MONTANA ADMINISTRATIVE REGISTER

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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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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 found at the back of each register.

Inquiries regarding the rulemaking process, including material found in the Montana Administrative Register and the Administrative Rules of Montana, may be made by calling the Administrative Rules Bureau at (406) 444-2055.

Page Number

TABLE OF CONTENTS

NOTICE SECTION

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

In the matter of the proposed amendment of Rule 6.6.126 pertaining to unethical practices	))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 16, 1999, the State Auditor and Commissioner of Insurance proposes to amend Rule 6.6.126 pertaining to "unethical practices" by broker-dealers and salesmen.

2. The proposed rule amendments are as follows (new material is underlined; material to be deleted is interlined):

6.10.126 "UNETHICAL PRACTICES" BY BROKER-DEALERS AND SALESMEN DEFINED (1) For purposes of 30-10-201~~(12)(g)~~, MCA, "unethical practices" by a broker-dealer means, but is not limited to:

(1)(a) through (2)(g) remain the same.

AUTH: 30-10-107, MCA
IMP: 30-10-201, MCA

3. Rule 6.6.126 is being amended to correct a typographical error that cites the wrong code subsection.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604, and must be received no later than July 30, 1999.

5. If a person who is directly affected by the proposed amendment wishes to express their data, views and arguments orally or in writing at a public hearing, they must make a written request for a hearing and submit this request along with any written comments they have to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604. A written request for hearing must be received no later than July 30, 1999.

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

directly affected has been determined to be 15 persons based on the 150 persons who have indicated interest in the rules of this agency and who the agency has determined could be directly affected by these rules.

7. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written requests may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to the office at 406-444-3497, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

MARK O'KEEFE, State Auditor
and Commissioner of Securities

By: _____
David L. Hunter
Deputy State Auditor

By: _____
Gary Spaeth
Rules Reviewer

Certified to the Secretary of State this 28th day of May, 1999.

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

In the matter of the proposed amendment of Rule 6.6.1105 pertaining to allowable exclusions and restrictions	))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On August 16, 1999, the State Auditor and Commissioner of Insurance proposes to amend Rule 6.6.1105 pertaining to allowable exclusions and restrictions.

2. The proposed rule amendments are as follows (new material is underlined; material to be deleted is interlined):

6.6.1105 ALLOWABLE EXCLUSIONS AND RESTRICTIONS (1) Any contract to which the rates provided by ARM 6.6.1103 apply may contain provisions excluding or restricting coverage in the event of ~~pregnancy, intentionally~~ intentional and self-inflicted injury, foreign travel or residence, flight in non-scheduled aircraft, or war or military service.

(2) and (3) will remain the same.

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

3. Rule 6.6.1105 is being amended due to the passage of Section 49-2-309, Montana Code Annotated, in 1983, which makes it unlawful to discriminate on the basis of sex in the issuance or operation of any type of insurance policy, plan or coverage. The Montana Supreme Court has held that distinctions based upon pregnancy constitute the type of gender-based discrimination prohibited by Section 49-2-309, MCA. Bankers Life and Casualty Co. v. Peterson 263 Mont. 156, 866 P.2d 241 (1993).

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604, and must be received no later than July 30, 1999.

5. If a person who is directly affected by the proposed amendment wishes to express their data, views and arguments orally or in writing at a public hearing, they must make a written request for a hearing and submit this request along with any written comments they have to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604. A written request for hearing must be received no later than July 30, 1999.

6. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative rule review committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 30 persons based on the 300 persons who have indicated interest in the rules of this agency and who the agency has determined could be directly affected by these rules.

7. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written requests may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to the office at 406-444-3497, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: _____
Frank Cote
Deputy Insurance Commissioner

By: _____
Gary Spaeth
Rules Reviewer

Certified to the Secretary of State this 28th day of May, 1999.

BEFORE THE DEPARTMENT OF CORRECTIONS
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I through XLIV pertaining to the operation and physical condition of a private correctional facility and the security, safety, health, treatment and discipline of persons confined in a private correctional facility	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF NEW RULES

TO: All Interested Persons

1. On July 7, 1999, at 9:30 a.m., a public hearing will be held in the first floor conference room at the Department of Corrections, 1539 11th Avenue, Helena, Montana, to consider the proposed adoption of new rules I through XLIV pertaining to the operation and physical condition of a private correctional facility, and the security, safety, health, treatment and discipline of persons confined in a private correctional facility.

2. Any person/party may be placed on the Department of Corrections' list of interested persons/parties by contacting Claudia Johnson, Administrative Support, in writing at the address listed below.

3. The Department of Corrections will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, please contact the Department no later than July 2, 1999, to advise the Department of the nature of the accommodation you need. Please contact Claudia Johnson, P.O. Box 201301, Helena, MT 59620-1301, telephone (406) 444-7917, FAX (406) 444-4920. Persons with disabilities who need an alternative accessible format of this document in order to participate in the rule making process are requested to contact Ms. Johnson.

4. The proposed new rules provide as follows:

Rule I PURPOSE (1) These rules establish the licensing requirements for the operation, security, and physical condition, as well as for the safety, health, treatment and discipline of persons confined in a private correctional facility within the state of Montana pursuant to 53-30-604, MCA, providing that a private correctional facility conform to applicable American correctional association (ACA), and national commission of correctional health care standards (NCCHC), and providing that a facility achieve accreditation from ACA and NCCHC within three years of the date it begins

operation, and maintains ACA accreditation thereafter.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule II DEFINITIONS (1) "Department" means the department of corrections provided for in 2-15-2301, MCA.

(2) "Private correctional facility" means a correctional facility that is either privately operated or privately owned and operated. The term includes a regional correctional facility, as defined in 53-30-503, MCA, if privately operated or privately owned and operated.

(a) The term does not include a private detention center or a regional jail governed by Title 7, chapter 32, part 22, MCA.

(3) "Licensing agent" means the department employee designated to conduct site visits, conduct licensing studies and perform all other duties regarding the licensing of private prisons pursuant to these rules.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule III FACILITY LICENSE (1) Each private correctional facility within the state of Montana must be licensed by the department. The facility's current license must be prominently displayed in the general administration area of the facility.

(2) The department shall issue a one-year private prison license to any private correctional facility that has fulfilled the requirements of law and these rules.

(3) The department shall renew the license annually on the expiration date of the previous year's license if the facility continues to meet the requirements of law and these rules.

(4) The department may issue a provisional license for up to six months to any license applicant which:

(a) has met all applicable requirements for fire, life safety and health standards; and

(b) has agreed in writing to comply fully with all requirements established by these rules within the time period covered by the provisional license.

(5) The department may renew a provisional license if the license applicant shows good cause for failure to comply fully with all of the requirements within the time period covered by the prior provisional license. The total time period covered by the initial provisional license and renewals may not exceed one year.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule IV LICENSING PROCEDURES (1) A private correctional facility must apply to the department for its initial license at least 90 days prior to the date it intends to be open for operation.

(2) The facility must apply in writing with a letter requesting a licensing review and a completed licensing application on a form provided by the department.

(3) A facility that has a current license under these rules and needs a yearly renewal license must send the request for a renewal licensing review to the department licensing agent at least 60 days prior to the date its current license expires on the renewal form provided by the department.

(4) Upon receipt of an application for license or renewal license, the department must conduct a licensing review to determine if the applicant meets the applicable licensing requirements established in the law and these rules. A licensing review or renewal licensing review must include an on-site visit, as well as interviews with inmates and correctional staff.

(5) The facility must permit the department licensing agent:

(a) unlimited and immediate access to all areas of the facility at all times; and

(b) to inspect all written and electronic records related to the operation of the facility.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule V LICENSE REVOCATION AND DENIAL (1) The department, after written notice to the applicant or licensee, may deny, suspend, restrict, revoke or reduce to provisional status a license upon finding that the facility:

(a) is not in substantial compliance with the licensing requirements established by these rules;

(b) has made any misrepresentations to the department, either negligent or intentional, regarding any aspect of its management or operation of the facility;

(c) has failed to comply with its plan to correct areas of noncompliance identified by a license review as required in [Rule IV];

(d) has failed to remedy practices or procedures identified by the department which continue to place the public, staff or offenders in imminent risk of escape, serious bodily harm or property damage; and

(e) is in default of the contract with the state under which it is operating the facility.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule VI HEARING (1) Any applicant or licensee who wishes to contest the department's licensing action refusing to grant a license, restricting, suspending, reducing to provisional, or revoking a license may request a contested case hearing as provided in 2-4-601, MCA.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule VII PURPOSE AND MISSION (1) The facility must have

a written policy and procedure manual, approved by the department, which establishes the facility's mission, goals, objectives and standard operating procedures, and establishes a system of regular review of policies and procedures.

(2) The facility must be established by being subject to a current contract with the state of Montana or one of its subdivisions to operate a private prison.

(3) The facility must have a written mission statement that delineates the facility's mission within the context of the Montana correctional system.

(4) The facility may not house a person charged or convicted in another state or charged or convicted in federal court in another state.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule VIII FACILITY WARDEN (1) The facility must be headed by a warden who is in charge of all inmates, personnel, volunteers, programs and activities connected with the facility.

(2) The qualifications for the position of warden are at a minimum, the following:

(a) bachelor's degree in an appropriate discipline; and

(b) demonstrated administrative ability and leadership.

(3) The degree requirement may be satisfied by completion of a career development program that includes work-related experience, training, or college credits at a level of achievement equivalent to a bachelor's degree.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule IX FACILITY ORGANIZATION (1) The facility must have a written document describing its organization. This description must include an organizational chart.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule X POLICY AND PROCEDURE MANUAL (1) Policies and procedures for operating the facility must be:

(a) approved by the department; and

(b) contained in a manual that is accessible to all employees and the department.

(2) The facility must update and review this manual annually.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XI MEDIA ACCESS (1) The facility must have a written policy, procedure and practice which:

(a) allows representatives of the media access to the facility consistent with preserving inmates' right to privacy and maintaining order and security; and

(b) provides for the dissemination of information about

the facility to the public, governmental agencies, and the media.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XII INMATE FUNDS (1) The facility must have control of inmate personal funds held by the facility by accepted accounting procedures.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XIII STAFFING REQUIREMENTS (1) Facility staffing requirements for all categories of personnel must be determined on an ongoing basis to ensure that inmates have access to staff, programs and services.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XIV BACKGROUND/CRIMINAL RECORD CHECK (1) The facility must obtain a background investigation criminal record check on all new employees in accordance with department requirements to detect any criminal convictions that relate specifically to job performance.

(2) The facility may not hire any person with a prior felony conviction without department approval.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XV DRUG-FREE WORKPLACE (1) The facility must have a written policy and procedure that specifies support for a drug-free workplace for all employees. The policy must:

(a) require that all potential employees pass a drug and alcohol test prior to beginning work at a facility; and

(b) include pre-employment testing and ongoing drug testing in conformity with state law.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XVI PERSONNEL FILES (1) The facility must maintain a current, accurate, and confidential personnel record on each employee.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XVII TRAINING AND STAFF DEVELOPMENT (1) The facility must provide staff training and development in accordance with Montana law.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XVIII INMATE POPULATION MOVEMENT (COUNT) (1) The facility must have a strict accountability system to physically count every inmate.

(2) The facility must have a written plan to control inmate movement within and outside the facility that is approved by the department.

(3) The facility must have written policy and procedures governing the transportation of inmates outside the facility.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XIX BUILDING AND SAFETY CODES (1) The facility must comply with all applicable federal, state and/or local building codes and fire safety codes.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XX INMATE HOUSING (1) Inmate housing areas must conform to applicable ACA standards as to size, space, furnishings, toilets, and showers.

(2) Handicapped inmates must be housed in a manner that provides for their safety and security.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXI EXERCISE AND RECREATION (1) General population inmates must be provided access to at least one hour daily of indoor or outdoor exercise.

(2) The facility must provide adequate space for inmates to exercise in accordance with ACA standards.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXII VISITING AREAS (1) The facility must provide sufficient space for inmates to receive visits from approved visitors.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXIII FIRE AND LIFE SAFETY (1) The facility must have a written fire and life safety plan that is in accordance with the department policy on fire and life safety.

(2) All employees must be trained to this plan.

(3) The facility must have a written policy, procedure and practice which:

(a) specifies the facility's fire prevention regulations and practices; and

(b) provides for a comprehensive and thorough monthly inspection of the facility by a qualified fire and life safety officer.

(4) Facility specifications for the selection and purchase of facility furnishings must indicate the fire safety performance requirements of the materials selected.

(5) Facility policy must provide that the facility does not allow smoking or any tobacco products on premises.

(6) Facility policy must provide for:

(a) separate containers for combustible refuse at accessible locations throughout the facility;

(b) special containers for flammable liquids and rags used with flammable liquids, which containers are emptied and cleaned daily; and

(c) the control and use of all flammable, toxic and caustic materials.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXIV EMERGENCY RESPONSE PLAN (1) The facility must have a written emergency response plan that complies with the department's emergency preparedness plan, and provides:

(a) that all personnel are trained in the implementation of the plan; and

(b) for a written evacuation plan to be used in the event of fire or major emergency which includes:

(i) location of building/room floor plans;

(ii) use of exit signs and directional arrows for traffic flow;

(iii) location of a publicly posted plan;

(iv) at least quarterly drills in all facility locations, ncluding administrative areas; and

(v) provisions for the release of inmates from locked areas.

(2) Facility policy must provide that any work stoppage or riot plans are communicated only to appropriate supervisory personnel or other personnel directly involved in the implementation of those plans.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXV USE OF FORCE, RESTRAINTS AND CHEMICAL AGENTS (1) The facility must have use of force, use of restraints, and use of chemical agent policies that are approved by the department.

(2) The facility must have a written policy and procedure governing the use of firearms which is approved by the department.

(3) Facility policy must provide that instruments of restraint such as handcuffs, leg irons or belly chains are never applied as punishment.

(4) Facility policy must provide that 4-point restraint is only applied with the approval of the warden.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXVI SECURITY MANUAL (1) The facility must maintain a written manual containing procedures for facility security and control, with detailed instructions for implementing these procedures. The manual must be approved by the department and available to all facility staff.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXVII CONTROL OF CONTRABAND (1) The facility must have a written policy, procedure and practice to provide for search of the facility and inmates to control contraband and provide for its disposition which is approved by the department.

(2) Facility policy, procedure and practice must require that all pat searches, frisk searches, strip searches and body cavity searches are performed in accordance with ACA standards.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXVIII KEY AND TOOL CONTROL (1) The facility must have a written policy, procedure and practice controlling the use of keys, tools, culinary and medical equipment.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXIX INJURIES INCURRED IN A FACILITY INCIDENT (1) The facility must have a written policy, procedure and practice to provide that all persons injured in an incident receive immediate medical examination and treatment.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXX FACILITY SECURITY THREATS, ESCAPES (1) The facility must have written plans that specify procedures to be followed in situations that threaten facility security. Such situations include but are not limited to riots, hunger strikes, disturbances, escapes, and taking of hostages. These plans must be made available to all applicable personnel and reviewed annually and updated as needed.

(2) The facility must have on file written mutual aid agreements with the cooperating agencies in its area.

(3) The facility must have a written policy, procedure and practice to ensure that pedestrians and vehicles leave and enter the facility at designated points in the perimeter.

(4) The facility's perimeter must be controlled by appropriate means to:

(a) provide that inmates remain within the perimeter; and

(b) prevent access by the general public without proper authorization.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXI RULES AND DISCIPLINE (1) The facility must have written policies, procedures and practices regarding disciplinary actions, approved by the department which:

(a) define in writing the rules of conduct, sanctions and procedures for violations;

(b) must be communicated to all inmates and staff; and

(c) provide that when an inmate allegedly commits an act

covered by criminal law, the case is referred to appropriate court or law enforcement officials for consideration for prosecution.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXII SPECIAL MANAGEMENT (1) The facility must have a written policy and procedure, approved by the department, to provide for removal from general population of inmates who threaten the secure and orderly management of the facility or persons that must be protected from harm by other inmates by placement in special units.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXIII INMATE CLASSIFICATION (1) The facility must have a written policy and procedure, approved by the department, for the objective classification of inmates remanded to its custody.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXIV INMATE RIGHTS (1) The facility must have a written policy, procedure and practice to ensure the right of inmates to have:

(a) access to courts and legal counsel;

(b) access to a law library, or a person trained in the law;

(c) reasonable access with media subject to limitations necessary to maintain order and security and protect inmates' privacy; and

(d) protection from unreasonable searches.

(2) The facility must have a written policy, procedure and practice that protects inmates from personal abuse, corporal punishment, personal injury, disease, property damage, and harassment.

(3) The facility must have a written inmate grievance procedure that is made available to all inmates. The procedure must include at least one level of appeal.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXV ADMISSION (1) The facility must have a written policy and procedure that governs the admission of inmates to the system approved by the department.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXVI PERSONAL PROPERTY (1) The facility must have a written policy and procedure governing the control of inmate personal property and funds.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXVII MENU, DIETS, FOOD SERVICE (1) The facility's dietary allowances and plan must be reviewed at least annually by a qualified nutritionist or dietician to ensure that it meets the nationally recommended dietary allowances for males age 25-50 years as provided by the national research council food and nutrition board.

(2) The facility must have a written policy, procedure and practice that:

(a) requires food service staff take into consideration food flavor, texture, temperature, appearance and palatability; and

(b) provides for special diets as prescribed by appropriate medical or dental personnel.

(3) The facility must obtain documentation by an independent, outside source that food service facilities and equipment meet established state and local health and safety codes.

(4) The facility must have a written policy, procedure and practice for adequate health protection for all inmates and staff in the facility, and inmates and other persons working in the food service, including the following:

(a) when the facility's food services are provided by an outside source, the facility must have written verification that the outside provider complies with state and local regulations regarding food service;

(b) all food handlers must be instructed to wash their hands upon reporting to duty and after using toilet facilities; and

(c) the director of food service or designee must monitor inmates and other persons working in food service each day for health and cleanliness.

(5) The facility must have a written policy, procedure and practice requiring weekly inspections of all food service areas, including dining and food preparation areas and equipment, by administrative, medical or dietary personnel. These may include the person supervising food service operations or designee. Administrative, medical or dietary personnel must check refrigerator and water temperatures daily.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXVIII SANITATION AND HYGIENE (1) The facility must have a written policy, procedure and practice requiring the following inspections:

(a) weekly sanitation inspections of all facility areas by a qualified staff member;

(b) comprehensive and thorough monthly inspections by a safety/sanitation specialist; and

(c) at least annual inspections by state and/or local sanitation and health officials.

(2) The facility's potable water source and supply, whether owned and operated by the public water department or

the facility, must be certified by an independent source outside the facility to be in compliance with state and local law.

(3) The facility must provide for a waste disposal system in accordance with an approved plan by the appropriate regulatory agency.

(4) The facility must provide for the control of vermin and pests.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XXXIX HEALTH CARE (1) The facility must have a written policy, procedure and practice providing that all medical, psychiatric, and dental matters involving medical judgment are the sole province of the responsible physician, mental health provider, and dentist, respectively.

(2) The facility must ensure that:

(a) personnel who provide health care services to inmates have attained the appropriate state and federal licensure, certification, or registration requirements;

(b) the duties and responsibilities of such personnel are governed by written job descriptions approved by the health authority; and

(c) verification of current credentials and job descriptions are on file in the facility.

(3) The facility must ensure that all treatment to inmates by health care personnel other than a physician, dentist, psychologist, optometrist, podiatrist, or other independent provider is performed pursuant to written or direct orders by personnel authorized by law to give such orders. Nurse practitioners and physician's assistants may practice within the limits of applicable laws and regulations.

(4) The facility must have a written policy, procedure and practice that provides for emergency care and meets or exceeds the ACA standards for adult correctional facilities.

(5) The facility must have a written policy and practice that prohibits the use of inmates for medical, pharmaceutical, or cosmetic purposes. This policy may not preclude individual treatment of an inmate based on his or her need for a specific medical procedure that is not generally available.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XL PHARMACEUTICALS (1) The facility must have a written policy, procedure and practice approved by the department which provide for the proper management of pharmaceuticals and address the following subjects:

(a) a formulary developed for the facility;

(b) prescription practices, including requirements that:

(i) psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy;

(ii) "stop order" time periods are required for all medications; and

(iii) the prescribing provider reevaluates a prescription

prior to its renewal;

(c) procedures for medication receipt, storage, dispensing and administration or distribution;

(d) maximum security storage and periodic inventory of all controlled substances, syringes and needles;

(e) dispensing of medicine in conformance with appropriate federal and state law;

(f) administration of medication by persons properly trained and under the supervision of the health authority and facility administrator or designee; and

(g) accountability for administering or distributing medications in a timely manner, according to physician orders.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XLI HEALTH SCREENING (1) The facility must have a written policy, procedure and practice requiring medical, dental and mental health screening to be performed pursuant to ACA standards for adult correctional facilities.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XLII INMATE WORK PROGRAMS (1) The facility must have a written policy, procedure and practice that:

(a) requires all able-bodied inmates to work unless assigned to an approved education or training program; and

(b) provides that inmates receive pay comparable to that received by inmates in the department's adult correctional facilities.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XLIII MAIL, TELEPHONE, VISITING (1) The facility must have a written policy and procedure governing the following:

(a) inmate correspondence;

(b) postage allowance for indigent inmates;

(c) inmate access to publications;

(d) inspection of incoming and outgoing inmate mail; and

(e) inspection for and disposition of contraband.

(2) The facility must have a written policy, procedure and practice providing for:

(a) inmate access to telephones; and

(b) inmate visitation.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

Rule XLIV RELIGIOUS PROGRAMS (1) The facility must have a written policy, procedure and practice that provides for inmates to have the opportunity to participate in practices of their religious faith deemed essential by the faith's governing body, limited only by documentation showing threat to the safety of persons involved in such activity or that the

activity itself disrupts order in the facility.

AUTH: 53-30-603 and 53-30-604, MCA
IMP: 53-30-604, MCA

5. The adoption of Rules I through XLIV is reasonably necessary to implement the legislative directives for the operation and physical condition of a private correctional facility, and the security, safety, health, treatment and discipline of persons confined in a private correctional facility in 53-30-604, MCA (1997). These rules are also necessary to implement the legislative directive for licensure of a private correctional facility by the department in 53-30-603, MCA (1997).

6. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Lois Adams, Rule Reviewer, Montana Department of Corrections, P. O. Box 201301, Helena, MT 59620-1301, and must be received no later than July 15, 1999.

7. The bill sponsor notice requirements of 2-4-302, MCA apply and have been fulfilled.

8. Lois Adams, Rule Reviewer, will preside over and conduct the hearing.

Rick Day, Director
Department of Corrections

Lois Adams
Rule Reviewer

Certified to the Secretary of State June 4, 1999.

