminal Ass'n, 140 Mont. 523, 536, 374 P.2d 231, 238 (1962), the Montana Supreme Court stated that "[w]here the [statutory] language is clear and unambiguous we cannot be guided by what is asserted to have been intended." The same rule applies here. The language of chapter 527 clearly states what coverage is to be provided by uniform health benefit plans and the language of the mandated benefit provisions of title 33, chapter 22, clearly apply to all disability plans. There is no basis in the statutory language on which to imply an exception to this language which would exclude application of the mandated benefit provisions.

I find nothing to the contrary in the Supreme Court's decision in State ex rel. Griffin v. Greene, 104 Mont. 460, 469-70, 67 P.2d 995, 999-1000 (1937). In that case, the legislature passed a law creating certain regulations on movie theaters and assessing a tax. The bill as originally introduced provided that the tax was to be collected annually. During legislative consideration, an amendment was added to require collection of the tax quarterly, but the reference to annual tax collections was inadvertently left in place, so that as enacted the bill provided for both quarterly and annual tax collection. The Supreme Court resolved the uncertainty in the statutory language by holding that the original annual collection language was obviously left in the bill in "manifest error" when the quarterly collection amendment was adopted, and was therefore to the disregarded. Here, unlike in Griffin, the statute on its face contains no ambiguous or contradictory provisions, only an assertion that the adopted statute does not reflect the legislative intent. Griffin does not hold that the statute can be rewritten in this circumstance to bring it into conformance

with a legislative intent that does not appear in the statutory language.

I conclude that the newly-enacted uniform health benefit plan statutes are not ambiguous. Any such insurance plan must include coverage for the services and articles enumerated in Mont. Code Ann. § 33-22-1521(2). The plans are not exempt from the provisions of title 33, chapter 22, which require additional benefits; where they overlap, sections 33-22-245 and -522 must control, as they are more specific to the uniform health benefit plans and more recent.

THEREFORE, IT IS MY OPINION:

> Uniform health benefit plans, authorized by 1995 Montana Laws chapter 527, must include coverage for the services and articles specifically referred to in sections 33-22-245 and -522 and the mandated benefit provisions of title 33, chapter 22.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/bch/brf

VOLUME NO. 46 OPINION NO. 18

CITIES AND TOWNS - Financial responsibility for costs of precommitment custody of persons who are seriously mentally ill;
COUNTIES - Financial responsibility for costs of precommitment custody of persons who are seriously mentally ill;
HOSPITALS - Financial responsibility for costs of precommitment custody of persons who are seriously mentally ill;
MENTAL HEALTH - Financial responsibility for costs of precommitment custody of persons who are seriously mentally ill;
PUBLIC HEALTH AND HUMAN SERVICES, DEPARTMENT OF - Financial responsibility for costs of precommitment custody of persons who are seriously mentally ill;
MONTANA CODE ANNOTATED - Title 53, chapter 21; sections 7-32-222(3); 53-21-102, -124, -129, -132(2), -139(2);
OPINIONS OF THE ATTORNEY GENERAL - 43 Op. Att'y Gen. No. 5 (1989).

HELD: Subject to the limitations contained in Mont. Code Ann. § 53-21-132(2), the county of residence is financially responsible for costs incurred in connection with the detention and precommitment custody of persons taken into protective custody pursuant to Mont. Code Ann. § 53-21-124 or -129.

June 5, 1996

Mr. David L. Nielsen
Helena City Attorney
316 North Park Avenue
Helena, MT 59623

Dear Mr. Nielsen:

Your predecessor requested my opinion on the following question:

> Is the City of Helena financially responsible for hospitalization and other related medical costs incurred on behalf of persons taken into protective custody in accordance with the provisions of Mont. Code Ann. §§ 53-21-101 to -198?

The letter of request states that the question of the city's possible responsibility arises in situations where the Helena police are called to a scene where someone may be extremely emotionally upset or threatening suicide, but may not have violated the law. Two assumptions underlie my response to your question. First, I assume that the "protective custody" to which you refer would include "emergency" situations in which a person is detained by a peace officer under the authority of Mont. Code Ann. § 53-21-129(1) based on probable cause to believe that the person or another person "is in imminent danger of death or serious bodily injury" as a result of the detained person's serious mental illness. See Mont. Code Ann. §§ 53-21-

102(4) (defining "emergency situation") and 53-21-102(15) (defining "seriously mentally ill"); see also In re E.P., 241 Mont. 316, 322, 787 P.2d 322, 326 (1989). Second, I assume from the submissions of the city and the county supporting their respective positions that the question is primarily concerned with expenses that arise as a result of the precommitment proceedings, such as costs of detention in a hospital setting and costs of evaluations, and not with extraordinary expenses, such as unanticipated medical emergencies, which may be incurred during precommitment detention but are not related to the commitment proceedings. I accordingly express no opinion here on the responsibility of the county or the city for extraordinary expenses not directly related to precommitment proceedings under Montana Code Annotated title 53, chapter 21.

The Montana Supreme Court has interpreted these provisions of law several times, often emphasizing concern for procedural safeguards. In re G.P., 246 Mont. 195, 806 P.2d 3 (1990); In re E.P., 241 Mont. 316, 787 P.2d 332 (1990); Reiser v. Prunty, 224 Mont. 1, 727 P.2d 538 (1986); In re M.C., 220 Mont. 437, 716 P.2d 203 (1986); In re Shennum, 210 Mont. 442, 448-51, 684 P.2d 1073, 1076-78 (1984). Clearly, in order to be taken into protective custody or detained, a person must be in an "emergency situation" and appear to be "seriously mentally ill," as those terms are defined in statute. See also 43 Op. Att'y Gen. No. 5 (1989).

The responsibility for payment of costs such as hospitalization is set forth in statute:

> The county of residence shall also pay **all precommitment expenses**, including transportation to a mental health facility, **incurred in connection with the detention, examination, and precommitment custody** of the respondent. The fact that a person is examined, hospitalized, or receives medical, psychological, or other mental health treatment pursuant to this part does not relieve a third party from a contractual obligation to pay for the cost of the examination, hospitalization, or treatment.

