RESERVE

MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 2

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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NOTICE SECTION

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

In the matter of the proposed amendment of ARM 12.6.901 relating to the restriction of motor-propelled water craft on various lakes in the Seeley Lake area and Beavertail Pond.	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULE 12.6.901

To: All Interested Persons.

1. On February 18, 19, 20, and 25, 1997, the Fish, Wildlife and Parks Commission (commission) will hold public hearings to consider the amendment of rule 12.6.901 as proposed in this notice. The hearings are scheduled as follows:

February 18, 1997 7:00 - 9:00 p.m.
Department of Fish, Wildlife & Parks Headquarters
Commission Room
1420 East Sixth Avenue
Helena, MT 59620

February 19, 1997 7:00 - 9:00 p.m.
Department of Fish, Wildlife & Parks
Great Falls Regional Office
4600 Giant Springs Road
Great Falls, MT 59406

February 20, 1997 7:00 - 9:00 p.m.
Department of Fish, Wildlife & Parks
3201 Spurgin Road
Missoula, MT 59804

February 25, 1997 7:00 - 9:00 p.m.
Seeley Lake Community Center
Seeley Lake, MT 59868

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

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

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

Beaverhead County through Mineral County remain the same.

Missoula County: (A) through (F) remain the same.
(G) Lake Dinah
(H) Morrell Lake

Powell County through Toole County remain the same.

(b) The following waters are closed to the use of all boats propelled by machinery of over 10 horsepower, except in cases of use for search and rescue, official patrol, or for scientific purposes:

(i) Remains the same.

(ii) other waters of the state as follows:

Hill County and Lincoln County remain the same.

Missoula County: (A) Blanchard Lake (on Clearwater River)
(B) Elbow Lake (on Clearwater River)

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

Big Horn County through Madison County remain the same.

Missoula County: (A) through (D) remain the same.
(E) Placid Creek: From its headwaters to the confluence with Placid Lake.
(F) Salmon Lake: The Clearwater River from the Placid Lake Road Bridge to Salmon Lake; that portion known as Legendary Lodge Narrows near the south end of the lake; and the area south of Salmon Cove Point (Eagle's Nest) to the lake's outlet.
(G) Upsata Lake

(d) and (e) remain the same.

(f) The following waters are limited to manually operated boats and boats powered by electric motors:

Dawson County and Fergus County remain the same.

Missoula County: (A) Beavertail Pond
(B) Clearwater Lake
(C) Colt Lake
(D) Cottonwood Lake
(E) Elsina Lake

(F) Hidden Lake
(G) Rainy Lake
(H) Spook Lake
(I) Summit Lake

Richland County through (2) remain the same.

AUTH: 87-1-303, MCA IMP: 87-1-303, MCA

3. The rationale for the proposed amendment is as follows: This amendment to ARM 12.6.901 is proposed to address safety issues of motorized water craft on various lakes in the Seeley Lake area and Beavertail Pond, to protect nesting and rearing waterfowl, and to address water quality issues associated with potential contamination by gasoline and oil on closed basins or high mountain lakes.

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 Rich Clough, Region Two Supervisor, Montana Fish, Wildlife & Parks, 3201 Spurgin Road, Missoula, Montana 59801, and must be received no later than February 28, 1997.

5. Rich Clough, or another hearing examiner designated by the department will preside over and conduct the hearing.

RULE REVIEWER

Robert N. Lane

FISH, WILDLIFE AND PARKS COMMISSION

Patrick J. Graham, Secretary

Certified to the Secretary of State on January 13, 1997.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of rule 17.30.716 eliminating a list of activities predetermined to be nonsignificant and adopting a category of nonsignificance for individual sewage systems	)))))	NOTICE OF SUPPLEMENTAL PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE (Water Quality)

To: All Interested Persons

1. On December 5, 1996, on page 3103 of the Montana Administrative Register, Issue No. 23, the Board gave notice of public hearing for proposed amendment of rules to amend the above-captioned rule.

2. On February 24, 1997, at 1:30 p.m., the Board will hold an additional public hearing in Room 111 of the Metcalf Building, 1520 E. 6th Ave., Helena, Montana, to consider the amendment of the above-captioned rule.

3. The Board is proposing these amendments in order to simplify review of individual sewage systems under the nondegradation policy by providing categorical exemptions for systems that will produce nonsignificant changes in water quality due to construction requirements, location and site conditions. Based on its experience, the Department has determined that sewage systems located on lots that meet the conditions described in these amendments would be nonsignificant under the criteria in ARM 17.30.715. The board is noticing this amendment again because the previous notice was not sent to the newspapers for publication as required in 75-5-307, MCA.

4. 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 the Board of Environmental Review, Department of Environmental Quality, Metcalf Building, PO Box 200901, Helena, MT 59620-0901, no later than February 24, 1997.

5. Claudia Massman has been designated to preside over and conduct the hearing.

BOARD OF ENVIRONMENTAL REVIEW

CINDY E. YOUNKIN, Chairperson

Reviewed by:

JOHN F. NORTH, Rule Reviewer

Certified to the Secretary of State January 13, 1997.

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

In the matter of the amendment of rules 11.14.106, 11.14.601, 11.14.602, 11.14.604, 11.14.605, 11.14.607 through 11.14.610 pertaining to excluding care of children of a single family from day care facility licensing and registration rules, and state payment for registered or licensed day care and unregistered day care	)	NOTICE OF THE PROPOSED AMENDMENT OF RULES NO PUBLIC HEARING IS CONTEMPLATED

TO: All Interested Persons

1. On March 10, 1997, the Department of Public Health and Human Services proposes to amend rules 11.14.106, 11.14.601, 11.14.602, 11.14.604, 11.14.605, 11.14.607 through 11.14.610 pertaining to excluding care of children of a single family from day care facility licensing and registration rules, and state payment for registered or licensed day care and unregistered day care.

2. The rules as proposed to be amended provide as follows. New language that is to be added is underlined. Language that is being deleted is interlined.

11.14.106 COUNTING CHILDREN IN CARE (1) remains the same.

(2) Absent an applicable exclusion, ~~A~~a provider of supplemental parental care to three or more children shall be licensed or registered as a day care facility.

(3) remains the same.

AUTH: Sec. 52-2-704, MCA
IMP: Sec. 52-2-704 and 52-2-731, MCA

11.14.601 PURPOSE AND GENERAL LIMITATIONS (1) This subchapter of rules pertains to payment for child day care services provided to parents eligible for benefits funded under section 5082 of the Omnibus Reconciliation Act of 1990, Public Law 101-508, entitled "Child Care and Development Block Grant Act of 1990." These rules also pertain to subsequent re-funding of this program. In addition, this subchapter's requirements for certification ~~and registration~~ of legally unregistered providers under ARM 11.14.609, apply to all day care programs administered by the department where the department allows participation of legally unregistered providers.

(2) and (3) remain the same.

(4) ~~There are two types of "registration" referred to in this subchapter.~~ All providers must ~~"register"~~ be certified for the purpose of ~~participating in the block grant program~~ receiving payment under a state assisted child care program. ~~Block grant registration~~ Certification under a state assisted child care program is separate and apart from registration as a group or family day care home, or licensure as a day care center, and means simply that the provider has been approved as eligible to receive state payment for day care services as allowed by this subchapter. Those operating as a group or family day care home or day care center as defined by department rule and the Montana Child Care Act remain subject to day care facility registration and licensing rules in addition to requirements for ~~block grant registration~~ certification under this subchapter.

(5) through (7) remain the same.

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

11.14.602 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) through (4) remain the same.

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

(6) through (8)(o) remain the same.

(p) food stamp benefits;

(q) children's earned income;

(r) SSDI payments; and

(s) high school, college or junior college scholarships.

(9) remains the same

(10) "Provider" means both legally unregistered providers, and licensees and registrants of other day care facilities.

(11) and (12) remain the same.

(13) "Children from the same family" means children who are of the same sibling group.

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

11.14.604 ELIGIBILITY OF PARENTS FOR PAYMENT (1) through (5) remain the same.

(6) Child day care benefits allowed for training under this subchapter ~~for training~~ are also limited to:

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

(7) remains the same.

(8) Parents may only claim payment under this subchapter for child day care provided by:

(a) a legally unregistered provider who is ~~registered and~~ certified under this subchapter; or

(8)(b) remains the same.

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

11.14.605 INCOME ELIGIBILITY AND COPAYMENTS (1) through (7) remain the same.

(8) ~~The p~~Parent~~(s) is~~/are solely responsible for making the copayment to the provider. Parents failing to make copayments to their provider may be de-certified for benefits under this subchapter.

(9) remains the same.

(10) Reports under ~~subsection~~ (9) of this rule must be made to the district resource and referral office certifying eligibility for the parent~~(s)~~. The certifying district resource and referral office may act to ~~change/reduce/deny~~ change, reduce, or deny benefits under this subchapter based on information received from the parent~~(s)~~ or from any source.

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

11.14.607 REQUIREMENTS FOR DAY CARE FACILITIES, COMPLIANCE WITH EXISTING RULES, CERTIFICATION (1) through (3) remain the same.

~~(4) A provider of supplemental parental care to children of a single family in the home of the children must obtain a family day care home registration certificate if care is provided to more than two children, not counting the children of the provider over the age of two, prior to certification for payment of benefits under this subchapter.~~

~~(5) The maximum number of children for a family day care home registered under subsection (4) of this rule shall be determined in accordance with ARM 11.14.102(3). There shall be no group day care home registration under subsection (4) of this rule. The two child limit which is referred to in this rule and in ARM 11.14.609(6)(c) is not applicable to the requirements for counting children in care in ARM 11.14.102(3)-(5).~~

~~(6) As required by ARM 11.14.604(4), applications for day care facility registration to receive benefits under subsection (4) of this rule to provide care in the home of the children where the provider is a parent of the children, or a member of the household of the children, must be denied.~~

~~(7) Family day care homes required to register to provide care in the home of the children under subsection (4) of this rule must comply with all registration requirements of Title 11, chapter 14 of the Administrative Rules of Montana applicable to family day care homes except the following:~~

~~(a) proof of current fire and liability insurance coverage required by ARM 11.14.103(4)(c) and ARM 11.14.105(4)(d);~~

~~(b) the health requirement of ARM 11.14.414(3) requiring that an ill child be taken home;~~

~~(c) the health requirement of ARM 11.14.414(9)(c) prohibiting the use of home canned foods (if the foods were canned by the~~

~~parent(s) and the use of canned foods is approved by the parents.~~

~~(d) the health requirement of ARM 11.14.414(5) in regard to contact with adults with reportable communicable diseases and contagious illnesses if such adult is a member of the household; and~~

~~(e) requirements of ARM 11.14.501, regarding facilities caring for infants, documentation of the absence of unusual health risks.~~

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

11.14.608 LEGALLY UNREGISTERED PROVIDERS: INTRODUCTION (1) ~~Legally~~ Except where otherwise specified, unregistered providers are ~~generally~~ not subject to department licensing or registration requirements applicable to "day care facilities" as the term is defined by statutes and rules. ~~For example, providers caring only for children "related by blood or marriage", as the phrase is defined in the Montana Child Care Act, are not operating as day care facilities under Montana law.~~ Nevertheless, ~~these~~ legally unregistered providers must be properly ~~registered~~ certified under this subchapter to receive payment for child day care services ~~from block grant funds~~.

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

11.14.609 LEGALLY UNREGISTERED PROVIDERS: ~~BLOCK GRANT REGISTRATION AND~~ CERTIFICATION REQUIREMENTS (1) remains the same.

(2) In addition to completing all required application forms for ~~registration and~~ certification under this subchapter, and absent ~~an~~ a written exception granted by the regional administrator, applicants for certification to provide child day care as legally unregistered providers must truthfully attest in writing that he or she:

(2)(a) through (2)(c) remain the same.

(d) is not currently diagnosed or receiving therapy or medication for a mental illness or emotional disturbance which might create a risk to children in care. Mental illness or emotional disturbance which might create a risk to children in care shall be determined by a licensed psychologist or psychiatrist. ~~The~~ Prior to certification, the department may ~~request~~ require that an applicant to obtain a psychological or psychiatric evaluation at his or her own expense if there is reasonable cause to believe such a mental illness or emotional disturbance exists; or

(e) is not chemically dependent upon drugs or alcohol. Chemical dependence on drugs or alcohol shall be determined by a licensed physician or certified chemical dependency counselor. ~~The~~ Prior to certification, the department may ~~request~~ require that the provider ~~to~~ obtain an evaluation at his or her own expense if there is reasonable cause to believe chemical dependence exists.

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

(d) is currently diagnosed or receiving therapy or medication for a mental illness or emotional disturbance which might create a risk to children in care. Mental illness or emotional disturbance which might create a risk to children in care shall be determined by a licensed psychologist or psychiatrist. ~~The~~ Prior to certification, the department may ~~request~~ require that a provider, caregiver or other person ~~to~~ obtain a psychological or psychiatric evaluation at his or her own expense if there is reasonable cause to believe such a mental illness or emotional disturbance exists; or

(e) is chemically dependent upon drugs or alcohol. Chemical dependence on drugs or alcohol shall be determined by a licensed physician or certified chemical dependency counselor. ~~The~~ Prior to certification, the department may ~~request~~ require that the household member or other person in contact with the children ~~to~~ obtain an evaluation at his or her own expense if there is reasonable cause to believe chemical dependence exists.

(4) and (5) remain the same.

(6) Legally unregistered providers must also meet the following requirements to be registered under this subchapter:

(a) be eighteen years of age or older;

(b) limit the care they provide to a period less than twenty-four hours in any day;

(c) care for no more than two children at a time, unless the children are from the same family. If the children are from separate families, then a legally unregistered provider may care for no more than two children ~~not counting the children of the provider over the age of two. Registration of providers caring for children of a single family in the home of the children where such providers care for more children than allowed under this subsection must be pursuant to the requirements of ARM 11.14.607~~;
and

(d) within 6 months of application, attend a training or orientation session provided or approved by the department which includes health and safety issues.

(7) remains the same.

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

11.14.610 COPY OF CONTRACT FOR SERVICES (1) In addition to ~~registration and~~ certification requirements, providers must enter into a contract with parents for payment under this subchapter on the form provided by the department. The minimum agreed terms filled in on the form must be sufficient to verify selection of the provider by the parent(s) and indicate that the provider is willing to provide the child day care services. Once the contract is executed by the parent(s) and the provider, a copy must be delivered to the district resource and referral office providing ~~registration/~~ certification for the provider.

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

3. It is necessary to amend rule ARM 11.14.106 to address concerns of department staff and providers that the rule's text appears to require registration or licensure without regard to any applicable exclusion. (For applicable exclusions, see, e.g., ARM 11.14.102's definition of day care facility.)

In the amendments to rules following the proposed amendment of ARM 11.14.106, it is necessary to delete references to "registration" as a prerequisite for participation of legally unregistered providers in state assisted child care programs. The use of the term "registration" has caused confusion because "registration" is also used in the Montana Child Care Act and department rules to signify compliance with rules governing operation of day care facilities defined as group and family day care homes. The term "certification" is sufficient to indicate compliance of providers with requirements for state-paid day care. The term is also sufficient to indicate compliance for all the different types of providers participating in the benefits' program. Therefore, references to "registration" of legally unregistered providers should be deleted.

Necessary amendments to the exclusions from income provisions of ARM 11.14.602(8) are also contained in this notice. The sources excluded from "income" under the proposed changes to the rule are monies not generally available to cover day care expenses. Therefore, they should be excluded from the definition of income.

It is also necessary to amend rules ARM 11.14.607 and 11.14.609 to eliminate confusion growing out of special application of facility registration requirements for providers caring for the children of a single family. Under these rules, the department established a special category of facility "registration" for these types of providers. Under this subcategory, some of the family day care home registration requirements had to be met, (see amendments deleting language to ARM 11.14.607) and a day care facility certificate had to be issued, prior to authorization of payment for care in the home of a single family where the number of children in care exceeded 2, not counting the provider's children over the age of 2. The provisions of ARM 11.14.609 and 11.14.607 implementing this special type of family day care home registration are proposed to be deleted. The provisions have proved too difficult to implement, and too easily circumvented.

Similarly, the limitation in ARM 11.14.609(6)(c) creating a special method for counting a legally unregistered provider's children is proposed to be deleted. Under the current rule, an applicant claiming exclusion from day care facility rules (legally unregistered provider status) must count their own children under the age of two. If the total number of children is three or more,

then the provider is subject to day care facility rules. For example, a provider with two children under two years of age caring for one child for whom state payment may be made must register as a family day care home prior to participation in the program. Generally, the same provider caring for no state-paid children could care for up to two children in addition to his or her own children (regardless of the age of his or her own children) prior to regulation under day care facility requirements. This special counting requirement has also proved too cumbersome and confusing to administer.

Examples of the difficulties encountered under the special requirements outlined in the previous two paragraphs have been compiled by department staff. According to staff, families and providers avoid application of the rules imposing facility registration requirements by listing two providers for the three children, even though only one of the listed providers actually cares for the children. Other families omit children present in the home and forgo claims for their care to avoid facility regulation. Some families use two caregivers in different locations, and while the providers and the family are thus in compliance with the regulations, the child care situation for the family is unnecessarily inconvenient.

Similar problems are typically a cost of regulation, and often the department has taken the position that such costs are necessary to assist in ensuring the safety and health of children in care. However, experience has shown that these special requirements do little to ensure safe and healthy child care. Therefore, the rules should be amended as proposed.

The proposed changes also include amendments to ARM 11.14.609(2) and (3). The change to the first sentence of ARM 11.14.609(2) is necessary to require that an exception from the listed provider qualifications be in writing. The regional administrator's exercise of authority in granting exceptions should be recorded on paper so that the exception is specified and so that there is a clear history of the granting of the exception. Language added to (6)(c) of ARM 11.14.609 also provides clarification on the issue of caring for the children of a single family. As discussed in reference to the changes to ARM 11.14.607, providers of care to a single family are generally not required to be licensed or registered as a day care facility, and may participate without registration or licensure as a day care facility.

Additional changes in this rulemaking update terms and improve grammar.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later

than February 28, 1997.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620, no later than February 28, 1997.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Ten percent of those directly affected has been determined to be more than 25 based on the number of providers, children and families subject to the effects of rule changes pertaining to excluding care of children of a single family from day care facility licensing and registration rules, and state payment for registered or licensed day care and unregistered day care.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State January 13, 1997.

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

In the matter of the adoption of Rule I pertaining to minimum standards for a hospital -- swing beds	)))))	NOTICE OF THE PROPOSED ADOPTION OF RULE NO PUBLIC HEARING IS CONTEMPLATED

TO: All Interested Persons

1. On March 10, 1997, the Department of Public Health and Human Services proposes to adopt rule I pertaining to minimum standards for a hospital -- swing beds.