BEFORE THE COMMISSIONER OF LABOR
ACTING BY AND THROUGH THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the amendment of Montana's prevailing wage rates, pursuant to ARM 24.16.9007	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF PREVAILING WAGE RATES-NONCONSTRUCTION SERVICES

TO ALL INTERESTED PERSONS:

1. On July 9, 1999, at 11:00 a.m., a public hearing will be held in room 104 of the Walt Sullivan Building (Department of Labor and Industry Building), 1327 Lockey, Helena, Montana, to consider proposed amendments to the prevailing wage rate rule, ARM 24.16.9007. The Commissioner and the Department propose to incorporate by reference the 1999 nonconstruction services rates.

2. The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 5:00 p.m., July 6, 1999, to advise us of the nature of the accommodation that you need. Please contact the Office of Research and Analysis, Job Service Division, Attn: Ms. Kate Kahle, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-3239; TTY (406) 444-0532; fax (406) 444-2638.

3. The Commissioner, acting by and through the Department of Labor and Industry, proposes to amend ARM 24.16.9007 as follows: (new matter underlined, deleted matter interlined)

24.16.9007 ADOPTION OF STANDARD PREVAILING RATE OF WAGES

(1) Remains the same.

(a) through (e) Remain the same.

(f) The current non-construction services rates are contained in the ~~1997~~ revised 1999 version of "The State of Montana Prevailing Wage Rates-Non-construction Services ~~Service Occupations~~" publication.

(2) and (3) Remain the same.

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

REASON: Pursuant to 18-2-402 and 18-2-411(b)(5), MCA, the Commissioner and the Department are updating the standard prevailing wages for nonconstruction services occupations. The Department updates the prevailing wages for these nonconstruction services occupations every two years. There is reasonable necessity to amend the prevailing wages for nonconstruction services, which were last updated in 1997. Use of prevailing wage rates is required in public contracts by 18-2-422, MCA.

Following public comments made earlier this year, the Commissioner and the Department became aware of a number of collective bargaining agreements that applied to some non-construction occupations in various parts of the state. Pursuant to 18-2-402(3), MCA, prevailing wage rates cannot be set higher than the rate negotiated in an existing and current collective bargaining agreement. Accordingly, some of the revised rates have been lowered in order to comply with 18-2-402(3), MCA.

4. Interested parties may submit their data, views, or comments, either orally or in writing, at the hearing. Written data, views, or comments may also be submitted to:

Kate Kahle
Office of Research and Analysis
Job Service Division
Department of Labor and Industry
P.O. Box 1728
Helena, Montana 59624-1728

so that they are received by not later than 5:00 p.m., July 16, 1999.

5. The Department maintains a number of mailing lists of interested persons regarding a variety of topics. For more information about the mailing lists, or to have your name and address added to any or all of the interested persons lists, please contact Mark Cadwallader, Office of Legal Services, Department of Labor and Industry, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-4493; TTY (406) 444-0532.

6. The Department is not required to comply with the provisions of 2-4-302, MCA, regarding notification of the bill sponsor about the proposed action regarding these rules.

7. The Department proposes to make this amendment effective as soon as feasible.

8. The Hearings Bureau of the Centralized Services Division of the Department has been designated to preside over and conduct the hearing.

Kevin Braun,
Rule Reviewer

Patricia Haffey, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 4, 1999.

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

In the matter of the proposed amendment of ARM 24.30.102, related to occupational safety and health standards for public sector employment	NOTICE OF EXTENSION OF COMMENT PERIOD FOR THE PROPOSED AMENDMENT OF ARM 24.30.102

TO ALL INTERESTED PERSONS:

1. On April 8, 1999, pursuant to MAR Notice No. 24-30-123, the Department of Labor and Industry gave notice that it would hold a public hearing and take public comment concerning the proposed amendment of ARM 24.30.102. That notice was published at pages 617 through 620 of the 1999 Montana Administrative Register, issue no. 7.

2. On April 30, 1999, at 1:30 p.m., a public hearing was held in the first floor conference room at the Walt Sullivan Building (Dept. of Labor and Industry Building), 1327 Lockey Street, Helena, Montana, to consider the amendment of ARM 24.30.102, to generally incorporate by reference the current version of federal health and safety regulations.

3. Following the public hearing, the Department received requests to extend the public comment period. In response to the requests, and in order to give the interested parties and members of the public a full opportunity to comment on the proposed amendments, the Department has extended the public comment period to June 30, 1999. Written data, views or arguments may be submitted to:

John Maloney, Bureau Chief
Safety Bureau
Employment Relations Division
Department of Labor and Industry
P.O. Box 1728
Helena, Montana 59624-1728

and must be received by no later than 5:00 p.m., June 30, 1999.

Kevin Braun,
Rule Reviewer

Patricia Haffey, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: June 4, 1999.

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

In the Matter of the Proposed Adoption of a Rule Establishing the Meaning and Effect of the "Landfill Closure Provision" in Class D Motor Carrier Authorities	)))))	NOTICE OF PUBLIC HEARING

TO: All Interested Persons

1. On Wednesday, July 28, 1999, at 9:00 a.m., in the Bollinger Room, Public Service Commission (PSC) offices, 1701 Prospect Avenue, Helena, Montana, the PSC will hold a hearing to consider the proposal identified in the above titles and described in the following paragraphs, all related to establishing the meaning and effect of the landfill closure provision in PSC-issued Class D (solid waste transportation) motor carrier authorities. Anyone needing accommodations for physical, hearing, or sight impairment in order to attend and participate in the hearing should contact the PSC Secretary at (406) 444-6199 at least one week prior to hearing.

2. The proposed rule does not replace or modify any section currently found in the Administrative Rules of Montana.

3. The rule proposed for adoption provides as follows. NOTE: for the purpose of identifying or framing the primary issue involved in this rulemaking, subsection (2) of the proposed rule is stated in the alternative (i.e., alternatives "A" and "B"), only one of which will be the rule as adopted.

NEW RULE I. MEANING AND EFFECT OF CLASS D LANDFILL CLOSURE PROVISION (1) For purposes of this rule "landfill closure provision" means a provision within a Class D motor carrier authority which states "carrier is allowed to transport authorized commodities to certified landfills from the territory authorized," or a reasonable variation of that specific statement, and which has been inserted into a Class D authority on the commission's own motion or on request, and which has the purpose of preventing the underlying Class D authority from becoming meaningless in the event that, through closure or other restriction, a landfill within the territory authorized in the underlying Class D authority becomes unavailable to accept solid waste transported by the Class D carrier.

[Alternative "A"] (2) A landfill closure provision does not negate or modify any origination point, termination point, or other point-specific terms, route-specific terms, or other specific terms and conditions of the underlying authority, such as "between" and to-and-from" requirements, whether the terms are stated in the body of the Class D authority or in limitations attached to the Class D authority. A landfill

closure provision merely allows a transportation movement, otherwise authorized by the underlying Class D authority and executed in strict compliance with the underlying Class D authority, which would have been a lawful transportation movement to a certified landfill but for closure or restriction of that landfill, to extend to and terminate at any certified landfill.

[Alternative "B"] (2) A landfill closure provision negates all origination point, termination point, or other point-specific terms, route-specific terms, or other specific terms and conditions of the authority, such as "between" and "to-and-from" requirements, whether the terms are stated in the body of the Class D authority or in limitations attached to the Class D authority. A landfill closure provision allows a transportation movement commenced at any point within the geographical boundaries authorized in the underlying Class D authority or at any point on a designated route authorized in the underlying Class D authority to proceed directly to and terminate at any certified landfill.

AUTH: 69-12-201, MCA
IMP: 69-12-201, MCA

4. Rationale: The proposed rule is reasonably necessary to resolve conflicting interpretations, views, and opinions regarding the meaning and effect of the PSC's Class D "landfill closure provision," so all Class D motor carriers and other interested persons will understand how the provision is to be interpreted and applied.

5. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments (original and 10 copies) may also be submitted to Public Service Commission, Legal Division, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601, no later than July 28, 1999. (PLEASE NOTE: When filing comments pursuant to this notice please reference "Docket No. L-99.5.5-RUL.")

6. The Public Service Commission, a commissioner, or a duly appointed presiding officer may preside over and conduct the hearing.

7. The Montana Consumer Counsel, 616 Helena Avenue, P.O. Box 201703, Helena, Montana 59620-1703, phone (406) 444-2771, is available and may be contacted to represent consumer interests in this matter.

8. The bill sponsor notification requirements of 2-4-302, MCA, do not apply as this rulemaking is not the initial rulemaking on the statutes being implemented.

9. The PSC maintains a list of persons interested in PSC rulemaking proceedings and the subject or subjects in which each

person on the list is interested. Any person wishing to be on the list must make a written request to the PSC, providing a name, address, and description of the subject or subjects in which the person is interested. Direct the request to the Public Service Commission, Legal Division, 1701 Prospect Avenue, P.O. Box 202601, Helena, Montana 59620-2601.

Dave Fisher

Dave Fisher, Chairman

Reviewed By Robin A. McHugh

CERTIFIED TO THE SECRETARY OF STATE JUNE 3, 1999.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the adoption of a rule related to acquiring services to operate the State Employees' Charitable Giving Campaign	)))))	NOTICE OF ADOPTION OF A RULE RELATED TO ACQUIRING SERVICES TO OPERATE THE STATE EMPLOYEES' CHARITABLE GIVING CAMPAIGN

TO: All Concerned Persons

1. On April 8, 1999, the Department of Administration published notice of the proposed adoption of new Rule I concerning acquiring services to operate the State Employees' Charitable Giving Campaign at page 561 of the 1999 Montana Administrative Register, Issue Number 7.

2. The agency has adopted new Rule I (ARM 2.5.120) exactly as proposed.

3. One comment was received in support of the proposed rule.

BY: Lois Menzies
Lois Menzies, Director
Department of Administration

Dal Smilie
Dal Smilie, Rule Reviewer

Certified to the Secretary of State June 4, 1999

BEFORE THE BOARD OF CLINICAL LABORATORY SCIENCE PRACTITIONERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees and renewal	)))	NOTICE OF AMENDMENT OF ARM 8.13.303 FEES AND 8.13.304 RENEWAL

TO: All Concerned Persons:

1. On March 25, 1999, the Board of Clinical Laboratory Science Practitioners published a notice of public hearing on the proposed amendment of the above-stated rules at page 437, 1999 Montana Administrative Register, issue number 6. The hearing was held on April 14, 1999, in Helena, Montana.

2. The Board has amended the rules exactly as proposed.

3. The Board has thoroughly considered all comments and testimony received. Those comments, and the Board's responses thereto, are as follows:

COMMENT NO. 1: One comment was received expressing concern with students having to pay a temporary practice fee.

RESPONSE: The Board stated that, while working as a student, an individual does not need to obtain a temporary permit. The temporary permit is for someone who has graduated, is working and is waiting to take the national examination.

COMMENT NO. 2: One comment was received concerning the increase in the renewal fee.

RESPONSE: The Board stated that its fees are commensurate with program area costs. It also stated that it has waived its renewal fees numerous times since 1995.

COMMENT NO. 3: One comment was received expressing concern about the increase in the renewal fee and also that she must pay to belong to the association.

RESPONSE: The Board again stated that its fees are set commensurate with program area costs and that the renewal fee is going from $30 to $45, not $100. It also stated that state law requires a license to practice in Montana and that one is not required to belong to an association. Belonging to an association is an individual choice.

BOARD OF CLINICAL LABORATORY
SCIENCE PRACTITIONERS
JOANNE SCHNEIDER, CHAIRMAN

ANNIE M. BARTOS
RULE REVIEWER

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

Certified to the Secretary of State, June 4, 1999.

BEFORE THE BOARD OF NURSING
AND THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to quality assurance of advanced practice registered nurse practice	)))	NOTICE OF AMENDMENT OF ARM 8.32.1508 QUALITY ASSURANCE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE

TO: All Concerned Persons:

1. On January 14, 1999, the Board of Nursing and the Board of Medical Examiners published a notice of public hearing on the proposed amendment of the above-stated rule at page 22, 1999 Montana Administrative Register, issue number 1.

2. The rule has been amended exactly as proposed.

3. Several comments were received in support of the proposed amendments and the Board acknowledges the comments.

BOARD OF NURSING
BOARD OF MEDICAL EXAMINERS

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 4, 1999.

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

In the matter of the amendment of a rule pertaining to the Weights and Measures Bureau	)))	NOTICE OF AMENDMENT OF A RULE PERTAINING TO THE WEIGHTS AND MEASURES BUREAU

TO: All Concerned Persons:

1. On March 25, 1999, the Weights and Measures Bureau published a notice of proposed amendment of ARM 8.77.103, at page 469, 1999 Montana Administrative Register, issue number 6.

2. The Bureau has amended the rule exactly as proposed.

3. No comments or testimony were received.

WEIGHTS AND MEASURES BUREAU
JACK KANE, BUREAU CHIEF

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

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 4, 1999.

BEFORE THE TRAVEL PROMOTION AND DEVELOPMENT DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to the Tourism Advisory Council	)))	NOTICE OF AMENDMENT OF A RULE PERTAINING TO THE TOURISM ADVISORY COUNCIL

TO: All Concerned Persons:

1. On March 25, 1999, the Travel Promotion and Development Division published a notice of public hearing on the proposed amendment of ARM 8.119.101 at page 471, 1999 Montana Administrative Register, issue number 6. The hearing was held on February 25, 1999, in Helena, Montana.

2. The Division has amended the rule exactly as proposed.

3. No comments or testimony were received.

TRAVEL PROMOTION AND DEVELOPMENT DIVISION
MATTHEW COHN, DIRECTOR

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

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 4, 1999.

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

In the matter of the amendment of ARM 12.9.801 creating game damage hunt rosters	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On March 25, 1999, the Fish, Wildlife and Parks Commission (commission) published notice of the commission's consideration of a proposed amendment to ARM 12.9.801 regarding the creation of game damage hunt rosters at page 473 of the 1999 Montana Administrative Register, Issue Number 6.

2. The commission has amended ARM 12.9.801 as proposed.

3. No comments or requests for a hearing were received.

BY: S. A. Meyer

STAN MEYER
Commission Chairman

BY: John F. Lynch

JOHN F. LYNCH
Rule Reviewer

Certified to the Secretary of State June 4, 1999

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I through IV, the amendment of rules 18.9.306, 18.10.102 through 18.10.105, 18.10.121, 18.10.201, 18.10.202, 18.10.301, 18.10.302, 18.10.313, 18.10.314, 18.10.321 through 18.10.324, 18.10.404, 18.10.406 and 18.10.407 and the repeal of rules 18.10.101, 18.10.122, 18.10.123, 18.10.203, 18.10.303, 18.10.311, 18.10.312, 18.10.401 through 18.10.403, 18.10.405, 18.10.408, 18.10.501 and 18.10.502 concerning the Special Fuel Users Tax, Dealers and LPG Tax	)))))))))))))))))))	CORRECTED NOTICE OF AMENDMENT

TO: All Concerned Persons.

1. On April 8, 1999, the department published notice at page 645 of the 1999 Montana Administrative Register, Issue 7, of the adoption, amendment and repeal of the above-captioned rules.

2. The reason for the correction is that the notice of amendment interlined one word that should not have been interlined in 18.10.313 and failed to underline three words which were new text and should have been underlined in 18.10.406. The corrected rule amendments read as follows:

18.10.313 TERMINATION OF ~~LICENSE OR~~ A SPECIAL FUEL USER'S PERMIT (1) Upon ceasing operations in Montana, each special fuel user subject to 15-70-302, MCA, shall:

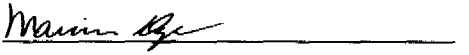
(1)(a) through (4) same as proposed.

AUTH: 15-70-104, MCA
IMP: 15-70-121 and 15-70-306, MCA

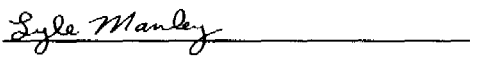
18.10.406 CARDTROL COMPLIANCE AND ADMINISTRATION (1) A special fuel ~~dealer~~ seller is responsible for payment of the tax on dyed special fuel dispensed through a cardtrol, keylock, or similar device from an unattended pump or dispensing unit if the seller knows the fuel is sold to a customer who ~~has not signed and filed with the dealer a proper affidavit allowing the purchase of fuel without payment of the tax~~ places the fuel directly into the supply tank of a vehicle not defined as or considered an off-road vehicle as in rule I.

AUTH: 15-70-104, MCA
IMP: 15-70-321~~ and 15-70-322~~, MCA

3. Replacement pages for the corrected notice of amendment will be submitted to the Secretary of State on June 30, 1999.

By: 

MARVIN DYE, Director
Montana Department of Transportation



Lyle Manley, Rule Reviewer

Certified to the Secretary of State June 4, 1999.

BEFORE THE BOARD OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I and II relating to inspector examination and certification.	))))	NOTICE OF ADOPTION

To: All Concerned Persons

1. On January 14, 1999, the board of livestock published notice of the proposed adoption of new Rules I and II concerning inspector examination and certification at page 47 of the 1999 Montana Administrative Register, Issue Number 1.

2. The agency has adopted new Rule I (ARM 32.2.501) and new Rule II (ARM 32.2.502) exactly as proposed.

3. No comments or testimony were received.

By: _____
Marc Bridges, Acting Exec. Officer
Board of Livestock
Department of Livestock

By: _____
Norman C. Petersen, Rule Reviewer
Assistant Attorney General
Agency Legal Services Bureau

Certified to the Secretary of State June 4, 1999.

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

In the matter of the adoption of Rules I and II, the transfer and amendment of rules 20.11.108, 20.11.109, 20.11.110, 20.11.112, 20.11.113, 20.11.115, 20.11.116, 20.11.117 and 20.11.118 and the repeal of rules 20.11.114 and 20.11.119 pertaining to state facility reimbursement	)	NOTICE OF ADOPTION, TRANSFER AND AMENDMENT AND REPEAL

TO: All Interested Persons

1. On March 25, 1999, the Department of Public Health and Human Services published notice of the proposed adoption, transfer and amendment and repeal of the above-stated rules at page 492 of the 1999 Montana Administrative Register, issue number 6.

2. The Department has transferred and amended rules 20.11.108, 20.11.109, 20.11.110, 20.11.112, 20.11.113, 20.11.115, 20.11.116, 20.11.117 and 20.11.118 and repealed rules 20.11.114 and 20.11.119 as proposed.

3. The Department has adopted the rules I (37.2.702) and II (37.2.703) as proposed.

4. No comments or testimony were received.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

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

In the matter of the adoption of Rules I through XLI and the amendment of rules 37.37.105, 37.37.303, 46.2.202, 46.12.202, 46.12.204, 46.12.501, 46.12.502, 46.12.502A, 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, 46.12.1708, 46.12.1713, 46.12.1902, 46.12.4810, 46.12.5007, 46.20.103, 46.20.106, 46.20.110, 46.20.114, 46.20.117, 46.20.120, 46.20.123 and 46.20.126 pertaining to coverage and reimbursement of mental health services for medicaid eligible and certain other low income individuals	)	NOTICE OF ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On April 22, 1999, the Department of Public Health and Human Services published notice of the proposed adoption and amendment of the above-stated rules at page 723 of the 1999 Montana Administrative Register, issue number 8.

2. The Department has amended rules 37.37.105, 37.37.303, 46.12.202, 46.12.502, 46.12.506, 46.12.507, 46.12.514, 46.12.570, 46.12.1708, 46.12.1713, 46.12.1902, 46.12.4810, and 46.20.123 as proposed.

3. The Department has adopted the rules VI (46.12.586), IX (46.12.586C), XVIII (46.12.599A), XXIII (46.12.599F), and XXIV (46.12.599G) as proposed. Rule XXXVI is not being adopted.

4. The Department has adopted the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

RULE I (46.12.502B) MEDICAID MENTAL HEALTH SERVICES, AUTHORIZATION REQUIREMENTS (1) Prior authorization is required for all mental health services provided to a medicaid recipient under the Montana medicaid program, except for those services designated by the department.

(2) through (5) remain as proposed.

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

RULE II (46.20.113) MENTAL HEALTH SERVICES PLAN, AUTHORIZATION REQUIREMENTS (1) The prior authorization, notification and other provisions of ARM 46.12.502B apply to the mental health services plan ~~entitled with~~ provided in this subchapter.

(a) For purposes of applying the provisions of ARM 46.12.502B to the mental health services plan, references in ARM 46.12.502B to "medicaid recipient" and "recipients" shall be deemed references to mental health services plan members, and references to the "Montana medicaid program" shall be deemed references to the mental health services plan.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-201 and 53-21-202, MCA

RULE III (46.12.578) LICENSED ~~CLINICAL~~ PSYCHOLOGIST SERVICES, DEFINITION (1) Licensed ~~clinical~~ psychologist services are those services provided by a licensed ~~clinical~~ psychologist, which are within the scope of practice permitted by Title 37, chapter 17, MCA, and covered under the provisions of these rules.

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

RULE IV (46.12.579) LICENSED ~~CLINICAL~~ PSYCHOLOGIST SERVICES, REQUIREMENTS (1) remains as proposed.

(2) For purposes of medicaid coverage and reimbursement, licensed ~~clinical~~ psychologist services are limited to the services designated in the department's Covered Psychologist CPT Codes List (April 1999). The department hereby adopts and incorporates herein by reference the Covered Psychologist CPT Codes List (April 1999). A copy of the Covered Psychologist CPT Codes List (April 1999) 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.

(3) Group therapy services provided by a licensed ~~clinical~~ psychologist must have no more than eight individuals participating in the group.

(4) When an eligible child receives licensed ~~clinical~~ psychologist services, and the psychologist consults with the parent as part of the child's treatment, time spent with the parent may be billed to medicaid under the child's name, subject to the requirements of these rules. The provider shall indicate on the claim that the child is the patient and state the child's diagnosis. He shall also indicate consultation was with the parent.

(5) Licensed ~~clinical~~ psychologist services must be supported by records as required in ARM 46.12.308.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in-person services. Telephone contacts are not a licensed ~~clinical~~ psychologist service.

(7) Licensed ~~clinical~~ psychologist 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 psychological services. These noncovered services include:

(a) services provided by a licensed ~~clinical~~ psychologist who is employed or under a contract with a hospital;

(7)(b) and (7)(c) remain as proposed.

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 V (46.12.579A) LICENSED ~~CLINICAL~~ PSYCHOLOGIST SERVICES, REIMBURSEMENT (1) remains as proposed.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed ~~clinical~~ psychologist services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) ~~59%~~ 62% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(2)(b) remains as proposed.

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

RULE VII (46.12.586A) LICENSED CLINICAL SOCIAL WORK SERVICES, REQUIREMENTS (1) through (5) remain as proposed.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in-person services. Telephone contacts are not a licensed clinical social worker service.

(7) through (8)(c) remain as proposed.

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 VIII (46.12.586B) LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT (1) remains as proposed.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed clinical social worker services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) ~~47%~~ 62% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(2)(b) remains as proposed.