Mont. Code Ann. § 53-21-132(2) (emphasis added). As the Montana Supreme Court has said in interpreting this section, "[p]ursuant to this statute certain expenses incurred must be paid by the county." In re H.C., 218 Mont. 386, 389, 708 P.2d 1007, 1009 (1985). Precommitment custody is such a cost since it is enumerated in the statute.

There is some dispute as to the applicability of the case of Montana Deaconess Medical Center v. Johnson, 232 Mont. 474, 758 P.2d 756 (1988). That case involved a dispute over financial responsibility for medical costs incurred by a defendant who was arrested by city policemen but ultimately

charged with a violation of state law. The Court did not find the only related statute, Mont. Code Ann. § 7-32-2222(3), to be of much help and looked to the courts of other states adopting the "nature of the crime" approach as opposed to the "custody and control" approach in holding the county financially responsible for the medical costs.

I do not find the Court's "common law" approach in the Montana Deaconess case to be persuasive here in light of the Court's declared preference for a strict reading of Montana's statutes regarding the treatment of the seriously mentally ill. M.C. v. Department of Institutions, 211 Mont. 105, 682 P.2d 956 (1984); In re H.C., supra; In re M.C., 220 Mont. 437, 716 P.2d 203 (1985); Reiser v. Prunty, 224 Mont. at 8-14.

I find in the provisions of Mont. Code Ann. § 53-21-139(2) further support for the position that the responsibility for precommitment services provided to persons suspected of being seriously mentally ill rests with the counties. That subsection authorizes the Department of Public Health and Human Services to "provide information and technical assistance regarding needed services and assist counties in developing county plans for crisis intervention services," which are defined elsewhere in the section as programs designed to provide safe, short-term alternatives to incarceration in jail for seriously mentally ill persons who are taken into protective custody. Like the other statutes in this area, there is no mention in this statute of any responsibility on municipalities arising from the fact that the event which gave rise to the person's detention occurred within the geographic limits of the municipality.

I have been directed to no authority, and my research has disclosed none, which would require a municipality to assume the cost of providing services in this area. The statutes clearly place that financial responsibility on the county of residence of the person suspected of being seriously mentally ill.

THEREFORE, IT IS MY OPINION:

> Subject to the limitations contained in Mont. Code Ann. § 53-21-132(2), the county of residence is financially responsible for costs incurred in connection with the detention and precommitment custody of persons taken into protective custody pursuant to Mont. Code Ann. § 53-21-124 or -129.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/rfs/bjh

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

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

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

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

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

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

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

Use of the Administrative Rules of Montana (ARM):

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

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1996. This table includes those rules adopted during the period April 1, 1996 through June 30, 1996 and any proposed rule action that was pending during the past 6-month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1996, 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 1995 and 1996 Montana Administrative Registers.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number. These will fall alphabetically after department rulemaking actions. Accumulative Table entries will be listed with the department name under which they were proposed, e.g., Department of Health and Environmental Sciences as opposed to Department of Environmental Quality.

GENERAL PROVISIONS, Title 1

1.2.419 Filing, Compiling, Printer Pickup and Publication of the Montana Administrative Register, p. 2239, 2694

ADMINISTRATION, Department of, Title 2

2.6.101 Insurance Requirements for Independent Contractors, p. 705
2.11.101 and other rule - Solicitation - Access Limitations, p. 1, 544
2.21.507 Jury Duty and Witness Leave, p. 2313, 131
2.21.1101 and other rules - The Education and Training Policy, p. 2317, 132
2.21.1201 and other rules - Personnel Policy, p. 945
2.21.1601 and other rules - The Alternate Work Schedules Policy, p. 2321, 134
2.21.1711 and other rule - Overtime and Nonexempt Compensatory Time, p. 2544, 404
2.21.1802 and other rules - Exempt Compensatory Time, p. 2546, 405

I-IV Long Term Care - Standards for Marketing - Appropriate Sale Criteria - Nonforfeiture Requirements - Forms, p. 1729, 2242, 143

I-V Regulation of Managed Care Community Networks, p. 1819, 2675

I-X Actuarial Opinion, p. 842, 1371

I-XIV Medicare Select Policies and Certificates, p. 9, 907

6.2.103 and other rules - Procedural Rules of the State Auditor's Office, p. 1227

6.6.401 and other rules - College Student Life Insurance, p. 2573, 264

6.6.503 and other rules - Medicare Supplement Insurance, p. 947

6.6.1101 and other rules - Credit Life - Disability Insurance, p. 955

6.6.1104 Limitation of Presumption of Reasonableness of Credit Life - Disability Rates, p. 7, 746, 1131

6.6.1506 Premium Deferral and Cash Discounts, p. 2722, 413

6.6.2001 and other rules - Unfair Trade Practices on Cancellations, Non-renewals, or Premium Increases of Casualty or Property Insurance, p. 2720, 414

6.6.2007 and other rules - Unfair Trade Practices on Cancellations, Non-renewals, or Premium Increases of Casualty or Property Insurance, p. 869, 1370

6.6.2301 and other rules - Montana Insurance Assistance Plan, p. 2448, 265

6.6.2901 and other rules - Prelicensing Education Program, p. 2444, 266

6.6.3201 and other rules - Pricing of Noncompetitive or Volatile Lines, p. 2446, 267

6.6.3802 and other rule - Trust Agreement Conditions - Conditions Applicable to Reinsurance Agreements, p. 2718, 415

6.6.4001 Valuation of Securities other than those Specifically Referred to in Statutes, p. 2575, 268

6.6.4102 and other rules - Fee Schedules - Continuing Education Program for Insurance Producers and Consultants, p. 963

6.6.4102 and other rule - Insurance Licensee Continuing Education Fees - Continuing Education Program Administrative Rule Definitions, p. 2325, 2793

6.6.5001 and other rules - Small Employer Health Benefit Plans and Reinsurance, p. 1472, 2127, 141

6.10.102 and other rules - Securities Regulation, p. 2724, 1133

6.10.122 Securities Regulation - Broker-Dealer Books and Records, p. 15, 1136

(Classification Review Committee)

6.6.8001 and other rules - Informal Advisory Hearing Procedure - Agency Organization - Adoption of Model Rules - Definitions - Administrative Appeal of Classification Decision - General Hearing Procedure - Updating References to the NCCI Basic Manual for