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

RULE I MINIMUM STANDARDS FOR A HOSPITAL -- SWING BEDS

(1) A long term care patient occupying a hospital swing bed must be transferred within 5 days (excluding weekends and holidays) to a facility offering skilled nursing care or intermediate nursing care after learning that a skilled or intermediate nursing care bed is available or in the case of a prospective notification, within 5 days of the date the nursing home bed becomes available, unless the patient's physician certifies in writing that the transfer is not medically appropriate. The facility must be located within a 25 mile radius of the hospital and be capable of providing the appropriate level of care.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

3. Swing beds are temporary long term care beds in hospitals. A facility providing skilled nursing care or intermediate nursing care is required to meet specific resident and quality of care requirements for residents residing in their facility. A swing bed hospital service provider, however, is required to meet some, but not all, of those requirements. To ensure that a patient who requires long term care receives all the services necessary to promote and maintain the patient's highest potential, the department proposes, in Rule I, that a long term care patient in a hospital swing bed be transferred to a facility offering skilled nursing care or intermediate nursing care within 5 days from notice of the availability of a bed in that facility. The facility must be located within a 25 mile radius of the hospital and be capable of providing the appropriate level of care.

Currently, the swing bed requirements in ARM 46.12.510 through

46.12.513 apply only to Montana hospitals that have been enrolled as Medicaid swing bed providers. There are some Montana hospitals with swing beds that are not enrolled with Medicaid as a swing bed provider, and are therefore not regulated under the Medicaid swing bed requirements. Those hospitals are not required under any other law or rules to transfer a long term care patient occupying a swing bed to a long term care facility upon notice of bed availability. The standards proposed for adoption in Rule I will therefore regulate swing beds in Montana hospitals, whether or not those hospitals are enrolled as Medicaid swing bed providers. Of note, the Medicaid swing bed requirements require transfer within a shorter period of time than the 5 day transfer period proposed in Rule I. A Montana hospital that is enrolled with Medicaid as a swing bed provider, by meeting the Medicaid swing bed requirements, will comply with the standards proposed for adoption in Rule I.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than February 28, 1997.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620, no later than February 28, 1997.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Ten percent of those directly affected has been determined to be 15 based on the number of individuals affected by rules covering minimum standards for a hospital -- swing beds.

Dawn Sliva
Rule Reviewer

Russell E. Cater acting
Director, Public Health and Human Services

Certified to the Secretary of State January 13, 1997.

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

In the matter of the amendment of 16.10.1507 pertaining to area requirements, deck areas, handholds for swimming pools and spas	)))))	NOTICE OF THE PROPOSED AMENDMENT OF A RULE NO PUBLIC HEARING IS CONTEMPLATED

TO: All Interested Persons

1. On March 10, 1997, the Department of Public Health and Human Services proposes to amend ARM 16.10.1507 pertaining to area requirements, deck areas, handholds for swimming pools and spas.

2. The rule as proposed to be amended provides as follows. New language that is to be added is underlined. Language that is being deleted is interlined.

16.10.1507 AREA REQUIREMENTS, DECK AREAS, HANDHOLDS

(1) and (2) remain the same.

(3) The deck surface must meet the following requirements:

(a) The deck surface must be impervious and easily cleanable, and must entirely surround the swimming pool.

(b) Use of deck carpet is not permitted within 6 feet of the pool or spa.

(c) If deck carpet is used, it must be clean and be maintained in good repair.

(d) The department may allow a deviation from (3)(a) and (b) above after the applicant submits to the department:

(i) a written application that demonstrates to the department that the deviation does not have the potential to cause adverse public health effects, the use of deck carpeting is necessary for safety purposes due to the nature of the pool or spa, and no reasonable alternative to the use of deck carpeting exists; and

(ii) a written plan that describes measures ensuring the deck carpeting is thoroughly cleaned daily and appropriate methods of cleaning and sanitizing will be used.

(4) through (11) remain the same.

AUTH: Sec. 50-53-103, MCA
IMP: Sec. 50-53-107, MCA

3. Use of deck carpet within 6 feet of the pool or spa is not currently allowed under ARM 16.10.1507(3)(b) nor does the deviation procedure in ARM 16.10.1507(3)(d) authorize the department to allow a deviation from ARM 16.10.1507(3)(b). The department believes, after careful consideration, that there are certain circumstances, based upon the nature of the pool or spa,

that might necessitate the use of deck carpeting within 6 feet of the pool. Accordingly, it is necessary to amend ARM 16.10.1507(3)(d) to allow the department to grant a deviation from ARM 16.10.1507(3)(b) if the applicant, submitting the deviation request, shows that public health and safety can be maintained with, and no reasonable alternative exists to, the use of deck carpeting.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than February 28, 1997.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments to Laura Harden, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620, no later than February 28, 1997.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date. Ten percent of those directly affected has been determined to be more than 25 based on the number of individuals affected by the rule change pertaining to area requirements, deck areas, and handholds for swimming pools and spas.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State January 13, 1997.

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

In the matter of the adoption, amendment and repeal of rules in Titles 11 and 46 pertaining to mental health managed care services for medicaid recipients and other eligible persons	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION, AMENDMENT AND REPEAL OF RULES

TO: All Interested Persons

1. On February 18, 1997, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of rules I through IX; amendment of rules 11.13.101, 11.13.116, 11.13.201, 11.13.203, 11.13.205, 11.13.207, 11.13.211, 11.13.219, 46.2.202, 46.12.202, 46.12.204, 46.12.501, 46.12.502, 46.12.506, 46.12.507, 46.12.508, 46.12.509, 46.12.509A, 46.12.514, 46.12.516, 46.12.517, 46.12.570, 46.12.571, 46.12.572, 46.12.573, 46.12.1701, 46.12.1902, 46.12.2011, 46.12.4810, 46.12.5007; and repeal of rules 11.13.102, 11.13.112, 11.13.213, 11.13.217, 46.12.314, 46.12.580, 46.12.581, 46.12.582, 46.12.587, 46.12.588, 46.12.589, 46.12.590, 46.12.591, 46.12.592, 46.12.593, 46.12.595, 46.12.597, 46.12.599, 46.12.620, 46.12.622, 46.12.624, 46.12.1107, 46.12.1108, 46.12.1109, 46.12.1110, 46.12.1111, 46.12.1112, 46.12.1113, 46.12.1114, 46.12.1925, 46.12.1926, 46.12.1927, 46.12.1928, 46.12.1929, 46.12.1930, 46.12.1945, 46.12.1946, 46.12.1947, 46.12.1948, 46.12.1949, 46.12.1950 and 46.12.1951.

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 February 2, 1997, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] MENTAL HEALTH ACCESS PLAN, DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) "Adult" means an individual that is not a youth as defined in this rule.

(2) "Applicant" means an individual who is not a medicaid recipient and for whom the process to determine member eligibility has been initiated but not completed.

(3) "Correctional or detention facility" means:

(a) the Montana state prison, including the Warm Springs correctional facilities;

(b) the Montana women's correctional center;

(c) the Pine Hills school;

(d) the Billings transition center;

(e) the Youth Evaluation program;

(f) Montana youth alternatives campus and wilderness components, only when the youth has been placed in the program by the department or the Montana Department of Corrections;

(g) a Department of Corrections boot camp;

(h) a pre-release center;

(i) a juvenile detention center; or

(j) any privately operated or out-of-state facility that the state of Montana may choose to utilize in place of one of the above facilities or categories of facilities.

(4) "Covered diagnosis" means a diagnosis that is one of the ICD-9-CM or DSM-IV diagnoses identified and indicated as covered in attachment B to the department's managed mental health care request for proposals number 9709-K (October 1996). The department hereby adopts and incorporates by reference attachment B to the department's managed mental health care request for proposals number 9709-K (October 1996). A copy of the attachment may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(5) "Emergency" means a serious medical or behavioral condition resulting from mental illness which arises unexpectedly and manifests symptoms of sufficient severity to require immediate care to avoid jeopardy to the life or health of the member or harm to another person by the member.

(6) "Family" means a group of two or more persons related by birth, marriage or adoption who live together. All such related individuals are considered as members of one family.

(7) "Federal poverty level" or "FPL" means the 1996 poverty guidelines for the 48 contiguous states and the District of Columbia as published under the "Annual Update of the HHS Poverty Guidelines" in the federal register of March 4, 1996 and subsequent annual updates.

(8) "Managed care organization" or "MCO" means the entity with which the department has contracted to implement and operate the mental health access plan. The term includes the MCO's designee where the context allows.

(9) "Medicaid recipient" or "recipient" means an individual who has been determined medicaid eligible by the department and is receiving services through the Montana medicaid program.

(10) "Medically necessary" or "medically necessary services" means services and supplies which are required for

diagnosis, prevention or treatment of mental health conditions and which are:

(a) appropriate and consistent with the member's diagnosis;

(b) consistent with treating the symptoms of a mental illness or treating a mental condition; and

(c) appropriate with regard to standards of good practice and generally recognized by the scientific community as effective.

(d) The medicaid program definition of medically necessary services in ARM 46.12.102 does not apply to the term as used in this subchapter.

(11) "Member" means, with respect to the plan, an individual (or, as the context allows, the parent or guardian of the individual) eligible, according to the requirements of [Rule II], for services and receiving or attempting to receive services under the plan.

(12) "Mental health access plan" or "MHAP" or "plan" means the mental health access plan described in this subchapter.

(13) "Mental health services" means services covered as specified in [Rule IV] when provided with respect to a covered diagnosis.

(14) "Provider" means a person or entity that has enrolled and entered into a written contract with the MCO in accordance with the requirements of [Rule III] to provide mental health services to members.

(15) "Provider contract" means the written contract entered into between the MCO and a person or entity to provide mental health services to recipients.

(16) "Serious emotional disturbance" or "SED" means a serious emotional disturbance as defined in attachment A to the department's managed mental health care request for proposals number 9709-K (October 1996). The department hereby adopts and incorporates by reference the definition of serious emotional disturbance set forth in attachment A to the department's managed mental health care request for proposals number 9709-K (October 1996). A copy of the attachment may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(17) "Severe disabling mental illness" means a severe disabling mental illness as defined in attachment A to the department's managed mental health care request for proposals number 9709-K (October 1996). The department hereby adopts and incorporates by reference the definition of severe disabling mental illness set forth in attachment A to the department's managed mental health care request for proposals number 9709-K (October 1996). A copy of the attachment may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(18) "Total family income" means the total annual cash

receipts, as defined by the Bureau of the Census and cited in the "Annual Update of the HHS Poverty Guidelines" in the federal register of March 4, 1996, of all members of a family. Regular and continuing sources of income will be appropriately annualized for purposes of determining the annual income level. Extraordinary and nonrecurring income will be considered only for the 12 month period following receipt.

(a) Total family income does not include:

(i) money received as assets drawn down such as withdrawals from a bank or the sale of a house or a car; or

(ii) income tax refunds, gifts, loans, one-time insurance payments, except as beneficiary of a life insurance policy, or compensation for injury.

(19) "Youth" means an individual who has not yet attained 18 years of age, except that for purposes of the definition of serious emotional disturbance, "youth" may include an individual who has not yet attained 21 years of age if the person is enrolled in a full-time special education program.

AUTH: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113 and 53-6-701, MCA
IMP: Sec. 41-3-1103, 52-1-103, 53-6-113, 53-1-601, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-21-139, 53-21-202, MCA

[RULE II] MENTAL HEALTH ACCESS PLAN, MEMBER ELIGIBILITY

(1) Individuals that the department has determined eligible for medicaid through the usual medicaid application and eligibility determination processes are eligible for covered services under the plan. No application or other enrollment is required for an individual who has been determined medicaid eligible by the department.

(a) Eligibility under the plan includes coverage of services provided to a medicaid eligible member back to the date of retroactive eligibility, but provided no earlier than April 1, 1997.

(2) Individuals that have not been determined by the department to be eligible for medicaid are eligible for covered services under the plan if:

(a) the individual is a youth with a serious emotional disturbance or an adult with a severe disabling mental illness; and

(b) except as excluded by definition in (Rule I (18)(a)), the family of which the individual is a member has a total family income, without regard to other family resources, at or below 200% of the most recently published federal poverty level.

(3) For purposes of determining the total family income under (2)(b):

(a) the family will not be permitted to spend down to the required level of income;

(b) all cash receipts are considered as income, regardless

of source;

(c) family debts, expenses and other financial circumstances are not considered;

(d) the most recently published federal poverty level (FPL) is the FPL most recently published in the federal register as of the end of the month immediately preceding the month in which the application is submitted to the MCO.

(4) The MCO will determine eligibility for non-medicaid eligible individuals. The MCO will also determine the copayment amounts applicable to individuals determined eligible under (2).

(a) Applications and information regarding eligibility for non-medicaid eligible individuals will be available at all local county human services departments and from the MCO.

(b) Applications, together with required income statements and income verification, must be submitted to the MCO on the forms provided by the MCO.

(c) The applicant must submit with the application a completed and signed income statement and the necessary documentation to verify the income reported.

(5) For purposes of (4)(c), necessary income verification may include one or more of the following or other appropriate and persuasive documentation:

(a) pay stubs or other pay statements;

(b) employee's W-2 forms;

(c) state or federal income tax returns and associated forms and schedules;

(d) union records;

(e) check copies;

(f) self-employment bookkeeping records;

(g) sales and expenditure records;

(h) employer's wage or payroll records;

(i) award notices or award letters;

(j) correspondence specifying a benefit;

(k) records of any government payer;

(l) court records or correspondence from attorneys;

(m) financial institution records;

(n) insurance company correspondence or records; or

(o) college or university financial aid correspondence or records.

(6) For non-medicaid individuals determined eligible for the plan under (2), eligibility and the copayment amounts determined by the MCO are effective for a period of one year unless the federal poverty level or the member's income or family composition changes before the expiration of the 1 year eligibility period.

(a) Eligibility must be redetermined within 1 year after the most recent determination or sooner based upon changes in income, family composition or the federal poverty level. Members may be required by the MCO to submit completed forms and verification by a specified date for purposes of eligibility redetermination.

(b) Non-medicaid eligible members must notify the MCO of any change in total family income or family composition within 30 days of the change. Failure to so notify the MCO will be grounds for termination of eligibility until such time as complete and accurate income and family composition information is provided to the MCO.

(c) The MCO must adjust the maximum amount of copayment due from any member or member family within 5 working days of receiving documentation of changes in income or family composition that would change the copayment maximum calculated under [Rule VI(4)].

(d) If a member's plan eligibility will end based upon a change in the federal poverty level, income or family composition, termination of eligibility will be effective no earlier than 30 days after mailing of written notice of termination by the MCO to the member.

(e) An individual is liable to the MCO and the MCO may collect from the individual the actual cost of any services furnished to the individual, including any additional copayment amount that may be due, because of misrepresentation of income or a failure to notify the MCO of material changes in income or family composition.

(7) If an individual attempts to access mental health services through the plan in an emergency, the individual will be presumed eligible and will receive medically necessary services for a covered diagnosis. If the individual is subsequently determined ineligible for the plan or fails to complete an application for plan eligibility within 60 days following completion of emergency treatment, the individual shall be liable for and may be billed by the provider at its usual and customary private pay charges or by the MCO for the amount of payments actually made by the MCO to the provider for the services provided.

(8) In addition to meeting any additional member notification and education requirements under its contract with the department, the MCO must provide all applicants with current, accurate, understandable information regarding covered diagnoses, available services, procedures to access services, financial liability for services obtained outside the plan, the amount of and financial liability for copayments and grievance and appeal procedures.

(a) Members must comply with the procedures specified by the MCO in accordance with (8) to obtain or access services under the plan.

AUTH: Sec. 41-3-1103, 53-2-201, 53-6-113, 53-6-131, 53-6-701, and 53-6-706, MCA
IMP: Sec. 41-3-1103, 53-2-201, 53-1-601, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA

[RULE III] MENTAL HEALTH ACCESS PLAN, PROVIDER PARTICIPATION (1) Providers of services may request enrollment in the plan and may participate in the plan only upon approval of enrollment and according to the written contract between the provider and the MCO and the requirements of this subchapter.

(2) Providers in the following categories may request enrollment in the plan:

(a) acute care hospitals;

(b) residential treatment facilities;

(c) therapeutic youth group homes;

(d) community mental health centers;

(e) Montana state mental health institutions, i.e., the Montana state hospital and Montana mental health nursing care center;

(f) psychiatrists;

(g) primary care physicians;

(h) advanced practice registered nurses;

(i) physician assistants;

(j) licensed psychologists;

(k) licensed clinical social workers;

(l) licensed professional counselors;

(m) therapeutic foster care providers;

(n) transitional living group homes;

(o) federally qualified health centers (FQHCs) which currently provide mental health services; and

(p) other categories designated by the MCO.

(3) The MCO will enroll as providers all individuals or entities in the categories of providers specified in (2) if they apply for enrollment, if they are appropriately licensed, certified, or otherwise meet the minimum qualifications required by the MCO for the category of service, and if they agree to the terms of the provider contract.

(a) A provider may be denied enrollment for good cause, which must be communicated in writing to the provider by the MCO. A participating provider has no right to an administrative review or fair hearing as provided in ARM 46.2.201, et seq., 46.12.409, 46.12.509A, 46.12.1268 or any other department rule for a denial of enrollment.

(b) There are no limitations on the total number of providers which may be enrolled or on the time period in which enrollment may be accepted. However, enrollment does not imply or create any guarantee of or right to any level of utilization or reimbursement for any provider.

(4) The provisions of ARM 46.12.301, 46.12.302, 46.12.304, 46.12.306, 46.12.307, 46.12.309 and 46.12.310 and other medicaid program laws, rules and regulations do not apply to participating providers or the services provided under these rules, except as specifically provided in this subchapter or the provider contract.

(a) The provisions of ARM 46.12.303 related to payment in full apply to payments by the MCO to providers, except as

otherwise provided in this subchapter. The remaining provisions of ARM 46.12.303, relating to claim submission and other matters do not apply to providers with respect to mental health services provided under the plan.

(b) The provisions of ARM 46.12.308 regarding maintenance of records and related issues applies to mental health services provided under the plan.

(i) The department and any legally authorized agency of the state or federal government may inspect any facilities and records pertaining to services provided under the plan, including those of any provider participating in the plan.

(ii) Upon request, providers must provide complete copies of medical records to the department, the MCO or the hearing officer.

(c) For all members, providers must comply with confidentiality requirements that apply to information regarding medicaid recipients.

(5) Providers may rely upon the state-issued medicaid card as proof of plan eligibility.