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

RULE X (46.12.586D) LICENSED PROFESSIONAL COUNSELOR SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) For purposes of medicaid coverage and reimbursement, licensed professional counselor services ~~for purposes of medicaid reimbursement~~ are limited to the services designated in the department's Covered Licensed Professional Counselor CPT Codes List (April 1999). The department hereby adopts and incorporates herein by reference the Covered Licensed Professional Counselor CPT Codes List (April 1999). A copy of the Covered Licensed Professional Counselor CPT Codes List (April 1999) 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.

(3) through (5) remain as proposed.

(6) Services provided through interactive video systems are considered to be face-to-face services and are covered and reimbursed in the same fashion as in-person services. Telephone contacts are not a professional counselor service.

(7) through (8)(c) remain as proposed.

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 XI (46.12.586E) LICENSED PROFESSIONAL COUNSELOR SERVICES, REIMBURSEMENT (1) remains as proposed.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for licensed professional counselor services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) ~~47%~~ 62% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(2)(b) remains as proposed.

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

RULE XII (46.12.596A) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, PURPOSE AND DEFINITIONS (1) The purpose of ARM 46.12.596A through 46.12.596F is to specify provider participation and program requirements and to define the basis and procedure the department will use to pay for ~~residential treatment~~ inpatient psychiatric services for individuals under age 21. Facilities in which these services are available are hereinafter referred to as providers.

(2) As used in this subchapter, the following definitions apply:

(a) "Devoted to the provision of ~~residential~~ inpatient psychiatric care for persons under the age of 21" means ~~a~~ an inpatient psychiatric hospital facility or residential treatment facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.

(b) "Inpatient hospital psychiatric care" means hospital based active psychiatric treatment provided under the direction of a physician. The individual's psychiatric condition must be of such a nature as to pose a significant danger to self, others or the public safety. Inpatient hospital psychiatric care is the briefest possible inpatient hospital stay necessary to provide the intensive psychiatric intervention and stabilization required to evaluate and/or stabilize the individual for discharge to the least restrictive appropriate setting for continuing care and treatment of the individual's psychiatric condition. The therapeutic intervention or evaluation must be designed to achieve the patient's discharge from inpatient hospital status to a less restrictive environment at the earliest possible time.

(c) "Inpatient psychiatric hospital facility" means a psychiatric facility licensed by the department, or the equivalent agency in the state in which the facility is located, as a hospital and devoted to the provision of inpatient psychiatric care for persons under the age of 21.

~~(b)~~ (d) "Patient day" means a whole 24-hour period that a person is present and receiving ~~residential treatment~~ inpatient psychiatric services. Even though a person may not be present for a whole 24-hour period, the day of admission and, subject to the limitations and requirements of ARM 46.12.596C, therapeutic home leave days are patient days. The day of discharge is not a patient day for purposes of reimbursement.

(2)(c) remains as proposed but is renumbered (2)(e).

~~(d)~~ (f) "Residential treatment facility" means a psychiatric facility licensed by the department, or the equivalent agency in the state in which the facility is located, as a residential treatment facility as defined in 50-5-101, MCA or the equivalent category in the state where the facility is located, and devoted to the provision of inpatient psychiatric care for persons under the age of 21.

~~(e)~~ (g) "~~Residential treatment services~~ Inpatient psychiatric services" means inpatient hospital psychiatric care or residential psychiatric care provided in accordance with these rules and applicable state and federal requirements, including but not limited to 42 CFR 440.160 and 441.150 through 441.156 (1997), which provide definitions and program requirements and which the department hereby adopts and incorporates by reference. A copy of the cited regulations may be obtained through the Department of Public Health and Human Services, ~~111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210~~ Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. ~~Residential treatment~~ Inpatient psychiatric services are services that comply with the

requirements of these rules and the above-cited federal regulations and are provided in ~~a~~ an inpatient psychiatric hospital facility or residential treatment facility that is devoted to the provision of ~~residential~~ inpatient psychiatric ~~care~~ services for persons under the age of 21.

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 XIII (46.12.596B) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, PARTICIPATION REQUIREMENTS (1) remains as proposed.

(2) ~~Residential treatment~~ Inpatient psychiatric service providers, as a condition of participation in the Montana medicaid program, must comply with the following requirements:

(a) maintain a current license as a hospital or a residential treatment facility under the rules of the department's quality assurance division to provide inpatient hospital psychiatric care or residential psychiatric care, or, if the provider's facility is not located within the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the facility is located;

(b) maintain a current certification for Montana medicaid under the rules of the department's quality assurance division to provide inpatient hospital psychiatric care or residential psychiatric care or, if the provider's facility is not located within the state of Montana, meet the requirements of (2)(g) and (2)(h);

(c) for all providers, enter into and maintain a current provider enrollment form with the department's fiscal agent to provide ~~residential treatment~~ inpatient psychiatric services;

(2)(d) through (2)(f) remain as proposed.

(g) for hospital providers:

(i) comply with 42 CFR sections 482.1 through 482.62 and meet the requirements of section 1861(f) of the Social Security Act, which are federal regulations and statutes setting forth requirements for psychiatric hospitals. The department hereby adopts and incorporates herein by reference the above-cited regulations and statutes. Copies of these regulations and statutes 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; or

(ii) be accredited by the joint commission on accreditation of health care organizations (JCAHCO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit psychiatric hospitals for medicaid participation.

(2)(g) and (2)(h) remain as proposed but are renumbered (2)(h) and (2)(i).

~~(i)~~ (j) provide ~~residential~~ inpatient psychiatric ~~care~~ services according to the service requirements for individuals under age 21 specified in Title 42 CFR, part 441, subpart D (1997), which is a federal regulation which is herein incorporated by reference. A copy of these regulations may be

obtained through the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951;

~~(j)~~ (k) agree to indemnify the department in the full amount of the state and federal shares of all medicaid ~~residential treatment~~ inpatient psychiatric services reimbursement paid to the facility during any period when federal financial participation is unavailable due to facility failure to meet the conditions of participation specified in these rules or due to other facility deficiencies or errors.

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

RULE XIV (46.12.596C) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT (1) For ~~residential treatment~~ inpatient psychiatric services provided on or after July 1, 1999, the Montana medicaid program will pay a provider for each patient day as provided in these rules.

(a) Medicaid payment is not allowable for treatment or services provided in a residential treatment facility that are not within the definition of residential psychiatric care in ARM 46.12.596A and unless all other applicable requirements are met.

(b) Medicaid payment is not allowable for treatment or services provided in an inpatient psychiatric hospital facility that are not within the definition of inpatient hospital psychiatric care in ARM 46.12.596A and unless all other applicable requirements are met.

(2) For ~~residential treatment~~ inpatient psychiatric services provided by a residential treatment facility in the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a bundled per diem rate as specified in (3), less any third party or other payments.

(3) The statewide bundled per diem rate for ~~residential treatment~~ inpatient psychiatric services provided by all Montana residential treatment facility providers is $262.71 per patient day.

(a) The rate provided in ~~this rule~~ (3) for residential treatment facility providers located in the state of Montana is the final rate, and such rate will not be adjusted retrospectively based upon more recent cost data or inflation estimates. Cost settlements will not be performed.

(4) The rate provided in ~~this rule~~ (3) is an all-inclusive bundled rate. Except as provided in (4)(a)~~,~~ and (b)~~,~~ ~~and (c)~~ the per diem payment rate covers and includes all psychiatric services, all therapies required in the recipient's plan of care, and all other services and items related to the psychiatric condition being treated, that are provided while the recipient is admitted to the residential treatment facility, including but not limited to services provided by licensed ~~clinical~~ psychologists, licensed clinical social workers, and licensed professional counselors, and lab and pharmacy services. These services must be reimbursed from the provider's all-inclusive rate except as provided in (4)(a)~~,~~ and (b)~~,~~ ~~and (c)~~

and are not separately billable.

(a) ~~Subject to (4)(a)(i), the~~ The professional component of physician services is separately billable according to the applicable rules governing billing for physician services.

~~(i) For recipients admitted to and receiving services in residential treatment facilities, medicaid reimbursement for separately billable psychiatric physician services is limited to one visit per week.~~

(4)(b) remains as proposed.

(5) For inpatient psychiatric services provided by inpatient psychiatric hospital facilities located in the state of Montana, the Montana medicaid program will pay a provider according to the diagnosis related groups (DRG) prospective payment system described in ARM 46.12.505. In addition to the prospective DRG rate, providers will be reimbursed for the following:

(a) capital-related costs as set forth in ARM 46.12.505(4);

(b) cost or day outliers as set forth in ARM 46.12.505(6) and (7);

(c) catastrophic case payments as set forth in ARM 46.12.505(8); and

(d) disproportionate share hospital payments as provided in ARM 46.12.505(15) and (16).

(6) Inpatient psychiatric hospital facilities will not be reimbursed for inpatient psychiatric services in addition to the prospective DRG rate for medical education costs, certified registered nurse anesthetist costs or other costs or components.

(a) The provisions of ARM 46.12.505(2)(d)(i), (2)(d)(ii), (9), (10) and (11) apply for purposes of reimbursement under (5).

~~(5)~~ (7) Payment for ~~residential treatment~~ inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 46.12.502(3) and these rules. The Montana medicaid program will not make payment according to ARM 46.12.502(3)(b) or (c) for inpatient psychiatric services provided by residential treatment facilities located outside the state of Montana unless the department or its designee determines, as provided in this rule, that the services were unavailable in the state of Montana.

(a) Residential psychiatric care will not be determined to be unavailable in the state of Montana unless:

(i) the recipient has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because the facilities cannot meet the recipient's treatment needs; or

(ii) the recipient has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because a bed is not available, and the recipient's psychiatric condition prevents the recipient from being temporarily and safely placed in another setting while awaiting placement in an in-state residential treatment facility.

(b) The department or its designee will not commence a

preadmission review for or certify an admission to an out-of-state residential treatment facility until receiving from the prospective facility written verification that the recipient cannot be served within the state of Montana. Written verification must be provided in a form approved by the department or its designee, and must be completed and signed on behalf of in-state facilities indicating that the requirements of (7)(a)(i) or (7)(a)(ii) are met. In-state facilities that do not complete, sign and return the form by fax to the prospective out-of-state provider within 3 days after receipt will be deemed to be unable to serve the recipient.

(8) Reimbursement for ~~residential treatment~~ inpatient psychiatric services provided to Montana medicaid recipients in facilities located outside the state of Montana will be a percentage of the provider's usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the facility's medicare intermediary or by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If the provider does not submit the medicare cost report and other financial information necessary to determine the cost to charge ratio, the percentage will equal 60% of the provider's usual and customary charges.

~~(6)~~ (a) For facilities located outside the state of Montana, the department may set an interim rate and pay for services using the interim rate until sufficient information has been submitted to determine the provider's final rate under ~~(5)~~ (8). The interim rate shall be 60% of the provider's usual and customary charges. If the department pays using an interim rate or, if the department pays for services at a rate determined under ~~(5)~~ (8) but subsequently obtains additional information necessary to fully apply ~~(5)~~ (8), the department may settle the rates and adjust any overpayment or underpayment in accordance with ARM 46.12.596D.

~~(a)~~ (b) In addition to the requirements of ~~(6)~~ (8)(a), the department may require out-of-state providers to submit a copy of their most recent audit report in those instances where the provider has not prepared or is not required to prepare a health care financing administration (HCFA) form 2552. The audit report must have been performed in accordance with generally accepted auditing standards as defined by the American institute of certified public accountants.

~~(7)~~ (9) Reimbursement will be made to a residential treatment facility provider for reserving a bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit;

(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic home visit;

~~(c)~~ (d) the recipient is absent from the provider's facility for no more than 72 consecutive hours per absence,

unless the department or its designee determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence~~.~~; and

(e) if the therapeutic home visit is in excess of 48 hours, the visit has been approved by the department in advance of the visit. Requests for approval under this subsection must be received by the department or its designee at least 2 working days in advance of the start of the visit.

~~(8)~~ (10) No more than 14 days per recipient in each rate year will be allowed for therapeutic home visits. For purposes of this 14-day limit, all therapeutic home visits must be included whether or not such visits were of sufficient length to require advance approval under (9)(e).

(a) The provider must report to the department or its designee each therapeutic home visit of 48 hours or less within 30 days after the start of the visit. Each visit must be reported on a form acceptable to the department.

~~(9)~~ (11) ~~The provider must submit to the department or its designee a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a recipient leaves the facility for a therapeutic home visit.~~ Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the addictive and mental disorders division or its designee.

~~(10)~~ (12) Providers must bill for ~~residential treatment~~ inpatient psychiatric services using the revenue codes designated by the department.

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

RULE XV (46.12.596D) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, COST SETTLEMENT AND UNDERPAYMENT (1) and (2) remain as proposed.

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

RULE XVI (46.12.596E) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) remains as proposed.

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

RULE XVII (46.12.596F) ~~RESIDENTIAL TREATMENT~~ INPATIENT PSYCHIATRIC SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW AND INSPECTIONS OF CARE (1) through (1)(b) remain as proposed.

(2) ~~In accordance with 42 CFR, part 456, subpart I, the~~ The department or its agents may conduct periodic inspections of care in residential treatment facilities participating in the

medicaid program.

(3) Medicaid reimbursement is not available for ~~residential treatment~~ inpatient psychiatric services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need for services that complies with the requirements of 42 CFR, part 441, subpart D and these rules.

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

(i) be completed, signed and dated prior to, but no more than 30 days before admission; and

(ii) be made by an independent team of health care professionals that ~~includes a physician that~~ has competence in diagnosis and treatment of mental illness~~, preferably in child psychiatry~~ and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, a licensed mental health professional and, for residential psychiatric care, an intensive case manager employed by a mental health center.

(3)(b) through (4) remain as proposed.

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

RULE XIX (46.12.599B) INSTITUTIONS FOR MENTAL DISEASES, DEFINITIONS In ARM 46.12.599A through 46.12.599G the following definitions apply:

(1) through (9) remain as proposed.

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

RULE XX (46.12.599C) INSTITUTIONS FOR MENTAL DISEASES, PROVIDER PARTICIPATION REQUIREMENTS (1) An institution for mental diseases, as a condition of participation in the Montana medicaid program under ARM 46.12.599A through 46.12.599G, must be a nursing facility that meets the following requirements:

(1)(a) through (1)(d)(vi) remain as proposed.

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

RULE XXI (46.12.599D) INSTITUTIONS FOR MENTAL DISEASES, INDIVIDUAL TREATMENT PLANS (1) Institutions for mental diseases providing services under ~~these rules~~ ARM 46.12.599A through 46.12.599G must provide for and maintain recorded individual plans of treatment and care to ensure that institutional care maintains the recipient at, or restores the recipient to, the greatest possible degree of health and independent functioning. The plans must include:

(1)(a) through (1)(e) remain as proposed.

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

RULE XXII (46.12.599E) INSTITUTIONS FOR MENTAL DISEASES, REIMBURSEMENT (1) The Montana medicaid program does not cover and will not reimburse for services provided in institutions for mental diseases, except:

(a) as provided in ARM 46.12.596A through 46.12.596F for medicaid recipients under age 21 receiving services in ~~residential treatment~~ inpatient psychiatric facilities; or

(b) as provided in ~~this rule~~ ARM 46.12.599A through 46.12.599G for medicaid recipients age 65 or over receiving nursing facility services in a nursing facility that the department has determined to be an institution for mental diseases under ARM 46.12.599B.

(2) through (4) remain as proposed.

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

RULE XXV (46.12.1921) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, ELIGIBILITY (1) remains as proposed.

(2) "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person:

(a) presents an imminent risk of suicide as determined by a licensed mental health professional; or

(b) meets the requirements that:

(i) the person has a severe mental illness as indicated by:

(A) ~~medication is necessary to control the symptoms of mental illness~~ the person has been hospitalized for at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Spring campus) at least once;

(2)(b)(i)(B) through (2)(b)(ii)(D) remain as proposed.

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

RULE XXVI (46.12.1922) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, DEFINITIONS (1) through (4)(c) remain as proposed.

(5) "Crisis response" means immediate action by an intensive case manager or care coordination case manager for the purpose of supporting or assisting a client or other person in response to a client's mental health crisis. Crisis response must be made in a manner consistent with the least restrictive alternative measures or settings available for the client's condition. Crisis response may include contact with a client's family members if necessary and appropriate.

AUTH: 53-2-201 and 53-6-113, MCA

IMP: 53-6-101, MCA

RULE XXVII (46.12.1923) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, SERVICE COVERAGE (1) Case management services for adults with severe and disabling mental illness include:

(a) assessment;

(b) case planning;

(c) assistance in daily living; ~~and~~

(d) coordination, referral and advocacy~~.~~ ; and

(e) crisis response.

(2) remains as proposed.

(3) Care coordination case management services for adults with severe disabling mental illness are case management services, as specified in (1), provided in accordance with these rules by a licensed mental health center or a practitioner. Care coordination case management services may include telephone services.

(a) For purposes of ARM 46.12.1921 through 46.12.1924B, a practitioner is a physician, mid-level practitioner, licensed ~~clinical~~ psychologist, licensed clinical social worker or licensed professional counselor.

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

RULE XXVIII (46.12.1924) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, SERVICE REQUIREMENTS (1) remains as proposed.

(2) Intensive case management services for adults with severe disabling mental illness must be provided according to a case management plan which must:

(a) be developed jointly by the case manager and the client;

(b) identify measurable objectives;

(c) specify strategies to achieve defined objectives;

(d) identify agencies and contacts which will assist in meeting the objectives; ~~and~~

(e) identify natural and community supports to be utilized and developed~~.~~; and

(f) include an objective to serve the client in the least restrictive and most culturally appropriate therapeutic environment possible for the client which is also directed toward facilitating preservation of the client in the family unit, or preventing out-of-community placement or facilitating the client's return from acute or residential psychiatric care.

(3) remains as proposed.

(4) Intensive case management services for adults with severe disabling mental illness must be provided by ~~an individual case manager with a case load of no more than 22 clients at any given time.~~ a provider whose individual case managers' case loads average no more than 22 adults per FTE (full-time equivalent) per calendar month, calculated including all of the provider's adult intensive case managers and adult

case management clients for each calendar month.

(a) Individual intensive case manager case loads may include care coordination case management clients. For purposes of calculating the provider's average case load under (4), the first 1 through 4 care coordination clients served by each intensive case manager shall be counted as 1 intensive case management client, and each additional 1 through 4 care coordination clients shall be counted as 1 additional intensive case management client.

(b) The Montana medicaid program will cover and reimburse intensive case management services provided to adults with severe disabling mental illness only if provided by an intensive case manager whose services are limited to intensive case management and/or care coordination services, and who does not provide additional services such as therapy.

(5) Intensive case management services for adults with severe disabling mental illness must be delivered in accordance with the individual recipient's needs, but in all cases where the client is in service for the entire month must include at least ~~three~~ 2 hours of intensive case management services including 1 face-to-face ~~contacts~~ contact with the client per calendar month.

(6) Care coordination case management services for adults with severe disabling mental illness must include at least 1 face-to-face contact with the client per month. The contact may be for purposes other than providing care coordination services, such as to provide another covered service.

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

RULE XXIX (46.12.1924A) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, PROVIDER REQUIREMENTS (1) remains as proposed.

(2) Intensive case management services for adults with severe disabling mental illness must be provided by a licensed mental health center:

(a) with a license endorsement permitting the mental health center to provide intensive case management services to the population being served; and

(b) enrolled in the Montana medicaid program as a case management services provider.

(3) remains as proposed.

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

RULE XXX (46.12.1924B) CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, REIMBURSEMENT

(1) remains as proposed.

(2) For intensive case management services for adults with severe disabling mental illness, the provider may bill:

(a) the full monthly rate for:

(i) recipients ~~admitted and served beginning prior to~~ in

service on or before the 15th day of the calendar month and throughout the remainder of the calendar month; or

(ii) recipients ~~admitted and served from~~ in service at the beginning of the month and discharged on or after the ~~15th~~ 16th day of the month; or

(b) one-half the monthly rate for:

(i) recipients ~~admitted and served beginning~~ in service on or after the ~~15th~~ 16th day of the calendar month and throughout the remainder of the calendar month; or

(ii) recipients ~~admitted and served from the beginning of the month~~ in service and discharged ~~prior to the 15th~~ on or before the 15th day of the month.

(3) and (3)(a) remain as proposed.

(b) Group care coordination services ~~must include a minimum~~ may not exceed a maximum of 4 8 participants per group.

(c) A provider may not bill medicaid for care coordination services for any period for which the provider bills for intensive case management services for the same recipient.

(d) The Montana medicaid program will not pay more than 1 provider for intensive case management services for the same period of time for the same resident.

(4) The department may, in its discretion, designate a single provider to provide intensive case management services in a designated geographical region. Any provider designated as the sole intensive case management provider for a designated geographical region must, as a condition of such designation, agree to serve the entire designated geographical region.

(4) and (5) remain as proposed but are renumbered (5) and (6).

(a) for intensive case management services for adults with severe disabling mental illness, ~~$224.09~~ $224.00 per full month and $112.00 per half month per recipient; and

(5)(b) through (5)(b)(ii) remain as proposed but are renumbered (6)(b) through (6)(b)(ii).

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

RULE XXXI (46.12.1941) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, ELIGIBILITY (1) remains as proposed.

(2) "Serious emotional disturbance (SED)" means with respect to a youth that the youth meets the following requirements ~~of (2)(a), (b) or (c), and meets the requirements of (2)(d)~~:

(a) is identified as having an emotional disturbance as defined in 20-7-401(8), MCA with respect to which the youth is currently receiving special education services;

(b) presents an imminent risk of suicide as determined by a licensed mental health professional; or

(c) meets all of the following 3 requirements:

(i) the youth demonstrates a need for specialized services to address serious problems related to emotional disturbance in at least 2 of the 4 areas of family relationships, peer

relationships, school performance, and delinquent behavior;

(ii) the youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe: attention deficit/hyperactivity disorder (314.00, 314.01, 314.9); childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90); oppositional defiant disorder (313.81); pervasive developmental disorder not otherwise specified (299.80); Asperger's disorder (299.80); separation anxiety disorder (309.21); reactive attachment disorder of infancy or early childhood (313.89); schizo affective disorder (295.70); mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90); psychotic disorder not otherwise specified (298.9); obsessive-compulsive disorder (300.3); dysthymic disorder (300.4); depressive disorder not otherwise specified (311); cyclothymic disorder (301.13); generalized anxiety disorder (overanxious disorder) (300.02); posttraumatic stress disorder (chronic) (309.81); dissociative identity disorder (300.14); sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89); anorexia nervosa (severe) (307.1); bulimia nervosa (severe) (307.51); kleptomania (312.32); pyromania (312.33); trichotillomania (312.39); intermittent explosive disorder (312.34); and personality disorder (301.4, 301.5, 301.81); or conduct disorder (312.8) when accompanied by at least one of the diagnoses listed above; and

(2)(c)(iii) through (2)(c)(iii)(D) remain as proposed.