Workers' Compensation and Employers' Liability Insurance, 1980 Edition, p. 985, 2138, 2682

6.6.3801 Updating References to the NCCI Basic Manual for Workers Compensation and Employers Liability Insurance, 1996 ed., p. 1348

6.6.8301 Updating References to the NCCI Basic Manual for Workers Compensation and Employers Liability Insurance, 1996 ed., p. 866, 1372

6.6.8301 Updating References to the NCCI Basic Manual for Workers' Compensation and Employers' Liability Insurance, 1996 ed., p. 2728, 547

COMMERCE, Department of, Title 8

8.2.207 General Rules of the Department - Process Servers - Polygraph Examiners - Private Employment Agencies - Public Contractors, p. 2175, 2794

8.2.208 Renewal Dates, p. 346, 1373

(Board of Alternative Health Care)

I Vaginal Birth After Cesarean (VBAC) Delivery, p. 348

8.4.505 and other rule - High Risk Pregnancy - Conditions Which Require Physician Consultation, p. 1377, 2684

(Board of Athletics)

8.8.2804 and other rules - Athletic Events - Participants, p. 969

(Board of Barbers)

8.10.403 and other rules - Barbers, Barber Shops and Barber Schools, p. 1432

(Board of Chiropractors)

8.12.601 and other rules - Chiropractors, p. 974

(Board of Clinical Laboratory Science Practitioners)

8.13.304 and other rules - Practice of Clinical Laboratory Science, p. 350, 1296

(Board of Cosmetologists)

8.14.802 License Examinations, p. 871

8.14.802 Emergency Amendment - License Examinations, p. 416

(Board of Dentistry)

8.16.405 and other rule - Fee Schedules, p. 1823, 2686

8.16.408 and other rules - Applications to Convert Inactive Status Licenses to Active Status Licenses - Dental Hygienists - Definitions - Use of Auxiliary Personnel and Dental Hygienists - Dental Auxiliaries, p. 1380, 2469, 2795

(Professional and Occupational Licensing Bureau)

8.19.101 and other rules - Transfer from the Department of Justice - Fire Prevention and Investigation, p. 1825, 2087, 748

(Board of Horse Racing)
8.22.501 and other rules - Definitions - General Provisions - Claiming, p. 217, 763

8.22.703 and other rule - Exercise Persons - Pony Persons, p. 1350
8.22.703 and other rules - Horse Racing Industry, p. 2178, 2796

(Board of Medical Examiners)
8.28.401 and other rules - Physician - Acupuncturist - Emergency Medical Technician - Physician Assistant-Certified - Podiatrist - Nutritionist Licensure, p. 1736, 2480, 144, 269
8.28.911 and other rule - Nutritionists, p. 616

(Board of Nursing)
I Temporary Practice Permits for Advanced Practice Registered Nurses, p. 2450, 419
8.32.304 and other rules - Advanced Practice Registered Nursing - Licensure by Examination - Re-examination - Licensure by Endorsement - Foreign Nurses - Temporary Permits - Inactive Status - Conduct of Nurses - Fees - Duties of President - Approval of Schools - Annual Report, p. 2181, 418
8.32.413 Conduct of Nurses, p. 353, 1489

(Board of Occupational Therapists)
8.35.401 and other rules - Practice of Occupational Therapy, p. 1448

(Board of Outfitters)
8.39.202 and other rules - Outfitting Industry, p. 2327, 668, 909
8.39.518 and other rules - Fees - Moratorium - Operations Plan Review, p. 1761, 2388, 2797, 145, 765

(Board of Pharmacy)
8.40.404 and other rules - Fees - Dangerous Drugs - Transmission of Prescriptions by Facsimile, p. 1834, 2689
8.40.1601 and other rules - Out-of-State Mail Service Pharmacies, p. 2339, 220, 1297

(Board of Physical Therapy Examiners)
8.42.402 and other rules - Examinations - Fees - Renewals - Temporary Licenses - Licensure by Endorsement - Exemptions - Foreign-Trained Applicants - Unprofessional Conduct - Disciplinary Actions, p. 1837, 2483

(Board of Plumbers)
8.44.402 and other rules - Definitions - Fees - Medical Gas Piping Installation Endorsements, p. 1842, 2798

(Board of Psychologists)
I Licensure of Senior Psychologists, p. 2452, 151

(Board of Public Accountants)
8.54.402 and other rules - Examinations - Out-of-State Candidates for Examination - Education Requirements - Fees, p. 1460
8.54.402 and other rules - Emergency Amendment - Examinations - Out-of-State Candidates for Examination - Education Requirements - Fees, p. 1490

(Board of Radiologic Technologists)
8.56.402 and other rules - Radiologic Technologists, p. 618, 1138

(Board of Realty Regulation)
8.58.406A and other rules - Realty Regulation, p. 1609, 2397, 2799

(Board of Sanitarians)
8.60.401 and other rules - Sanitarians, p. 626, 985

(Board of Passenger Tramway Safety)
8.63.504 and other rule - Registration of New, Relocated or Major Modification of Tramways - Conference Call Meetings, p. 633, 1299

(Board of Veterinary Medicine)
8.64.402 and other rule - Fees - Licensees from Other States, p. 2189, 2800

(Building Codes Bureau)
8.70.101 Incorporation by Reference of Uniform Building Code, p. 707
8.70.101 Emergency Amendment - Building Permit Fees, p. 676
8.70.101 and other rules - Building Codes, p. 2342, 420
8.70.108 and other rules - Incorporation by Reference of CABO One and Two Family Dwelling Code - Funding of Code Enforcement Programs - Extension of Municipal Jurisdictional Area - Incorporation by Reference of Safety Code for Elevators and Escalators, p. 1475
8.70.208 and other rule - Emergency Amendment - Funding of Code Enforcement Programs - Extension of Municipal Jurisdictional Area, p. 1494

(Weights and Measures Bureau)
8.77.107 and other rules - Fees - Commodities - Random Inspection of Packages - Petroleum Products - Metric Packaging of Fluid Milk Products, p. 1845, 2486