(6)(a) A participating provider has no right to an administrative review or fair hearing as provided in ARM 46.2.201, et seq., 46.12.409, 46.12.509A, 46.12.1268 or any other department rule for:

(i) a denial of payment by the MCO to the provider for a service provided to a recipient;

(ii) a denial of approval or coverage of a service available from the provider or provided by the provider to a recipient; or

(iii) any other issues related to the provider contract, the provision of services to recipients or the plan.

(b) The provider's sole remedy is as may be provided under the contract or as provided by law based upon the contract.

AUTH: Sec. 41-3-1103, 53-2-201, 53-6-113, MCA
IMP: Sec. 41-3-1103, 53-1-601, 53-2-201, 53-6-113, 53-6-116, 53-6-701 and 53-6-705, MCA

[RULE IV] MENTAL HEALTH ACCESS PLAN, COVERED SERVICES

(1) Medically necessary mental health services for a covered diagnosis are covered under the plan for members, except as provided in this subchapter.

(2) Covered services include:

(a) crisis stabilization and emergency services available 24 hours per day each day of the year;

(b) evaluation and assessment;

(c) treatment planning and service coordination;

(d) community inpatient hospitalization for stabilization of psychiatric conditions;

(e) Montana state hospital inpatient psychiatric hospitalization;

(f) Montana mental health nursing care center services for

extended care of psychiatric conditions;

(g) residential treatment facility services for children and adolescents;

(h) physician, advanced practice nurse, and physician assistant services for screening and identifying psychiatric conditions and for medication management;

(i) outpatient hospital care for psychiatric conditions, including necessary emergency room care for covered diagnoses;

(j) a psychotropic drug formulary, as specified in (6), for non-medicaid eligible members;

(k) medication management;

(l) psychological assessments, individual, group and family therapy, and consultations performed by licensed psychologists, licensed clinical social workers, and licensed professional counselors for treatment of specified diagnoses in private practice or in community mental health centers;

(m) intensive case management services for adults with a serious disabling mental illness and for youths with severe emotional disturbance;

(n) mental health services provided in a nursing facility that are beyond the scope of services required by law to be provided by the nursing facility;

(o) the therapeutic component of therapeutic youth group home care and therapeutic foster care services for children and adolescents;

(p) day treatment services for adults with severe disabling mental illness;

(q) supported living services, to include community living skills development, social rehabilitation services, crisis residential services, transitional and other supported housing such as group homes, and supportive counseling, for members with a serious mental illness;

(r) rehabilitation services including supported employment and other vocational supports for adults with severe disabling mental illness and for youths with severe emotional disturbance;

(s) school-based day treatment for children and adolescents;

(t) school-based prevention services for at-risk children and adolescents;

(u) family, consumer and parent information and education services;

(v) respite services for families of youths with severe emotional disturbance and for families who are primary caregivers of adults with severe disabling mental illness;

(w) appropriate educational services for youths in covered stays in a child psychiatric hospital or residential treatment facility; and

(x) other services, including consumer-operated alternatives, designated by the MCO.

(3) The category of services, the particular provider of services, the duration of services and other specifications

regarding the services to be covered for a particular recipient may be determined and may be restricted by the MCO based upon and consistent with the services medically necessary for the member, the availability of appropriate alternative services, the relative cost of services, the member's treatment plan objectives and other relevant factors.

(a) The MCO shall make available to members and participating providers its:

(i) criteria or standards used for restricting a member to a provider or set of providers;

(ii) processes for reviewing and criteria for authorizing inpatient and residential admissions and for discharging inpatients to step-down services.

(4) The MCO may require prior authorizations for any particular services other than emergency services and a specified number of outpatient visits as stated in the MCO's contract with the department. The MCO must notify members of current, accurate and understandable information regarding the services subject to prior authorization and all requirements for accessing services.

(a) Members must comply with the procedures specified by the MCO in accordance with [Rule II(8)] to obtain or access services under the plan.

(5) Coverage of medically necessary mental health services for a covered diagnosis will not be denied solely because the member also has a non-covered diagnosis.

(6) For non-medicaid eligible members, the plan covers the medically necessary psychotropic medications listed in the MHAP drug formulary. The initial drug formulary is contained in attachment D to the department's managed mental health care request for proposals number 9709-K (October 1996). The department in consultation with the MCO, may revise the formulary from time to time and the MCO must notify members of revisions to the formulary. A copy of the current formulary may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(7) Except as provided in (7)(a), the plan will cover medically necessary mental health services for covered diagnoses for members who are residents of nursing facilities, regardless of whether the services are provided in the nursing facility.

(a) The plan will not cover services defined as "nursing facility services" in ARM 46.12.1222 or otherwise required by law to be provided by the nursing facility and will not cover or reimburse the nursing facility for services provided by the nursing facility.

(b) Subsection (7)(a) does not apply to the state hospital at Warm Springs or the Montana mental health nursing care center.

(8) Regardless of diagnosis, members admitted voluntarily or involuntarily to the Montana state hospital, will receive

Montana state hospital services under the plan, except for the following members:

(a) forensic admissions under 46-14-202(1), MCA (court-ordered evaluations), 46-14-221, MCA (fitness to proceed), 46-14-301(2), MCA (not guilty by reason of lack of mental state) or 46-14-312(1), MCA (treatment sentence);

(b) inmates transferred from a correctional or detention facility for treatment;

(c) individuals covered and served under a contract between Montana state hospital and Indian Health Services; and

(d) individuals detained at the Montana state hospital prior to a commitment hearing under 53-21-124 or 53-21-129, MCA.

(9) Regardless of diagnosis, members admitted voluntarily or involuntarily to the Montana mental health nursing care center will receive all long-term care services under the plan, including medically necessary mental health services.

(10) For members dually eligible for medicare and medicaid, the MCO must pay the medicare coinsurance and deductible amounts that apply to any medicare-reimbursed services in treatment of a covered diagnosis, if the member chooses to obtain mental health services outside the plan.

(11) Native American members may choose to access medically necessary services for a covered diagnosis either through the plan or, if eligible, through the Indian Health Service, except that Native American members admitted to the Montana state hospital will, if eligible, be covered under contract with Indian Health Services rather than under the plan.

(12) The plan covers appropriate medically necessary mental health services for any covered diagnosis for a member with a primary diagnosis of mental retardation or developmental disability, but does not cover treatment, habilitation or other services required by the member's mental retardation or developmental disability.

(13) The plan does not cover:

(a) any form of transportation services;

(b) prescription or other drugs for medicaid eligible recipients, but the plan covers medically necessary psychotropic drugs as provided in (6) of this rule for persons eligible for the plan under [Rule II(2)];

(c) detoxification, drug or alcohol treatment or rehabilitation, regardless of the member's diagnosis.

(14) The services described in (13)(a), (b) and (c), even if necessary with respect to a mental health condition, will be covered for medicaid recipients under the medicaid program to the extent provided under applicable medicaid requirements.

(15) A member who is an inmate in or incarcerated in a correctional or detention facility is not entitled to services under the plan, except as specifically provided in these rules.

(a) The plan will cover discharge planning services in relation to a covered diagnosis prior to release from a correctional or detention facility for a member who is:

(i) a youth under the custody of the department's division of child and family services or the Department of Corrections and who is in a correctional or detention facility;

(ii) a member who is a prisoner in the Montana correctional system;

(iii) a member who is a forensic patient, as specified in (8)(a), admitted to the Montana state hospital; or

(iv) a member being held in a juvenile correction facility.

(b) A member may receive medically necessary mental health services for covered diagnoses after leaving the correctional or detention facility, except that the plan will not cover the individual's security or detention needs.

AUTH: Sec. 41-3-1103, 52-1-103, 53-6-706, and 53-2-201, MCA

IMP: Sec. 41-3-1103, 52-1-103, 53-1-405, 53-1-601, 53-2-201, 53-6-116, 53-6-701, 53-6-705, 53-6-706, 53-21-139, 53-21-202, MCA

[RULE V] MENTAL HEALTH ACCESS PLAN, PROVIDER REIMBURSEMENT

(1) Reimbursement of providers for mental health services provided to members under the plan is as provided in the provider contract. Other department rules, including medicaid rules, are not applicable except as specifically provided in this subchapter or the provider contract.

(2) Provider claims for mental health services provided to members under the plan must be submitted to the MCO for payment as specified in the provider contract. Except for encounter claims submitted to the department's medicaid management information system (MMIS) contractor as specified in the provider contract, provider claims for mental health services provided under the plan will not be accepted or processed by the department, Consultec or other department agents. Payments will not be made to the provider by the department, Consultec or other department contractor, other than the MCO as specified in the provider contract.

(3) Providers must accept the amounts payable under the provider contract, including any copayments the provider is permitted by the contract to collect from the member and retain, as payment in full for services provided to members. For purposes of this rule, the requirements of ARM 46.12.303 regarding payment in full apply to the provider and for purposes of applying such provisions the term "MCO" shall be substituted for "department."

(4) The MCO is responsible for investigating and collecting member's third party resources and seeking payment from these sources, as provided in the provider contract.

(a) To the extent and in the manner specified by the provider contract, the MCO or the provider is entitled to payment of or credit for all funds collected from third party resources.

(b) A complete record of all payments received from third party sources must be maintained and reported as required in the contract.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-1-601, 53-2-201, 53-6-701 and 53-6-705, MCA

[RULE VI] MENTAL HEALTH ACCESS PLAN, MEMBER COPAYMENTS

(1) Copayments may be charged to and collected from members by providers or the MCO only as provided in this rule.

(2) Medicaid-eligible members may not be charged or required to pay copayments for mental health services provided under the plan. This rule does not in any way reduce the liability of a resident of a state institution to pay charges for the cost of care as provided in Title 53, chapter 1, part 4, MCA and implementing rules.

(3) Except as provided in this rule and subject to the limits specified in (4), members who are not medicaid eligible shall pay copayments as follows:

(a) a copayment of $10.00 for each outpatient service or session, including but not limited to individual therapy, group therapy, evaluation or assessment, crisis service, prescription, in-home service, and community rehabilitation service;

(b) a copayment of $50.00 per day for each day in any 24-hour out-of-home service, including but not limited to inpatient hospitalization, residential treatment, therapeutic group care, and therapeutic foster care; and

(c) a copayment of $50.00 for each emergency room visit.

(4) For any calendar month, the total amount of copayments under (3) shall not exceed:

(a) for any member or member family with a total family income less than or equal to 125% of the federal poverty level, 5% of one-twelfth of the annual total family income;

(b) for any member or member family with a total family income greater than 125% and less than or equal to 175% of the federal poverty level, 10% of one-twelfth of the annual total family income; and

(c) for any member or member family with a total family income greater than 175% and less than or equal to 200% of the federal poverty level, 15% of one-twelfth of the annual total family income.

(5) The MCO may refuse to provide services under the plan, except emergency services or services provided by the Montana state hospital or the Montana mental health nursing care center, to any member who has accumulated unpaid copayments more than 90 days in arrears in excess of an amount equal to 2.5 times the monthly maximum copayment established for the member of family under (4), if:

(a) the member or the member's family are not making a good faith effort to pay accumulated copayments; and

(b) the MCO has made good faith efforts to collect the amount owed.

(6) Residents of the Montana state hospital and the Montana mental health nursing care center, whether or not medicaid eligible, will be liable to the institution for amounts assessed by the department pursuant to Title 53, chapter 1, part 4, MCA and implementing rules. Residents of the Montana state hospital and the Montana mental health nursing care center will not be responsible in addition to such amounts for the copayments specified in this rule. Copayments due to the MCO with respect to these residents will be settled by the department with the MCO on a periodic basis as provided in the contract between the MCO and the department.

(7) The provisions of ARM 46.12.204 are not applicable to mental health services provided under the plan.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-131, MCA
IMP: Sec. 53-1-405, 53-1-601, 53-2-201, 53-6-113 and 53-6-131, MCA

[RULE VII] MENTAL HEALTH PLAN, MEMBER NOTICE AND APPEAL RIGHTS (1) Subject to the requirements of this rule, a member has the right to a fair hearing as provided for claimants at ARM 46.2.201, et seq., regarding denials of eligibility or service coverage for mental health services under the plan.

(2) The MCO must notify the member or the member's designated representative in writing of a decision denying a request for services. The notice must be provided within 10 days after a decision is made by the MCO. The requirements of ARM 46.2.204 do not apply to the notice. The notice must state:

(a) the member's name and identifying information;

(b) a statement of the decision, including the specific services, dates and other information necessary to identify the matter at issue;

(c) a concise statement of the reasons for the decision;

(d) the legal authority supporting the decision; and

(e) an explanation of how to contest the determination and a telephone number to call for additional information.

(3) If the MCO fails to provide notice or fails to timely provide notice or if a notice required by (2) fails to comply substantially with the requirements of (2), the remedy shall be provision of a new notice which does comply substantially with (2) and a new opportunity to contest the decision specified in the notice. A failure to give adequate or timely notice under (2) shall not entitle the member to an authorization.

(4) The MCO will provide a written procedure for resolution of grievances brought by a member or the member's representative. A member may submit a grievance to the MCO within 10 days after mailing of notice of the decision to the member or the member's designated representative. A member must exhaust the MCO's grievance procedure before exercising the administrative review panel procedure specified in (5).

(5) If the MCO in whole or in part denies a member's

grievance regarding a denied request for approval of services, the member or the member's representative may request that the department conduct an administrative panel review of the MCO's decision. The request must be submitted in writing to the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The request must be received by the division within 30 days of the date of the mailing of the notice of the MCO's denial of the grievance.

(a) The department may request additional supporting information or documentation from the member, the provider or the MCO for purposes of reviewing and deciding the administrative review panel case.

(b) The department will convene a panel of 3 members, selected by the department with due consideration of the necessary qualifications for the case at issue, to consider and decide the matter. The panel proceeding will be conducted informally. The panel will consider the written materials submitted, the rationale for the decision provided by the MCO. In its discretion, if the department panel finds that resolution of the issues would be aided, the panel or members of the panel may contact persons involved in the case, interested agencies or mental health professionals and may request that the member, the member's representative, a mental health professional, a representative of the MCO, a provider representative or other appropriate persons to appear in person or by telephone conference to discuss the case.

(c) The department must make a decision on the administrative panel review and notify the member or the member's representative in writing of the decision.

(6) The administrative review panel decision is final and binding on the MCO. The MCO is not entitled to an administrative hearing as provided in ARM 46.2.201, et seq., 46.12.409, 46.12.509A, 46.12.1268 or any other department rule to contest an adverse administrative review panel decision.

(7) A member has the right of appeal as provided at ARM 46.2.201, et seq., to contest an adverse administrative review panel decision, but must exhaust the administrative review panel procedure before a fair hearing may be requested from the department under the provisions of ARM 46.2.201, et seq.

(8) A member that does not timely submit a grievance or a request for an administrative panel review will be deemed to have accepted the agent's determination and is not entitled to any further notice or appeal opportunity.

(9) For purposes of ARM 46.2.202(1)(c), the 90 day appeal period starts on the day the department mails to the member or the member's representative a written notice of the administrative review panel decision.

(10) The administrative review process provided in ARM 46.2.208 does not apply to a member request for a fair hearing to contest an administrative review panel decision under (7).

(11) The member and the MCO are the parties to a fair hearing case brought by a recipient under this rule. The department is not a party to a fair hearing case brought by a member under this rule.

(12) The provisions of this rule apply in addition to the applicable provisions of ARM 46.2.201, et seq., except that the provisions of this rule shall control in the event of a conflict with the provisions of ARM 46.2.201, et seq. The provisions of ARM 46.12.409, 46.12.509A, 46.12.1268 or any other department appeal or hearing provision do not apply to a review or hearing under this rule.

(13) A member is not entitled to continuation of benefits under ARM 46.2.206 or 42 CFR part 431, subpart E, unless the decision at issue is a rescission by the MCO of a specifically granted approval for a particular service for a specific period of time. The member is not entitled to a continuation of benefits where the MCO granted approval for a service for a period of time or number of units but the MCO denies approval for additional periods or units of service.

AUTH: Sec. 2-4-201, 53-2-201, 53-6-113 and 53-6-706, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-1-601, 53-6-113 and 53-6-706, MCA

[RULE VIII] MENTAL HEALTH ACCESS PLAN, TRANSITION FROM RULES IN EFFECT PRIOR TO APRIL 1, 1997 (1) Notwithstanding any provision of this subchapter, under no circumstances will the plan cover services provided prior to April 1, 1997.

(2) Individuals receiving mental health services prior to April 1, 1997 under any state program including but not limited to medicaid, managing resources Montana, a state mental health program, or a state child and family services program, will not be entitled under any such program to further mental health services provided on or after April 1, 1997. This rule applies regardless of whether the member has completed any prescribed course of treatment, whether admission occurred, or continued stay or services were approved for any particular period of time under such program. Continued state funding will be available for mental health services provided on or after April 1, 1997 only as provided in this subchapter.

(3) Information and assistance in assuring a transition to the plan that allows for continuation of medically necessary services without interruption will be provided upon request by the MCO.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-1-601 and 53-2-201, MCA

[Rule IX] THERAPEUTIC YOUTH GROUP HOME, APPLICABILITY AND PARTICIPATION (1) ARM Title 11, chapter 13, subchapter 1

applies to services that the department, in its discretion, elects to provide to a youth through a contract between the provider and the department outside the mental health managed care program provided under [Rules I through VIII]. These rules do not entitle a youth to any of the services described in this subchapter.

(2) Participation of therapeutic family care agencies and treatment families in the department's program for therapeutic family care depends on compliance with applicable licensing and program requirements. Participation is limited to agencies and families with which the department, in it discretion, has entered into a written contract.

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122, 41-3-1105 and 52-1-103, MCA

3. The rules as proposed to be amended provide as follows. New language that is being added is underlined. Language that is to be deleted is interlined.

11.13.101 THERAPEUTIC YOUTH GROUP HOME, DEFINITIONS

(1) and (2) remain the same.

(3) "Moderate level" means the supervision and intensity of treatment required in a therapeutic youth group home as specified in ARM 11.13.104 to manage and treat children who present emotional and/or behavioral disorders as ~~evidenced by meeting three or more of the medical necessity criteria set forth in ARM 11.13.102~~ determined by the department. Therapeutic interventions such as individual and group therapy are provided several times per week. In addition to the treatment, the children are provided with 24 hour awake staff supervision.

(4) "Campus based" means the supervision and intensity of treatment required in a therapeutic youth group home as specified in ARM 11.13.106 to manage and treat children who present severe emotional and/or behavioral disorders as ~~evidenced by meeting four or more of the medical necessity criteria set forth in ARM 11.13.102~~ determined by the department. Treatment, therapeutic interventions and supervision are tailored to the age and diagnosis of the children served. Therapeutic interventions are individualized and are provided several times per day. Campus based level care is provided on a campus where treatment is provided throughout the milieu. In addition to treatment, the children are provided with 24 hour awake staff supervision.