(E) has displayed behavior considered seriously detrimental to the youth's growth, development or welfare, or to the safety or welfare of others~~; and~~.

~~(d) Unless behavior results from emotional disturbance or a youth is dually diagnosed, a youth does not meet the definition of serious emotional disturbance if the youth has a primary problem of:~~

~~(i) developmental disability;~~

~~(ii) substance abuse or chemical dependency;~~

~~(iii) sexual or physical abuse victimization; or~~

~~(iv) character and personality disorders characterized by lifelong and deeply ingrained anti social behavior patterns including sexual behaviors which are abnormal and prohibited by statute.~~

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

RULE XXXII (46.12.1942) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, DEFINITIONS (1) through (4)(g) remain as proposed.

(5) "Crisis response" means immediate action by an intensive case manager or care coordination case manager for the

purpose of supporting or assisting a client or other person in response to a client's mental health crisis. Crisis response must be made in a manner consistent with the least restrictive alternative measures or settings available for the client's condition. Crisis response may include contact with a client's family members if necessary and appropriate.

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

RULE XXXIII (46.12.1943) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, SERVICE COVERAGE (1) Case management services for youth with serious emotional disturbance include:

(a) assessment;
(b) case planning;
(c) assistance in daily living; ~~and~~
(d) coordination, referral and advocacy~~.~~; and
(e) crisis response.

(2) remains as proposed.

(3) Care coordination case management services for youth with serious emotional disturbance are case management services, as specified in (1), provided in accordance with these rules by a licensed mental health center or a practitioner. Care coordination case management services may include telephone services.

(a) For purposes of ARM 46.12.1941 through 46.12.1944B, a practitioner is a physician, mid-level practitioner, licensed ~~clinical~~ psychologist, licensed clinical social worker or licensed professional counselor.

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

RULE XXXIV (46.12.1944) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, SERVICE REQUIREMENTS

(1) through (3) remain as proposed.

(4) Intensive case management services for youth with serious emotional disturbance must be provided by ~~an individual case manager with a case load of no more than 20 clients at any given time.~~ a provider whose individual case managers' case loads average no more than 20 youth per FTE (full-time equivalent) per calendar month, calculated including all of the provider's youth intensive case managers and youth case management clients for each calendar month.

(a) Individual intensive case manager case loads may include care coordination case management clients. For purposes of calculating the provider's average case load under (4), the first 1 through 4 care coordination clients served by each intensive case manager shall be counted as 1 intensive case management client, and each additional 1 through 4 care coordination clients shall be counted as 1 additional intensive case management client.

(b) The Montana medicaid program will cover and reimburse

intensive case management services provided to youth with serious emotional disturbance only if provided by an intensive case manager whose services are limited to intensive case management and/or care coordination services, and who does not provide additional services such as therapy.

(5) Intensive case management services for youth with serious emotional disturbance must be delivered in accordance with the individual recipient's needs, but in all cases where the client is in service for the entire month must include at least ~~three~~ 2 hours of intensive case management services including 1 face-to-face ~~contacts~~ contact with the client per calendar month.

(6) Care coordination case management services for youth with serious emotional disturbance must include at least 1 face-to-face contact with the client per month. The contact may be for purposes other than providing care coordination services, such as to provide another covered service.

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

RULE XXXV (46.12.1944A) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, PROVIDER REQUIREMENTS

(1) remains as proposed.

(2) Intensive case management services for youth with serious emotional disturbance must be provided by a licensed mental health center:

(a) with a license endorsement permitting the mental health center to provide intensive case management services to the population being served; and

(b) enrolled in the Montana medicaid program as a case management services provider.

(3) remains as proposed.

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

RULE XXXVII (46.12.1944B) CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, REIMBURSEMENT

(1) remains as proposed.

(2) For intensive case management services for youth with serious emotional disturbance, the provider may bill:

(a) the full monthly rate for:

(i) recipients ~~admitted and served beginning prior to~~ in service on or before the 15th day of the calendar month and throughout the remainder of the calendar month; or

(ii) recipients ~~admitted and served from~~ in service at the beginning of the month and discharged on or after the ~~15th~~ 16th day of the month; or

(b) one-half the monthly rate for:

(i) recipients ~~admitted and served beginning~~ in service on or after the ~~15th~~ 16th day of the calendar month and throughout the remainder of the calendar month; or

(ii) recipients ~~admitted and served from the beginning of~~

~~the month~~ in service and discharged ~~prior to the 15th~~ on or before the 15th day of the month.

(3) Care coordination case management services for youth with serious emotional disturbance will be reimbursed on a fee per unit of service basis. For purposes of this rule, a unit of service is a period of 15 minutes.

(a) Medicaid reimbursement for care coordination case management services for youth with serious emotional disturbance is limited to a total of 4 hours (16 units of service) per calendar month.

(b) Group care coordination services ~~must include a minimum~~ may not exceed a maximum of 4 8 participants per group.

(c) A provider may not bill medicaid for care coordination services for any period for which the provider bills for intensive case management services for the same recipient.

(d) The Montana medicaid program will not pay more than 1 provider for intensive case management services for the same period of time for the same resident.

(4) The department may, in its discretion, designate a single provider to provide intensive case management services in a designated geographical region. Any provider designated as the sole intensive case management provider for a designated geographical region must, as a condition of such designation, agree to serve the entire designated geographical region.

(4) and (5) remain as proposed but are renumbered (5) and (6).

(a) for intensive case management services for youth with serious emotional disturbance, ~~$246.50~~ $246.00 per full month and $123.00 per half month per recipient; and

(5)(b) through (5)(b)(ii) remain as proposed but are renumbered (6)(b) through (6)(b)(ii).

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

RULE XXXVIII (46.12.1471) MENTAL HEALTH CENTER SERVICES, DEFINITIONS (1) through (4) remain as proposed.

(5) "Community-based psychiatric rehabilitation and support" means ~~service~~ services provided in home, school, workplace, and community settings for adults with severe and disabling mental illness and youth with ~~severe~~ serious emotional disturbance. Services are provided by trained mental health personnel under the direction of and according to individualized treatment plans prepared by licensed professionals. ~~and~~ The services are provided outside of normal clinical or mental health program settings and are designed to assist individuals in developing the skills, behaviors, and emotional stability necessary to live successfully in the community. Community-based psychiatric rehabilitation and support services are provided on a face-to-face basis with the recipient, family members, teachers, employers or other key individuals in the recipient's life when such contacts are clearly necessary to meet goals established in the recipient's individual treatment plan.

(a) Community-based psychiatric rehabilitation and support

includes but is not limited to the following services:

(i) evaluation and assessment of symptomatic, behavioral, social and environmental barriers to independent living and community integration;

(ii) assisting the consumer to develop communication skills, develop self-management of psychiatric symptoms, and develop social networks necessary to minimize social isolation and increase opportunities for a socially integrated life;

(iii) assisting the consumer to develop daily living skills and behaviors necessary for maintenance of a home and family, an appropriate education, employment or vocational situation, and productive leisure and social activities;

(iv) immediate intervention in a crisis situation and referral to necessary and appropriate care and treatment.

(b) Community-based psychiatric rehabilitation and support does not include the following services:

(i) interventions provided in day treatment or partial hospitalization programs;

(ii) interventions provided in a hospital, nursing home or residential treatment facility;

(iii) interventions provided by staff of crisis facilities, group homes or therapeutic foster care providers in such facilities, homes or settings;

(iv) services provided as part of the recipient's intensive case management plan;

(v) therapeutic interventions by licensed practitioners, regardless of the location of the service; and

(vi) activities which are purely recreational in nature.

(6) through (8) remain as proposed.

(9) "In-training practitioner services" are services provided under the supervision of a licensed practitioner by an individual who has completed all academic requirements for licensure as a psychologist, clinical social worker or licensed professional counselor and is in the process of completing the supervised experience requirement for licensure. The in-training practitioner's services must be supervised by a licensed practitioner in the same field, and, other than licensure, the services are subject to the same requirements that apply to licensed practitioners.

~~(9)~~ (10) "Mental health center services" means child and adolescent day treatment services, adult day treatment services, community-based psychiatric rehabilitation and support~~, multi-disciplinary discharge treatment planning~~ respite care, school-based mental health services, in-training practitioner services and the therapeutic component of crisis intervention services, foster care for mentally ill adults and mental health group home services, as defined in these rules.

(10) remains as proposed but is renumbered (11).

~~(11) "Multi disciplinary discharge treatment planning" means a formal meeting to develop an aftercare treatment plan which will enable an individual in an institution for mental disease or residential treatment center to access community based services.~~

(12) "Practitioner" means a physician, mid-level

practitioner, licensed ~~clinical~~ psychologist, licensed clinical social worker or licensed professional counselor.

(13) remains as proposed.

(14) "Respite care" means relief services that allow family members, who are regular care givers for an adult with severe disabling mental illness or a youth with serious emotional disturbance, to be relieved of their care giver responsibilities for a temporary, short term period.

(15) "School-based mental health services" means mental health center services provided to a child or adolescent in the client's school according to an individualized treatment plan. School-based mental health services includes individual and group therapies, family therapy, care coordination case management, observation and support in the classroom, consultation with teachers, other school personnel, parents and other significant people in the life of the child or adolescent.

(14) remains as proposed but is renumbered (16).

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 XXXIX (46.12.1472) MENTAL HEALTH CENTER SERVICES, REQUIREMENTS (1) remains as proposed.

(2) Mental health center services may be provided only by a facility which:

(a) is licensed as a mental health center by the department in accordance with the provisions of Title 50, chapter 5, part 2, MCA, and implementing administrative rules~~.~~; or

(b) has been providing mental health center services under the mental health access plan and has, prior to July 1, 1999, applied for a mental health center license. A mental health center participating in the Montana medicaid program under this subsection, will not be permitted to participate in the medicaid program on or after January 1, 2000 unless it receives licensure with applicable endorsement(s) as a mental health center prior to January 1, 2000.

(3) through (4) remain as proposed.

(5) In addition to the clinical records required by mental health center license rules, the provider must maintain for day treatment services the records required by ARM 46.12.308, which shall include but are not limited to documentation of the recipient's attendance for the required period of time for the service billed and ~~daily notes concerning the recipient's participation and progress in the treatment program~~ entry of progress notes in the recipient's record at least every 30 days and upon any significant change in the recipient's condition.

(6) For purposes of medicaid billing and reimbursement of day treatment services:

(a) a full day requires that the recipient has attended the day treatment program for a minimum of 5 hours during the treatment day; and

(b) a half day requires that the recipient has attended the day treatment program for a minimum of ~~3~~ 2 hours during the

treatment day.

(7) remains as proposed.

(8) School-based mental health services must be provided through a program of services staffed by at least 2 mental health workers who work exclusively in the school. At least 1 of the 2 mental health workers must be a licensed psychologist, licensed clinical social worker, or licensed professional counselor with a maximum case load of 12 school or pre-school children.

(a) School-based mental health services must be provided according to an individualized treatment plan designed by a licensed professional staffing the school-based mental health services program.

(b) In addition to any clinical records required by mental health center license rules, the provider must maintain for school-based mental health services the records required by ARM 46.12.308, which shall include but are not limited to documentation of the client's attendance in school and in program services, progress notes for each individual therapy session and weekly overall progress notes.

(9) Services billed as community-based psychiatric rehabilitation and support may not be counted toward the time requirements for any other service or billed by the provider as any other type or category of service.

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 XL (46.12.1473) MENTAL HEALTH CENTER SERVICES, COVERED SERVICES (1) Mental health center services, covered by the medicaid program, include the following:

(a) adult day treatment services;

(b) child and adolescent day treatment services;

(c) community-based psychiatric rehabilitation and support;

(d) ~~multi-disciplinary discharge treatment planning~~ respite care services;

(e) school-based mental health services;

(f) in-training practitioner services; and

~~(e)~~ (g) the therapeutic component of:

(i) crisis intervention services;

(ii) foster care for mentally ill adults; and

(iii) mental health adult group home services.

~~(2) Adult day treatment services and child and adolescent day treatment services are limited to a combined total of 15 treatment days per month for an adult and 20 treatment days per month for a child or adolescent. Medicaid will not cover or reimburse day treatment services in excess of these limits.~~

~~(3)~~ (2) The therapeutic component of crisis intervention services includes all crisis intervention services provided by the mental health center and, except as provided in ~~(5)~~ (4)(a), its staff, but does not include room and board.

(4) and (5) remain as proposed but are renumbered (3) and (4).

(a) Mental health center services may include practitioner services provided according to mental health center license requirements as part of mental health center services. To the extent otherwise permitted by applicable medicaid rules, such practitioner services may be billed by the mental health center ~~provider~~ either as mental health center services or by the practitioner under the applicable medicaid category of service, but may not be billed as both mental health center services and practitioner services.

(b) Mental health center services, covered by the medicaid program, include the medical director component of a physician's services to the mental health center, but do not include the professional component of physician services covered in ARM 46.12.2001 through 46.12.2003. The professional component of physician services may be billed according to the provisions of ~~(5)~~ (4)(a) or ARM 46.12.2001 through 46.12.2003.

~~(6)~~ (5) To the extent provided as part of mental health center services in accordance with ~~(5)~~ (4)(a):

(6)(a) through (7)(c) remain as proposed but are renumbered (5)(a) through (6)(c).

~~(8) Mental health center services do not include community living support services, transitional living services or services provided by telephone.~~

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

RULE XLI (46.12.1473A) MENTAL HEALTH CENTER SERVICES, REIMBURSEMENT (1) through (1)(c) remain as proposed.

(2) The medicaid fees for mental health center services are:

(a) for adult day treatment services:

(i) $38.25 per treatment day for a full day; or

(ii) $22.95 per treatment day for a half day;

(b) for child and adolescent day treatment services:

(i) $59.75 per treatment day for a full day; or

(ii) $35.85 per treatment day for a half day;

(c) for community-based psychiatric rehabilitation and support, $20.00 per hour for individual services and $6.00 per recipient per hour for group services;

(d) ~~for multi-disciplinary discharge treatment planning (50-60 minutes), $150.00 per meeting, including all participants; and~~ for respite care services, $10.00 per hour up to a maximum of $60.00 for a 24-hour period, and no more than $120.00 per calendar month per recipient;

(e) for school-based mental health services, $51.00 per school day for which the client attends school and receives school-based mental health services;

(f) for in-training practitioner services, the same rate applicable to licensed practitioners for the category of service; and

~~(e)~~ (g) for the therapeutic component of:

(i) crisis intervention services, $200.00 per treatment day, exclusive of room and board;

(ii) foster care for mentally ill adults, ~~$40.00~~ $44.00 per treatment day, exclusive of room and board; and

(iii) mental health adult group home services, $55.00 per treatment day, exclusive of room and board.

(3) remains as proposed.

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

5. The Department has amended the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

46.2.202 OPPORTUNITY FOR HEARING (1) through (3) remain as proposed.

(4) Medical assistance providers of ~~residential treatment~~ inpatient psychiatric 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 as proposed.

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, 53-6-111, 53-6-113 and 53-20-305, MCA

46.12.204 RECIPIENT REQUIREMENTS, COPAYMENTS (1) Except as provided in (2) through (4), each recipient must pay to the provider the following copayments not to exceed the cost of the service:

(1)(a) through (1)(w) remain as proposed.

(x) licensed ~~clinical~~ psychologist services, $2.00 per service;

(1)(y) and (1)(z) remain as proposed.

(aa) ~~child and adolescent day treatment or~~ adult day treatment services provided by a mental health center under ARM 46.12.1471 through 46.12.1473A, $0.00 per half-day and $1.00 per full day; and

(ab) community-based psychiatric rehabilitation and support services provided by a mental health center under ARM 46.12.1471 through 46.12.1473A, ~~$2.00~~ $1.00 per 1 hour unit of individual service.

(2) through (4) remain as proposed.

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

46.12.501 SERVICES PROVIDED (1) through (1)(z) remain as proposed.

(aa) licensed ~~clinical~~ psychologist services;

(ab) licensed clinical social worker services;

(ac) licensed professional counselor services;

(ad) ~~residential treatment~~ inpatient psychiatric services;

(1)(ae) through (3)(b)(ii) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-103, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA

46.12.502A RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) through (2)(k) remain as proposed.

(1) licensed ~~clinical~~ psychologists;

(2)(m) through (13) remain as proposed.

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

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT (1) through (11)(c) remain as proposed.

(d) ~~Subject to (d)(i), the~~ The professional component of physician services, including psychiatrist services, is separately billable according to the applicable department rules governing billing for physician services.

~~(i) For recipients admitted to and receiving services in a half day or full day partial hospitalization program, medicaid reimbursement for separately billable psychiatric physician services is limited to one visit per week.~~

(11)(e) and (12) remain as proposed.

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

46.12.509 ALL HOSPITAL REIMBURSEMENT, GENERAL (1) through (1)(a)(i)(E) remain as proposed.

(b) Medicaid reimbursement is not available for outpatient partial hospitalization services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need, certifying that:

(i) the recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning;

(ii) the recipient cannot be safely and appropriately treated or contained in a less restrictive level of care;

(iii) proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician;

(iv) the recipient can be safely and effectively managed in a partial hospitalization setting without significant risk of

harm to self or others;

(v) the services can reasonably be expected to improve the recipient's condition or prevent further regression; and

(vi) the recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services.

(c) For recipients determined medicaid eligible by the department as of the time of admission to the partial hospitalization program, the certificate of need required under (1)(b) must:

(i) be completed, signed and dated prior to, but no more than 30 days before, admission; and

(ii) be made by an independent team of health care professionals that ~~includes a physician that~~ has competence in diagnosis and treatment of mental illness~~, preferably in child psychiatry~~ and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, a licensed mental health professional and an intensive case manager employed by a mental health center.

(d) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need required under (1)(b) must:

(i) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the admission to the outpatient partial hospitalization program; or

(B) 90 days after the eligibility determination for recipients determined eligible after discharge from the outpatient partial hospitalization program;

(ii) cover the recipient's period from admission to the outpatient partial hospitalization program through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care.

(e) All certificates of need required under (1)(b) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(1)(b) remains as proposed but is renumbered (1)(f).

(2) through (8) remain as proposed.

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

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~~ inpatient psychiatric services for individuals under age 21, targeted case management and federally qualified health

center services.

(2) through (6) remain as proposed.

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

46.12.516 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), MEDICAL AND OTHER SERVICES

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

(g) The therapeutic portion of medically necessary therapeutic youth group home treatment is covered if the treatment is ordered by a licensed physician, licensed ~~clinical~~ psychologist, masters level licensed clinical social worker (MSW) or a licensed professional counselor (LPC), and prior-authorized by the department or its designee according to the provisions of ARM 46.12.502B.

(i) The therapeutic portion of intensive level therapeutic youth group home treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide intensive level therapeutic youth group home services~~, to a recipient who meets medical necessity criteria in (2)(h) 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 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide campus based therapeutic youth group home services~~, to a recipient who meets medical necessity criteria in (2)(h) 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 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide moderate level therapeutic youth group home services~~, to a recipient who meets medical necessity criteria in (2)(h) 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.

(v) If the therapeutic youth group home provider's facility is not located within the state of Montana, the provider must maintain a current license in the equivalent category under the laws of the state in which the facility is located.

~~(h) The therapeutic portion of therapeutic youth group home treatment is medically necessary for purposes of this rule only if for moderate level therapeutic youth group home services the recipient meets at least three of the criteria in (2)(g)(i) through (iv), for campus based level therapeutic youth group home services the recipient meets at least four of the criteria in (2)(g)(i) through (iv), and for intensive level therapeutic youth group home services the recipient meets at least five of~~

~~the criteria in (2)(g)(i) through (iv).~~

~~(i) The recipient is at risk of psychiatric hospitalization or placement in a residential treatment facility licensed by the department.~~

~~(ii) The recipient has been removed from his or her home and has a mental or emotional disorder, the severity of which impairs his or her ability to function in a less restrictive environment.~~

~~(iii) The recipient exhibits behavior which indicates disturbances of a severe or persistent nature, or is at risk of developing disturbances due to mental illness or a history of sexual, physical or emotional trauma.~~

~~(iv) The recipient is currently placed, or has a history of previous placement(s), in an inpatient psychiatric hospital or a residential treatment facility licensed by the department and continues to require 24 hour supervision and treatment at a less restrictive level of care.~~

~~(v) The recipient has a poor treatment prognosis in a level of care lower than the moderate or intensive therapeutic youth group home level.~~

~~(vi) The recipient has a primary diagnosis of mental illness or serious emotional disturbance (SED) as defined in [RULE XXXII], or the recipient is both SED and developmentally disabled.~~

(h) Medicaid reimbursement is not available for therapeutic youth group home services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need. The certificate of need must certify the necessary level of care and, for intensive level services, must certify that 4 of the criteria in (2)(h)(i) through (v) are met, or for moderate or campus-based level services, must certify that 3 of the criteria in (2)(h)(i) through (v) are met.

(i) the recipient is experiencing psychiatric symptoms of a severe or persistent nature that require more intensive treatment and clinical supervision than can be provided by outpatient mental health services;

(ii) the recipient is at significant risk for placement in a more restrictive environment if therapeutic living care is not provided, or the recipient is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;

(iii) the recipient's prognosis for beneficial treatment at a level of care lower than therapeutic living is very poor because the recipient demonstrates one or more of the following:

(A) significantly impaired interpersonal or social functioning;

(B) significantly impaired educational or occupational functioning;

(C) lack of family or other community or social support networks;

(D) impairment of judgment;

(E) poor impulse control;

(iv) the recipient exhibits an inability to perform daily living activities due to a mental, emotional or eating disorder; and

(v) the recipient exhibits maladaptive or disruptive behaviors due to a mental, emotional or eating disorder.

(i) For recipients determined medicaid eligible by the department as of the time of admission to the therapeutic youth group home, the certificate of need required under (2)(h) must:

(i) be completed, signed and dated prior to, but no more than 30 days before, admission; and

(ii) be made by an independent team of health care professionals that ~~includes a physician that~~ has competence in diagnosis and treatment of mental illness~~, preferably in child psychiatry~~ and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, a licensed mental health professional and an intensive case manager employed by a mental health center.

(j) For recipients determined medicaid eligible by the department after admission to or discharge from the therapeutic youth group home, the certificate of need required under (2)(h) must:

(i) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the admission to the therapeutic youth group home; or

(B) 90 days after the eligibility determination for recipients determined eligible after discharge from the therapeutic youth group home;

(ii) cover the recipient's period from admission to the therapeutic youth group home through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care.

(k) All certificates of need required under (2)(h) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

~~(i)~~ (l) The therapeutic portion of medically necessary therapeutic family care treatment is covered for recipients with a primary diagnosis of SED as defined in ARM 46.12.1942, or with both an emotional disturbance and a developmental disability, if the treatment is ordered by a licensed physician, licensed ~~clinical~~ psychologist, masters level licensed clinical social worker (MSW) or a licensed professional counselor (LPC), and prior-authorized by the department or its designee according to the provisions of ARM 46.12.502B.