(Consumer Affairs Office)
8.78.202 and other rules - Repair and Servicing of Automobiles - Consumer Reporting Agencies - Operation of Proprietary Schools, p. 1352

(Banking and Financial Institutions Division)
8.80.108 Limitations on Loans, p. 355
8.80.307 Dollar Amounts to which Consumer Loan Rate are to be Applied, p. 986

(Local Government Assistance Division)
8.83.401 and other rules - State Grants to Counties for District Court Assistance, p. 988

(Board of Milk Control)
8.86.301 Elimination of Minimum Wholesale and Retail Prices - Producer Price Formulas, p. 2192, 2691

(Local Government Assistance Division)
I & II and other rules - 1996 Federal Community Development Block Grant Program - 1996 Treasure State Endowment (TSEP) Program - 1987 and 1988 Federal Community Development Block Grant Programs, p. 2454, 1300

(Board of Investments)
8.97.715 and other rules - Municipal Finance Consolidation Program - Montana Cash Anticipation Financing Program, p. 360, 766, 910

(Economic Development Division)
8.99.401 and other rules - Microbusiness Advisory Council, p. 636

(Board of Housing)
8.111.303 and other rules - Financing Programs - Qualified Lending Institutions - Income Limits - Loan Amounts, p. 2202, 2801
8.111.305 and other rules - Lending Institutions - Loan Servicers, p. 2577, 679

(Board of Science and Technology Development)
8.122.601 Application Procedures for a Seed Capital Technology Loan - Submission and Use of Executive Summary, p. 2204, 548, 912

(Montana Lottery)
8.127.407 and other rule - Retailer Commission - Sales Staff Incentive Plan, p. 1479

EDUCATION, Title 10

(Office of Public Instruction)
10.20.201 and other rules - School Finance - Budgeting and Funding, p. 1230

(Board of Public Education)
I Class 7 American Indian Language and Culture Specialist, p. 2089, 2803
10.57.211 Test for Certification, p. 2457, 680
10.57.301 Endorsement Information, p. 990

10.57.403 and other rule - Class 3 Administrative Certificate - Class 5 Provisional Certificate, p. 1769, 2802
10.57.405 Class 5 Provisional Certificate, p. 2377, 2802

(State Library Commission)
10.102.5102 and other rule - Allocation of Funding Between Federations and Grant Programs - Arbitration of Disputes Within Federations, p. 18, 1374

FISH, WILDLIFE, AND PARKS, Department of, Title 12

I Application Process and Criteria for a Scientific Collectors Permit, p. 373, 1148
12.6.1604 and other rules - Regulation of Roadside Zoos - Game Bird Farms - Fun Farms- Migratory Game Bird Avicultural Permits - Tattooing of Certain Captive Predators, p. 1002

(Fish, Wildlife, and Parks Commission)
12.4.102 Stream Access Definitions in Rules, p. 994
12.6.901 Water Safety on Johnson and South Sandstone Reservoirs, p. 710, 1375
12.6.901 Restriction of Motor-Propelled Water Craft on the Clark Fork River, p. 712, 1376
12.6.901 Creating a No Wake Speed Zone near Rock Creek Marina in Fort Peck Reservoir, p. 2459, 270
12.9.105 and other rules - Wild Turkey Policy - 10-80 Baits - Reintroduction of Peregrine Falcon, p. 1014

(Fish, Wildlife, and Parks Commission and Department of Fish, Wildlife, and Parks)
I-XII and other rule - Future Fisheries Program - Categorical Exclusions, p. 1866, 153
12.2.304 and other rules - Natural Resources Policies - Public Participation, p. 997
12.3.104 and other rules - Licensing, p. 221, 768
12.3.107 and other rules - Issuance of Hunting, Fishing and Trapping Licenses, p. 991
12.4.202 and other rules - Hunter Access and Landowner Incentives Under the Block Management Program, p. 483, 1139
12.7.401 and other rules - Fish Ladders - River Restoration Program, p. 1007
12.8.101 and other rules - State Park System - State Recreational Waterway System - Cultural Resources, p. 1011
12.9.208 Abandonment of the Skalkaho Game Preserve, p. 2731, 549

HEALTH AND ENVIRONMENTAL SCIENCES, Department of, Title 16

I-VII Aboveground Tanks - Minimum Standards for Aboveground Double-walled Petroleum Storage Tank Systems, p. 1087, 2491

16.45.402 and other rule - Underground Storage Tanks - Minimum Standards for Underground Piping, p. 1081, 2488

16.45.1101 and other rule - Underground Storage Tanks - Minimum Standards for Double-walled UST Systems, p. 1084, 2489

ENVIRONMENTAL QUALITY, Department of, Title 17

16.2.101 and other rules - MEPA - Transfer of Department of Health and Environmental Sciences and Department of State Lands Procedural Rules for the Montana Environmental Policy Act, p. 1497

16.40.101 and other rules - Occupational Health - Transfer from Department of Health and Environmental Sciences - Radiation Control - Occupational Health, p. 433, 681

16.44.101 and other rules - Hazardous Waste - Transfer from Department of Health and Environmental Sciences - Hazardous Waste Management, p. 2416

17.54.102 and other rules - Updating Federal Incorporations by Reference, p. 20, 1382

(Board of Environmental Review)

I Water Quality - Temporary Water Standards for Daisy Creek, Stillwater River, Fisher Creek, and the Clark's Fork of the Yellowstone River, p. 1652, 1872, 2211, 1049

16.8.701 and other rules - Air Quality - Adopting the Current Federal Definition of Volatile Organic Compounds, p. 1019

16.8.701 and other rules - Air Quality - Volatile Organic Compounds Definitions, p. 1645, 2410

16.8.704 and other rules - Air Quality - Updating the Incorporations by Reference and References to the MCA to the Most Recent Regulations and Statutes - Combining Certain Provisions of the Air Quality Rules, p. 1034

16.8.705 and other rule - Air Quality - Replacing Equipment Due to Malfunctions, p. 1640, 2411

16.8.1101 and other rules - Air Quality - Adding Human Health Risk Assessment to the Preconstruction Permit Application Requirements for Incineration Facilities Subject to 75-2-215, MCA, p. 1026