(5) "Intensive level" means the supervision and intensity of treatment required in a therapeutic youth group home as specified in ARM 11.13.108 to manage and treat children who present severe emotional and/or behavioral disorders as ~~evidenced by meeting five or more of the medical necessity~~

~~criteria set forth in ARM 11.13.102~~ determined by the department. Treatment, therapeutic interventions and supervision are tailored to the age and diagnosis of the children served. Therapeutic group and individual interventions are provided several times per day. In addition, specialized behavior management techniques are incorporated into the treatment and supervision of children requiring intensive level services. The children are provided with 24 hour awake supervision.

(6) and (7) remain the same.

~~(8) "Medical necessity statement" documents the moderate, campus based or intensive level of therapeutic youth group home services ordered by the physician, clinical psychologist, master level social worker (MSW), or licensed professional counselor (LPC).~~

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA
IMP: Sec. 41-3-1102, 41-3-1142 and 52-2-111, MCA

11.13.116 MEDICAL NECESSITY, ADDITIONAL CASE RECORDS

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

(a) referral form/authorization for services;

(b) ~~medical necessity statement;~~

~~(c)~~ individual treatment plan, signed by the LCS, which documents the child's response to treatment (progress or lack of progress), and the staff's interaction and involvement with the client; and

~~(d)~~ (c) weekly clinical progress notes, reviewed and signed by the LCS, which summarize the child's program participation and psychosocial/behavioral status and functioning.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA

11.13.201 THERAPEUTIC FAMILY CARE, COMPLIANCE WITH APPLICABLE REQUIREMENTS (1) Title 11, Chapter 13, Subchapter 2 applies to services that the department, in its discretion, elects to provide to a youth through a contract between the provider and the department outside the mental health managed care program provided under [Rules I through VIII]. These rules do not entitle a youth to any of the services described in this subchapter.

(2) Participation of therapeutic family care agencies and treatment families in the department's program for therapeutic family care depends on compliance with applicable licensing and program requirements. Participation is limited to agencies and families with which the department, in it discretion, has entered into a written contract.

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

11.13.203 THERAPEUTIC FAMILY CARE, DEFINITIONS

(1) remains the same.

~~(2) "Certification" or "certified" means that therapeutic family care requirements for medicaid covered therapeutic family care have been met including the applicable medical necessity criteria for the moderate or intensive level of therapeutic family care and the requirement that the service be ordered by a licensed clinical professional on a medical necessity statement.~~

(3) through (6) remain the same in text but are renumbered (2) through (5).

~~(7)~~ (6) Intensive level" means the supervision and intensity of treatment required in a therapeutic family as specified in this subchapter to manage and treat youths who present severe emotional and/or behavioral disorders as ~~evidenced by meeting five or more of the medical necessity criteria set forth in ARM 11.13.213~~ determined by the department in accordance with ARM 11.13.205. This level of therapeutic family care must be ~~certified~~ reapproved by the department every 90 days. An individual treatment plan, developed according to the youth's age, diagnosis and behaviors, determines treatment needs. This level requires:

(a) the services of a mental health assistant who receives routine guidance from the treatment parents; and

(b) specialized support services.

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

~~(9) "Medical necessity statement" means the document which is used to establish the certification criteria in ARM 11.13.213 for intensive or moderate therapeutic family care ordered by a licensed clinical professional.~~

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

~~(11)~~ (9) "Moderate level" means the supervision and intensity of treatment required in a therapeutic family as specified in this subchapter to manage and treat youths who present severe emotional and/or behavioral disorders as ~~evidenced by meeting four or more of the medical necessity criteria set forth in ARM 11.13.213~~ determined by the department in accordance with ARM 11.13.205. An individual treatment plan, developed according to the youth's age, diagnosis and behaviors, determines treatment needs. Specialized behavior management techniques are required for some youth at this level of therapeutic family care.

~~(12) "Severe emotional disturbance" (SED) has the meaning as defined in ARM 46.12.1946.~~

(13) through (18) remain the same in text but are renumbered (10) through (15).

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

11.13.205 THERAPEUTIC FAMILY CARE, LEVELS OF SERVICE (1) and (2) remain the same.

(3) Youths not ~~certified~~ approved by the department for therapeutic family care may be placed with certified youths in a treatment family when:

(3)(a) remains the same.

(b) this service is necessary to maintain a parent/child relationship when the parent is a youth who has been ~~certified~~ approved by the department for therapeutic family care; or

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

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

11.13.207 THERAPEUTIC FAMILY CARE, STAFF (1) through (3) remain the same.

(a) is responsible for the overall provision of therapeutic services for youths ~~certified~~ approved by the department to receive therapeutic family care through the provision of clinical oversight, supervision and consultation;

(3)(b) through (7)(b)(iii) remain the same.

(iv) supervise and/or care for a youth or youths other than the youth ~~certified~~ approved by the department to receive intensive level therapeutic family care; or

(7)(b)(v) remains the same.

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

11.13.211 THERAPEUTIC FAMILY CARE, INDIVIDUAL TREATMENT PLAN (1) through (3)(f) remain the same.

~~(g) include the initial medical necessity statement and any subsequent certifications as required in ARM 11.13.213;~~

~~(h)~~ (g) include chemotherapy as prescribed, response to the chemotherapy, all physical reactions and the recommendation for continuance/discontinuance. The youth's attitude toward the prescribed chemotherapy will also be recorded.

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

11.13.219 THERAPEUTIC FAMILY CARE, MEDICAL NECESSITY, ADDITIONAL CASE RECORDS (1) remains the same.

~~(a) medical necessity statement and required recertifications;~~

(1)(b) through (1)(d)(v) remain the same in text but are renumbered (1)(a) through (1)(c)(v).

(vi) ~~other~~ any medicaid reimbursed services;

(1)(d)(vii) and (viii) remain the same in text but are renumbered (1)(c)(vii) and (viii).

AUTH: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA

IMP: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

46.2.202 OPPORTUNITY FOR HEARING (1) through (2)(a) remain the same.

(3) Nursing facilities ~~and institutions for mental disease~~ contesting adverse department actions, other than medical assistance providers appealing eligibility determinations as a real party in interest, shall be granted the right to a hearing as provided in ARM 46.12.1268.

(4) Medical assistance providers of ~~residential treatment services for individuals under age 21,~~ inpatient hospital services, outpatient hospital services, swing-bed hospital services, federally qualified health center services and case management services for high risk pregnant women contesting adverse department actions, other than medical assistance providers appealing eligibility determinations as a real party in interest, shall be granted the right to a hearing as provided in ARM 46.12.509A.

(5) and (6) remain the same.

AUTH: Sec. 2-4-201, 41-3-1142, 53-2-201, 53-2-606, 53-2-803, 53-3-102, 53-4-111, 53-4-212, 53-4-403, 53-4-503, 53-5-304, 53-6-111, 53-6-113, 53-7-102 and 53-20-305, MCA
IMP: Sec. 2-4-201, 41-3-1103, 53-2-201, 53-2-306, 53-2-606, 53-2-801, 53-4-112, 53-4-404, 53-4-503, 53-4-513, 53-5-304, 53-6-101, 53-6-111, 53-6-113 and 53-20-305, MCA

46.12.202 ~~PROCEDURES FOLLOWED IN PROCESSING APPLICATIONS~~ SELECTION OF PROVIDER (1) ~~Any~~ Except as otherwise provided in title 46, chapter 12 or [Rules I through VIII] any individual eligible for medical assistance may obtain the services available from any institution, agency, pharmacy, or practitioner, qualified to perform such services and participating under the program, including an organization which provides these services or arranges for their availability on a prepayment basis.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-6-116 and 53-6-132, MCA

46.12.204 RECIPIENT REQUIREMENTS, COPAYMENTS (1) ~~Each~~ Except as provided in (2) through (4) or [Rule VI], each recipient~~, unless eligible for an exemption,~~ must pay to the provider the following co-payments not to exceed the cost of the service:

(1)(a) through (j) remain the same.

~~(k) licensed clinical psychologist services, $1.00 per service;~~

(1)(l) through (q) remain the same in text but are renumbered (1)(k) through (p).

~~(r) licensed clinical social worker services, $1.00 per service;~~

(1)(s) through (w) remain the same in text but are renumbered (1)(q) through (u).

~~(x) licensed professional counselor services, $1.00 per service~~.

(2) through (4) remain the same.

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

46.12.501 SERVICES PROVIDED (1) ~~The~~ Except as otherwise provided in this rule, the following medical or remedial care and services shall be available to all persons who are certified eligible for medicaid benefits under this chapter (including deceased persons, categorically related, who would have been eligible had death not prevented them from applying)~~, except certain recipients of AFDC related medical assistance as provided in (2)~~. However, only those medical or remedial care and services also covered by medicare shall be available to a person who is certified eligible for medicaid benefits as a qualified medicare beneficiary under ARM 46.12.4101 and 46.12.4102.

(1)(a) through (w) remain the same.

~~(x) psychological services;~~

~~(y) licensed clinical social workers' services;~~

~~(z) inpatient psychiatric services;~~

(1)(aa) through (ad) remain the same in text but are renumbered (1)(x) through (aa).

(2) Individuals who are recipients of assistance in the pathways, community services or job supplement components of the families achieving independence in Montana (FAIM) project and who are 21 years of age or older and all recipients of AFDC-related medical assistance only who are participating in the FAIM project and are 21 years of age or older will receive basic medicaid benefits, except that pregnant women will be entitled to all services specified in (1)(a) through (1)~~(ad)~~(aa) of this rule. Basic medicaid benefits are the services specified in (1)(a) through ~~(1)(ad)~~ (1)(aa) of this rule except the following:

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

(4) Regardless of any other provision of this chapter, mental health services, as defined in [Rule I], are available to medicaid recipients only as provided in [Rules I through VIII].

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-6-101, 53-6-103, 53-6-131 and 53-6-141, MCA

46.12.502 SERVICES NOT PROVIDED BY THE MEDICAID PROGRAM (1) through (3)(d) remain the same.

(4) Regardless of any other provision of this chapter, mental health services, as defined in [Rule I], are explicitly

excluded from coverage under the Montana medicaid program, and are available to medicaid recipients only as provided in [Rules I through VIII].

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-103, 53-6-116, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.506 OUTPATIENT HOSPITAL SERVICES, DEFINITION (1) through (4) remain the same.

~~(5) "Partial hospitalization services" means partial hospitalization as defined in the Montana medicaid partial hospitalization policy (May 1995 edition). The department adopts and incorporates by reference the Montana medicaid partial hospitalization policy (May 1995 edition). A copy of the policy may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

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

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

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

46.12.507 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) through (2)(c) remain the same.

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

(a) diagnostic services, including:

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

(3)(a)(ii) and (iii) remain the same.

~~(iv) psychological tests;~~

(3)(a)(v) and (vi) remain the same in text but are renumbered (iv) and (v).

(3)(b) through (4) remain the same.

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

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT (1) remains the same.

(2) Except for the services reimbursed as provided in (3) through ~~(12)~~ (11), all facilities will be reimbursed on a retrospective basis. Allowable costs will be determined in

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

(2)(a) remains the same.

(3) Except as otherwise specified in these rules, the following outpatient hospital services will be reimbursed under a prospective payment methodology for each service as described in (4) through ~~(12)~~ (11) of this rule.

(4) through (5)(c)(ii) remain the same.

(d) For hospital emergency room and clinic visits determined by the department to be unstable, the fee will be a stop-loss payment. If the provider's net usual and customary emergency room or clinic charges are more than 400% or less than 75% of the fee specified in (5)(b), the visit is unstable and the net charges will be paid at the statewide cost to charge ratio specified in ~~(12)~~ (11). For purposes of the stop-loss provision, the provider's net emergency room or clinic charges are defined as total usual and customary claim charges less charges for laboratory, imaging, other diagnostic and any non-covered services.

(e) Emergency visits as defined in (5)(a)(ii) and other emergency room and clinic visits as defined in (5)(a)(iii) with ICD-9-CM surgical or major diagnostic procedure codes will be grouped into one of the ambulatory surgery day procedure groups described in ~~(11)~~ (10).

(6) and (7) remain the same.

~~(8) Partial hospitalization services will be reimbursed on a prospective per diem rate basis as follows:~~

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

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

~~(c) The per diem rates specified in subsections (7)(a) and (b) are bundled prospective per diem rates for full day programs and half day programs, as defined in ARM 46.12.506. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, biologicals, supplies, equipment, therapies, nurses, social workers, psychologists, licensed professional counselors and other outpatient services, that are part of or incident to the partial hospitalization program, except as provided in (7)(d).~~

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

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

(9) through (11)(b) remain the same in text but are renumbered (8) through (10)(b).

(c) Except as provided in ~~(11)~~ (10)(c)(i) and (ii), the payment specified in ~~(11)~~ (10)(b) or (d) is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment and other outpatient hospital services. For purposes of outpatient hospital ambulatory surgery services, a visit includes all outpatient hospital services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event.

(11)(c)(i) through (11)(c)(ii) remain the same in text but are renumbered (10)(c)(i) through (10)(c)(ii).

(d) For hospital ambulatory surgery services, day procedure groups determined by the department to be unstable will be reimbursed a stop-loss payment. If the provider's net usual and customary charges are more than 400% or less than 75% of the fee specified in ~~(11)~~ (10)(b), the day procedure group is unstable and the net charges will be paid at the statewide cost to charge ratio specified in ~~(12)~~ (11). For purposes of the stop-loss provision, the provider's net ambulatory surgery charges are defined as total usual and customary claim charges less charges for any non-covered services.

(e) If the department's outpatient hospital ambulatory surgery fee schedule described in ~~(1)~~ (10)(b) does not assign a fee for a particular DPG, the DPG will be reimbursed at the statewide average outpatient cost to charge ratio specified in ~~(12)~~ (11).

(f) Ambulatory surgery services for which the primary ICD-9-CM procedure code is not included in the day procedure grouper described in ~~(11)~~ (10)(a) will be reimbursed under the retrospective cost basis as specified in ARM 46.12.508(2).

(12) remains the same in text but is renumbered (11).

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

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

(A) ~~inpatient psychiatric services provided in an acute care general hospital or a distinct part psychiatric unit of an acute care general hospital;~~

~~(B)~~ inpatient rehabilitation services;

~~(C)~~ (B) all inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana; or

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

~~(E) outpatient partial hospitalization~~.

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

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

46.12.509A ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS (1) The following administrative review and fair hearing process applies to providers of inpatient and outpatient hospital services, swing-bed hospital services, ~~residential treatment services for individuals under age 21,~~ targeted case management and federally qualified health center services.

(2) through (6) remain the same.

AUTH: Sec. 2-4-201 and 53-6-113 MCA
IMP: Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-111, 53-6-113 and 53-6-141, MCA

46.12.514 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), PURPOSE AND SCOPE (1) through (2)(b) remain the same.

(3) Regardless of the provisions of ARM 46.12.514 through 46.12.517, mental health services, as defined in [Rule I], are available to recipients under age 21 only as provided in [Rule I through VIII].

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

46.12.516 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES, ADDITIONAL SERVICES (1) through (1)(d) remain the same.

~~(e) The therapeutic portion of therapeutic youth group home treatment is covered when the treatment is considered appropriate by a physician, psychiatrist, clinical psychologist, masters level social worker (MSW) or a licensed professional counselor (LPC).~~

~~(i) The therapeutic portion of intensive level therapeutic youth group home treatment, as defined in ARM Title 11, chapters 12 and 13, is covered when provided by a therapeutic youth group home, licensed by the department and under contract with the department to provide intensive level therapeutic youth group home services, to a child who meets medical necessity criteria at ARM Title 11, chapter 13 for placement at the intensive level of treatment.~~

~~(ii) The therapeutic portion of campus based therapeutic youth group home treatment, as defined in ARM Title 11, chapters 12 and 13, is covered when provided by a therapeutic youth group home, licensed by the department and under contract with the~~

~~department to provide campus based therapeutic youth group home services, to a child who meets medical necessity criteria at ARM Title 11, chapter 13 for placement at the campus based level of treatment.~~

~~(iii) The therapeutic portion of moderate level therapeutic youth group home treatment, as defined in ARM Title 11, chapters 12 and 13, is covered when provided by a therapeutic youth group home, licensed by the department and under contract with the department to provide moderate level therapeutic youth group home services, to a child who meets medical necessity criteria at ARM Title 11, chapter 13 for placement at the moderate level of treatment.~~

~~(iv) Medicaid will not reimburse for room, board, maintenance or any other non therapeutic component of youth group home treatment.~~

~~(f) The therapeutic portion of therapeutic family care treatment is covered when the treatment is considered appropriate by a physician, psychiatrist, clinical psychologist, masters level social worker (MSW) or a licensed professional counselor (LPC).~~

~~(i) The therapeutic portion of intensive level therapeutic family care treatment, as provided by ARM 11.13.201 through 11.13.221, is covered when provided by a therapeutic family care agency, licensed by the department and under contract with the department to provide intensive level therapeutic family care service, to a child who meets the medical necessity criteria in ARM 11.13.213 for placement at the intensive level of treatment.~~

~~(ii) The therapeutic portion of moderate level therapeutic family care treatment, as provided by ARM 11.13.201 through 11.13.221, is covered when provided by a therapeutic family care agency, licensed by the department to provide moderate level therapeutic family care service, to a child who meets the medical necessity criteria in ARM 11.13.213 for placement at the moderate level of treatment.~~

~~(iii) Medicaid will not reimburse for room, board, maintenance or any other non therapeutic component of therapeutic family care treatment.~~

(1)(g) through (h)(ii) remain the same in text but are renumbered (1)(e) through (f)(ii).

(iii) Requests for prior authorization may be made in writing to the Department of Public Health and Human Services, ~~Medicaid Services Division~~ Health Policy and Services Division, ~~111 N. Sanders~~ 1400 Broadway, P.O. Box ~~4210~~ 202951, Helena, MT ~~59604-4210~~ 59620-2951, or by phoning the ~~medicaid services~~ health policy and services division at (406) 444-4540.

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

46.12.517 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT (1) through (3)(b) remain the same.