(i) The therapeutic portion of intensive level therapeutic family care treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic family care agency licensed by and contracted with the department to provide intensive level therapeutic family care service~~, to a recipient who meets the medical necessity criteria in (2)(j) for placement~~

~~at the intensive level of treatment~~.

(ii) The therapeutic portion of moderate level therapeutic family care treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic family care agency licensed by and contracted with the department to provide moderate level therapeutic family care service~~, to a recipient who meets the medical necessity criteria in (2)(j) for placement at the moderate level of treatment~~.

(iii) The therapeutic portion of permanency therapeutic family care treatment, as defined in (2)(l)(iii)(A), is covered if provided by a therapeutic family care agency licensed by and contracted with the department to provide intensive therapeutic family care services.

(A) Permanency therapeutic family care treatment is intensive level therapeutic family care treatment for which the family placement is permanent and which includes:

(I) care coordination case management;

(II) individual, family and group therapies;

(III) clinical supervision provided by a licensed psychologist on a 1:20 ratio;

(IV) a treatment manager who is a masters or bachelors level social worker with three years experience, on a 1:6 ratio;

(V) therapeutic aide services averaging at least 10 hours per week;

(VI) respite care at least one weekend per month; and

(VII) additional specialized training for families.

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

~~(j) The therapeutic portion of therapeutic family care treatment is medically necessary for purposes of this rule only if for moderate level therapeutic family care services the recipient meets at least four of the criteria in (2)(g)(i) through (iv), or for intensive level therapeutic family care services the recipient meets at least five of the criteria in (2)(g)(i) through (iv).~~

~~(i) The recipient displays behaviors which indicate an emotional disturbance of a severe or persistent nature which requires more intensive treatment interventions and supervision than can be provided through outpatient mental health treatment.~~

~~(ii) The recipient has a poor treatment prognosis in a level of treatment lower than moderate or intensive therapeutic family care.~~

~~(iii) The recipient is at risk of psychiatric hospitalization or placement in a psychiatric residential treatment facility or therapeutic youth group home licensed by the department if therapeutic family care is not provided.~~

~~(iv) The recipient is currently being treated or has a history of treatment in psychiatric hospitals, psychiatric residential treatment and/or therapeutic youth group homes and continues to require supervision and mental health treatment in a less restrictive level of care.~~

~~(v) The recipient exhibits an inability to perform activities of daily living due to psychiatric symptoms.~~

~~(vi) The recipient exhibits maladaptive or disruptive behaviors due to serious emotional disturbance and/or physical and/or sexual abuse.~~

(m) Medicaid reimbursement is not available for therapeutic youth family care services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need. The certificate of need must certify the necessary level of care and, for intensive level services, must certify that 4 of the criteria in (2)(m)(i) through (v) are met, or for moderate level services, must certify that 3 of the criteria in (2)(m)(i) through (v) are met.

(i) the recipient is experiencing psychiatric symptoms of a severe or persistent nature that require more intensive treatment and clinical supervision than can be provided by outpatient mental health services;

(ii) the recipient is at significant risk for placement in a more restrictive environment if therapeutic family care is not provided, or the recipient is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;

(iii) the recipient's prognosis for beneficial treatment at a level of care lower than therapeutic family care is very poor because the recipient demonstrates one or more of the following:

(A) significantly impaired interpersonal or social functioning;

(B) significantly impaired educational or occupational functioning;

(C) lack of family or other community or social support networks;

(D) impairment of judgment;

(E) poor impulse control;

(iv) the recipient exhibits an inability to perform daily living activities due to a mental, emotional or eating disorder; and

(v) the recipient exhibits maladaptive or disruptive behaviors due to a mental, emotional or eating disorder.

(n) For recipients determined medicaid eligible by the department as of the time of admission to the therapeutic youth family care, the certificate of need required under (2)(m) must:

(i) be completed, signed and dated prior to, but no more than 30 days before, admission; and

(ii) be made by an independent team of health care professionals that ~~includes a physician that~~ has competence in diagnosis and treatment of mental illness~~, preferably in child psychiatry~~ and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, a licensed mental health professional and an intensive case manager employed by a mental health center.

(o) For recipients determined medicaid eligible by the

department after admission to or discharge from the therapeutic youth family care, the certificate of need required under (2)(m) must:

(i) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the admission to the therapeutic youth family care; or

(B) 90 days after the eligibility determination for recipients determined eligible after discharge from the therapeutic youth family care;

(ii) cover the recipient's period from admission to the therapeutic youth family care through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care.

(p) All certificates of need required under (2)(m) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(3) remains as proposed.

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 (2) remain as proposed.

(3) Reimbursement for the therapeutic portion of therapeutic youth group home treatment services is as follows:

(a) for intensive level therapeutic youth group home services, $156 per patient day; ~~or~~

(b) for campus based therapeutic youth group home services, $127.40 per patient day; or

(c) for ~~campus based or~~ moderate level therapeutic youth group home services, $84.16 per patient day.

(4) Reimbursement for the therapeutic portion of therapeutic family care treatment services is as follows:

(a) for intensive level therapeutic family care services, $59.27 per patient day; ~~or~~

(b) for moderate level therapeutic family care services, $39.75 per patient day~~.~~; or

(c) for permanency therapeutic family care services, $110 per patient day, which covers and includes all individual, group and family therapy, respite care and care coordination case management services provided to the recipient.

(5) remains as proposed.

(6) Reimbursement will be made to a provider for reserving a therapeutic youth group home or therapeutic youth family care, other than permanency therapeutic family care, bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit;

(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic home visit;

(d) the recipient is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department or its designee determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence; and

(e) if the therapeutic home visit is in excess of 48 hours, the visit has been approved by the department in advance of the visit. Requests for approval under this subsection must be received by the department or its designee at least 2 working days in advance of the start of the visit.

(7) No more than 14 days per recipient in each rate year will be allowed for therapeutic home visits. For purposes of this 14-day limit, all therapeutic home visits must be included whether or not such visits were of sufficient length to require advance approval under (6)(e).

(a) The provider must report to the department or its designee each therapeutic home visit of 48 hours or less within 30 days after the start of the visit. Each visit must be reported on a form acceptable to the department.

(8) Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the addictive and mental disorders division or its designee.

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

46.12.5007 PASSPORT TO HEALTH PROGRAM: SERVICES

(1) through (2)(i) remain as proposed.

(j) licensed ~~clinical~~ psychologists services provided in ARM 46.12.578 through 46.12.579A;

(2)(k) through (2)(aa) remain as proposed.

(ab) admission for ~~residential treatment~~ inpatient psychiatric services as provided in ARM 46.12.596A through 46.12.1923;

(ac) therapeutic youth group home or therapeutic youth family care services under the EPSDT program;

(2)(ac) and (2)(ad) remain as proposed but are renumbered (2)(ad) and (2)(ae).

(3) and (4) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-116, MCA

46.20.103 MENTAL HEALTH SERVICES PLAN, DEFINITIONS

(1) through (13) remain as proposed.

(14) "Serious emotional disturbance~~" or "(SED)~~" means with respect to a youth that the youth meets the following requirements ~~of (14)(a), (b) or (c), and meets the requirements of (d)~~:

(14)(a) through (14)(c)(i) remain as proposed.

(ii) the youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe: attention deficit/hyperactivity disorder (314.00, 314.01, 314.9); childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90); oppositional defiant disorder (313.81); pervasive developmental disorder not otherwise specified (299.80); Asperger's disorder (299.80); separation anxiety disorder (309.21); reactive attachment disorder of infancy or early childhood (313.89); schizo affective disorder (295.70); mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90); psychotic disorder not otherwise specified (298.9); obsessive-compulsive disorder (300.3); dysthymic disorder (300.4); depressive disorder not otherwise specified (311); cyclothymic disorder (301.13); generalized anxiety disorder (overanxious disorder) (300.02); posttraumatic stress disorder (chronic) (309.81); dissociative identity disorder (300.14); sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89); anorexia nervosa (severe) (307.1); bulimia nervosa (severe) (307.51); kleptomania (312.32); pyromania (312.33); trichotillomania (312.39); intermittent explosive disorder (312.34); and personality disorder (301.4, 301.5, 301.81); or conduct disorder (312.8) when accompanied by at least one of the diagnoses listed above; and

(14)(c)(iii)(A) through (14)(c)(iii)(D) remain as proposed.

(E) has displayed behavior considered seriously detrimental to the youth's growth, development or welfare, or to the safety or welfare of others.

~~(d) Unless behavior results from emotional disturbance or a youth is dually diagnosed, a youth does not meet the definition of serious emotional disturbance if the youth has a primary problem of:~~

~~(i) developmental disability;~~

~~(ii) substance abuse or chemical dependency;~~

~~(iii) sexual or physical abuse victimization; or~~

~~(iv) character and personality disorders characterized by lifelong and deeply ingrained anti social behavior patterns including sexual behaviors which are abnormal and prohibited by statute.~~

(15) through (15)(b)(i) remain as proposed.

(A) ~~medication is necessary to control the symptoms of mental illness~~ the person has been hospitalized at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Springs campus) at least once;

(15)(b)(i)(B) through (18) remain as proposed.

AUTH: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113, 53-6-131 and 53-6-701, MCA

IMP: Sec. 41-3-1103, 52-1-103, 53-1-601, 53-1-602, 53-2-

201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-21-139 and 53-21-202, MCA

46.20.106 MENTAL HEALTH SERVICES PLAN, MEMBER ELIGIBILITY (1) through (8)(c) remain as proposed.

(d) Termination of eligibility, based upon a change in the federal poverty level, income or family composition, may not be effective earlier than ~~30~~ 10 days after mailing of written notice of termination to the member.

(8)(e) through (11) remain as proposed.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation rates, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

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, 53-1-602, 53-2-201, 53-6-101, 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

46.20.110 MENTAL HEALTH SERVICES PLAN, PROVIDER PARTICIPATION (1) through (1)(b) remain as proposed.

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

(2)(a) through (2)(e) remain as proposed.

(f) licensed ~~clinical~~ psychologists;

(2)(g) through (2)(j) remain as proposed.

(3) The department may, in its discretion, enroll as providers 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 department for the category of service, and if they agree to the terms of the provider agreement.

(a) Nothing in these rules requires the department to enroll any particular provider or category of provider to provide services under the plan. The department, in its discretion, may deny enrollment to any provider or category of provider. The department may, in its discretion, limit services, rates, eligibility or the number of persons determined eligible under the plan based upon such factors as availability of funding, the degree of financial need, the degree of medical need or other factors.

(i) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(A) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(B) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

(3)(b) through (5)(a)(iii) remain as proposed.

(b) An enrolled provider shall be provided an opportunity for administrative review and fair hearing as provided in ARM Title 46, chapter 2, subchapter 2 to contest a denial of correct payment by the department to the provider for a service provided to a member if:

(5)(b)(i) through (6) remain as proposed.

AUTH: Sec. 2-4-201, 41-3-1103, 53-2-201, 53-6-113, MCA
IMP: Sec. 2-4-201, 41-3-1103, 53-1-601, 53-2-201, 53-6-113, 53-6-116, 53-6-701, 53-6-705 and 53-21-202, MCA

46.20.114 MENTAL HEALTH SERVICES PLAN, COVERED SERVICES (1) remains as proposed.

(2) Covered services include:

~~(a) non hospital crisis intervention and emergency services available 24 hours per day each day of the year;~~

~~(b)~~ (a) evaluation and assessment of psychiatric conditions by licensed and enrolled mental health ~~provider~~ providers;

(2)(c) and (2)(d) remain as proposed but are renumbered (2)(b) and (2)(c).

~~(e)~~ (d) ~~physician, advanced practice nurse, and physician assistant services~~ primary care providers, as defined in ARM 46.12.4801(18), for screening and identifying psychiatric conditions and for medication management;

(2)(f) and (2)(g) remain as proposed but are renumbered (2)(e) and (2)(f).

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

(2)(i) remains as proposed but is renumbered (2)(h).

~~(j)~~ (i) the therapeutic component of therapeutic youth group home care and therapeutic family care services for children and adolescents and for members and medicaid eligible individuals, room and board in therapeutic youth group homes and therapeutic youth family care if funding for room and board is not available from any other source; and

~~(k) day treatment services for adults with severe disabling mental illness; and~~

~~(l) day treatment for children and adolescents with serious emotional disturbance.~~

(i) mental health center services.

(3) This subchapter is not intended to and does not establish an entitlement for any individual to be determined eligible for or to receive any services under the plan. 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 member may be determined and may be restricted by the department or its designee 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, the availability of funding, the degree of financial need, the degree of medical need and other relevant factors.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

(4) through (10)(c) remain as proposed.

(11) This subchapter is not intended to and does not establish an entitlement for any individual to be determined eligible for or to receive services under the plan. The department may limit services, rates, eligibility or the number of persons determined eligible under the plan based upon such factors as availability of funding, the degree of financial need, the degree of medical need or other factors.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

AUTH: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113, 53-6-

131 and 53-6-706, MCA

IMP: Sec. 41-3-1103, 52-1-103, 53-1-405, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA

46.20.117 MENTAL HEALTH SERVICES PLAN, PROVIDER REIMBURSEMENT (1) Reimbursement of enrolled providers for mental health services covered under the plan and provided to plan members is as provided in ARM Title 46, chapter 12 for the same service or category of service under the Montana medicaid program, except as otherwise provided in this subchapter.

(1)(a) through (1)(a)(i) remain as proposed.

(b) For inpatient psychiatric services provided to a plan member in a residential treatment facility, the reimbursement rate shall be the medicaid rate provided in ARM 46.12.596C, less the amount of the educational component rate as established by the Montana office of public instruction. The educational component rate is available upon requests from the department's addictive and mental disorders division.

(c) For the room and board component of therapeutic youth group home and therapeutic youth family care, the rate is:

(i) $24.18 per patient day for moderate level therapeutic youth group home;

(ii) $28.98 per patient day for intensive level therapeutic youth group home;

(iii) $28.75 per patient day for campus based therapeutic youth group home; and

(iv) $28.42 for all levels of therapeutic youth family care.

(2) remains as proposed.

(3) Providers must accept the amounts payable under this rule 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, except as provided in this subchapter.

(a) Providers may bill a member who fails to show up for a scheduled service if such billing is consistent with a written policy maintained and posted by the provider, if the member has been informed of the policy in writing and if the policy applies equally to private pay patients and members.

(4) remains as proposed.

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

IMP: Sec. 53-1-601, 53-2-201, 53-6-101, 53-6-116, 53-6-701, 53-6-705 and 53-21-202, MCA

46.20.120 MENTAL HEALTH SERVICES PLAN, PREMIUM PAYMENTS, AND MEMBER COPAYMENTS (1) A member of the plan must pay to the provider the following copayment not to exceed the cost of the service:

(a) for each outpatient visit or service, other than pharmacy services, $10 or a lesser amount designated by the department;

(b) for each filling of a prescription, the lesser of the

cost of that particular filling or ~~$10~~ $25, or a lesser amount designated by the department; and

(c) for each ~~inpatient~~ out-of-home admission, $50 or a lesser amount designated by the department.

(2) remains as proposed.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-131, MCA
IMP: Sec. 53-1-405, 53-1-601, 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-131, MCA

46.20.126 MENTAL HEALTH SERVICES PLAN, TRANSITION FROM RULES IN EFFECT PRIOR TO JULY 1, 1999 (1) remains as proposed.

(2) Services provided prior to July 1, 1999 will be subject to the applicable rules in effect prior to July 1, 1999. Member eligibility, service coverage and provider reimbursement will be governed by the rules in effect with respect to the date of service, regardless of any change in the contractual relationship between the department and the managed care organization (MCO). Services provided on or after May 1, 1999 and before July 1, 1999 which meet all requirements will be reimbursed by the MCO according to the MCO's established rates for participating and non-participating providers in effect as of April 30, 1999, unless otherwise agreed in writing by the MCO and the department.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-1-601, 53-1-612, 53-2-201 and 53-21-202, MCA

6. The Department has thoroughly considered all commentary received. The comments received and the department's response to each follow:

GENERAL COMMENTS

COMMENT: The public comment period for these changes has been inadequate. There should also be more time to review the RFP draft. The Department should allow additional comments.

RESPONSE: The Department must adopt a system for coverage and reimbursement of mental health services to take effect July 1, 1999, to replace the Mental Health Access Plan. If the Department is to meet this mandatory effective date, the final notice must be completed and filed with the office of the Secretary of State no later than June 4, 1999. This filing date does not allow extension of the comment period. As the Department has acknowledged, the interim system provided in these proposed rules has required design of a complex system in a short period of time, and the proposal undoubtedly is imperfect. The Department fully expects and welcomes continuing comment and suggestions as the interim system is implemented, and the Department expects that adjustment will be necessary. Nonetheless, the Department must move forward at this time to adopt the proposed system.

The Department has not drafted or issued any Request for Proposals (RFP) for a replacement managed care system and no RFP comment period had been determined. There is no RFP review period to extend.

COMMENT: The Department should give the mental health agencies the capitation payments. The proposal that has been presented will not benefit the consumers.

RESPONSE: Paying a provider a capitated rate is not possible without a waiver of the Health Care Financing Administration (HCFA) regulations. The rule proposal defines an interim plan to serve the mental health needs of medicaid recipients and certain other low income individuals while the Department designs a replacement managed care program or programs. The Department believes that the proposed rules will benefit consumers of publicly funded mental health services.

COMMENT: All providers within the same region should receive the same contract for services and fees.

RESPONSE: The proposed rules do not contemplate or address contracts for specific services. The Department believes the proposed system accomplishes equity among all providers of a type with regard to fees and services, not only on a regional basis, but statewide.

COMMENT: The Department should adopt a less complicated system than MHAP. The unbillable time that this management of care has imposed on my practice is phenomenal.

RESPONSE: The Department believes that the system established by the proposed rules will be less complicated for providers. For example, the Department will not require any prior authorization for outpatient services.

COMMENT: The mental health services ombudsman should be a primary consumer, preferably nominated by and belonging to mental health groups such as National Alliance for Mental Health (NAMI) or Mental Health Association (MHA).

RESPONSE: The proposed rules do not address the Ombudsman. An Ombudsman for mental health services was established by the 1999 Legislature in Senate Bill 534. That bill does not provide for implementation of the Ombudsman provision through the rule making process. The Ombudsman position is currently being advertised by, and will be filled through, the Governor's office.

COMMENT: Intensive case management is not treatment but an adjunct for treatment. It does not make sense to divert funds to bolster case management at the expense of treatment.

RESPONSE: Funds are not being diverted to bolster case

management under the proposed system. The rules impose no limitations or restrictions on outpatient services, and restrictions on out-of-home services are intended only to ensure the services are appropriate and medically necessary. The Department does not intend that case management services be substituted for any treatment service.

COMMENT: It is absurd to think or even suggest we can continue to serve our clients, our citizens, in a professional, ethical manner within this proposed system of rules.

COMMENT: The Department's head in the sand attitude concerning the realities of community mental health care do not serve the citizens of this state well and make extremely poor public policy.

COMMENT: To say that the bulk of the proposal is ludicrous would be an understatement. It appears that the author or authors have an extremely limited idea as to the needs of clients and the availability of clinical services.

COMMENT: Leadership in the transition period should be shifted to someone in the Department who is new and fresh. The public, clients and legislators have lost faith and confidence in the failed management and planning of the last two years.

RESPONSE: The Department has made a concerted effort to devise an interim plan for mental health services that will result in the least possible disruption to consumers and to providers. We have attempted to find ways to preserve those aspects of the Mental Health Access Plan that mental health stakeholders have indicated were important to retain. In devising the proposed system and the associated rules we have had to be cognizant of the limitations imposed by the available options, federal requirements, the constricted time frame available to us, and by the funding limitations imposed on mental health services by the Montana Legislature. The comments fail to recognize that, with a return to a fee for service medicaid program, the Department must work within the rigid categorical restrictions of federal medicaid law. In addition, the Department must work within the budgetary limitations imposed by the Legislature. Within these parameters, the Department has attempted to allow as much flexibility as possible and to provide the broadest coverage possible. The Department believes that the proposal presents a reasonable and workable program of publicly funded services.

SERVICE COVERAGE

COMMENT: In ARM 46.20.114, some but not all mental health center services are included as covered MHSP services. Did the Department intend to cover only some mental health center services?

RESPONSE: No, the Department intended to provide MHSP coverage

of all mental health centers covered by medicaid. The final rule will be revised accordingly.

COMMENT: It appears the state will not fund respite services, psychosocial activities, wrap-around services for families, therapeutic aide services, mental health assistant services. Concern is expressed that the State will most probably not be funding the lower-cost services such as family-based services, mental health assistants, respite care and room and board for therapeutic foster care and group home care. The Department should provide a service code and rate for mental health assistants or wraparound workers. Family based service and respite should be included at $58/hr for family based and $32/day for respite.

There appears to be an absence of rule and reimbursement for some essential services, including intensive assisted living, a specialized level of care. Rules should be developed and a rate structure proposed so that this service can continue to be an option. The proposal does not have rates for either supported living or medication monitoring.

RESPONSE: The proposed rules provide for coverage of therapeutic aides, "wrap-around" services and similar services through the category of community-based psychiatric rehabilitation and support services provided by mental health centers. Intensive assisted living is a similar service covered as community-based psychiatric rehabilitation and support services. Medication monitoring is also covered under this service when performed by non-licensed professionals and registered nurses. It is also covered when provided by licensed professionals under the particular practitioner category of service. The Department has also included coverage of respite care in the final rule.

The Department has attempted to design these services in a flexible fashion to meet the needs of mental health service consumers. The extent to which the Department will be able to maintain these coverages during the interim period ultimately will depend upon the approval of required medicaid state plan amendments by the Health Care Financing Administration (HCFA).

COMMENT: We are concerned that we will not be reimbursed under the new rules for adult group home services, moderate intensity, in our licensed personal care facility. We implore you to continue to provide special contracts and to continue paying for services that we are providing.

COMMENT: If personal care facility services are not funded, it is going to be putting about 20 Mental Health Center clients on the street.

RESPONSE: The Department proposes to cover medicaid requests and Mental Health Services Plan (MHSP) beneficiaries currently

in personal care facilities through direct contracts with providers. Therefore, no rules are established for reimbursement of this service.

COMMENT: Dedicated crisis response therapists are not recognized in the proposed rules, nor is there a reimbursement rate to cover this service. There is no reimbursement mechanism for emergencies or crisis response services. The rules should allow for the Department to contract with the mental health centers to support the crisis response teams in the state.

RESPONSE: The rules provide funding for crisis stabilization facilities and crisis services under care management and community-based psychiatric rehabilitation and support. Crisis services provided by licensed practitioners are also covered. The Department proposes to obtain crisis response telephone services through direct contracts with providers rather than through rules. Therefore, no rules are established for reimbursement of this service.