16.8.1107 Air Quality - Public Review of Air Quality Preconstruction Permit Applications, p. 488, 1149

16.8.1301 and other rule - Air Quality - Open Burning in Eastern Montana, p. 1634, 2412

16.8.1402 and other rule - Air Quality - Particulate Emission Limits for Fuel Burning Equipment and Industrial Processes, p. 1636, 2413

16.8.1414 Air Quality - Sulfur Oxide Emissions from Lead Smelters, p. 1644, 2414

16.8.1419 Air Quality - Fluoride Emissions - Phosphate Processing, p. 1017

16.8.1429 and other rule - Air Quality - Adopting Federal Regulations for the Administration of Maximum Achievable Control Technology Standards, p. 1024
16.8.1903 and other rule - Air Quality - Air Quality Operation Fees - Air Quality Permit Application Fees, p. 1648, 2415
16.8.2026 Air Quality - Acid Rain, p. 1022
16.20.603 and other rules - Water Quality - Surface and Groundwater Water Quality Standards - Mixing Zones - Nondegradation of Water Quality, p. 2212, 555
17.30.640 and other rules - Water Quality - Water Quality, p. 1047
26.2.641 and other rules - MEPA - Montana Environmental Policy Act for the Department of State Lands, p. 491, 1150

(Department of Environmental Quality and Board of Environmental Review)
16.16.101 and other rules - Water Quality - Transfer from Department of Health and Environmental Sciences - Water Quality, p. 493, 1499

TRANSPORTATION, Department of, Title 18

I and other rules - Establishing Refund Percentages for PTO or Auxiliary Engines - Motor Fuels, p. 2733, 913
I-IV Staggered Registration of Motor Carriers with Multiple Fleets of Vehicles, p. 1773, 2422
18.6.202 and other rules - Outdoor Advertising Regulations, p. 39
18.8.101 and other rules - Motor Carrier Services Program, p. 714

(Transportation Commission)
18.6.211 Application Fees for Outdoor Advertising, p. 2091, 158

CORRECTIONS, Department of, Title 20

(Board of Pardons and Parole)
20.25.101 and other rules - Revision of the Rules of the Board of Pardons and Parole, p. 2461

JUSTICE, Department of, Title 23

Notice of Proposed Amendments to the Certificate of Public Advantage and Approving the Merger of Columbus Hospital and Montana Deaconess Medical Center, p. 1481A
Notice of Application for Certificate of Public Advantage by the Columbus Hospital and Montana Deaconess Medical Center, Great Falls, Montana, p. 2579

PUBLIC HEALTH AND HUMAN SERVICES, Department of, Title 37

BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 2-15-108, MCA, is that the Secretary of State publish monthly in the ***Montana Administrative Register*** a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments effective in May 1996, appear. Vacancies scheduled to appear from July 1, 1996, through September 30, 1996, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a board should refer to the bill that created the board for details about the number of members to be appointed and necessary qualifications.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of June 1, 1996.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES FROM MAY, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Blue Ribbon Telecommunications Task Force (Administration)			
Ms. Kimberly Obbink	Governor	Winters	5/13/1996
Bozeman			1/1/1997
Qualifications (if required): ex-officio member			
Board of Real Estate Appraisers (Commerce)			
Mr. Patrick Asay	Governor	reappointed	5/1/1996
Manhattan			5/1/1999
Qualifications (if required): appraiser			
Board of Realty Regulation (Commerce)			
Ms. Laura Odegaard	Governor	Allen	5/9/1996
Billings			5/9/2000
Qualifications (if required): realtor			
Board of Regents of Higher Education (Education)			
Ms. Margie Thompson	Governor	Johnson	5/9/1996
Butte			2/1/2003
Qualifications (if required): Republican from District 2			
Board of Science and Technology Development (Commerce)			
Mr. Monte Giese	Governor	Sullivan	5/29/1996
Great Falls			1/1/1997
Qualifications (if required): early stage financing of private businesses			
Board of Veterans' Affairs (Military Affairs)			
Mr. Thaddeus Mayer	Governor	reappointed	5/18/1996
Missoula			5/18/2001
Qualifications (if required): veteran			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Indian Burial Preservation Board (Commerce)			
Dr. Ken Deaver	Governor	Foor	5/1/1996
Billings			8/22/1996
Qualifications (if required): member of the Montana Archaeological Association			
Low Income Energy Advisory Council (Public Health and Human Services)			
Mr. Matt Dale	Governor	not listed	5/1/1996
Helena			2/13/1998
Qualifications (if required): representing the general public			
Ms. Lee Harn	Governor	not listed	5/1/1996
Miles City			2/13/1998
Qualifications (if required): representing the general public			
Rep. Royal C. Johnson	Governor	not listed	5/1/1996
Billings			2/13/1998
Qualifications (if required): member of the Montana State Legislature			
Mr. Allen Nicholson	Governor	not listed	5/1/1996
Helena			2/13/1998
Qualifications (if required): representing non-energy related enterprises			
Ms. Barbara Sullivan	Governor	not listed	5/1/1996
Helena			2/13/1998
Qualifications (if required): LIEAP recipient			
Mr. Carl Visser	Governor	not listed	5/1/1996
Billings			2/13/1998
Qualifications (if required): representing non-energy related enterprises			
Mr. Michael Wall	Governor	not listed	5/1/1996
Helena			2/13/1998
Qualifications (if required): representing private-sector non-energy enterprises			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Vocational Rehabilitation Advisory Council (Public Health and Human Services)			
Mr. Ian Wall Helena Qualifications (if required): none specified	Director	not listed	5/15/1996 0/0/0
State Employees' Combined Campaign Steering Committee (Administration)			
Ms. Marcia Armstrong Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Mr. Thomas S. Berg Great Falls Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Mr. Shawn F. Bubb Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Mr. Clyde Dailey Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Ms. Jane Hamman Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Ms. Gayle Joslin Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Ms. Adeline Miller Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MAY, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
State Employees' Combined Campaign Steering Committee (Administration) Cont.			
Mr. Bob Nichol Bozeman Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Ms. Kathy Ramirez Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0
Ms. Mary Wright Helena Qualifications (if required): none specified	Director	not listed	5/28/1996 0/0/0