~~(c) Reimbursement for the therapeutic portion of intensive, campus based and moderate level therapeutic youth group home treatment services shall be as specified in a fee schedule set and maintained by the department as follows:~~

~~(i) An initial per diem fee shall be set by the department for each level of service in an amount equal to a percentage of the department's non-medicaid per diem rate effective for the same level of service, where such percentage is the same percentage of total non-medicaid payments for therapeutic youth group home treatment services which is reasonably allocable to the therapeutic component of the services.~~

~~(A) For purposes of setting the initial fee for intensive and moderate level therapeutic youth group home treatment services, the department's non-medicaid per diem rate shall be the department's non-medicaid per diem rate effective January 1, 1993. For purposes of setting the initial fee for campus based services, the department's non-medicaid per diem rate shall be the DFS per diem rate effective July 1, 1993.~~

~~(B) For purposes of setting fees under (3)(c)(i), the therapeutic component of youth group home treatment services excludes room, board, maintenance and other non-therapeutic services.~~

~~(ii) Initial fees set under (1) shall be increased or decreased only as authorized or directed by the legislature.~~

~~(d) Reimbursement for the therapeutic portion of intensive and moderate level therapeutic family care treatment services shall be as specified in a fee schedule set and maintained by the department as follows:~~

~~(i) An initial per diem fee shall be set by the department for each level of service in an amount equal to a percentage of the department's non-medicaid per diem rate effective for the same level of service, where such percentage is the same percentage of total non-medicaid payments for therapeutic family care treatment services which is reasonably allocable to the therapeutic component of the services.~~

~~(A) For purposes of setting the initial fee for intensive and moderate level therapeutic family care treatment services, the department's non-medicaid per diem rate shall be the department's non-medicaid per diem rate effective July 1, 1995.~~

~~(B) For purposes of setting fees under (3)(d)(i), the therapeutic component of therapeutic family care treatment services excludes room, board, maintenance and other non-therapeutic services.~~

~~(ii) Initial fees set under (1) shall be increased or decreased only as authorized or directed by the legislature.~~

(4) remains the same.

(5) Information regarding current reimbursement or copies of fee schedules for EPSDT services may be obtained from the Department of Public Health and Human Services, ~~Medicaid Services Division~~ Health Policy and Services Division, ~~111 N. Sanders~~ 1400 Broadway, P.O. Box ~~4210~~ 202951, Helena, Montana

~~59604 4210~~ 59620-2951.

(6) remains the same.

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

46.12.570 CLINIC SERVICES, DEFINITIONS (1) "Clinic services" means preventive diagnostic, therapeutic, rehabilitative, or palliative items or services provided under the direction of a physician by an outpatient facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients independent of a hospital. Clinic services may be provided in ~~mental health centers,~~ diagnostic centers, surgical centers and public health departments.

(2) through (4) remain the same.

~~(5) "Adolescent day treatment" means mental health day treatment services provided to persons who are enrolled as students in elementary or secondary schools.~~

~~(6) "Individuals with clinic privileges" means those persons who are either employed by or under contract to a mental health center who meet the criteria developed by the state mental health authority to provide and bill for one or more of the mental health services purchased by the department. These criteria are included in contracts between the state mental health authority and each mental health center.~~

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

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

46.12.571 CLINIC SERVICES, REQUIREMENTS (1) through (5)(d) remain the same.

~~(6) Services specified in ARM 46.12.572(3) are provided by those individuals with clinical privileges except that day treatment is provided by or under the supervision of individuals with clinical privileges.~~

~~(7) Family counseling will be covered only when a medicaid eligible member of the family has been determined to be in need of mental health services and is involved in the family therapy.~~

(8) through (9)(b)(ii) remain the same in text but are renumbered (6) through (7)(b)(ii).

~~(10) Twelve hours total per state fiscal year may be used for psychological testing of the recipient, and consultation with family members or agencies involved with the care of the recipient. The 12 hours shall count against the time limits on consultation by licensed clinical social workers provided in ARM 46.12.588, on appraisals and consultation by licensed professional counselors provided for in ARM 46.12.622 and on testing and consultation by psychologists provided in ARM 46.12.581.~~

~~(a) For every unit of time spent in face to face contact with the recipient for psychological testing, two units of time~~

~~may be allowed for test interpretation (record review, scoring and report writing).~~

~~(11) Psychological services and social worker services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ARM 46.12.505 are not reimbursable as clinic services. These noncovered services include:~~

~~(a) services provided by the licensed clinical social workers or psychologists who are staff of a mental health center which has a contract with a hospital involving consideration;~~

~~(b) services provided for purposes of discharge planning as required by 42 CFR Part 482.21; and~~

~~(c) services including but not limited to group therapy, that are required as a part of licensure or certification.~~

~~(12) Individual therapy includes diagnostic interviews where testing instruments are not used.~~

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

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

46.12.572 CLINIC SERVICES, COVERED PROCEDURES (1) through (2)(j)(iv) remain the same.

~~(3) Clinic services, covered by the medicaid program, include the following services provided by a mental health center:~~

~~(a) individual therapy including psychological testing and evaluation and family therapy;~~

~~(b) adolescent day treatment;~~

~~(c) group therapy;~~

~~(d) emergency services; and~~

~~(e) adult treatment.~~

~~(4)~~ (3) Clinic services, covered by the medicaid program, include the following services provided by a diagnostic clinic:

(a) speech therapy;

(b) audiology;

(c) hearing aids;

~~(d) psychologist services;~~

~~(e) social work services;~~

(4)(f) through (h) remain the same in text but are renumbered (3)(d) through (f).

(5) and (6) remain the same.

~~(7) Clinic services, covered by the medicaid program do not include the provision by a mental health center of community living support services, transitional living services or services provided by telephone.~~

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

46.12.573 CLINIC SERVICES, REIMBURSEMENT (1) through (2) remain the same.

~~(3) Medicaid payment for mental health clinic services shall be the lowest of:~~

~~(a) the provider's actual (submitted) charge for the service;~~

~~(b) the amount allowed by medicare (for services covered by medicare); or~~

~~(c) the department's medicaid fee for the individual mental health clinic determined in accordance with subsections (4) or (5), as applicable.~~

~~(4) Effective July 1 of each year, the department will establish a new medicaid fee schedule for each mental health clinic which is participating in the medicaid program and which has filed with the department a cost report for the state fiscal year ending one year prior to the effective date of the new fee schedule. For purposes of this section, such cost reporting year shall be known as the "base year." The fee schedule shall specify a per unit fee and shall apply to all services provided during the state fiscal year for which the fee schedule is effective. The fees established in accordance with this section shall not be subject to retrospective settlement.~~

~~(a) The fee schedule shall specify a fee per unit of service for each of the five services or groups of services listed in ARM 46.12.572(3)(a) through (e).~~

~~(i) For purposes of this section, a unit of service shall mean a 15 minute period of service.~~

~~(b) The fee for each service or group of services listed in ARM 46.12.572(3)(a) through (e) shall be determined by the department by dividing the base year allowable cost of providing the service or group of services by the number of units of that service or group of services provided during the base year.~~

~~(i) Each mental health clinic participating in the medicaid program must file annually with the department a cost report and a copy of an audited financial statement applicable to the cost reporting period. Cost reports and financial statements must be mailed or delivered to the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, Helena, MT 59604 4210.~~

~~(A) The cost report shall be in the form and shall contain the information required by the department, and shall be based on the mental health clinic's audited financial statement. The financial statement shall be prepared in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants. The annual audit shall be prepared in accordance with generally accepted auditing standards as defined by the American institute of certified public accountants and the office of management and budget circular A 133, Audit of Institutions of Higher Education and Other Non Profit Organizations. Forms or information regarding the required forms may be obtained by contacting the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, Helena, MT 59604 4210, (406)~~

~~444-4540.~~

~~(B) The cost report and audited financial statement must be filed with the department no later than the November 30 immediately following the end of the cost reporting period.~~

~~(c) Cost reports may be audited and are subject to verification by the department.~~

~~(ii) The allowable cost of providing the service or group of services shall be determined by the department for each provider based upon the cost report and financial statement filed by the provider with the department in accordance with subsection (i). The fee schedule for the state fiscal year beginning on July 1 shall be established based upon provider's base year cost report. For example, state fiscal year 1993 fee schedules shall be established using state fiscal year 1991 cost reports.~~

~~(iii) Reported costs are not allowable costs if the department, in its discretion, determines that the costs are not related to patient care or are not reasonable in amount. Unreasonable cost reporting allocations of indirect cost to a service or group of services shall be subject to review and redetermination by the department for purposes of establishing the provider's fee schedule.~~

~~(5) For new mental health clinics which have not filed a base year cost report, the department shall establish a fee schedule according to the methodology specified in subsection (4) based upon the provider's report of estimated allowable costs. The fees established in accordance with this section shall not be subject to retrospective settlement.~~

~~(a) The allowability of any estimated cost for purposes of establishing the provider's fee schedule shall be subject to the department's approval according to the provisions of subsection (4)(b)(ii).~~

~~(b) New mental health clinics which have not filed a base year cost report must file with the department a report of estimated allowable costs.~~

~~(i) The report must estimate the provider's allowable costs and units of service for the initial reporting period for each of the five services or groups of services listed in ARM 46.12.572(a) through (e).~~

~~(ii) The report must be filed by the provider within 90 days after the beginning of its initial cost reporting period. The report must be submitted in the form and detail required by the department. Forms or information regarding the required form may be obtained by contacting the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, Helena, MT 59604-4210, (406) 444-4540.~~

(6) through (7)(c) remain the same in text but are renumbered (3) through (4)(c).

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

46.12.1701 FEDERALLY QUALIFIED HEALTH CENTERS, DEFINITIONS (1) through (1)(a) remain the same.

(b) "FQHC services" means ambulatory services for which the Montana medicaid program will reimburse an FQHC under the provisions of ARM 46.12.1707 and includes the following services:

(1)(b)(i) through (1)(b)(iv) remain the same.

~~(v) clinical psychologist services;~~

~~(vi) clinical social worker services;~~

~~(vii)~~ (v) services and supplies incidental to the services of a ~~clinical psychologist, clinical social worker,~~ physician assistant, nurse practitioner, or nurse midwife, which would be covered if such services would otherwise be covered if furnished by a physician or incidental to physician services;

(1)(b)(viii) through (1)(b)(xi) remain the same in text but are renumbered (1)(b)(vi) through (1)(b)(ix).

(1)(c) through (1)(d) remain the same.

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

46.12.1902 CASE MANAGEMENT SERVICES, GENERAL ELIGIBILITY (1) Persons who are medicaid recipients and are from the following groups are eligible for case management services:

(a) high risk pregnant women; and

(b) ~~adults with severe and disabling mental illness;~~

~~(c)~~ persons age 16 and over with developmental disabilities; ~~and~~

~~(d) youth with severe emotional disturbance~~.

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

46.12.2011 MID-LEVEL PRACTITIONER SERVICES, DEFINITIONS For the purpose of these rules, the following definitions will apply:

(1) through (13) remain the same.

~~(14) "Psychiatric counseling" means individual, family, or group therapy relating to psychosocial, behavioral, or emotional issues which is the primary purpose of the visit.~~

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

46.12.4810 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) through (1)(ab) remain the same.

(2) An HMO is not required to provide the following services unless the contract with the department provides otherwise:

(a) remains the same.

(b) institutions for mental disease services ~~as defined at ARM 46.12.1107 et seq.~~;

(2)(c) through (2)(n) remain the same.

(o) targeted case management services for adults with severe and disabling mental illness ~~as defined at ARM 46.12.1925 et seq.~~; for persons age 16 and over with developmental disabilities ~~as defined at ARM 46.12.1935 et seq.~~; and for youth with severe emotional disturbance ~~as defined at ARM 46.12.1945 et seq.~~;

(2)(p) remains the same.

(q) clinical social worker services ~~as defined at ARM 46.12.587 et seq.~~;

(r) licensed professional counselor services ~~as defined at ARM 46.12.620 et seq.~~;

(s) psychologist services ~~as defined at ARM 46.12.580 et seq.~~;

(t) community mental health center services ~~as defined at ARM 46.12.570 et seq.~~;

(u) residential treatment center services ~~as defined at ARM 46.12.590 et seq.~~;

(v) therapeutic group home services ~~as defined at ARM 46.12.516 et seq.~~;

(w) therapeutic foster care services ~~as defined at ARM 46.12.516~~;

(2)(x) through (5) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

46.12.5007 PASSPORT TO HEALTH PROGRAM: SERVICES (1) through (1)(a)(xi) remain the same.

(b) aspects of services listed in (1)(a) that do not require prior authorization by the enrollee's primary care provider:

(1)(b)(i) through (1)(b)(xi) remain the same.

(2) The primary care provider's authorization is not required for any of the following medicaid services:

(2)(a) through (2)(k) remain the same.

(l) mental health centers as ~~defined in ARM 46.12.570~~ provided in [Rules I through VIII];

(2)(m) remains the same.

(n) licensed clinical psychologists services as ~~defined in ARM 46.12.580~~ provided in [Rules I through VIII];

(o) licensed clinical social work services as ~~defined in ARM 46.12.585~~ provided in [Rules I through VIII];

(2)(p) remains the same.

(q) licensed professional counselor services as ~~defined in ARM 46.12.620~~ provided in [Rules I through VIII];

(2)(r) through (2)(z) remain the same.

(aa) institution for mental disease services as ~~defined in ARM 46.12.1108~~ provided in [Rules I through VIII];

(2)(ab) and (2)(ac) remain the same.

(ad) case management services as defined in ARM 46.12.1901 through 46.12.1903, 46.12.1916, ~~46.12.1926 and~~ 46.12.1935 or as provided in [Rules I through VIII];

(2)(ae) remains the same.

(af) admission for residential treatment services as ~~defined in ARM 46.12.590~~ provided in [Rules I through VIII];

(2)(ag) through (3).

(4) Nothing in this rule reduces or otherwise affects the requirements that must be met under [Rules I through VIII] to obtain or access mental health services as defined in [Rule I].

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 53-6-116, MCA

4. Rule 11.13.102 as proposed to be repealed is on page 11-622 of the Administrative Rules of Montana.

Auth: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA
Imp: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA

Rule 11.13.112 as proposed to be repealed is on page 11-627 of the Administrative Rules of Montana.

Auth: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA
Imp: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA

Rule 11.13.213 as proposed to be repealed is on pages 11-630.6 and 11-630.7 of the Administrative Rules of Montana.

Auth: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
Imp: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

Rule 11.13.217 as proposed to be repealed is on page 11-630.8 of the Administrative Rules of Montana.

Auth: Sec. 41-3-1103, 52-1-103 and 52-2-111, MCA
Imp: Sec. 41-3-1103, 41-3-1122 and 41-3-1105, MCA

Rule 46.12.314 as proposed to be repealed is on page 46-1168 of the Administrative Rules of Montana.

Auth: Sec. 53-6-115, MCA
Imp: Sec. 53-6-115, MCA

Rule 46.12.580 as proposed to be repealed is on page 46-1329.6 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101 and 53-6-141, MCA

Rule 46.12.581 as proposed to be repealed is on pages 46-1329.6 and 46-1329.7 of the Administrative Rules of Montana.

Auth: Sec. 53-2-201 and 53-6-113, MCA
Imp: Sec. 53-6-101 and 53-6-141, MCA

Rule 46.12.582 as proposed to be repealed is on pages 46-1329-7 and 46.1329.8 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101 and 53-6-141, MCA

Rule 46.12.587 as proposed to be repealed is on page 46-1330.2 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rule 46.12.588 as proposed to be repealed is on pages 46-1330.2 and 46-1331 of the Administrative Rules of Montana.

Auth: Sec. 53-2-201 and 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rule 46.12.589 as proposed to be repealed is on page 46-1331 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rules 46.12.590 and 46.12.591 as proposed to be repealed are on pages 46-1332 through 46-1336 of the Administrative Rules of Montana.

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

Rule 46.12.592 as proposed to be repealed is on pages 46-1336 through 46-1340 of the Administrative Rules of Montana.

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

Rule 46.12.593 as proposed to be repealed is on pages 46-1341 through 46-1344 of the Administrative Rules of Montana.

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

Rule 46.12.595 as proposed to be repealed is on page 46-1345 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-2-201, 53-6-111, 53-6-113 and 53-6-141, MCA

Rule 46.12.597 as proposed to be repealed is on page 46-1347 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-111, 53-6-113 and 53-6-141 MCA;

Rule 46.12.599 as proposed to be repealed is on pages 46-1347 through 46-1351 of the Administrative Rules of Montana.

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

Rules 46.12.620, 46.12.622 and 46.12.624 as proposed to be repealed are on pages 46-1386 through 46-1397 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rules 46.12.1107, 46.12.1108 and 46.12.1109 as proposed to be repealed are on pages 46-1533 through 46-1535 of the Administrative Rules of Montana.

Auth: Sec. 53-2-201 and 53-6-113, MCA
Imp: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA

Rule 46.12.1110 as proposed to be repealed is on page 46-1535 of the Administrative Rules of Montana.

Auth: Sec. 53-2-201 and 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rules 46.12.1111, 46.12.1112 and 46.12.1113 as proposed to be repealed are on pages 46-1536 through 46-1537 of the Administrative Rules of Montana.

Auth: Sec. 53-2-201 and 53-6-113, MCA
Imp: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA

Rule 46.12.1114 as proposed to be repealed is on page 46-1537 of the Administrative Rules of Montana.

Auth: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
Imp: Sec. 2-4-201, 53-2-201, 53-2-606, 53-6-101, 53-6-111 and 53-6-113, MCA

Rules 46.12.1925, 46.12.1926, 46.12.1927, 46.12.1928,

46.12.1929 and 46.12.1930 as proposed to be repealed are on pages 46-2419 through 46-2422 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

Rules 46.12.1945, 46.12.1946, 46.12.1947, 46.12.1948, 46.12.1949, 46.12.1950 and 46.12.1951 as proposed to be repealed are on pages 46-2437 through 46-2442 of the Administrative Rules of Montana.

Auth: Sec. 53-6-113, MCA
Imp: Sec. 53-6-101, MCA

5. The proposed rule changes implement the Montana Mental Health Access Plan (MHAP). The MHAP is a program to furnish publicly funded mental health services to medicaid-eligible and other lower income Montana citizens in a manner which will increase access to a flexible, consumer-centered array of high quality, cost effective mental health services through an integrated, risk based system of managed care. The Department of Public Health and Human Services (DPHHS) has obtained a waiver of certain federal medicaid requirements from the federal Department of Health and Human Services under section 1915 of the Social Security Act to implement the plan. The department has contracted with a managed care organization to administer the plan, which will become effective April 1, 1997.

Montana currently provides public mental health services to lower income citizens through several distinct and separate programs administered by DPHHS. Until the agency reorganization that became effective July 1, 1995, these programs were spread among several different state agencies.