COMMENT: Drop-in services will disappear on July 1, 1999 if there is no provision for continued funding. This service provides an important consumer to consumer linkage and recognizes the need for social and supportive services outside the normal business hours.

COMMENT: We wish to see our Great Falls drop-in Center reopened.

RESPONSE: The Department hopes to be able to directly contract with some or all of the exiting drop-in programs in order to continue this service. No rules are necessary.

COMMENT: The plan fails to provide preventative funding.

RESPONSE: It is unclear what particular services are at issue in this comment. The Department believes that all medically necessary mental health services should be at least in part directed at preventing any deterioration in the recipient's condition and preventing the need for more restrictive and expensive services.

COMMENT: The overall health of our community relies on all the services we can get. Please be mindful of us and all the service our illnesses call for.

RESPONSE: The Department has made a concerted effort to devise an interim plan for mental health services that will result in the least possible disruption to consumers and to providers. We have attempted to find ways to preserve those aspects of the Mental Health Access Plan that mental health stakeholders have indicated were important to retain. The Department has attempted to provide the broadest possible array of services possible within its programmatic, administrative and funding

capacity.

COMMENT: The rules do not appear to contain any provision for services for sex offender treatment. Treatment for sexual offenders and victims of physical abuse needs to be included.

COMMENT: Outpatient treatment for sex offender treatment should be included.

COMMENT: Certain clinical conditions are denied authorization for treatment, i.e., victims of sex abuse and physical abuse.

RESPONSE: Medically necessary services delivered by an enrolled provider to a medicaid beneficiary who is a sex offender or a victim of abuse are reimbursable when delivered in accordance with the proposed rules. Similarly, medically necessary services provided to a Mental Health Services Plan beneficiary for treatment of a covered diagnosis are reimbursable when delivered in accordance with the proposed rules. "Sex offender" and "victim of physical abuse" denote a legal status rather than a medical diagnosis. Services described in the proposed rules are available to treat mental illness or emotional disturbance.

COMMENT: There needs to be flexibility in the system to reimburse clinicians for phone services to their clients. Services by phone are essential elements in care in rural Montana. Many times a phone is the only way of contacting our clients.

RESPONSE: The proposed rules do not prevent a mental health provider from contacting a client by telephone. Telephone contact with or on behalf of the client can be reimbursed as intensive case management or as care coordination case management services. There are no CPT codes for billing telephone contact with a client, and therapy delivered by telephone cannot be reimbursed under Medicaid or the Montana Mental Health Services Plan.

COMMENT: Two program areas are not included in the proposed rules. We are proposing the development of an "intensive day treatment" subcategory under the broad category of "child and adolescent day treatment services". We are also proposing the development of a third category under therapeutic foster or family care, which is the permanent adoptive treatment homes or PATH level.

RESPONSE: The Department has reviewed information on the "intensive day treatment" category of service, which has been offered under the Mental Health Access Plan (MHAP) program. The service does not appear to be sufficiently distinct from the mental health center child and adolescent day treatment services to justify a separate and considerably higher reimbursement rate. It is permissible under the proposed rules to offer additional therapy to young people receiving day treatment when

the day treatment program does not fully meet a consumer's treatment needs.

The Department does believe there is justification for a third level of therapeutic family care for situations in which the foster placement is permanent and will result in either adoption or permanent family care. This level of service requires more extensive training of families and a greater degree of support provided to the families, and includes individual, family, and group therapy, and respite care. The establishment of permanent homes for troubled children and youth is an important Department goal. The Department will adopt a "Permanency Therapeutic Family Care" service in the final rules.

COMMENT: Montana Hospital Association (MHA) opposes the Department's decision to refuse any payment for emergency room and inpatient hospital treatment provided to non-medicaid eligible low-income Montanans. MHA believes that refusing to cover inpatient hospital stabilization will lead to increased costs imposed on counties while patients are committed to the Montana State Hospital at Warm Springs, and increased costs at MSH. The rules should allow for emergency room and inpatient hospital payments at the same rate provided for in the crisis intervention programs operated by centers and the per diem cost of care delivered by the MSH.

RESPONSE: Since the Department's funding for mental health services has not increased significantly, we do not have the financial ability to add this benefit. In its other comments, the MHA has encouraged the Department to make these rules conform exactly to the prior payment system. Under that system the State provided no coverage for emergency room or inpatient services for the people who will be covered under the Mental Health Services Plan.

COMMENT: I advocate strongly for pharmacy coverage under the non-medicaid program.

RESPONSE: The proposed rules provide coverage of a pharmacy benefit under the Mental Health Services Plan (MHSP).

HOSPITAL SERVICES

COMMENT: I do not understand why inpatient psychiatric services to children in freestanding psychiatric hospitals is disallowed, but such services are allowed in community hospitals. The Department should include freestanding acute psychiatric licensed hospitals in the reimbursement structure for medicaid.

RESPONSE: The Department will add coverage of freestanding psychiatric hospital services for medicaid eligible individuals under age 21. These services will be added under the inpatient psychiatric services for individuals under age 21 option in federal medicaid law, and these services will be reimbursed

using the diagnosis related groups (DRG) prospective payment system applicable to general hospitals. The freestanding psychiatric hospital coverage is intended as a short term service for purposes of crisis stabilization and evaluation, rather than longer term treatment.

COMMENT: We support the proposal to implement a statewide bundled per diem for residential treatment services. We are requesting that the state evaluate the increased medication costs incurred by providers in the past three years.

COMMENT: The Department is reducing fee schedules for residential and partial hospitalization care, among others, to levels below those in place prior to the MHAP. MHA recommends that the Department establish fee schedule payments at rates equal to the pre-MHAP program amounts.

COMMENT: MHA opposes the per diem rate of $262.71 proposed for residential treatment facilities. The Department should adopt a rate closer to the $293 per day paid prior to the MHAP.

RESPONSE: The proposed partial hospitalization and residential treatment center (RTC) rates for the interim period reflect the rates in effect immediately prior to the implementation of MHAP. For partial hospitalization services, the proposed rates are not a reduction from pre MHAP rates. For RTC services, at the time of MHAP implementation, the State was part way through a process of transition from individual provider-specific rates to a single statewide rate. The proposed RTC rate is a single statewide rate which is an average of provider rates in effect immediately prior to MHAP implementation. The rate adopted in these rules is $262.71. The average rate for the three Montana residential treatment facilities for state fiscal year 1997 was $255.00 per diem. Given the limited funding available and the anticipated short-term duration of the interim system, the Department does not have the capacity to complete a review or study of medication costs at this time.

Prior to the implementation of MHAP, residential treatment center services were not covered for children and youth who were not eligible for Medicaid. Only in extreme circumstances were general fund dollars authorized by regional MRM programs for this level of care. In those circumstances, the reimbursement per diem was established at $208, exclusive of the cost of education.

During the interim period, residential treatment center services will be included in the plan of benefits for both Medicaid and Mental Health Services Plan children and youth. The MHSP reimbursement per diem is anticipated to be approximately $235 with educational costs billed separately to OPI, an increase over the previously allowed $208. Furthermore, residential treatment centers that hold an additional hospital license may continue to provide acute inpatient care to medicaid recipients.

Acute care in a stand-alone facility was not covered under the previous Medicaid fee for service program. The Department believes the proposed RTC rates are adequate to reasonably compensate providers and to provide access to services for medicaid recipients and plan members.

COMMENT: Out of State providers should not be reimbursed at a higher rate than in-state providers.

RESPONSE: Montana facilities will be reimbursed under a single statewide rate that is based upon historical cost experience of the Montana facilities. Out of state facilities will be reimbursed based upon a cost to charge ratio approach. The cost experience of out of state facilities may vary widely and bears no relation to the cost data upon the which the Montana facility rate is based. Language will be added to the final rule to require that out of state facilities will be used on a very limited basis, only when the in-state facilities are unable to serve the individual. In those cases where the in-state facilities are unable to serve the individual, the cost to charge ratio approach to reimbursement of out of state facilities allows payment of a rate that will be adequate to assure reasonable access to facilities that are able to serve these individuals.

COMMENT: In Rule XIV (46.12.596C), we do not believe that the restriction of one billable psychiatric physician service per week supports the requirement that residential treatment services be individualized. This limit should be dropped from the rule. The limit on physician care is prohibited by federal medicaid rules. Medicaid-eligible children are entitled to receive necessary physician services during a stay in a residential treatment facility.

RESPONSE: The Department's intent in implementing a restriction on the frequency of separately billable physician visits for recipients of residential treatment facility services was to discourage abuse of the opportunity for separate billing and to encourage responsible and cost-effective use of limited funding for mental health services. Although the Department continues to believe that the physician services necessary generally can be provided within this limit by the physician and by other treatment staff under the direction of the physician, the Department will delete the proposed physician visit limit from both the inpatient psychiatric services and partial hospitalization rules. Claims for physician services provided in these settings will be subject to retrospective review for medical necessity.

COMMENT: In Rule XIV (46.12.596C), will the request for a therapeutic home visit form be required for every home visit, or only those lasting longer than 72 hours?

RESPONSE: To obtain payment for therapeutic leave days, the

Department or its designee must approve the leave in advance if the leave is more than 48 hours. If the leave is to be more than 72 hours, the length of the leave must also be approved. The provider must request prior approval by the Department or its designee at least two days prior to the absence for leave in excess of 48 hours. All therapeutic visits of 48 hours or less must be reported to the Department within 30 days and will count toward the 14-day limit. The Department will adopt language in the final rule applying the same therapeutic leave policy to any 24-hour level of care, including residential treatment center, therapeutic group home, and therapeutic foster care. The rules describe the process to obtain authorization, and include limits on the total number of days allowed for therapeutic leave. The policy will apply under both medicaid and the MHSP.

COMMENT: In Rule XVII (46.12.596F), will the provider be required to submit a certificate of need for each claim submitted?

RESPONSE: Providers must submit a certificate of need at the time that authorization for residential treatment services is requested. The certificate of need is submitted to the Department's utilization review agent with the request for authorization, and is not included with claims submission. The Department will adopt language in the final rule applying the certificate of need requirement to inpatient psychiatric services, including residential treatment center, as well as therapeutic group home, therapeutic family care, and outpatient partial hospitalization. The rules describe the certificate of need requirements. The certificate of need requirements will apply under both the medicaid and the MHSP.

The certificate of need requirement applies to inpatient hospital psychiatric care in freestanding psychiatric facilities, as it is required by federal law for inpatient psychiatric services for individuals under age 21. However, for inpatient hospital services, the signature of an intensive case manager will not be required. The freestanding psychiatric hospital services cannot be covered by medicaid under the general hospital category because they are institutions for mental disease which can be covered only through the under 21 option.

COMMENT: In Rule XVII (46.12.596F), we are requesting that the Department allow us to make the certificate of need part of our 28-day treatment plan updates instead of creating a separate document.

RESPONSE: The certificate of need referenced in Rule XVII must be done separately in order to comply with federal requirements. This particular certificate of need is done only once for each recipient's stay. The facility must also certify the need for continuing inpatient services periodically, but this certification may be contained in the facility's treatment plans

and need not consist of a separate document.

COMMENT: The Department requires partial hospitalization programs to provide six hours of treatment for a full-day of care, and four hours of treatment for a half-day of care but requires fewer hours of care for day treatment provided by mental health centers. MHA suggests that the Department make the treatment requirements the same for both providers.

RESPONSE: Partial hospitalization represents an acute level of care that is provided to individuals experiencing severe psychiatric symptoms. The program requirements and the reimbursement rate have been established to reflect the higher patient acuity and intensity of treatment provided in this setting. In contrast, day treatment services are designed to address behaviors and symptoms at a less restrictive level of care through a mental health center program. The two programs differ substantially in authorization requirements, treatment provided, and rate of reimbursement. The Department believes that the attendance requirements are appropriate to fulfill its expectations of the treatment outcomes of the two programs.

COMMENT: In Rule XVII(2) (46.12.596F), the federal requirement for inspections of care in inpatient psychiatric facilities no longer applies.

RESPONSE: The Department agrees. We will delete the reference to the federal regulation. However, the Department will retain the discretionary authority to perform inspections of care in order to assure the quality of services provided top medicaid recipients and plan members.

THERAPEUTIC YOUTH GROUP HOME AND THERAPEUTIC YOUTH FAMILY CARE SERVICES

COMMENT: The criteria for therapeutic youth group home in ARM 46.12.516(h) has an error, referring to medical necessity criteria in (2)(g)(i) through (iv). I believe this reference should be to (2)(j)(l) through (vi).

RESPONSE: The comment correctly notes the error. However, the medical necessity criteria for therapeutic youth group care and for therapeutic youth family care will be deleted from the rules. The rules will include a requirement for a certificate of need for placement in this treatment setting.

COMMENT: I oppose ARM 46.12.516(2)(h) stating that "Medicaid will not reimburse for room, board, maintenance or any other non-therapeutic component of therapeutic family care treatment." By eliminating coverage of this service, the proposed rules serve to eliminate access to these services for non-Medicaid eligible persons. Who pays for the cost of room, board, maintenance or other non-therapeutic components of youth group

home treatment for Medicaid patients? This rule potentially eliminates a segment of the population, albeit relatively small, from receiving service by not allowing for a means or method to pay the room and board costs. I suggest funding be established to allow for the payment of room and board for individuals who are not in the custody of the state.

RESPONSE: Federal medicaid requirements do not permit medicaid reimbursement for the room and board component of the therapeutic youth group home and family care settings, and room board in these settings was not covered by medicaid prior to the implementation of MHAP. The Department will include language in the final rule providing that the cost of room and board for medically necessary therapeutic group and therapeutic family care will be provided as a service through the MHSP for both medicaid recipients and MHSP members when payment is not available from any other source.

COMMENT: ARM 46.12.517 lists the reimbursement rate for campus-based group homes and moderate as the same. The Department's proposed rules for coverage and reimbursement of the therapeutic component of therapeutic youth group home services conflicts with the proposed rates published by the Department on its website on April 12. That publication indicated that moderate level services would be reimbursed at a rate of $84.16 per patient day, and campus-based services at a rate of $127.40 per patient day.

RESPONSE: The rates published on the Department's website are correct. The appropriate changes have been made in ARM 46.12.517.

COMMENT: In ARM 46.12.5007(2), therapeutic group and foster (family) care were not included on the list of services that do not require the prior approval of primary care providers under Passport to Health.

RESPONSE: Therapeutic youth group home and family care have been added to the list of services that do not require prior approval of the primary care provider under the Passport to Health program.

COMMENT: In ARM 46.12.517(5), the definition of patient day implies that any part of a day that a youth is absent from the home that the provider will not receive payment. If the youth was granted a 6 hour home visit to begin this transition, this proposed language could preclude payment to the therapeutic youth group home provider for that day of service.

RESPONSE: The referenced rule defines "patient day" for the purpose of establishing payment parameters requiring that the covered person must be present and receiving services for a complete day except for the day of admission and should not be interpreted to mean that the recipient must be at all times

present in the youth group home or family care setting. It is not the intent of the Department to withhold payment for days in which the youth may be off the premises for a home visit or other therapeutically indicated activity. Revisions to the proposed rules include provisions for reimbursement during therapeutic family leave in this setting.

COMMENT: ARM 46.12.516 provides that therapeutic youth group home and family care providers must be licensed to provide the particular level of care, i.e., intensive, etc. Licenses do not specify the level, which is addressed through contract with the department.

RESPONSE: The Department agrees and has revised the rule accordingly.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND RURAL HEALTH CLINIC (RHC) SERVICES

COMMENT: Regarding ARM 46.12.1708, the explanation provided by the Department for why the current rule differentiates between physical health and mental health visits for FQHCs is incorrect. The proposed change will place the Department in conflict with federal law governing FQHCs and should not be made.

RESPONSE: The Department disagrees. The commenter does not explain how the proposed change conflicts with federal law or identify the federal law which purportedly conflicts with the proposed change. The Department believes that the proposed change is an appropriate element of reinstituting medicaid coverage of mental health service provided by federally qualified health centers (FQHC) and consistent with federal law.

COMMENT: Regarding ARM 46.20.117, is it correct that FQHCs and rural health centers (RHCs) will be reimbursed for covered MHSP services at their all-inclusive per visit rate, subject to settlement on an annual basis to cost, just like Medicaid services for mental health? Also, will MHSP payments be included in quarterly supplemental payments to these providers as required for Medicaid managed care services?

RESPONSE: It is correct FQHCs and RHCs will be reimbursed for covered MHSP services at their all-inclusive per visit rate, subject to settlement on an annual basis, and subject to applicable caps and productivity screening guidelines. This will be done for MHSP claims in the same manner and as part of the same settlement as the medicaid settlement. However, MHSP payments will not be included in quarterly supplemental payments to these providers. Moreover, under the interim program no supplemental payments will be made for either medicaid or MHSP services, because there will be no separate managed care rate requiring supplementation. Services will be reimbursed at the medicaid rate in the first instance.

PRACTITIONER SERVICES - PHYSICIANS, MID-LEVEL PRACTITIONERS, PSYCHOLOGISTS, SOCIAL WORKERS AND PROFESSIONAL COUNSELORS

COMMENT: The use of the term "clinical" in licensed clinical psychologist" is inappropriate since that term is not used in license statutes and rules.

RESPONSE: The Department agrees and has eliminated such use of the term throughout the final rules.

COMMENT: Reimbursement rates for the same type of service must be equal. If psychologists and clinical social workers are providing the same service, they should be paid the same rate. However, if the psychologist is providing only testing services, then that should be clearly identified and paid at a higher rate.

COMMENT: A Ph.D. is paid at a higher rate than an LCSW for therapy, the exact same service. These rates are unacceptable.

RESPONSE: The Department will amend the proposed rules to specify that all outpatient practitioners (i.e., psychologists, social workers and licensed professional counselors) will receive the same rate of reimbursement for identical services.

COMMENT: Outlying offices are at risk of closing due to the proposed outpatient rate of $35.19 per hour. I propose that you retain the current rate of $60 per hour for rural counties.

COMMENT: Licensed professionals in the rural areas have a disproportionate amount of their clients on medicaid. So if the Department is serious about both equity and maintaining a relatively stable delivery system during the interim, the Department should seriously consider maintaining the rural differential. A rate drop from $60 to $52.80, a 12% rate drop for the rural for the interim would not be survivable. Maintaining the rural rate structure in place under MHAP is of critical importance. For urban counties in the range of $45/hr. the rate for group therapy should be structured at 1/3 of the individual rate.

RESPONSE: While the Department appreciates the potential benefit to recipient access to services from reimbursing rural providers at a higher rate, several considerations preclude implementation of a tiered rate structure. The Department would be unable to implement a rural differential for just one class of providers - equity would demand a similar differential for all medicaid providers. Budget impacts would be substantial. Finally, the present automated claims payment system would require extensive modification in order to implement a tiered reimbursement structure. Therefore, the Department is unable to adopt this recommendation. The Department will, however, adopt a final rule raising the proposed rates for all 3 practitioner categories, i.e., psychologists, social workers and professional

counselors.

COMMENT: The rate for reimbursement for outpatient services delivered by mental health professionals is inadequate. Outpatient therapy is the most cost-effective way of delivering treatment services and the horizontal integration of care is only possible because of the clinical supervision offered by a trained mental health professional.

COMMENT: The proposed reimbursement structure for services provided by an LCSW or LCPC is inadequate to support professional staffing.

COMMENT: Given a choice between the current managed care program under MCP and the proposed delivery of mental health services and rate reduction in individual therapy, I would without hesitation choose the MCP managed care program.

RESPONSE: The Department has reexamined the reimbursement rates proposed for outpatient mental health practitioners (licensed psychologists, licensed social workers, and licensed professional counselors) and in the interest of insuring access to services for medicaid and Mental Health Service Plan beneficiaries, the Department will increase reimbursement for those providers to 62% of the Department's established resource based relative value scale (RBRVS).

COMMENT: It is important to clarify which CPT codes are available and what the anticipated reimbursement rates will be for these services.

RESPONSE: The Department will issue a "Mental Health Manual" for providers prior to July 1, 1999 which will detail how providers bill for services and how services will be reimbursed. A list of available CPT codes is available from the Department upon request to AMDD, PO Box 202951, Helena, MT 59620-2951.

COMMENT: The figures derived in the proposal regarding reimbursement rates for professional practitioners appear to be designed for independent practitioners in the community who provide only one service.

RESPONSE: The proposed reimbursement rates cover a number of distinct services and will apply equally to all outpatient practitioners, either in private practice or practicing within an agency or facility. The RBRVS scale addresses the various types of services provided by these provider types.

COMMENT: Rule V (46.12.519A) references Health Care Provider Coding System (HCPCS) as the source for procedure codes and modifiers to be used when billing for services. We believe you meant to say CPT. Again on page 5, Rule VIII (46.12.586B), the rule references (HCPCS).

RESPONSE: The references to HCPCS are correct. The HCPCS codes correspond to the CPT codes.

COMMENT: The proposed rules do not provide for reimbursement for practitioners to attend treatment teams meetings for youth. I recommend the current funding, under the category "environmental intervention" be continued, with one team meeting reimbursed each ninety days.

RESPONSE: Outpatient practitioners may be reimbursed for participating in treatment team meetings under care coordination case management services.

COMMENT: Proposed Rule IV (46.12.579) and proposed Rule V (46.12.579A) are unclear about medicaid coverage for licensed clinical psychologist services provided to patients in a skilled nursing facility. We request that proposed Rule IV (46.12.579) be clarified to state that services by licensed clinical psychologists provided to residents in a skilled nursing facility are covered, provided that they otherwise meet eligibility requirements.

RESPONSE: The proposed rules do not restrict reimbursement to licensed practitioners by place of service other than the restriction on inpatient services that are a part of a diagnostic related group payment. The medicaid nursing facility rules define and reimburse nursing facility services, and permit ancillary billing of practitioner services to the extent such services are not within the definition of nursing facility services and to the extent all other requirements are met.

COMMENT: Will the Department continue to pay providers using video?

RESPONSE: The rules will be amended to treat services provided by outpatient practitioners over interactive video systems to be considered the same as "face-to-face" services and reimbursed accordingly. Appropriate CPT codes are available for physicians and mid-level practitioners providing interactive video services.

COMMENT: Would Rule VII (46.12.586A) preclude non-therapeutic group homes and shelter care facilities who have an LCSW on staff from providing out-patient mental health counseling services to residents placed in their facilities?

RESPONSE: No, the proposed rule only limits the place of service for licensed clinical social workers in the context of services delivered in an inpatient setting as part of the diagnosis related group payment. The practitioner would, of course, be required to meet participation requirements and enroll in the medicaid program.

COMMENT: It is unclear as to whether inpatient physician services will be reimbursed directly to a mental health center or to the facility. It is also unclear what the expected reimbursement rates will be for MHC psychiatrists who admit and treat MHC clients to local hospitals.

RESPONSE: Physicians practicing in a mental health center may bill Montana Medicaid or the Montana Mental Health Services Plan under their individual provider number or under the mental health center's provider number.