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
9-1-1 Advisory Council (Administration)		
Mr. Bill Wade, Circle Qualifications (if required): none specified	Director	9/26/1996
Mr. Dave Mason, Helena Qualifications (if required): none specified	Director	9/26/1996
Sheriff Lee Edmisten, Virginia City Qualifications (if required): none specified	Director	9/26/1996
Mr. James Anderson, Helena Qualifications (if required): none specified	Director	9/26/1996
Dr. Drew Dawson, Helena Qualifications (if required): none specified	Director	9/26/1996
Mr. Dan Green, Helena Qualifications (if required): none specified	Director	9/26/1996
Ms. Judy Frazer, Kalispell Qualifications (if required): none specified	Director	9/26/1996
Mr. Marshall Kyle, Missoula Qualifications (if required): none specified	Director	9/26/1996
Maj. Irwin L. Garrick, Helena Qualifications (if required): none specified	Director	9/26/1996
Mr. Mike Sederholm, Lewistown Qualifications (if required): none specified	Director	9/26/1996

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
9-1-1 Advisory Council (Administration) Cont.		
Mr. Tom Kelly, Columbus Qualifications (if required): none specified	Director	9/26/1996
Ms. Kay McKenna, Helena Qualifications (if required): none specified	Director	9/26/1996
Mr. Art Bicsak, Great Falls Qualifications (if required): none specified	Director	9/26/1996
Mr. Al Brockway, Helena Qualifications (if required): none specified	Director	9/26/1996
Lt. Billi Heigh, Helena Qualifications (if required): none specified	Director	9/26/1996
Mr. Rick Newby, Miles City Qualifications (if required): none specified	Director	9/26/1996
AIDS Advisory Council (Public Health and Human Services)		
Ms. Alison James, Clancy Qualifications (if required): student representative	Governor	8/18/1996
Ms. Pam Carter, Bozeman Qualifications (if required): none specified	Governor	8/18/1996
Rep. John Bohlinger, Billings Qualifications (if required): legislator	Governor	8/18/1996
Rev. D. Gregory Smith, Helena Qualifications (if required): none specified	Governor	8/18/1996

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
AIDS Advisory Council (Public Health and Human Services) Cont.		
Ms. Pam Bragg, Helena Qualifications (if required): public member	Governor	8/18/1996
Mr. David Herrera, Billings Qualifications (if required): none specified	Governor	8/18/1996
Mr. Terry Cyr, Missoula Qualifications (if required): public member	Governor	8/18/1996
Mr. Frank Gary, Butte Qualifications (if required): public member	Governor	8/18/1996
Mr. Steve Bennetts, Great Falls Qualifications (if required): none specified	Governor	8/18/1996
Ms. Rita Munzenrider, Kalispell Qualifications (if required): none specified	Governor	8/18/1996
Pastor Paul Goodman, Billings Qualifications (if required): none specified	Governor	8/18/1996
Dr. Connie O'Connor, Helena Qualifications (if required): none specified	Governor	8/18/1996
Ms. Verbena Savior, Poplar Qualifications (if required): none specified	Governor	8/18/1996
Mr. David G. Rice, Havre Qualifications (if required): none specified	Governor	8/18/1996

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
AIDS Advisory Council (Health and Environmental Sciences)	Cont.	
Dr. Elizabeth Olberding, Helena	Governor	8/18/1996
Qualifications (if required): none specified		
Ms. Terri Dunn, Whitefish	Governor	8/18/1996
Qualifications (if required): none specified		
Mr. Marshall Miller, Helena	Governor	8/18/1996
Qualifications (if required): none specified		
Aging Advisory Council (Governor)		
Ms. Pauline Nikolaisen, Kalispell	Governor	7/18/1996
Qualifications (if required): member from Region IV		
Ms. Mary Alice Rehbein, Lambert	Governor	7/18/1996
Qualifications (if required): member from Region I		
Ms. Dorothea C. Neath, Helena	Governor	7/18/1996
Qualifications (if required): member from Region IV		
Ms. Vi Thomson, Missoula	Governor	7/18/1996
Qualifications (if required): member from Region XI		
Agricultural Development Council (Agriculture)		
Ms. Julie Burke, Glasgow	Governor	7/1/1996
Qualifications (if required): active in agriculture		
Mr. Everett Snortland, Conrad	Governor	7/1/1996
Qualifications (if required): active in agriculture		
Mr. John Swanz, Judith Gap	Governor	7/1/1996
Qualifications (if required): active in agriculture		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Alfalfa Leaf-Cutting Bee Advisory Committee (Agriculture)		
Mr. Tim Wetstein, Joliet	Governor	7/1/1996
Qualifications (if required): member of Montana Alfalfa Seed Association		
Alternative Health Care Board (Commerce)		
Dr. Michael Bergkamp, Helena	Governor	9/1/1996
Qualifications (if required): naturopath		
Board of Banking (Commerce)		
Mr. Loren Tucker, Virginia City	Governor	7/1/1996
Qualifications (if required): public member		
Mr. Robert T. Baxter, Thompson Falls	Governor	7/1/1996
Qualifications (if required): officer of a state bank		
Board of Barbers (Commerce)		
Ms. Adeline Fisher, Butte	Governor	7/1/1996
Qualifications (if required): public member		
Mr. Rodney L. Grover, Helena	Governor	7/1/1996
Qualifications (if required): barber		
Board of Cosmetologists (Commerce)		
Ms. Mary Brown, Helena	Governor	7/1/1996
Qualifications (if required): licensed cosmetologist		
Board of Hearing Aid Dispensers (Commerce)		
Mr. Walter Hopkins, Great Falls	Governor	7/1/1996
Qualifications (if required): hearing aid dispenser		
Mr. Ben Havdahl, Helena	Governor	7/1/1996
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Board of Landscape Architects (Commerce)		
Mr. Jim Foley, Billings	Governor	7/1/1996
Qualifications (if required): licensed architect		
Board of Medical Examiners (Commerce)		
Dr. Richard Beighle, Missoula	Governor	9/1/1996
Qualifications (if required): doctor of medicine		
Board of Nursing (Commerce)		
Ms. Denise Hochberger, Chester	Governor	7/1/1996
Qualifications (if required): licensed practical nurse		
Ms. Jean E. Ballantyne, Billings	Governor	7/1/1996
Qualifications (if required): registered nurse and an educator		
Board of Pharmacy (Commerce)		
Mr. Ed J. Harrington, Belgrade	Governor	7/1/1996
Qualifications (if required): pharmacist		
Board of Physical Therapy Examiners (Commerce)		
Mr. Robert Bruce Bowman, Lewistown	Governor	7/1/1996
Qualifications (if required): physical therapist		
Board of Private Security Patrol Officers and Investigators (Commerce)		
Rep. Gay Ann Masolo, Townsend	Governor	8/1/1996
Qualifications (if required): public member		
Board of Psychologists (Commerce)		
Dr. Evan Lewis, Jefferson City	Governor	9/1/1996
Qualifications (if required): licensed psychologist		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Board of Public Accountants (Commerce)		
Ms. Ivah G. Schmitz, Missoula Qualifications (if required): licensed public accountant	Governor	7/1/1996
Board of Radiologic Technologists (Commerce)		
Dr. Dennis S. Yutani, Glasgow Qualifications (if required): medical doctor	Governor	7/1/1996
Ms. Debbie Sanford, Lewistown Qualifications (if required): limited permit technologist	Governor	7/1/1996
Ms. Judy Martz, Butte Qualifications (if required): public member	Governor	7/1/1996
Ms. Cynthia L. Smith, Billings Qualifications (if required): radiologic technologist	Governor	7/1/1996
Board of Sanitarians (Commerce)		
Ms. Patricia M. Switzer, Richey Qualifications (if required): public member	Governor	7/1/1996
Board of Veterinary Medicine (Commerce)		
Dr. Kenneth Joe Bruchez, Hobson Qualifications (if required): veterinarian	Governor	7/31/1996
Dr. John H. Leeds, Havre Qualifications (if required): veterinarian	Governor	7/31/1996