Persons who have low incomes and who meet certain categorical requirements are eligible for medicaid. Available services are defined and limited by the minimum coverage requirements of federal law and the federally classified optional services offered by the state. Medicaid services include several institutional services, services of psychiatrists, psychologists and other mental health professionals, various outpatient services and group home and foster care. Medicaid services are funded by a combination of state and federal dollars, with the state share of funds being appropriated through three separate program budgets.

The Addictive and Mental Disorders Division of DPHHS contracts with a more limited array of providers, including the state's five regional community mental health centers, to serve the mental health needs of certain low income individuals who do not meet medicaid eligibility requirements. Services are purchased

primarily for adults with severe and disabling mental illnesses and children and adolescents with serious emotional disturbances. The division's programs include the Managing Resources Montana (MRM) program, designed as a form of managed care for severely emotionally disturbed children and adolescents. The Addictive and Mental Disorders Division also operates two institutions that serve persons with mental illness, the Montana State Hospital and the Montana Mental Health Nursing Care Center.

The Division of Child and Family Services operates a separate program to serve the mental health needs of children who become the responsibility of the state because of abuse, neglect, abandonment or court order. Many of these children are served through the medicaid program. The program is designed to meet certain housing needs, such as the residential cost of therapeutic group home care, as well as mental health needs of the child, often within the residential setting itself.

Recent long term growth rates in medicaid mental health expenditures averaging approximately 10% annually, combined with an increasing perception among legislators, administrators, service providers and consumers that the existing system was not meeting needs or expectations, led to a search for systemic change that would provide confidence that the public mental health system was both effective and efficient. Concerns of various constituencies include effective expenditure of tax dollars, improvement of services and effective service of priority needs, greater predictability and control of expenditures, efficacy demonstrated by measurable outcomes, elimination of arbitrary reimbursement categories and other artificial limitations, and greater responsiveness and emphasis on community settings.

The MHAP was developed as a response to these concerns. Goals of the system include: rational treatment decisions made according to the needs of the individual; adaptability of the system to take into account the changing needs of the individual and the full range of available treatments; a more complete continuum of care with rapid development of alternative and innovative treatment settings and modalities as new needs and opportunities are identified and as knowledge progresses; greater predictability of expenditures and measurability of effectiveness; an integrated service system across the state with timely access to a coherent continuum of services for all consumers; continuity across service settings; and services of known, high, uniform and improving quality.

The MHAP is intended to fully integrate the state's system of publicly funded mental health care. The MHAP will include all funding sources presently used by the state in providing mental health services, including all state general funds, funds for

operation of the Montana State Hospital and the Montana Mental Health Nursing Care Center, federal and state medicaid funds, federal mental health block grant funds, and third party and copayment funds.

Rules I through VIII define the plan and will be contained in a separate subchapter. Rule I defines terms used throughout Rules I through VIII. The plan is set forth in considerable additional detail in the department's request for proposals number 9709-K. A copy of the RFP is available upon request by writing to the department's Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 or by calling the division at (406) 444-3964.

The federal waiver allows the plan to integrate medicaid and non-medicaid services, whereas previously the rigid categorical limitations of medicaid eligibility and service requirements precluded service of both medicaid and non-medicaid individuals under one comprehensive system. The plan will cover all medicaid eligible individuals and other individuals with total family income at or below 200% of the federal poverty level. Rule II specifies the persons eligible for services under the plan and the process for obtaining eligibility, in accordance with the federal waiver. All medicaid eligible individuals will be enrolled automatically in the plan. Medicaid eligibility information will be transmitted electronically from the department to the Managed Care Organization (MCO).

Rule II also specifies the non-medicaid individuals who will be eligible for services under the plan. For non-medicaid eligibles, eligibility will be determined by the MCO. The MCO's contract with the department requires the MCO to establish a variety of easily accessible locations for eligibility application, including at certain service locations. The rule specifies the application process and the information that may be required from an applicant. The duration of eligibility, reporting requirements and the effects of changes in income, household composition and federal poverty levels are specified. The rules provide for a one year span of eligibility, barring significant changes in income or other eligibility factors, thus minimizing the burden of maintaining eligibility. A presumptive eligibility provision is included to allow instant access to the system in emergency cases. The MCO is required by its contract with the state to undertake extensive measures to notify and inform plan members of eligibility requirements, covered services, prior authorization requirements, copayment requirements and other matters.

Rule II specifies provider requirements for participation in the plan. Participating providers will participate based upon a contractual relationship with the MCO, rather than based upon a legal relationship with the state. The rule requirements are

minimal, because provider credentialing and other participation requirements will be a matter of contract between the provider and the MCO. Thus, the bulk of provider requirements will be addressed in the provider contract rather than in administrative rules. Rule II accordingly sets out a minimal framework for the MCO-provider relationship. The rule sets forth the categories of providers that the MCO is required under its contract to enroll. All qualified providers in these categories that agree to the terms of the provider contract will be permitted to enroll. Enrollment, however, does not guarantee the provider any particular rate of utilization or reimbursement.

Rule II specifies that providers under the plan enroll separately in the plan through the MCO, and need not be medicaid providers. The requirements of the medicaid program generally do not apply, with some exceptions. The exceptions are in areas where requirements are necessary to provide certain protections to plan members, who in most cases will be medicaid recipients, and to provide a basis for oversight to monitor and assure contract compliance. For example, the medicaid payment in full, record keeping and confidentiality requirements apply. Compliance with these requirements will be through the provider contract rather than by state audit.

Because providers participate based upon a contractual relationship with the MCO rather than based upon a legal relationship with the department, Rules II and V specify that providers will not be entitled to administrative hearings before the department to contest actions of the MCO and other matters pertaining to the plan. Any disputes will be matters of contract between the provider and the MCO.

Rule IV Specifies the services that will be covered under the plan. Services must be medically necessary as defined in Rule I. This definition is separate and distinct from the definition of medical necessity under the medicaid program. The definition has been developed specifically for mental health services. Services will be provided under the plan only for treatment of covered diagnoses, except for residents at the Montana State Hospital and the Montana Mental Health Nursing Care Center, for whom all care will be covered under an all-inclusive rate. Covered and excluded diagnoses are specifically identified in the attachment adopted in Rule I. Rule IV also specifies treatment of various specific service categories and member groups. Rule IV also specifies certain services not covered under the plan. For example, transportation services and alcohol and chemical dependency services are not covered. Prescription drugs will continue to be provided to medicaid recipients under the medicaid program, but will be provided to other members under the plan. Rule IV provides that the MCO must notify and inform members of the requirements for accessing services, including any prior authorizations requirements, and

of its criteria for restricting members to particular providers or sets of providers.

Consistent with the principle that providers will participate based upon a contractual relationship with the MCO, rather than based upon a legal relationship with the state, Rule V specifies that reimbursement to service providers will be as provided in the provider's contract with the MCO. The rates of reimbursement will be negotiated between the MCO and the provider. All claims will be submitted to and paid by the MCO. The provider contract will specify who will investigate and collect third party payments and who will be entitled to the payments. The contract will also specify how collection, reporting and payment or crediting of member copayments will be handled.

Rule VI specifies the copayments that may be charged and collected for services under the plan. Medicaid recipients will not be subject to any copayments for services provided under the plan, while non-medicaid members will be required to make the copayments specified in Rule VI. Copayments will be subject to a monthly maximum, depending upon family income. Residents of the Montana State Hospital and the Montana Mental Health Nursing Care Center will not be responsible for copayments, but will continue to be responsible for the cost of their care based upon ability to pay, according to state law.

Rule VII specifies the appeal rights and procedures available to plan members. Members are entitled to a fair hearing under the provisions of ARM 46.2.201, et seq., but must first exhaust the grievance and administrative review processes provided by the MCO and the department. The department's contract with the MCO requires the MCO to provide procedures designed to achieve speedy and equitable resolution of disputes. The department will provide a panel review procedure for members that are not satisfied with the outcome of the grievance procedure. The MCO will not be permitted to appeal an adverse decision of the panel, but a recipient may request a fair hearing if not satisfied with the decision. The procedures are designed to provide a speedy, fair and informal process to resolve disputes quickly, while reserving to the member the right to a fair hearing if the procedures do not satisfactorily resolve the issue.

Rule VIII addresses issues regarding transition from current service programs to the plan. The plan will cover only services provided on or after April 1, 1997. All mental health services will be provided under the plan on and after that date, and it will be necessary to follow the appropriate procedures for plan coverage if continuing services are desired. The MCO will provide assistance in easing transition to the plan. The rule contains the information necessary to contact the MCO for

assistance.

In ARM Title 11, chapter 13, rules 11.13.101, 11.13.116, 11.13.201, 11.13.203, 11.13.205, 11.13.207, 11.13.211 and 11.13.219 are amended, 11.13.102, 11.13.112, 11.13.213 and 11.13.217 are repealed and new Rule IX is proposed to coordinate these provisions with the plan. Youths will no longer be entitled to therapeutic youth group home and foster care services under these rules and the Division of Child and Family Services will no longer certify youths for treatment under these rules. The rules will serve only to specify the standards that will be required in the event the division contracts for care for a particular youth outside the plan. The division will determine the appropriate placement and level of care in such circumstances, and medical necessity statements or certificates will not be required. Such placements will be made only by contract with the division. Therapeutic youth group home and foster care services generally will be covered under the plan according to plan requirements.

Mental health services generally will be covered under the plan and no longer be covered under the medicaid program. Accordingly, the medicaid program rules are amended at ARM 46.2.202, 46.12.204, 46.12.501, 46.12.506, 46.12.507, 46.12.508, 46.12.509, 46.12.509A, 46.12.516, 46.12.517, 46.12.570, 46.12.571, 46.12.572, 46.12.573, 46.12.1701, 46.12.1902, 46.12.2011, 46.12.4810 and 46.12.5007 to remove references to mental health services that will no longer be covered under the medicaid program, including mental health components of the outpatient hospital program, the EPSDT program, the clinic services program, federally qualified health center program, the case management program and mid-level practitioners program.

In addition, the medicaid program rules are repealed at ARM 46.12.580, 46.12.581, 46.12.582, 46.12.587, 46.12.588, 46.12.589, 46.12.590, 46.12.591, 46.12.592, 46.12.593, 46.12.595, 46.12.597, 46.12.599, 46.12.620, 46.12.622, 46.12.624, 46.12.1107, 46.12.1108, 46.12.1109, 46.12.1110, 46.12.1111, 46.12.1112, 46.12.1113, 46.12.1114, 46.12.1925, 46.12.1926, 46.12.1927, 46.12.1928, 46.12.1929, 46.12.1930, 46.12.1945, 46.12.1946, 46.12.1947, 46.12.1948, 46.12.1949, 46.12.1950 and 46.12.1951. These repealed rules provided for coverage of services that no longer will be covered under the medicaid program, but rather will be covered under the plan. These services include psychologists, social workers, professional counselors, residential treatment facilities, institutions for mental disease, case management services for youths with severe emotional disturbances and for adults with severe and disabling mental illness.

Language is added to ARM 46.12.202, 46.12.501, 46.12.502 and 46.12.514 to clarify that mental health services are available

to medicaid recipients only under and according to the requirements of the plan and not under the medicaid program. ARM 46.12.314 is repealed because it unnecessarily repeats statutory language.

Copies of this notice are available from all local county human services offices. The medicaid advisory council has been notified of the proposed changes.

The estimated budgetary impact of these rule changes is as follows:

The mental health managed care program is anticipated to achieve in savings of $2,739,000 (total state and federal funds) in the first year and $3,066,000 in the second year of operation. Total expenditures are estimated to be $80,000,000 per year for mental health services.

6. The proposed rules, amendments and repeals will apply to services provided on or after April 1, 1997.

7. 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 February 24, 1997.

8. 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

Russell E. Carter, acting
Director, Public Health and Human Services

Certified to the Secretary of State January 13, 1997.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of rule 2.4.136 relating to state accounting.	)NOTICE OF AMENDMENT OF RULES))

To: All Interested Persons:

1. On December 5, 1996 the Department of Administration published notice of the proposed amendment of rule 2.4.136 relating to state accounting on page 3095 of the 1996 Montana Administrative Register, issue number 23.

2. The Department has amended 2.4.136 as proposed, but with the following changes:

2.4.136 REIMBURSEMENT FOR RECEIPTABLE LODGING (1) Employees shall be reimbursed for their actual out-of-pocket lodging expenses, including room tax, up to the maximum amounts set by 2-18-501, MCA, for in-state and out-of-state travel. Lodging in those areas specifically designated as high cost ~~cities~~ will be reimbursed at actual cost. The department of administration will issue a quarterly memo designating those high cost ~~cities~~ areas which qualify for reimbursement of lodging at actual cost.

(2)(a) All areas within the State of Montana are designated as high cost under the following circumstances:

(i) lodging costs have temporarily escalated due to special functions such as fairs, sporting events or conventions;

(ii) emergency travel arrangements preclude being able to find accomodations at state rates; or

(iii) remote locations with limited accomodations within a 15 mile radius preclude obtaining accomodations at state rates.

(b) An agency director may approve reimbursement of lodging at actual cost under the circumstances listed in (2)(a) upon receipt of adequate justification from an employee along with the original lodging facility receipt. ~~The expenditure of these costs may not cause the agency to overexpend its appropriation authority.~~ AN AGENCY MAY NOT ALLOW EXPENDITURES UNDER (1) THAT WILL OVEREXPEND THE AGENCY'S APPROPRIATION AUTHORITY.

(3) In order to claim lodging reimbursement ~~of this nature~~, ~~a bona fide~~ the original ~~copy of a~~ receipt from a licensed lodging facility must be attached to the travel expense voucher, form DA-101, and retained by the agency. Other receipts, such as credit card receipts, are not acceptable.

~~(2)~~(4) Language remains the same. AUTH: Sec. 2-18-501 MCA; IMP, 2-18-501 MCA

3. The Department accepted written comments through January 2, 1997. The Department has thoroughly considered the comment received. The comment, in summary form, and the Department's response thereto is as follows:

COMMENT NO. 1: A comment was received stating that the last sentence in ARM 2.4.136(2)(b)which says that an agency may not overexpend its appropriation authority in incurring these potentially higher lodging rates is superfluous since this is already in statute. The comment suggested deleting the sentence or rewording it to more clearly state the intent of the Department.

RESPONSE: The Department concurred with the suggested rewording of the sentence and has amended the rule as shown above.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Lois Menzies, Director

Certified to the Secretary of State this 13th day of January, 1997.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of rules 2.5.401, 2.5.404, 2.5.406 2.5.602, 2.5.605 and 2.5.702 relating to state purchasing.	NOTICE OF AMENDMENT OF RULES

To: All Interested Persons:

1. On December 5, 1996 the Department of Administration published notice of the proposed amendment of rules 2.5.401, 2.5.404, 2.5.406, 2.5.602, 2.5.605 and 2.5.702 relating to state purchasing on page 3097 of the 1996 Montana Administrative Register, issue number 23.

2. The Department has amended 2.5.401, 2.5.406, 2.5.602, 2.5.605 and 2.5.702 exactly as proposed.

3. The Department has amended 2.5.404 as proposed, but with the following changes:

2.5.404 BID PREPARATION ~~(1) All bids must be signed by an authorized person.~~

(2) through (5) remain the same but are renumbered (1) through (4).

~~(6)~~ (5) Payment will be due 30 days from: ~~the issuance of a signed Montana purchase order and:~~

(a) the receipt of a properly executed claim; or

(b) upon SATISFACTORY RECEIPT ~~delivery~~ of the merchandise OR SERVICE, ~~received in a satisfactory condition,~~ whichever is later.

(7) through (9) remain the same but are renumbered (6) through (8)

(AUTH: Sec. 18-4-221 MCA; IMP, Sec. 18-4-221 MCA.)

4. The Department accepted written comments through January 2, 1997. No written or oral comments were received.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Lois Menzies, Director

Certified to the Secretary of State this 7th day of January, 1997.

BEFORE THE BOARD OF THE
STATE COMPENSATION INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the amendment of rules 2.55.321, 2.55.322, 2.55.324, 2.55.325 and 2.55.327, pertaining to premium rate setting.	**NOTICE OF AMENDMENT OF RULES**

TO: All Interested Persons:

1. On October 24, 1996, the State Compensation Insurance Fund published notice of the proposed amendment of rules 2.55.321, 2.55.322, 2.55.324, 2.55.325, and 2.55.327, at pages 2627-2634 of the 1996 Montana Administrative Register, Issue No. 20.

2. The Board has amended rules 2.55.321, 2.55.322, 2.55.324, 2.55.325, and 2.55.327 as proposed.

3. The Board thoroughly considered the following comment:

COMMENT:

Liberty Northwest expressed concern with the overall process of rate making, rather than with any of the proposed amendments. The concern is related to the State Fund setting its own rates without participation by rating bureaus or regulatory review by persons knowledgeable about the industry. It was proposed that the legislature require the State Fund's process conform to that of other insurers.

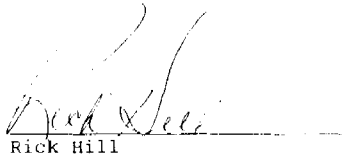
RESPONSE:

The Board of Directors appreciates the comment. It should be noted that the State Fund sets rates with participation of a "rating bureau", NCCI, Montana's advisory organization designated by the Insurance Commissioner. State Fund rates incorporate NCCI's rates into the State Fund rate making formulas. The proposed amendments to the rule actually enhance the incorporation of NCCI rates into State Fund rates. The State Fund regulatory review is managed by the Office of the Legislative Auditor. That office contracts with an independent actuary to review the adequacy of State Fund rates. In addition the State Fund consults with an independent actuary from Tillinghast. The State Fund's uniqueness sets it apart from other insurers and supports an independent rate making process. The State Fund, by making its own rates, more closely tracks Montana experience. Some of the factors supporting our uniqueness are the fact the State Fund writes all business, regardless of risk or loss history, the numerous small employer's insured by the State Fund, the distribution of our

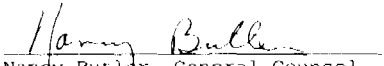
losses and the non-profit nature of the State Fund.

The comment was carefully considered but as not directed towards any specific proposed rule amendment, the Board respectfully declines to modify any proposed rule amendments.

Dal Smilie, Chief Legal Counsel
Rule Reviewer



Rick Hill
Chairman of the Board



Nandy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State January 6, 1997.

BEFORE THE BOARD OF PROFESSIONAL ENGINEERS
AND LAND SURVEYORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment, repeal and adoption of rules pertaining to the practice of professional engineers and land surveyors	NOTICE OF AMENDMENT, REPEAL AND ADOPTION OF RULES PERTAINING TO THE PRACTICE OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

TO: All Interested Persons:

1. On August 8, 1996, the Board of Professional Engineers and Land Surveyors published a notice of public hearing on the proposed amendment, repeal and adoption of rules pertaining to the practice of professional engineers and land surveyors, at page 2085, 1996 Montana Administrative Register, issue number 15. The hearing was held on September 5, 1996, in Helena, Montana.