Physicians may bill for any of the CPT-4 codes reimbursed by Montana Medicaid and will be reimbursed according to the Department's resource based relative value system. Those reimbursement amounts are posted on the Department's website or are available upon request from the Primary Care Bureau, Health Policy and Services Division, PO Box 202951, Helena, MT 59620.

COMMENT: In ARM 46.20.114(2)(e), for consistency purposes, we recommend that "physician, advanced practice nurse, and physician assistant services" be replaced with a reference to "primary care providers, as defined in ARM 46.12.4801(18)".

RESPONSE: The Department has made the suggested change.

COMMENT: The word "physician" is used numerous times throughout the rules. For the protection of patients the term should be specifically defined.

RESPONSE: The term already is defined in ARM 46.12.2001(1).

COMMENT: There is no way for nurses to bill independently for services. The rules do not set out a payment procedure for licensed master's level nurses who function as outpatient therapists.

COMMENT: I recommend that licensed nurses be included as practitioners for the purpose of care coordination.

RESPONSE: Montana medicaid covers only certain registered nurses as independent providers for the purposes of unsupervised service provision and reimbursement. Advanced practice registered nurses are covered as mid-level practitioners and may enroll with and be reimbursed by Montana Medicaid. Master's prepared nurses must achieve licensure as an advanced practice registered nurse or as a professional counselor in order to qualify for direct Medicaid or MHSP reimbursement. Registered or licensed practical nurses may be employed by mental health centers as intensive case managers, in day treatment programs or in other capacities delivering services for which the mental health center may be reimbursed.

MENTAL HEALTH CENTER SERVICES, CASE MANAGEMENT SERVICES AND SCHOOL-BASED SERVICES

COMMENT: The requirement that mental health centers be licensed will prevent some mental health centers that have applied for licensure and that served clients under MHAP from participating and serving clients as of July 1.

RESPONSE: The Department has amended the final rule to permit those mental health centers that were participating in MHAP and that applied for licensure before July 1, 1999, to participate through December 31, 1999. Such mental health centers will not be permitted to participate after December 31, 1999 unless they have obtained a mental health center license.

COMMENT: The proposal, if imposed, does not differentiate between a comprehensive mental health center and others who do not fall into that category, especially in regard to reimbursement rates.

RESPONSE: That is correct.

COMMENT: The Department should reimburse community mental health centers on a cost basis.

RESPONSE: Contrary to practice prior to implementation of the Mental Health Access Plan, the Department chooses not to establish reimbursement rates based upon provider cost. The limited time available for development and implementation of this interim system does not permit the gathering and analysis of cost data that is necessary for establishing cost-based rates. More importantly, the Department believes that cost-based reimbursement is antithetical to efficient and cost-effective service delivery.

COMMENT: Mental health day treatments should not be shut down.

RESPONSE: Day treatment services are reimbursable under the proposed rules.

COMMENT: I am concerned about the continuing rule that "mental health services must be provided by/or under the supervision of a licensed physician".

RESPONSE: Mental health center services are reimbursable under the medicaid state plan under the federal clinic services category. The federal definition of a clinic requires the supervision of a licensed physician.

COMMENT: I do not understand why certain services (such as intensive case management) are limited to only mental health centers. Why can't other providers capable of providing the services also be allowed to do so?

RESPONSE: Any service specified in these rules can be provided by an appropriately licensed and enrolled provider. Appropriate licensure for intensive case management services is licensure as a mental health center with endorsement for intensive case management. Any provider capable of providing the services which meets previously established licensure requirements can become licensed as a mental health center.

COMMENT: The Department should expand the definition of community-based psychiatric rehabilitation and support to include injections and pill box set-ups by LPN's and RN's. Nurses provide many levels of medication assistance to consumers. This service is not addressed in the rules or the reimbursement rates.

RESPONSE: These services may be billed as community-based psychiatric rehabilitation and support or billed with CPT-4 code 99211, when provided under the supervision of a physician or mid-level practitioner.

COMMENT: The Adult Foster Care program will be destroyed in your process of reduced rates.

RESPONSE: The Department has reviewed the cost of foster care for mentally ill adults and its reimbursement structure under the MHAP program. The final rule will establish a rate of $44.00 per treatment day, a $4.00 per day increase from the $40.00.

CASE MANAGEMENT

COMMENT: Caseloads - The case management case load for youth with SED and adults with SDMI should be an average number across the provider's case management staff. Without a flexible caseload cap, many of these families will have to go without services.

COMMENT: A realistic client load for either an adult or children case manager is 12. I would propose that the $295 case rate for adult and children case managers stay in effect for rural counties.

COMMENT: The caseload limits for child and adult case management should be removed.

COMMENT: The proposed caseloads (20-youth - 22-adults) coupled with extensive travel demands inherent in the delivery of case management would justify a 20% rate differential (i.e. $269 for ACM and $295 for CCM) in rural counties.

COMMENT: The intensive case management case load for youth should be no more than 16 to 20 clients per case manager.

COMMENT: A maximum caseload of 20 clients per youth case manager may have unintended consequences of limiting access to care especially in rural areas. AWARE, Inc. supports average caseload sizes of 20 at the currently proposed rate.

COMMENT: Adult case management caseload limit is ok.

COMMENT: Blended case management caseload should be allowed.

RESPONSE: Capped caseloads for intensive case management (ICM) are intended to prevent caseload growth to a level where quality services are not possible. The Department recognizes the need for some flexibility and has made the following changes to the rule: (a) The ICM caseload maximum will be based on the average caseloads across the provider's ICM staff. (b) Blended caseloads will be allowable. For purposes of calculating the provider's average caseload, the first 1 through 4 care coordination clients served by each intensive case manager shall be counted as 1 additional intensive case management client, and each additional 1 through 4 care coordination clients shall be counted as 1 additional intensive case management client. (c) Required minimum service/contact for ICM will be two hours of case management service including a minimum of one face-to face contact.

COMMENT: Three contacts per month with a youth and family that lives 60 miles or more away is not reasonable.

COMMENT: Three contacts would be reasonable if they were collateral and/or client.

COMMENT: When a case rate system is proposed, it should allow for more autonomy by the provider, so that the provider can focus resources in the areas most needed.

COMMENT: At these rates and with these limitations, clients in outlying areas will not be served due to no way of being reimbursed for the way that services need to be delivered to them because of their unique living circumstances. I recommend that the department require only one contact per month that can be either face to face or by telephone and that the department providers.

COMMENT: The artificial requirements for face-to-face contacts in case management and the limit on care coordination contacts make no clinical sense. As long as the case manager or professional is working on behalf of the client the time should be billable. The level of intervention and case management on the client's behalf should depend on the amount of need of the client not on some artificial number established by a state agency.

COMMENT: Remove the artificial upper limit on four care coordination hours per month.

COMMENT: The proposal appears to recommend that clinical case management can only be billed if it is face-to-face rather than telephonically. It is apparent the intent of this portion of the proposal is to provide free clinical case management for all the time spent while acting on the client's behalf when the individual(s) is/are unable to be seen face-to-face.

COMMENT: Face to face contacts need to occur on a regular basis and three contacts/month appears a reasonable expectation for many cases. However, dictating this raises many questions and situations in which services will need to be rendered but will not be reimbursed.

COMMENT: The requirement of three monthly face to face contacts lacks the flexibility necessary to provide adequate discharge planning and community based service for those in out-of-community care. A more flexible requirement would require three monthly contacts with the youth, family members or other collateral contacts.

RESPONSE: Under a monthly rate for case management services as proposed it would be irresponsible for the Department to not establish some minimal level of contact with and services on behalf of the client. The proposed reimbursement system is intended to allow providers the flexibility to respond to the needs of the client, but given the relatively high rate of reimbursement it is essential that the Department be assured of some level of service.

The Department recognizes that three face-to face contacts per month can be particularly difficult in view the extensive travel required in the state's more rural areas. The rule will be modified so that Intensive Case Management (ICM) will require one face-to-face contact per month with a minimum of two hours of case management service (including collateral contacts). This will allow substantially more than 50% of the Intensive Case Manager's time to be used on an "as needed" basis. If the client needs less than 2 hours of service per month, it at least raises the question of whether or not the client has a need for "intensive" level of case management.

It is the Department's position that: (a) the need for more than 4 hours of case coordination case management raises the question of whether or not Intensive Case Management would be more appropriate, and (b) financial constraints do not allow for unlimited billing for either Care Coordination or Intensive Case Management.

The Department appreciates the fact that collateral and phone contacts are very important. It is, and has been, our intent that defined case management activities provided via telephone and collateral contacts are appropriate and billable.

COMMENT: The entire concept of Care Coordination is unclear.

COMMENT: There are no service requirements for Care coordination case management.

COMMENT: We would suggest that the review period for care coordination be every 180 days and that the number of monthly contacts be one. We would also suggest that telephonic or other collateral contacts be allowed for those cases that are so far away as to preclude a face-to-face contact.

COMMENT: Rule XXVII (46.12.1923) and Rule XXXIII (46.12.1924) reference "intensive case management" and "care coordination" as two distinct services, yet no definition of these services is provided. Please explain why intensive case management services can only be provided by a licensed mental health center.

COMMENT: The definition of "practitioner" does not include certified rural health clinics or federally qualified health centers, both which currently provide case management services and/or may desire to do so in the future. We request that either RHCs and FQHCs be added to this definition or that the "primary care provider" definition in ARM 46.12.4801(18) (and referenced in proposed ARM 46.20.110) be utilized.

COMMENT: Does care coordination require that mental health center be endorsed for case management? Should care coordination providers have some minimal background?

COMMENT: The care coordination by licensed professionals is a very good idea, and may cut down on the overuse of intensive case management. It would be much more feasible to also include telephone care coordination.

COMMENT: I am pleased to see the addition of the new category of "care coordination". I would like to know who can provide that service and what is the procedure for authorization?

RESPONSE: Care Coordination case management is intended to allow for all of the case management services defined in the rule. The distinguishing factor between care coordination and intensive case management is the level of intensity. It is understood that for some care coordination clients there will often be extended periods of time during which no case management assistance is needed. The intent is that the service be available when needed and that the individual's mental health status be monitored on a regular basis. To be sure that the individual is seen regularly, the rule will be changed to specifically require a minimum of one face-to-face contact monthly. When a clinician is the care coordination case manager, the contact need not involve the provision of case management services. It should be noted that while there will be a requirement for face-to-face contact, and that although many case management services can only be done face-to-face, there is no requirement that only face-to-face services are billable.

As providers of intensive case management, licensed mental health centers must meet requirements pertaining to: supervision of staff; minimum qualifications including education, training and experience; training of supervisory and program staff; documentation of services; and policies and procedures (ARM 16.32.640). These requirements were designed specifically assure that providers of intensive case management services are qualified to effectively deliver the required services to adults with severe disabling mental illness and children and adolescents with serious emotional disturbance. RHCs and FQHCs are not required to meet the same criteria, nor are these criteria in the "primary care provider" definition in ARM 46.12.4801(18).

Care Coordination may be provided by a practitioner or by a mental health center enrolled in the Montana Medicaid program as a case management provider. Prior authorization is not required.

COMMENT: Intensive case management needs to be provided by a separate entity rather than a multi-faceted provider organization. The Department should seriously consider credentialing of case managers, requiring minimum academic preparation.

RESPONSE: Providing intensive case management to adults with severe and disabling mental illness and to children and adolescents with serious emotional disturbance requires substantial experience and knowledge regarding the target populations. The requirements for supervision and training and the minimum qualifications for hiring are established in ARM 16.32.640. Endorsement for intensive case management is contingent on meeting these requirements.

COMMENT: I propose that the rules make an exception to the partial-month reimbursement rate for people entering the community from the state hospital or residential treatment. Intense and time consuming interventions are usually required to support people who are making that kind of change.

COMMENT: Allow full month billing even if case management service initiated after 15th.

RESPONSE: Case management services should begin prior to discharge. Monthly case rate structure is designed to give providers flexibility to alter level of services according to varying individual needs.

COMMENT: The requirement for daily notes concerning participation and progress in day treatment is excessive.

RESPONSE: This item will be covered in the day treatment section.

COMMENT: In Rule XXXVI the Department's needs to make provisions for travel, long distance phone calls, faxes, and mailings.

RESPONSE: The rates established for intensive case management services are intended to cover the associated costs of providing the service. The Department has decided not to adopt this rule.

COMMENT: Reimburse case management on an hourly basis.

RESPONSE: An hourly rate offers an incentive to increase revenue by providing more service. Given the high and variable need levels of Intensive Case Management clients, limiting the amount of service is not a reasonable way to control costs. The monthly rate allows flexibility in service levels while allowing for some cost containment via limitation on caseload size.

Care Coordination will be reimbursed on the basis of 15 minute units of service. This method will allow providers to be reimbursed for the relatively small increments of time that are sometimes sufficient to provide the needed service. The 4 hour monthly cap should both allow adequate service time for this level of need and at the same time limit reimbursement costs.

COMMENT: To limit case management services to those who meet Intensive Case Management only certain diagnoses is cutting off our nose to spite our face.

COMMENT: The proposed definition for clients who would qualify for Intensive Case Management is extremely restrictive.

RESPONSE: Montana Medicaid is allowed by HCFA to reimburse for case management services through a program called Targeted Case Management under which the state must restrict the groups to which it will furnish case management. Montana has defined adults with a severe and disabling mental illness and children with a serious emotional disturbance as two of those groups. Therefore, case management must be restricted to those who meet the diagnostic and other criteria for these groups.

The Department chooses to limit case management services under the Mental Health Services Plan to these same two groups for the purposes of consistency and because of funding limitations.

COMMENT: Rule XXXII (46.12.1942) defining case management services mixes the models of strength based brokerage model and a service model. We would ask for clarity in this rule as to whether the state system is defined as a strength based brokerage model or service model.

RESPONSE: The definition of case management services was established to conform to the parameters of the federal Medicaid Targeted Case Management program. It was not specifically intended to be either a "Brokerage" or a "Strengths Based"

model.

COMMENT: The lack of financial incentive for a clinician to remain actively involved in the treatment team process once Intensive Case Management Services are opened is a primary concern.

RESPONSE: In situations where the clinician needs to provide an actual case management service, Care Coordination case management may, within the limitations imposed in the rule, be used to cover the time required to provide the service.

COMMENT: In the proposed rules, different rates and caseloads exist for adult and youth case management. There has been an assumption that youth case management is more difficult and time consuming than adult case management. I disagree with that assumption.

RESPONSE: A major reason for the differential rates and caseload sizes is the belief that the services to children and adolescents with serious emotional disturbances often involves a provider network that is more fragmented and complex. While this may not necessarily require more skill or be more difficult, it is expected to require more time to attend meetings and coordinate the various aspects of the required service delivery. Hence the lower caseload limit. Since it is assumed that the personnel and support costs for both types of case managers will be similar, the somewhat higher rate for youth case management is intended to offset the smaller caseload.

COMMENT: Definitions of case management should include crisis support.

COMMENT: The definition of assistance with daily living under intensive case management for children should be more oriented toward children issues.

RESPONSE: The rule will include crisis response as a case management service.

The examples of services in the definition of "assistance with daily living" for children and adolescents are not intended to be all inclusive. It is intended that case managers will be able to provide the needed services even though they may not always find exactly what is needed listed in the examples.

COMMENT: There should be a way to avoid having one provider bill for intensive case management while another bills for case coordination.

RESPONSE: Consideration has been given to the issue of whether or not to allow care coordination to be billed during the same month as intensive. Although there are concerns about possible

costs, allowing both services to be billed in the same month encourages private clinician participation in inter-agency service planning.

COMMENT: Requiring daily progress notes in adult day treatment simply creates excessive paperwork. The requirement is an example of micro-management. Certainly the staff could spend more time making daily notes but the Department will be paying for that rather than treatment.

RESPONSE: The Department will revise the rule to provide for less frequent documentation. The rule will be consistent with the licensure requirements in ARM 16.32.644(2)(h)(i) which requires progress notes to be entered every 30 days and upon any significant change in the client's condition.

COMMENT: Limiting child and adolescent day treatment to 20 treatment days per month ignores the licensing rules that indicate that the adolescent day treatment programs will operate at least 5 days a week. Individuals who have been psychiatrically hospitalized should have no limitations on the number of days they may participate in day treatment for the first 90 days after release from the hospital. To limit them to 15 days will also limit their community reintegration process at one of the most difficult times of their lives. The Department should change the number of billable days for adults from 15 to 20. The 15-day limit will discourage the development of evening, weekend and holiday programs for adult day treatment.

COMMENT: Setting limits on attendance time (days) is also unreasonable. Some clients need daily support and supervision. There are also the clients who go through periods of crises and need constant support in order for them not to be sent to Warm Springs.

COMMENT: In Rule XL (46.12.1473A), there needs to be up to 23 days allowed for day treatment for children and adolescents. The program staff need to be available every school day in order to be able to provide an adequate program.

RESPONSE: Limitations on the number of calendar days per month on which day treatment may be billed have been removed from both the child/adolescent and adult day treatment rules.

COMMENT: Minimum hours required in day treatment should be reduced to 2 for a half day and 4 for a full day. The ability of some children and adults to tolerate more than 2 hours in an intensely social environment is limited.

COMMENT: A large portion of our clients just need a place where they can "touch base". Requiring them to meet a time requirement is unreasonable.

RESPONSE: The required minimum hours to bill for a half day will be reduced from 3 hours to 2 hours. The full day requirement will remain at 5 hours, which the Department believes is the minimum number of hours necessary to justify a full day rate.

COMMENT: A preferred option would be reimbursement on an hourly basis.

COMMENT: Payment from the State should be in 1 hour increments, not 3 or 5-hour limitations. I need to be here all day, but some days when my illness is bothering me, I cannot stay in day treatment that long.

RESPONSE: Hourly rates would require a substantially more complicated billing and reimbursement process. They may also provide a fiscal incentive to provide more day treatment service than is clinically appropriate.

COMMENT: The definition of day treatment services does not include therapy and group which provides an incentive for providers to focus on billable hours instead of integrated service delivery. The Department should develop a bundled rate for day treatment services.

RESPONSE: Under the proposed rules and the medicaid state plan, day treatment and practitioner services (i.e., therapy) are distinct service categories. The Department understands and appreciates the concern with the maximization of billable services. The Department may in the future consider the development of a bundled definition and reimbursement structure for day treatment services. Such a service would need to be approached in a deliberative fashion with input from providers and consumers, and current time constraints do not permit such an approach for the current rule modifications.

COMMENT: The rules, as drafted, ignore the role of training professionals in community mental health settings who are on a licensure tract but need to fulfill the required hours of supervised practice before being able to sit for the licensure exam. There should be a clear statement that comprehensive mental health centers may continue to use "license eligible professionals" as long as such individuals are receiving licensed supervision and are on a licensure track leading toward a clinical license.

I suggest that rule or contract language be developed to include professionals who are on a licensure tract (sic) and masters level nurses in the reimbursement mechanism for professionals.

RESPONSE: The Department recognizes the importance of the professional training function performed by mental health centers and of the ensuing benefit to the state through the increase in the number of well-trained licensed mental health

practitioners. The failure to include provision for these individuals to deliver supervised, reimbursed services in a mental health center was an oversight. The Department has made changes to the proposed rules to allow for persons with appropriate advanced degrees pursuing licensure under the appropriate administrative rules of the licensing agency to provide supervised services within a mental health center that will be reimbursed by Medicaid or by the Mental Health Services Plan. These individuals may be employed by the centers or other providers to the extent permitted by licensure requirements and medicaid rules. However, these individuals cannot enroll as providers or bill directly for their services under practitioner categories, as this is not permitted by federal law.

COMMENT: Why is the state paying for multi-disciplinary discharge treatment planning when the centers provided this service to the state hospital for years at no cost? Payment for multidisciplinary discharge planning is unnecessary.

COMMENT: The multi-disciplinary discharge treatment planning definition needs to be clarified.

RESPONSE: The Department proposed multidisciplinary discharge treatment planning in an attempt to increase the incentive for good planning of aftercare services for people leaving state facilities and residential treatment centers. The comments indicate a lack of need to reimburse this service and it will, therefore, be deleted in the final rule.

COMMENT: The Department should add intensive case management services to the mental health center services rule.

RESPONSE: There would be no substantive difference in doing so. Intensive case management is considered as a distinct service for the purposes of these rules in order to promote clarity and understanding. This does not alter the requirement that intensive case management be provided by a licensed mental health center.

COMMENT: Mental health center case management licensure rules require treatment plan review "whenever there is a significant change" in client's condition. Should that language be incorporated into these rules?

RESPONSE: The Department has incorporated similar language in the requirements of the licensing rule apply to services provided by a mental health center rules.

COMMENT: Concern involves the lack of a proposed medicaid rule and reimbursement structure which would support continued operation of "inclusive or itinerant" day treatment.

COMMENT: I urge you to fund inclusive school based mental health programs the same way self-contained day treatment

programs are funded.

COMMENT: The state must assist the school in developing this full spectrum of services and not under-fund or structure the itinerant program so that it cannot afford to exist.

COMMENT: We ask that you draft sufficient flexibility in the rules to deliver school-based day-treatment services coupled with fair reimbursement rates, without confining students to a single classroom. Given the changes that you are proposing to the structure of the services, we stand to lose long standing programs that have allowed our students to be successful and remain in school. Treating them in their normal classroom environments is often the most effective prescription. Failure of the state to adequately support such flexible and innovative school-based programs will result in placement of more children and youth in high cost services such as hospitals, residential treatment and corrections. The current proposed rate structure coupled with the limitations imposed by the draft rules remove program flexibility and do not address the needs of many students in our schools today.

COMMENT: The proposal that allows for limited visits under case management or servicing children only in a self-contained setting will ultimately kill our program. We do not have enough students to fill a self-contained classroom and even if we did, we would try to mainstream these students as much as possible.

COMMENT: There should be a provision to allow a fair, reasonable and bundled rate for school-based mental health care that provides support to children in the mainstream educational system.

COMMENT: "Inclusive" day treatment services must continue to be available in schools, special education cooperatives and Head Start programs. DPHHS has proposed to reduce the reimbursement rates for "inclusive" day treatment services, while adequately funding only the "self contained" day treatment services.

RESPONSE: Contrary to several of the comments, the proposed rules do not require children to be in self-contained programs in order to receive mental health services in school. The proposed rules allow for reimbursement of individual and group therapy, observation and support of children in regular classrooms, family therapy and case management, in addition to self-contained day treatment. The comments on this issue have, however, helped the Department understand the value of a very intensive integrated approach to mental health services in schools. The Department will amend the rules to include "School-Based Mental Health Services" as a distinct service. The Department intends that this service will fully meet the child's needs for psychotherapy, family therapy, community based psychiatric rehabilitation and support and care coordination.