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Committee on Telecommunications Services for the Handicapped (Social and Rehabilitation Services)		
Ms. Joan Mandeville, Great Falls	Governor	7/1/1996
Qualifications (if required): represents Montana's Independent Local Phone Exchange Co.		
Ms. Cathy Brightwell, Helena	Governor	7/1/1996
Qualifications (if required): representative of an Interlata Interchange Carrier		
Mr. James L. Allen, Lolo	Governor	7/1/1996
Qualifications (if required): handicapped member		
Mr. Edward Van Tighem, Great Falls	Governor	7/1/1996
Qualifications (if required): handicapped member		
Community Services Advisory Council (Governor)		
Ms. Jan Kenitzer, Baker	Governor	7/1/1996
Qualifications (if required): representing private citizens		
Mr. Charles McCarthy, Helena	Governor	7/1/1996
Qualifications (if required): representing human services		
Ms. Norma Bixby, Lame Deer	Governor	7/1/1996
Qualifications (if required): representing tribal government		
Electrical Board (Commerce)		
Mr. Gene Kolstad, Billings	Governor	7/1/1996
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Family Support Services Advisory Council (Social and Rehabilitation Services)		
Ms. Sue Forest, Missoula	Governor	9/9/1996
Qualifications (if required): personnel preparation representative		
Ms. Sharon Wagner, Helena	Governor	9/9/1996
Qualifications (if required): represents Department of Health and Environmental Sciences		
Ms. Colleen Thompson, Glasgow	Governor	9/9/1996
Qualifications (if required): Headstart representative		
Ms. Sylvia Danforth, Miles City	Governor	9/9/1996
Qualifications (if required): service provider representative		
Ms. Millie Kindle, Malta	Governor	9/9/1996
Qualifications (if required): parent representative		
Ms. Maria Pease, Lodge Grass	Governor	9/9/1996
Qualifications (if required): parent representative		
Mr. Pete Surdock, Helena	Governor	9/9/1996
Qualifications (if required): represents Department of Corrections and Human Services		
Mr. Dan McCarthy, Helena	Governor	9/9/1996
Qualifications (if required): represents Office of Public Instruction		
Ms. Jackie Jandt, Helena	Governor	9/9/1996
Qualifications (if required): represents Department of Social and Rehabilitation Services		
Ms. Linda Botten, Bozeman	Governor	9/9/1996
Qualifications (if required): service provider representative		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Family Support Services Advisory Council (Public Health and Human Services) Cont.		
Mr. Phil Mattheis, Florence	Governor	9/9/1996
Qualifications (if required): medical/health care representative		
Rep. Matt McCann, Harlem	Governor	9/9/1996
Qualifications (if required): legislator		
Ms. Janice Lane, Forsyth	Governor	9/9/1996
Qualifications (if required): parent representative		
Ms. Kathy Cashell, Butte	Governor	9/9/1996
Qualifications (if required): parent representative		
Mr. Ted Maloney, Missoula	Governor	9/9/1996
Qualifications (if required): public member		
Ms. Georgia Rutherford, Browning	Governor	9/9/1996
Qualifications (if required): parent representative		
Ms. Sandi Marisdotter, Helena	Governor	9/9/1996
Qualifications (if required): service provider representative		
Ms. Chris Volinkaty, Missoula	Governor	9/9/1996
Qualifications (if required): service provider representative		
Ms. Barbara Stefanic, Laurel	Governor	9/9/1996
Qualifications (if required): preschool services representative		
Ms. Gwen Beyer, Polson	Governor	9/9/1996
Qualifications (if required): parent representative		
Mr. John Holbrook, Helena	Governor	9/9/1996
Qualifications (if required): state insurance governance representative		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Family Support Services Advisory Council (Social and Rehabilitation Services) Cont.		
Ms. Lynda Hart, Helena	Governor	9/9/1996
Qualifications (if required): represents Department of Family Services		
Ms. Beth Kenny, Helena	Governor	9/9/1996
Qualifications (if required): parent representative		
Ms. Christine Gutschenritter, Great Falls	Governor	9/30/1996
Qualifications (if required): represents Montana School for the Deaf and Blind		
Historical Society Board of Trustees (Historical Society)		
Ms. Virginia Lucht, Bigfork	Governor	7/1/1996
Qualifications (if required): public member		
Ms. Jean Birch, Great Falls	Governor	7/1/1996
Qualifications (if required): public member		
Ms. Anne Hibbard, Helena	Governor	7/1/1996
Qualifications (if required): public member		
Indian Burial Preservation Board (Commerce)		
Mr. John Pretty On Top, Crow Agency	Governor	8/22/1996
Qualifications (if required): representative of Crow Tribe		
Mr. Duncan Standing Rock, Sr., Box Elder	Governor	8/22/1996
Qualifications (if required): representative of Chippewa-Cree Tribe		
Mr. Gilbert Horn, Harlem	Governor	8/22/1996
Qualifications (if required): representative of Gros Ventre Tribe		
Mr. Mickey Nelson, Helena	Governor	8/22/1996
Qualifications (if required): representative of coroners' association		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Indian Burial Preservation Board (Commerce) Cont.		
Mr. Germaine White, Pablo	Governor	8/22/1996
Qualifications (if required): representative of Little Shell		
Lewis and Clark Bicentennial Celebration Advisory Council (Historical Society)		
Ms. Nancy Maxson, Missoula	Governor	8/26/1996
Qualifications (if required): represents Glacier Country		
Mr. Darrell Kipp, Browning	Governor	8/26/1996
Qualifications (if required): represents Glacier Country		
Ms. Mary Partridge, Miles City	Governor	8/26/1996
Qualifications (if required): represents Custer Country		
Mr. Loren Stiffarm, Harlem	Governor	8/26/1996
Qualifications (if required): represents Russell Country		
Dr. Robert Bergantino, Butte	Governor	8/26/1996
Qualifications (if required): represents Gold West Country		
Ms. Betty White, Ronan	Governor	8/26/1996
Qualifications (if required): represents Glacier Country		
Mr. John G. Lepley, Fort Benton	Governor	8/26/1996
Qualifications (if required): represents Russell Country		
Ms. Edythe McCleary, Hardin	Governor	8/26/1996
Qualifications (if required): represents Custer Country		
Mr. Mike Labriola, Great Falls	Governor	8/26/1996
Qualifications (if required): represents Russell Country		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Lewis and Clark Bicentennial Celebration Advisory Council (Historical Society) Cont.		
Mr. Robert Mann, Plentywood Qualifications (if required): represents Missouri River Country	Governor	8/26/1996
Col. Harold Stearns, Missoula Qualifications (if required): represents military affairs	Governor	8/26/1996
Ms. Gloria Wester, Laurel Qualifications (if required): represents Custer Country	Governor	8/26/1996
Ms. Diane Zimmerman, Missoula Qualifications (if required): represents Glacier Country	Governor	8/26/1996
Ms. Jeanne French, Plentywood Qualifications (if required): represents Missouri River Country	Governor	8/26/1996
Mr. Jack Hines, Big Timber Qualifications (if required): represents Yellowstone Country	Governor	8/26/1996
Mr. Tim Crawford, Helena Qualifications (if required): represents Gold West Country	Governor	8/26/1996
Ms. Jan Blayden, Missoula Qualifications (if required): represents Glacier Country	Governor	8/26/1996
Mr. Dennis Seibel, Bozeman Qualifications (if required): represents Yellowstone Country	Governor	8/26/1996