2. The Board has amended ARM 8.48.401, 8.48.403, 8.48.501, 8.48.502, 8.48.504, 8.48.505, 8.48.508, 8.48.601, 8.48.602, 8.48.603, 8.48.604, 8.48.801, 8.48.802, 8.48.901, 8.48.903, 8.48.1103, 8.48.1104, 8.48.1105, 8.48.1106, 8.48.1202, 8.48.1203, 8.48.1205, and 8.48.1206, exactly as proposed. The Board has repealed ARM 8.48.402, 8.48.404, 8.48.406, 8.48.503, 8.48.506, 8.48.510, 8.48.902, 8.48.1101, 8.48.1108, 8.48.1110, 8.48.1201, and 8.48.1204 exactly as proposed. The Board has adopted new rules II (8.48.511), and III (8.48.408) exactly as proposed. The Board will not amend 8.48.507 as proposed. The Board will adopt new rule I (8.48.905) as proposed, but with the following changes: (the authority and implementing sections will remain the same as proposed)

8.48.905 CONTINUING PROFESSIONAL COMPETENCY - CONTINUING EDUCATION (1) Every licensee shall meet the continuing professional competency (continuing education) requirements of these regulations for professional development as a condition for licensure renewal ~~commencing with 1998 renewals~~. Licensees shall begin accruing credits in 1998, to be reported with the 2000 renewal.

(2) through (9) will remain the same as proposed.

(10) If a license is not renewed by the board due to failure of the licensee to meet continuing education requirements, the board will notify the licensee in writing and the licensee shall have 90 days past date of notification to obtain continuing education acceptable to the board. If the licensee notifies the board in writing that the licensee intends to obtain the required continuing education within the 90-day period, the license expiration date will automatically be extended to the end of the 90-day period.

(a) Failure to obtain continuing education acceptable to the board within the 90-day period will result in non-renewal of the license;

(b) A licensee whose license is not renewed by the end of the 90-day period for failing to obtain the satisfactory PDH will be required to reapply, pay the appropriate fee and obtain the necessary PDH during the non-renewal period (not to exceed the annual requirement for two years acceptable to the board.)

3. The Board accepted written comment through December 2, 1996. The Board has thoroughly considered all comments received. Those comments, and the Board's responses thereto, are as follows:

COMMENT NO. 1: Fourteen comments were received stating the comment period should be extended to allow more time for all licensees to study the proposed changes and make recommendations to the Board at a later date.
RESPONSE: The Board concurred with the comment and extended the deadline period from September 5, 1996 to December 2, 1996 to allow further time to study the changes and make comments to the Board.

COMMENT NO. 2: One comment was received stating ARM 8.48.507 should not have used the word "mere," as this is insulting to the contracting industry.
RESPONSE: The Board did not find the use of the word "mere" in its proposed rule notice, and did not intend any insult to the contracting industry through any construction of the proposed rules.

COMMENT NO. 3: One comment was received stating new rule I on CE should not state it must be formal education by an instructor or third party, as the construction industry does not conduct education with instruction in a formal setting. Instead, engineering innovation should be counted, and must be documented.
RESPONSE: The Board noted that the proposed rules contain a broad listing of options for obtaining CE, and this should offer sufficient flexibility for all licensees. The current proposed rules include a variety of CE opportunities, and are not restricted to a formal classroom setting, but must meet the criteria set forth in the rules.

COMMENT NO. 4: Three comments were received stating 8.48.1202 (1) (c) should not require the reporting of alleged infractions, as this in itself is unprofessional conduct.
RESPONSE: The Board did not agree, and noted that the reporting of a violation actually constitutes professional conduct, and not unprofessional conduct. The proposed reporting language is appropriate. The Board felt it is the obligation of every professional to report violations to protect the health, safety and welfare of the public.

COMMENT NO. 5: Three comments were received stating ARM 8.48.1206 (2) should not be deleted, as this is the heart of the ethics provisions, and the MCA does not cover contract detail with enough specificity.
RESPONSE: The Board noted that the language on unprofessional conduct is now largely contained in statute at §37-1-316, MCA. Specifically, §37-1-316 (6), MCA contains the same prohibition on giving anything of value to a government employee or official to influence their decisions, as was previously contained in the rule at ARM 8.48.1206 (2). It is not necessary to repeat statutory language in a rule.

COMMENT NO. 6: Three comments were received stating new rule I mandating CE should not be adopted, which would force CE on the profession, as CE should not be imposed because of fear of legislative imposition, or to "thin the ranks" of those deemed uneducated. CE will additionally create bureaucracy and lengthy wastes of time.
RESPONSE: Due to rapidly changing technology, the Board felt CE is necessary to ensure that professional engineers and land surveyors are proficient in their fields. This will protect the public's health, safety and welfare.

COMMENT NO. 7: Two comments were received stating ARM 8.48.1103 should not delete the requirement that the officers in charge be registered, as this was the main purpose of this rule.
RESPONSE: The Board noted that many large corporations have officers who are not professional engineers or land surveyors. A professional engineer must still be in responsible charge of the projects, but it is not feasible or practical, nor does it protect the public to require the actual officers of the corporation to be professional engineers or land surveyors.

COMMENT NO. 8: Three comments were received stating new rule I on CE is not clear as to who would approve the CE courses, and what would happen if the licensee takes a course which is later disallowed. Also, a grace period should be allowed to make up deficiencies.
RESPONSE: The Board noted that the new CE rules should be implemented to get the process and requirement started. The Board will consider future rule changes, however, to streamline the process and clarify any difficulties with language or uncertainty as to approval of CE courses, etc. The Board did concur with the comment on addition of a grace period, however, and will amend the rule as shown above to add a grace period.

COMMENT NO. 9: One comment was received stating ARM 8.48.403 should not reduce the number of meetings held by the Board to only twice a year, as this will make the Board more inaccessible, and will not offer a benefit to the profession.
RESPONSE: The Board noted the proposed rule was not reducing the number of meetings to be held per year. The Board will continue to meet on its usual three to seven times per year

schedule. The proposed change instead actually increased the minimum number of meetings required per year.

COMMENT NO. 10: One comment was received stating ARM 8.48.401 (7) should not be deleted, as this section helps outline the secretary's duties and insure distribution of a roster biannually.
RESPONSE: The Board noted that staff are adequately supervised in performing administrative functions, and it is not necessary nor appropriate to try to list these functions in the rules.

COMMENT NO. 11: One comment was received stating ARM 8.48.403 sections should not be deleted, as they give some structure to the Board's proceedings.
RESPONSE: The Board noted its agendas are established before each meeting, and working off this agenda provides the flexibility as to order of items, etc., that is needed at the meetings. The Board generally acts under Robert's Rules of Order in conducting business, but has not found it necessary to formally adopt any procedural rules.

COMMENT NO. 12: One comment was received stating ARM 8.48.502 (2), (3), (4) should not be deleted, as they provide guidance to the Board during application review.
RESPONSE: The Board noted they were under a mandate from the Legislature to delete unnecessary rules, and streamline the language in others so as to reduce the amount of agency rules. These deletions will therefore streamline the rules, without using unnecessarily repetitive language.

COMMENT NO. 13: Five comments were received stating ARM 8.48.507 should not be amended, as the original wording is more clear and specific than the proposed changes. Only subsections (1)(b)(ix), and (4) appear to be sections mandated by new law.
RESPONSE: The Board concurred with comments on this rule, and voted to not adopt the amendments as proposed. The Board will instead issue a new Proposed Rule Notice which will contain different amendments to this rule in keeping with several comments received.

COMMENT NO. 14: One comment was received stating ARM 8.48.1106 (2) and (3) should not be amended. The commentor stated that notifying the local county attorney is a good fall-back position to have if satisfaction from the Board is not obtained. The Board should also assist anyone wishing to enter a complaint regarding an alleged violation of the law.
RESPONSE: The Board did not agree, as the new statutory authority of Title 37, Chapter 1, Part 3 passed by the 1995 Legislature and the procedures under these statutes are sufficient for handling complaints.

COMMENT NO. 15: Two comments were received stating ARM 8.48.1202(1)(c) and (d), and 8.48.1203(1)(a) and (c), and 8.48.1206(1) and (2) should all remain, and not be deleted, as these rules enforce many of the basic ethical requirements of the engineering profession, and need to be stated plainly.

RESPONSE: The Board noted that §37-1-316, MCA, now covers unprofessional conduct, and the language on these types of prohibited acts is therefore contained in statute. As the unprofessional conduct is sufficiently defined elsewhere, there is no need to repeat it in the rules.

COMMENT NO. 16: One comment was received stating new rule I (5) (d) should not limit credit for active participation in professional and technical societies to two PDH's per organization, as this will only reduce active participation in societies.
RESPONSE: The Board did not agree, and noted that two PDH credits are sufficient for these types of activities.

COMMENT NO. 17: One comment was received stating new rule III on screening panel should not include the concept of a three person panel to review complaints rather than the entire Board. The commentor stated this concept has the potential for fragmentation of the Board into groups which are not representative of the Board as a whole. It may also reduce the responsibility of the board through creation of a separate entity that is not the same as the whole Board, and reduce the role engineers play in compliant handling as a lower percentage of engineers will be on the panels than are on the Board.
RESPONSE: The Board noted that screening panel separation is required by statute at §37-1-303, and §37-1-307, MCA, and the Board may not therefore deviate from this statutorily required procedure. The Board has chosen three panel members, as the remaining Board members will be used to vote on the Final Orders and sanctions which may result from complaints. The Board cannot, however, by statute, use the entire Board to review complaints.

COMMENT NO. 18: One comment was received stating ARM 8.48.403 (5) should not be deleted, because if a board member misses three consecutive meetings, the member has missed an entire year's duty, and should be removed from office.
RESPONSE: The Board noted the Governor makes Board appointments, and removals as well. The Board cannot therefore impose additional requirements such as "missing three meetings" on the Governor. Section 2-15-1873, MCA, already states the governor may remove a member for misconduct, incompetency, neglect of duty or any other sufficient cause, so it is up to the governor to interpret and use that authority.

COMMENT NO. 19: One comment was received stating ARM 8.48.507 proposed amendments seem to relax the standards for experience, and should not be adopted.

RESPONSE: The Board noted it is not adopting the proposed amendments to this rule at this time, and will instead issue a new Notice of Proposed Amendment to encompass many of the comments' suggested changes.

COMMENT NO. 20: Two comments were received stating ARM 8.48.601 should not delete acceptance of certificates issued by the National Engineering Certificate Committee of the NCEE for comity. The comment stated these certificates were supposed to simplify the process for both the state and individual without easing requirements.
RESPONSE: The Board noted its proposed rule amendment did not delete acceptance of the NCEE certificates. The certificates are still accepted as outlined in the rule.

COMMENT NO. 21: Two comments were received stating ARM 8.48.1103 should not be changed in any way. The comment stated the current requirements insure that licensed individuals are in responsible charge of the work and that they have the authority to make decisions affecting the health, safety and welfare of the public.
RESPONSE: The Board noted the only change in this rule is to delete the requirement that officers of the corporation must be licensed persons. There is no change in the requirement that the person in responsible charge of the project must be a licensed professional engineer or land surveyor.

COMMENT NO. 22: Three comments were received stating ARM 8.48.1106(3) should state the Board will assist people wishing to enter complaints. The comment stated the complaint process is kept confidential, and if the complaint is dismissed, no harm has been done to the defendant. The comment also stated the rule should not stop at the screening panel, but should outline the entire process.
RESPONSE: The Board noted the Department of Commerce policy and procedure for all licensing boards is the process outlined in the rule. The steps after the screening panel vote are covered by the Montana Administrative Procedure Act (§2-4-101, MCA, et. seq.), and have always been followed by the Board.

COMMENT NO. 23: Two comments were received in support of requiring continuing education for professional engineers.
RESPONSE: The Board acknowledged receipt of the comment in support.

COMMENT NO. 24: One comment was received stating ARM 8.48.1203 (2) should read: "Licensees shall not affix their signatures or seals to any plans or documents dealing with subject matter in which they lack competence, nor to any such plan or document not prepared under their responsible charge."
RESPONSE: The Board felt the language in the rule as proposed is sufficient. The Board is not changing the intent of the rule in their proposed changes, and additionally had not proposed this section for change in this Notice anyway.

COMMENT NO. 25: One comment was received stating ARM 8.48.1204 should not be deleted, but retained, with only minor language changes from "registrant" to "licensee."
RESPONSE: The Board noted this language is now covered under 37-1-316, MCA, on unprofessional conduct. The Board is not deleting the conduct being prohibited as "unprofessional," they are just leaving the definition of the conduct to be contained elsewhere than in the rules.

COMMENT NO. 26: One comment was received stating new rule I on CE should allow licensees to meet the CE requirement by attendance at non-technical programs, as well as technical education.
RESPONSE: The Board noted the proposed rule allows the Board latitude to consider all CE requirements submitted, and will consider the non-technical as well as technical types of education.

COMMENT NO. 27: One comment was received stating that retired persons who are still performing limited engineering do not want to have to complete CE requirements to keep their license. The Board should allow an exemption from CE for retired persons.
RESPONSE: The Board noted it is requiring CE of all licensees to ensure competence and protection of the health, safety and welfare of the public. A blanket exemption for retired persons would not meet this goal.

BOARD OF PROFESSIONAL ENGINEERS
AND LAND SURVEYORS
J.G. SHOCKLEY, CHAIRMAN

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

Ann M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 13, 1997.

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the repeal, amendment and adoption of rules relating to school transportation.	))))	NOTICE OF REPEAL, AMENDMENT AND ADOPTION OF RULES RELATING TO SCHOOL TRANSPORTATION

TO: All interested persons.

1. On October 24, 1996, The Superintendent of Public Instruction (OPI) published notice of public hearing on the proposed repeal, amendment and adoption of the rules referenced above at pages 2689 through 2710 of the 1996 Montana Administrative Register, Issue No. 20.

2. A public hearing was held on November 19, 1996. The hearing was recorded and the tape is included in the file on this matter. In addition, written comments were received at the hearing and prior to the closing of the comment period.

3. After consideration of the comments received, the following rules are being repealed as proposed: 10.7.103 and 10.7.117. No comments were received on the repeal of these rules.

4. After consideration of the comments received, the following rules are being amended as proposed: 10.7.104, 10.7.105, 10.7.107, 10.7.108, 10.7.109, 10.7.110, 10.7.112, 10.7.113, 10.7.114, 10.7.116, 10.7.118 and 10.16.2503.

10.7.107 CONTINGENCY TRANSPORTATION AND BUDGET AMENDMENTS FOR TRANSPORTATION

COMMENT: The Rosebud County Superintendent commented in favor of the changes to this rule.

RESPONSE: OPI agrees.

10.7.110 STANDARDS FOR SCHOOL BUSES

COMMENT: Michael Dahlem, Attorney, commented that the January 31 date in this rule will cause school districts to lose state and county transportation reimbursement in the event the Montana Highway Patrol fails to conduct the second bus inspection by the deadline.

RESPONSE: State law requires two school bus inspections per year and Rule 10.7.110 states current practice. Clarification of the January 31 deadline in rule is made at the request of the Montana Highway Patrol. Failure to pass inspection by January 31, not this rule, will cause a district

to lose transportation reimbursement because the district will not be entitled to the money as a matter of law.

5. After consideration of the comments received, the following rule is being adopted as proposed and codified as follows: RULE I (10.7.106A). No comments were received on RULE I.

6. OPI will take no action on proposed RULES II, III and IV at this time.

COMMENTS: Blue Sky, Conrad, Froid, Roy, Sweet Grass, Vaughn and Winifred School Districts, County Superintendents of Choteau, Fergus, and Rosebud Counties and 4 citizens commented in opposition to proposed RULES II - IV. Melstone School District and 7 citizens commented in support of proposed RULES II - IV. The Montana School Board Assocation did not support or oppose the proposed rules but commented that the rules may violate current state law.

RESPONSE: Fergus County has requested an attorney general opinion on whether the operation of an unapproved route is a violation of statute and, if so, what the penalty should be. OPI will take no action on proposed RULES II - IV until that question is answered and the 1997 Montana Legislature has had the opportunity to address the issue if it chooses.

7. After consideration of the comments received, the following rules are being amended with the changes given below, new material underlined, deleted material interlined.

10.7.101 INTRODUCTION (1) remains the same as proposed.

(2) The following list briefly states in chronological order the administrative steps for school transportation. This list is not a substitute for the more detailed requirements stated in these rules:

(a) By the fourth Monday in June a district must:

(i) complete and sign transportation contracts (4 copies) for the ensuing year; and~~,~~

(ii) adopt a preliminary transportation budget~~; and,~~

~~(iii) send the preliminary transportation budget and contracts to the county superintendent~~.

(b) By July 1 a district must send to the county superintendent the preliminary transportation budget, copies of all completed school bus contracts and copies of all completed individual transportation contracts.

(b) through (j) remain the same as proposed, but relettered (c) through (k).

~~(k)~~(l) Sixty days after the beginning of the school year, or sixty days after employment, the first-aid competency requirement for new bus drivers must be completed.

(l) through (p) remain the same as proposed, but relettered (m) through (q).

~~(q)~~ (r) By February 1 a district must send the county superintendent 2 copies of transportation claims TR-5 and TR-6.

(r) through (ab) remain the same as proposed, but relettered (s) through (ac).

COMMENT: The Missoula County Superintendent commented generally in favor of the rule changes but 10.7.101(2)(a)(iii) should be reworded.

COMMENT: The Cascade Public School transportation supervisor generally favors this rule but commented that 10.7.101(2)(k) and (q) needed clarification.

COMMENT: The Heart Butte transportation supervisor commented in favor of the rules.

RESPONSE: OPI agrees with these comments and has made the suggested changes.

COMMENT: The Cascade Public School transportation supervisor commented that the wording of 10.7.101(2)(d) can be interpreted to mean that any inspection that had occurred thirty days prior to the beginning of the school year satisfied the inspection requirement.

COMMENT: Michael Dahlem, Attorney, commented that the January 31 deadline in 10.7.101(2)(p) for second semester inspection could result in school districts losing transportation reimbursement based on the Montana Highway Patrol's failure to conduct timely second semester inspections.

RESPONSE: State law requires two school bus inspections per year. Rule 10.7.101(2)(d) and (p) state both the current law and practice. The phrase "at least 30 days prior" comes from 61-9-502, MCA, which also states that there must be semiannual inspections. Semi-annual can only be interpreted to mean two a year, therefore, a district could not use prior year inspections.

Clarification of the January 31 deadline in rule is made at the request of the Montana Highway Patrol. The Highway Patrol has informed OPI that the Highway Patrol can complete second semester inspections by that date and interprets state law as requiring inspections by that date.

10.7.106 CONTENTS AND LIMITATIONS OF PUPIL TRANSPORTATION CONTRACTS (1) through (9) remain the same as proposed.

(10) The contract must be completed in its entirety, signed by the parent, legal guardian, or emancipated minor and signed by the chairman of the board of trustees on or before the fourth Monday in June preceding the school year for which the transportation is being provided. The signed contract is the authorization of the board of trustees to budget for that transportation expenditure necessary to meet the obligation

imposed on the district by the contract. Each party to the contract and the county superintendent must receive a copy of the contract.

COMMENT: The Missoula County Superintendent commented that the wording of 10.7.106(10) is unclear.

RESPONSE: OPI agrees and has made changes.

10.7.111 QUALIFICATION OF BUS DRIVERS (1) School bus drivers must be fully qualified in order for a district to receive state reimbursement for the bus. Qualifications for bus drivers are prescribed by 20-10-103, MCA, and by the board of public education. These require that the driver:

(a) through (c) remain the same as proposed.

(d) hold a driver's license with a the proper commercial vehicle operator's endorsement;

(e) through (g) remain the same as proposed.

COMMENT: The Cascade Public School transportation supervisor commented that the wording of 10.7.111 should be changed to state current federal law and practice.

RESPONSE: OPI agrees that school districts must follow federal requirements concerning licensing and drug testing. These rules are based on Montana law and do not conflict with the federal requirements.

10.7.115 SCHEDULE FOR BUS TRANSPORTATION (1) through (4) remain the same as proposed.

(5) If a bus route is made up of a series of legs where one complete set of students ~~get off~~ disembarks from the bus and ~~another~~ a new set of students ~~get on~~ boards, the riders must be reported on more than one TR-1 bus route form. The district must report the legs as separate parts of a single route (e.g., Route 1A, 1B and 1C) by submitting a separate form for each section of the route ending where all of the students ~~get off~~ disembark to board another bus or to attend school before the bus continues to another destination.

COMMENT: Chester School District opposes 10.7.115(5). They commented that the rules should take into account "shuttle" routes for purposes of calculating eligible transportees.

RESPONSE: OPI agrees that efficient use of buses should be encouraged when planning routes. The rule's intent is to emphasize that a route ends when all of the students on a bus disembark. A new route leg begins when a new set of students begin to board.

8. Based on the foregoing, the Superintendent of Public Instruction hereby repeals, amends and adopts the rules as proposed, with changes noted above. At this time, the State Superintendent will take no action on proposed new RULES II, III

and IV. The subject matter of these rules -- a school district's authority to operate a bus route that crosses district boundary lines -- is currently the subject of both a request for an attorney general opinion and proposed legislation. The State Superintendent will defer final action on these proposed new rules until both the Attorney General and the Legislature have had the opportunity to clarify or change the current law.

Geralyn Driscoll
Rule Reviewer
Office of Public Instruction

Nancy Keenan
Superintendent
Office of Public Instruction

Certified to the Secretary of State January 13, 1997.

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the amendment of rules 17.54.102, 17.54.201, 17.54.351, 17.54.404, and the adoption of new rule I, which adopts new federal regulations for the hazardous waste program.	NOTICE OF AMENDMENT AND ADOPTION OF RULES

(Waste Management)

To: All Interested Persons

1. On October 24, 1996, the department published notice of proposed amendment and adoption of the above-captioned rules at page 2711 of the Montana Administrative Register, Issue No. 20.

2. The rules were amended and adopted as proposed, with the following changes (new material is underlined; material to be deleted is interlined):

17.54.102 INCORPORATIONS BY REFERENCE Same as proposed.

17.54.201 DEFINITIONS Same as proposed.

17.54.351 REPRESENTATIVE SAMPLING METHODS; TOXICITY CHARACTERISTIC LEACHING PROCEDURE; CHEMICAL ANALYSIS TEST METHODS; AND TESTING METHODS Same as proposed.

17.54.404 MAINTENANCE OF REGISTRATION AND REGISTRATION FEES (1)-(3) Same as proposed.

(4) The size classes for determining the annual registration fee amount are defined in Table 1 below:

TABLE 1

Size Class	Annual Generation Rate (in tons)	Annual Reg. Fee	Relationship to the Three Generator Categories Defined in ARM 17.54.401
I	X ≤ 13	$ 75	Small generators/ Large generators
II	13 < X ≤ 100	$ 200	Large generators
III	100 < X ≤ 1000	$ 600	Large generators
IV	1000 < X ≤ 2500	$1000	Large generators
V	2500 < X	$1500	Large generators

(5)-(8) Same as proposed.

(This rule was adopted as proposed, but in the proposal notice the ≤ sign after the X did not print, so we are reprinting the table as it should appear with the < sign where it originally was in the rule.)

RULE I [17.54.3111] UNIVERSAL WASTE MANAGEMENT (1)-(2) Same as proposed.

(3)(a) The date a used electric lamp becomes a waste is the date the generator permanently removes it from its fixture. The date an unused lamp becomes a waste is the date the generator decides to discard it.

(b) A universal waste handler of hazardous waste electric lamps must:

(i) manage lamps in a way that prevents releases of the lamps, or components or residues from the lamps, to the environment;

~~(i)~~ (ii) contain unbroken lamps in packaging that will minimize breakage during normal handling conditions;

~~(ii)~~ (iii) contain broken lamps in packaging that will minimize releases of lamp fragments and residues; and

~~(iii)~~ (iv) label or mark lamps, or a container in which the lamps are contained, with any one of the following phrases: "universal waste--electric lamp(s)", "waste electric lamp(s)", or "used electric lamp(s)".

(c) If a universal waste handler of hazardous waste electric lamps crushes or otherwise breaks lamps as a part of its management practices, the crushing or breaking must be done in a manner consistent with (3)(b)(i) of this rule.

3. Comments on the proposed rules were received by the department and are summarized below, as well as the department's comments.

Comment: Norwest Banks expressed concern that the proposed Rule I refers to "electric lamps" rather than "fluorescent lamps". Norwest Banks commented that the rule should be changed to use the term "florescent lamps" and not "electric lamps".

Response: The definition of "electric lamp" proposed in ARM 17.54.201(32) includes fluorescent lamps, as well as incandescent, high intensity discharge (HID) and neon lamps. Because they are included within the definition of "electric lamp", florescent lamps may be managed as universal wastes. The proposed language has the advantage over the commenter's more restrictive suggestion in that it allows electric light bulbs other than fluorescent lamps to be included in the universal waste management system. For example, some common incandescent light bulbs exceed the toxicity characteristic for lead because of the solder used in the manufacture of the lamps. The language provided in the proposed rule would allow those lamps to be included in the universal waste management system. One of the rationales behind the universal waste management system is the need for reduced regulatory requirements for commonly generated waste streams. All types of electric lamps potentially meet this criterion. For these reasons, the department has retained the language as proposed.

Comment: The National Electrical Manufacturer's Association (NEMA) suggested the department clearly authorize crushing of lamps under proposed Rule I.

Response: The proposed Rule I does not prohibit the crushing of lamps, as long as generators and other handlers manage lamps in a manner which prevents releases of hazardous constituents to the environment. The department agrees that the rule should make clear that crushing of lamps is not prohibited under these circumstances. The Department has amended proposed Rule I accordingly.

Comment: NEMA suggested the department make clear that households and conditionally exempt small quantity generators are exempt from hazardous waste regulations.

Response: The department believes existing hazardous waste regulations make it sufficiently clear that generators of household hazardous waste and conditionally exempt small quantity generators are exempt from the hazardous waste regulations. See, ARM 17.54.307(2)(a), 17.54.402(2), and 40 CFR 273.1(b) (incorporated by reference in [Rule I]).

Comment: NEMA recommended states not require specific mercury recovery levels for recyclers of lamps.

Response: The department has not proposed any mercury recovery levels for recyclers of lamps.

Comment: NEMA recommended states not require recyclers of certain types of lamps to have the ability to recover mercury from lamps.

Response: The department has not proposed that recyclers of lamps have the ability to recover mercury lamps.

DEPARTMENT OF ENVIRONMENTAL QUALITY

MARK A. SIMONICH, Director

Reviewed by

JOHN F. NORTH
Rule Reviewer

Certified to the Secretary of State January 13, 1997.

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 September 30, 1996. This table includes those rules adopted during the period October 1, 1996 through December 31, 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 September 30, 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.

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BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 2-15-108, MCA, is that the Secretary of State publish monthly in the ***Montana Administrative Register*** a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments effective in December 1996, appear. Vacancies scheduled to appear from February 1, 1997, through April 30, 1997, 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 January 13, 1997.

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 DECEMBER, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Alfalfa Seed Committee (Agriculture)			
Mr. Tom Helm Toston Qualifications (if required): alfalfa seed grower	Governor	reappointed	12/21/1996 12/21/1999
Mr. Kenneth M. Sagmiller Ronan Qualifications (if required): alfalfa seed grower	Governor	reappointed	12/21/1996 12/21/1999
Mr. James Whitmer Bloomfield Qualifications (if required): alfalfa seed grower	Governor	Delp	12/21/1996 12/21/1999
Board of Environmental Review (Environmental Quality)			
Mr. Joe Gerbase Billings Qualifications (if required): local government planner	Governor	reappointed	12/31/1996 12/31/2000
Mr. Russell Hudson Libby Qualifications (if required): public member	Governor	reappointed	12/31/1996 12/31/2000
Mr. Roger Perkins Laurel Qualifications (if required): hydrologist	Governor	reappointed	12/31/1996 12/31/2000
Dr. Garon Smith Missoula Qualifications (if required): scientist	Governor	reappointed	12/31/1996 12/31/2000

BOARD AND COUNCIL APPOINTEES FROM DECEMBER, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Occupational Therapy Practice (Commerce)			
Ms. Linda Botten	Governor	reappointed	12/31/1996
Bozeman			12/31/2000
Qualifications (if required): occupational therapist			
Board of Speech-Language Pathologists and Audiologists (Commerce)			
Ms. Lynn Harris	Governor	reappointed	12/31/1996
Miles City			12/31/1999
Qualifications (if required): audiologist			
Department of Public Health and Human Services Advisory Council (Public Health and Human Services)			
Mr. Jim Adams	Governor	not listed	12/1/1996
Helena			12/1/1998
Qualifications (if required): none specified			
Ms. Ann Bartel	Governor	not listed	12/1/1996
Great Falls			12/1/1998
Qualifications (if required): none specified			
Rep. Ernest Bergsagel	Governor	not listed	12/1/1996
Malta			12/1/1998
Qualifications (if required): none specified			
Sen. Vivian M. Brooke	Governor	not listed	12/1/1996
Missoula			12/1/1998
Qualifications (if required): none specified			
Mr. Ken Caruso	Governor	not listed	12/1/1996
Huson			12/1/1998
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM DECEMBER, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Department of Public Health and Human Services Advisory Council (Public Health and Human Services) Cont.			
Ms. Nancy Espy Broadus Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Mr. Randy Haight Bozeman Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Fern Hart Missoula Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. June Hermanson Polson Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Sara Hudson Billings Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Sally Johnson Missoula Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Wendy Keating Billings Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Dr. Michael J. McLaughlin Great Falls Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998

BOARD AND COUNCIL APPOINTEES FROM DECEMBER, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Department of Public Health and Human Services Advisory Council (Public Health and Human Services) Cont.			
Ms. Joan Miles Helena Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Mr. Fred Patton Helena Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Dr. Bill Peters Bozeman Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Alicia Pichette Helena Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Mr. Bob Runkel Helena Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Ms. Deb Wade Helena Qualifications (if required): none specified	Governor	not listed	12/1/1996 12/1/1998
Peace Officers Standards and Training Council (Justice)			
Mr. Raymond C. Murray Missoula Qualifications (if required): public member	Governor	Zimmerman	12/18/1996 2/15/1998

BOARD AND COUNCIL APPOINTEES FROM DECEMBER, 1996

Appointee	Appointed by	Succeeds	Appointment/End Date
Risk Management Advisory Council (Administration)			
Mr. Bob Person	Governor	not listed	12/16/1996
Helena			8/26/1998
Qualifications (if required): representing Legislative Services Division			
State Emergency Response Commission (Military Affairs)			
Mr. Andrew Malcolm	Governor	Browning	12/18/1996
Helena			8/10/1999
Qualifications (if required): representing the Governor's Office			
Vocational Rehabilitation Divisions Advisory Council (Public Health and Human Services)			
Ms. Jane Tremper	Director	Wall	12/15/1996
Missoula			12/15/1998
Qualifications (if required): none specified			

VACANCIES ON BOARDS AND COUNCILS -- February 1, 1997 through April 30, 1997

Board/current position holder	Appointed by	Term end
Board of Architects (Commerce)		
Mr. John W. Peterson, Kalispell	Governor	3/27/1997
Qualifications (if required): registered architect		
Board of Athletics (Commerce)		
Dr. Andrew Vandolah, Conrad	Governor	4/25/1997
Qualifications (if required): public member		
Board of Clinical Laboratory Science Practitioners (Commerce)		
Dr. J. David Walker, Kalispell	Governor	4/16/1997
Qualifications (if required): physician qualified to direct a high complexity laboratory		
Ms. JoAnn Schneider, Clancy	Governor	4/16/1997
Qualifications (if required): clinical laboratory science practitioner		
Ms. Loraine Kay Crull, Missoula	Governor	4/16/1997
Qualifications (if required): clinical laboratory science practitioner		
Ms. Sonja Bennett, Billings	Governor	4/16/1997
Qualifications (if required): clinical laboratory science practitioner		
Dr. Joseph Rizza, Helena	Governor	4/16/1997
Qualifications (if required): physician qualified to direct a laboratory		
Board of County Printing (Commerce)		
Mr. Roy Aafedt, Great Falls	Governor	4/1/1997
Qualifications (if required): county commissioner		
Ms. Nancy Clark, Ryegate	Governor	4/1/1997
Qualifications (if required): public member		
Mr. Curtis Starr, Malta	Governor	4/1/1997
Qualifications (if required): representing the printing industry		

VACANCIES ON BOARDS AND COUNCILS -- February 1, 1997 through April 30, 1997

Board/current position holder	Appointed by	Term end
Board of County Printing (Commerce) Cont.		
Ms. Fern Hart, Missoula Qualifications (if required): county commissioner	Governor	4/1/1997
Mr. Verle Rademacher, White Sulphur Springs Qualifications (if required): representing the printing industry	Governor	4/1/1997
Board of Dentistry (Commerce)		
Ms. Lisa J. Hinebauch, Chinook Qualifications (if required): public member	Governor	3/29/1997
Mr. Clifford Christenot, Libby Qualifications (if required): denturist	Governor	3/29/1997
Mr. Jack Traxler, Missoula Qualifications (if required): public member and senior citizen	Governor	3/29/1997
Ms. Carol Ann Scranton, Kalispell Qualifications (if required): dentist	Governor	3/29/1997
Board of Hail Insurance (Agriculture)		
Mr. Vince Schmoeckel, Malta Qualifications (if required): public member	Governor	4/18/1997
Board of Livestock (Livestock)		
Ms. Nancy Espy, Broadus Qualifications (if required): cattle producer from Eastern District	Governor	3/1/1997
Mr. James F. Hagenbarth, Dillon Qualifications (if required): cattle producer from Western District	Governor	3/1/1997

VACANCIES ON BOARDS AND COUNCILS -- February 1, 1997 through April 30, 1997

Board/current position holder	Appointed by	Term end
Board of Optometry (Commerce)		
Dr. Cynthia Kinna Johnson, Wolf Point	Governor	4/3/1997
Qualifications (if required): optometrist		
Board of Professional Engineers and Land Surveyors (Commerce)		
Mr. Dennis F. Carver, Kalispell	Governor	4/23/1997
Qualifications (if required): professional engineer		
Mr. David M. Hummel, Jr., Billings	Governor	4/23/1997
Qualifications (if required): civil engineer		
Board of Regents of Higher Education (Education)		
Mr. Kermit R. Schwanke, Missoula	Governor	2/1/1997
Qualifications (if required): Republican from Western Congressional District		
Executive Board of Montana College of Mineral Science and Technology (Education)		
Ms. Catherine Williams, Butte	Governor	4/15/1997
Qualifications (if required): public member		
Executive Board of Eastern Montana College (Education)		
Ms. Kelly Holmes, Bozeman	Governor	4/15/1997
Qualifications (if required): public member		
Executive Board of Montana State University (Education)		
Mrs. Virginia Martin, Bozeman	Governor	4/15/1997
Qualifications (if required): public member		
Executive Board of Northern Montana College (Education)		
Ms. Debbie Leeds, Havre	Governor	4/15/1997
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- February 1, 1997 through April 30, 1997

Board/current position holder	Appointed by	Term end
Executive Board of Western Montana College (Education)		
Mr. Joe Womack, Dillon	Governor	4/15/1997
Qualifications (if required): public member		
Executive Board of the University of Montana (Education)		
Mr. Leonard Landa, Missoula	Governor	4/15/1997
Qualifications (if required): public member		
Montana Arts Council (Education)		
Ms. Beth Collier, Shelby	Governor	2/1/1997
Qualifications (if required): public member		
Mr. John B. Dudis, Kalispell	Governor	2/1/1997
Qualifications (if required): public member		
Mr. James M. Haughey, Billings	Governor	2/1/1997
Qualifications (if required): public member		
Ms. Carol Novotne, Fort Harrison	Governor	2/1/1997
Qualifications (if required): none specified		
Ms. Carol Brenden, Scobey	Governor	2/1/1997
Qualifications (if required): public member		
Public Employees Retirement Board (Administration)		
Ms. Carole Carey, Ekalaka	Governor	4/1/1997
Qualifications (if required): member of public employees' retirement system		
State Compensation Mutual Insurance Fund (Administration)		
Mr. Rick Hill, Helena	Governor	4/28/1997
Qualifications (if required): private for profit representative		

VACANCIES ON BOARDS AND COUNCILS -- February 1, 1997 through April 30, 1997

Board/current position holder	Appointed by	Term end
State Compensation Mutual Insurance Fund (Administration)	Cont.	
Mr. James A. Brouelette, Stevensville	Governor	4/28/1997
Qualifications (if required): private for profit representative		
Ms. Sandra D. Reiter, Billings	Governor	4/28/1997
Qualifications (if required): private for profit representative		
State Tax Appeal Board (Administration)		
Mr. Gregory Thornquist, Billings	Governor	3/1/1997
Qualifications (if required): public member		