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Mental Disabilities Board of Visitors (Governor)		
Ms. Helen C. Green, Big Sandy	Governor	8/1/1996
Qualifications (if required): represents mental disabilities organization		
Ms. Arlene Breum, Missoula	Governor	8/1/1996
Qualifications (if required): represents mental disabilities organization		
Ms. Marjorie Fehrer, Bozeman	Governor	8/1/1996
Qualifications (if required): consumer		
Mr. Wallace A. King, Helena	Governor	8/1/1996
Qualifications (if required): professional		
Mr. Robert W. Visscher, Livingston	Governor	8/1/1996
Qualifications (if required): professional		
Montana Mint Committee (Agriculture)		
Mr. Brian Schweitzer, Whitefish	Governor	7/1/1996
Qualifications (if required): active mint grower		
Noxious Weed Seed Free Advisory Council (Agriculture)		
Mr. Terry Turner, Havre	Director	9/17/1996
Qualifications (if required): representing weed districts		
Mr. LaMonte Schnur, Townsend	Director	9/17/1996
Qualifications (if required): forage producer		
Private Security Patrol Officers and Investigators (Commerce)		
Mr. Greg Noose, Bozeman	Governor	8/1/1996
Qualifications (if required): represents Peace Officers Standards and Training Advisory Council		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
State Advisory Council on Food and Nutrition (Health and Environmental Sciences)		
Sen. Ethel Harding, Polson	Governor	8/30/1996
Qualifications (if required): member of the Senate		
Ms. Lynn Paul, Bozeman	Governor	8/30/1996
Qualifications (if required): represents the MSU Extension Service		
Mr. David Thomas, Helena	Governor	8/30/1996
Qualifications (if required): none specified		
Mr. Gary Watt, Helena	Governor	8/30/1996
Qualifications (if required): represents OPI School Food Services Program		
Ms. Judy Morrill, Bozeman	Governor	8/30/1996
Qualifications (if required): represents food and nutrition programs for elderly		
Teachers' Retirement Board (Administration)		
Mr. James E. Cowan, Seeley Lake	Governor	7/1/1996
Qualifications (if required): public member		
Tourism Advisory Council (Commerce)		
Ms. Thelma M. Baker, Missoula	Governor	7/1/1996
Qualifications (if required): public member		
Mr. Carl Kochman, Great Falls	Governor	7/1/1996
Qualifications (if required): public member		
Mr. Ed Henrich, Anaconda	Governor	7/1/1996
Qualifications (if required): representing the Innkeepers		
Mr. Larry McRae, Kalispell	Governor	7/1/1996
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- July 1, 1996 through September 30, 1996

Board/current position holder	Appointed by	Term end
Tourism Advisory Council (Commerce) Cont.		
Mr. Arnold D. "Smoke" Elser, Missoula Qualifications (if required): public member	Governor	7/1/1996
Wheat and Barley Committee (Agriculture)		
Mr. Lanny Christman, Dutton Qualifications (if required): represents District IV	Governor	8/20/1996
Mr. Jim Squires, Glendive Qualifications (if required): represents District VII	Governor	8/20/1996