DEFINITIONS OF SEVERE DISABLING MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCE

COMMENT: The definition of severe disabling mental illness in the proposed case management and MHSP rules leaves out the reference to a 30 consecutive day hospitalization due to mental illness.

RESPONSE: The Department has re-inserted this provision consistent with the requirement under that applied under MHAP, i.e., a 30 consecutive day hospitalization at Montana State Hospital due to mental illness.

COMMENT: In the definition of adults with severe disabling mental illness the requirement that medication is necessary to control the symptoms of mental illness should be removed.

RESPONSE: This requirement appears twice in the rule language and the duplicate reference will be removed. However, the Department believes that this is an appropriate requirement and will retain it as part of the definition.

COMMENT: Rule XXXI(2)(d)(i) through (iv) (46.12.1941) defining serious emotional disturbance creates a primary/secondary distinction between emotional disturbance, developmental disabilities, substance abuse, abuse victimization, and character disorders. This requires making impossible distinctions. The exclusions at the end of the SED definition are confusing. Should refer to "primary diagnosis" rather than "primary problem".

COMMENT: A complete review of Rule XXV is imperative as some of the pertinent diagnoses were inadvertently omitted. Asperger's Disorder (299.80) and Obsessive-compulsive Disorder (300.3) should be included in the definition of serious emotional disturbance.

RESPONSE: The language regarding dually diagnosed individuals which was included in the SED definition will be omitted in the final rule. The Asperger's and Obsessive-compulsive Disorders will be added to the SED definition.

COPAYMENTS

COMMENT: ARM 46.12.204(2)(a) provides that individuals under 21 years of age are exempt from medicaid copayment.

RESPONSE: The Department has removed from the medicaid copayment rule all proposed copayments for services to individuals under age 21.

COMMENT: The Department should consider implementing a monthly maximum on copayments for clients.

COMMENT: A copayment is very difficult to collect from this population resulting in a de facto rate cut for the provider. I suggest that you reduce or eliminate the copayments for the services.

COMMENT: A copayment for day treatment services hampers the rehabilitation process. I do, however, support the charging of copayments for seeing clinical social workers, psychologists, and psychiatrists.

COMMENT: We do not want to have to pay a copay for attending day treatment. I cannot afford $1.00 a day.

COMMENT: Rules for recipient Copayments are scary. People with a level and intensity of illness that prohibits employment may not be able to pay.

COMMENT: In Rule XLI (46.12.1473A) charging a $10.00 copayment for prescriptions, along with all the other copay requirements, is unreasonable for individuals who have limited resources.

COMMENT: The copay rate for community-based psychiatric rehabilitation and support would be excessive for a family that utilizes 20 hours per month of therapeutic aide.

COMMENT: Community based psychiatric rehabilitation and support services has disproportionately high copayment (10%) compared to other services, which range from 1/2 to 3%.

RESPONSE: The copayments proposed in these ruled for medicaid services are consistent with copayments required for other medicaid services. There is an annual maximum copayment obligation for medicaid recipients.

Although the rules permit the Department to charge copayments for a variety of MHSP services, the Department will implement copayments only for pharmacy services at this time. The MHSP pharmacy benefit is an added benefit over what was previously available outside of the medicaid program, and the Department will incur significant cost in providing this benefit. The copayment serves the dual purpose of offsetting some of that cost and of serving as a disincentive for use of branded and non-preferred drugs.

For generic drugs the copayment will be only $5.00. For branded, preferred drugs the copayment will be $15.00, and for branded non-preferred drugs the copayment will be $25.00. The proposed rules have been modified to reflect this possible higher copayment. "Preferred" means that the drug's manufacturer has entered into a rebate agreement with the Department. These copayments reflect the increased cost to the Department for branded drugs and for non-preferred drugs.

The comment regarding the disproportionately high copayment for community based psychiatric rehabilitation and support services has merit, and the Department has amended the proposed rules to specify a copayment of $1.00 for that service. The comments regarding the burden of paying copayment for day treatment services also has merit, and the proposed rules have been amended to reflect no copayment for half-day day treatment service.

COMMENT: Requiring providers to develop systems and absorb the costs of collection of a copayment is an undue burden given the system as designed is contemplated to be in place for only 6 to 12 months.

RESPONSE: The copayments proposed in these rules for medicaid services are consistent with copayments required for other medicaid services and those providers have had to develop systems and absorb the cost of collection. Most providers deal with a number of different payers and have developed systems to accommodate the variety of reimbursement structures, limitations and copayments. MHSP copayments will be limited to drugs, and pharmacists have a well-developed system for managing copayments. The system being developed under the proposed rules will certainly be in effect for longer than six months and may well be in effect for longer than a year in at least some portions of the state.

COMMENT: It is unclear as to whether or not the provider retains the option of waiving the copay. Do providers have the flexibility to waive the copayments in instances when it presents a financial hardship? It is also not clear if the reimbursement for service provided by medicaid is exclusive of the copay.

RESPONSE: For medicaid services and for MHSP services reimbursement to the provider will be net of any applicable copayment. The provider is not required to collect a copayment.

ELIGIBILITY FOR MENTAL HEALTH SERVICES PROGRAM

COMMENT: We encourage the Department to make every effort to maintain services for non-medicaid people up to 150% of the poverty level and to be return it to the 200% level.

RESPONSE: The rules specify that MHSP eligibility will be limited to 150% of the Federal Poverty Level. Budget limitations preclude the Department from extending eligibility beyond that level.

COMMENT: There should be no requirement that non-medicaid eligibility requires medicaid denial.

RESPONSE: This requirement is a result of the very clearly expressed preference by legislators that the Department assure

that no one who is or could be eligible for medicaid be served under the MHSP or the non-medicaid component of any future managed care program. The federal government funds approximately 70% of the cost of medicaid services; all of the cost of MHSP services will be borne by the state.

When an applicant for MHSP services is referred to the County Office of Public Assistance and found eligible for Medicaid, that individual will then have access not just to the full range of mental health services but will also have coverage for many other health services. This should result in improved overall health care for many individuals with mental illness or emotional disturbance.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW

COMMENT: There should be provisions in the rules for certification that youth moving to out-of-home placements must exhaust community treatment resources first, requiring a signature and documentation, from a provider of intensive youth case management, that appropriate services cannot be provided in a less restrictive community placement.

COMMENT: The requirement for a certificate of need for residential treatment should include a new number (4) "Certificate of need must include documentation from a licensed provider of intensive youth case management that appropriate services cannot be provided in a less restrictive community placement."

RESPONSE: The Department believes these recommendations have merit and has modified the proposed rules to: (1) require a certificate of need for partial hospitalization, therapeutic youth group homes, and therapeutic family/foster care in addition to inpatient psychiatric services (residential treatment and freestanding psychiatric hospital); (2) require that the certificate of need be signed by an intensive case manager familiar with the recipient for whom placement is requested and certify that the individual cannot be safely and appropriately treated in a less restrictive level of care.

COMMENT: The proposed rule states the Department has the right to reconsider and deny previously authorized services. Providers will be providing services they have authorizations for in good faith and the Department can turn around and deny the services after they have been provided. This seems unfair, inefficient, and a duplication of time and energy.

RESPONSE: It is always the case for medicaid services that required prior authorization is not a guarantee of payment. In fact, payment of a claim submitted by a provider does not mean that the service was correctly billed and the payment to the provider was correct. For all medicaid services, periodic retrospective reviews are performed and may lead to the

discovery of incorrect billing. If a claim is paid and the Department later discovers that the service was incorrectly billed or the claim was erroneous in some other way, the Department is required by federal regulation governing the medicaid program to recover any overpayment which occurred. The same policies and procedures will apply to the Mental Health Services Plan.

COMMENT: Regarding Rule I (46.12.502B), it had been my understanding that prior authorization would only be required for out of home placements and acute in-patient services. How will the Department determine which services are subject to prior authorization? How will providers be notified of these requirements?

RESPONSE: At present the Department plans to require prior authorization only for out-of-home placements and partial hospitalization, but reserves the ability to require prior authorization for any mental health service provided to medicaid beneficiaries or under the MHSP. Providers will be given detailed instructions for prior authorization and continued stay certification through a variety of means, including a Mental Health Manual, provider training via interactive video, and by direct mailing.

COMMENT: Rule XVII(1) (46.12.1923) states that "prior to admission" the Department or its agent may evaluate "quality of services for each Medicaid recipient". What information will be utilized to evaluate quality prior to admission and what is the purpose in doing so?

RESPONSE: In this rule it is the evaluation of medical necessity that will be determined "prior to admission". Evaluation of the quality of services will be an ongoing activity, but obviously the evaluation of services to a particular recipient cannot be performed prior to the actual delivery of those services.

COMMENT: We all want to know who will be the "gatekeeper" responsible for authorization?

RESPONSE: The Department will contract with the Mountain Pacific Quality Health Foundation to perform all utilization management activities for mental health services described in the proposed rules.

COMMENT: The outcome data collecting instruments need to be developed by the state through the oversight committee.

COMMENT: I suggest the word "reasonable" be inserted prior to "outcome" in the first line of this sentence.

RESPONSE: The Department expects to obtain input on what would constitute useful and reasonable outcome measures from a variety

of interested persons, especially the Mental Health Oversight Advisory Council. A more specific statement would be premature at this time.

COMMENT: We would like to suggest a mental health passport provider system, set up similarly as the medical passport program (using licensed psychologists, social workers and professional counselors similar to the passport physicians), where the medicaid recipient can declare their provider, or have one randomly assigned when there is no preference. This would be the point of entry.

RESPONSE: While the recommendation is certainly worthy of further consideration, the present rule proposal deals only with an interim, fee-for-service system of delivering mental health services. The system proposed in this comment would require extensive development and a waiver of federal medicaid regulations and is outside the scope of the rules presently under consideration.

COMMENT: The recent and constant attempt to decertify children to lower levels of care is also of concern.

RESPONSE: The comment apparently refers to practices by the contractor for the Mental Health Access Plan. The proposed rules are not addressed to the MHAP contractor.

NOTICE, GRIEVANCE AND HEARING PROVISIONS

COMMENT: Regarding ARM 46.20.110(3)(b), how can a provider be denied their right to appeal an adverse Department decision? Regarding subsection (4)(c), if this rule only applies to non-Medicaid services why are "Medicaid overpayments" referenced?

COMMENT: The due process protections extended to medicaid beneficiaries should apply equally to non-medicaid beneficiaries of public mental health services in Montana.

RESPONSE: ARM 46.20.110 defines the parameters of provider participation in the Mental Health Services Plan and establishes equivalent requirements with provider participation under Medicaid. However, the MHSP is not an entitlement program for either provider or member participants. While the Department believes that it will be able to support a wide array of services to individuals under this program, actual service utilization or other factors arising following program implementation may require adjustments in, among other things, the number of providers that will be enrolled. The law does not require that an administrative hearing be provided with respect to Department determinations under the MHSP. The Department has voluntarily extended appeal rights where it believes they are necessary. However, the Department declines to adopt the same array of hearing procedures available under medicaid. Nothing in ARM 46.20.110 removes or restricts the appeal rights of

providers or recipients under the Medicaid program. ARM 46.20.110(4)(c) refers to medicaid overpayments only for purposes of adopting the medicaid procedures for addressing MHSP overpayments. Providers are accorded hearing rights regarding MHSP overpayment determinations and in other cases.

COMMENT: A grievance procedure and or full appeals process should be incorporated into the rules especially given the consequences in a retrospective review based system.

RESPONSE: The proposed rules provide for a hearing for a provider under both the medicaid program and the MHSP to challenge a Department overpayment determination. Informal processes will also be provided through the Department's contractor.

COMMENT: The Department should substantially rewrite the grievance and review rule, ARM 46.20.123, to appropriately accommodate the needs of people with mental illness as required by the American With Disabilities Act and to assure Montanans that its government and designees treats its most vulnerable citizens with patience, respect and fairness.

RESPONSE: The Department believes that the proposed rules comply with all legal requirements. The Department will comply with its legal obligations, but does not believe that it can draft hearing rules that address all of the various accommodation needs of persons with disabilities. The Department believes that the proposed rules provide appropriate procedures designed to correct mistaken or incorrect determinations, but does not believe the full blown adversarial hearing process is necessary or appropriate under this non-entitlement program.

COMMENT: The rule must conform with the requirements of 42 CFR 431.210, as well as other applicable medicaid provisions. The rules must clearly state that the right to a medicaid fair hearing is not contingent on completing any other grievance procedure.

RESPONSE: This rule does not address the medicaid fair hearing provisions, and the comments are beyond the scope of this rule. However, the Department believes that its medicaid fair hearing procedures comply with all applicable requirements. The Department does not believe that medicaid requirements preclude the use of preliminary informal processes designed to resolve disputes before they rise to the adversarial hearing level.

COMMENT: Consumers must be entitled to initiate a grievance even if they have not received written notice of denial. Any statement regarding services can be the basis for a grievance.

RESPONSE: Under the proposed rules, the Department or its designee will be required to notify consumers of denials in

writing. If a denial has in fact been made and communicated to the consumer, the Department agrees that the consumer should be able to initiate a grievance even if the denial is not issued in writing. In addition, a grievance should be available when a person is effectively denied services by a failure to make a determination. However, grievances should not be presented prematurely when the deliberative process is continuing, awaiting additional information or otherwise legitimately pending.

COMMENT: An "untimely" consumer grievance must receive the same consideration as a "timely" grievance if the consumer states that he did not receive notice of the denial or that his disability prevented him from acting promptly to preserve his rights.

RESPONSE: The Department will maintain consistent policies and procedures for appeals throughout its program. Consistency includes requirements for timeliness which the Department believes are reasonable and within the parameters established by law.

COMMENT: The Department's proposed rules for managed mental health care should clearly reference the notice and due process requirements of medicaid law.

COMMENT: The rule must require that a notice of the right to a fair hearing be provided to every consumer at the time of enrolling in the managed care system.

COMMENT: The managed care entity must provide written notice if any part of a request for service has been denied.

COMMENT: The managed care entity must complete its internal review of the grievance, issue its decision and refer any adverse decision to the Department for independent review within 20 days of the receipt of the grievance.

COMMENT: If a consumer believes that the managed care entity has failed to submit a denied grievance to the Department for review within 20 days of receipt of the grievance, the consumer or a designated representative may submit the grievance to the Department for review. The Department must issue its decision of a grievance submitted for informal review within 20 days of receipt of the grievance, unless the aggrieved consumer agrees to an extension of time.

COMMENT: The managed care entity must allow submission of a grievance orally as well as in writing and to provide every requested accommodation to help the consumer submit a grievance.

RESPONSE: The Department received numerous comments related to the need for regulation of appeal and grievance procedures of "the managed care entity". This rule does not address managed

mental health care and these comments are beyond the scope of this rule proceeding. The Department appreciates the suggestions provided, and although the Department will proceed with the development of an alternative managed care system, its immediate task is one of establishing a program of mental health service during the interim period. The proposed rule changes apply to the interim program. When necessary and appropriate, rule changes applicable to managed mental health services will be submitted for public comment.

COMMENT: The rules must provide for an expedited informal grievance review procedure.

RESPONSE: Expedited appeals and reconsideration are best addressed by the entity who is responsible for the issue under appeal. During the interim program, this would be one of the Department's agents, all of whom have incorporated a process for expedited appeal within their individual programs.

MISCELLANEOUS COMMENTS

COMMENT: I wish to comment and request changes in ARM 46.12.5007 regarding the Passport to Health program.

RESPONSE: The changes requested in the Passport to Health Program are beyond the scope of any modifications proposed in this rule amendment.

COMMENT: Elders living in nursing homes, with a mental health diagnosis, should be served in their residential setting.

RESPONSE: The proposed rules do not preclude persons residing in a long-term care facility from receiving services within the facility.

COMMENT: The term "clinical" should be eliminated from references to licensed psychologists, as it is not part of the terminology used in the psychologist licensing statutes.

RESPONSE: The Department has eliminated these references in the final rule.

COMMENT: A rule should be included in the adult case management rules providing for statewide availability of services, like the rule that appears in the youth targeted case management rules.

RESPONSE: The geographic availability rule in the youth case management rules is unnecessary and will be eliminated in the final rule. Both adult and youth case management services are available on a statewide basis to the extent of provider availability. The Department has also added language to the final rule providing that the Department can agree with a provider to designate the provider as the a sole provider of intensive case management in a geographic region and the

provider must agree to serve the entire area. The Department may need to invoke this provision in order to assure access throughout a particular geographic region.

COMMENT: How will the Department cover and reimburse service provided before July 1, 1999 but after the state re-assumed risk from Magellan?

RESPONSE: With respect to providers, recipients and members, the MHAP program remains in effect until July 1, 1999. Services coverage, eligibility, reimbursement and other MHAP issues will be addressed according to the same rules in effect as of April 30, 1999. The department has added language in the final rule to clarify this issue.

7. The rule changes will become effective on July 1, 1999 and will apply to eligibility determinations made and services provided on or after July 1, 1999.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

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

In the matter of the amendment of ARM 37.80.202 pertaining to child care assistance	))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On April 22, 1999, the Department of Public Health and Human Services published notice of the proposed amendment of the above-stated rule at page 685 of the 1999 Montana Administrative Register, issue number 8.

2. The Department has amended rule 37.80.202 as proposed.

3. No comments or testimony were received.

Dana Glenn
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

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

In the matter of the amendment of 46.12.502A, 46.12.515, 46.12.517, 46.12.541, 46.12.542, 46.12.806, 46.12.915, 46.12.1005, 46.12.1015 and 46.12.1025, pertaining to resource based relative value scale (RBRVS)	)	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On April 22, 1999, the Department of Public Health and Human Services published notice of the proposed amendment of the above-stated rules at page 800 of the 1999 Montana Administrative Register, issue number 8.

2. The Department has amended rule 46.12.541 as proposed.

3. The Department has amended the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.502A RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) through (3)(d)(ii) remain as proposed.

(4) The conversion factor used to determine the medicaid payment amount for the services covered by this rule for state fiscal year 2000 is:

(a) ~~$32.40~~ $33.60 for medical and surgical services, as specified in (2); and

(4)(b) through (7)(b)(ii) remain as proposed.

(iii) convert the average by report dollar value of a fee to an RVU value~~; or~~.

~~(c) if neither medicare nor medicaid sets RVUs, then reimbursement will be by report. For services provided on or after August 1, 1998, the "by report" rate is 55% of the provider's usual and customary charges.~~

(8) Except for physician administered drugs as provided in ARM 46.12.2003(3), ~~If~~ if neither medicare nor medicaid sets RVUs, then reimbursement is by report.

(8)(a) through (13) remain as proposed.

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

46.12.515 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REQUIRED SCREENING AND PREVENTIVE SERVICES (1) through (3) remain as proposed.

(4) The department hereby adopts and incorporates herein by reference the department's ~~EPSDT~~ provider manual~~, published~~ updated through June 1999. The ~~EPSDT~~ provider manual, ~~published~~ issued by the department ~~and sent~~ to all providers of EPSDT services, informs providers of the requirements applicable to the delivery of services ~~and specifies the methodologies and rates of reimbursement for services~~. A copy of the department's ~~EPSDT~~ provider manual is available from the Department of Public Health and Human Services, Health Policy and Services Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT, 59604-2951.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 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 (1)(c) remain as proposed.

(2) Reimbursement for outpatient chemical dependency treatment, nutrition, and private duty nursing services is specified in the department's EPSDT fee schedule. ~~EPSDT provider manual. The EPSDT provider manual, published by the department and sent to all providers of EPSDT services, informs providers of the requirements applicable to the delivery of services and specifies the methodologies and rates of reimbursement for services.~~ The department hereby adopts and incorporates herein by reference the department's fee schedule ~~EPSDT provider manual, published June~~ effective July 1, 1999 which sets forth the reimbursement rates for EPSDT services and other medicaid services. A copy of the ~~manual~~ fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) and (4) remain as proposed.

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

46.12.542 HEARING AID SERVICES, REIMBURSEMENT (1) and (1)(a) remain as proposed.

(b) the amount specified for the particular service or item in the department's ~~hearing aid~~ fee schedule ~~contained in the department's medicaid hearing aid services provider manual~~. The department hereby adopts and incorporates by reference the department's fee schedule effective July 1, 1999 which sets forth the reimbursement rates for hearing aid services and other medicaid services. ~~medicaid hearing aid services provider manual (June 1999). The manual contains requirements and instructions related to medicaid coverage and reimbursement of hearing aids.~~ A copy of the department's fee schedule ~~medicaid hearing aid services provider manual~~ may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) remains as proposed.

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

46.12.806 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, FEE SCHEDULE (1) through (2)(c)(i) remain as proposed.

(d) The department's fee schedule effective July 1, 1999 setting forth the reimbursement rates for prosthetic devices, durable medical equipment, medical supplies and other medicaid services, ~~for all oxygen and oxygen related items shall be set and maintained as follows:~~

~~(i) For all oxygen systems, portable and stationary, reimbursement will be made in accordance with the department's oxygen fee schedule dated June 1999~~, which is hereby adopted and incorporated by reference. A copy of the ~~oxygen~~ department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(e) For all diapers and diaper related supplies, the department's fee schedule shall be the diaper fee schedule dated June 1999, which the department hereby adopts and incorporates by reference. A copy of the department's June 1999 diaper fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

(2)(f) remains as proposed but is renumbered (2)(e).

(3) through (4)(b) remain as proposed.

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

46.12.915 EYEGLASSES, REIMBURSEMENT (1) through (2)(a)(i) remain as proposed.

(ii) the amount specified for the particular service or item in the department's fee schedule, ~~contained in the department's medicaid eyeglass services provider manual.~~ The department hereby adopts and incorporates by reference the department's fee schedule effective July 1, 1999 which sets forth the reimbursement rates for eyeglasses and other medicaid services. ~~medicaid eyeglass services provider manual (June 1999). The manual contains requirements and instructions related to medicaid coverage and reimbursement of contact lenses and dispensing fees.~~ A copy of the department's fee schedule ~~medicaid eyeglass services provider manual~~ may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT ~~5920~~ 59620-2951.

(2)(a)(iii) through (4) remain as proposed.

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

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT (1) through (1)(b) remain as proposed.

~~(2) The department's fee schedule for transportation is the following:~~

~~(a) personal or non commercial ground vehicle mileage current rate for state employees for the first 500 miles traveled in a month and $.15 per mile for miles traveled in excess of 500 miles in a month;~~

~~(b) regularly scheduled air, train, bus or air charter usual fee or rate negotiated with the department;~~

~~(c) commercial ground transportation, including taxi and limousine service for trips up to 16 miles total usual fee not to exceed a total of $10.47 for a one way trip;~~

~~(d) commercial ground transportation, including taxi and limousine service for trips exceeding 16 miles $.66 per mile that a person is a passenger.~~

(2) The department hereby adopts and incorporates by reference the department's fee schedule effective July 1, 1999 which sets forth the reimbursement rates for transportation, per diem and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(3) The department fee schedule for per diem items is the following:~~

~~(a) breakfast (12:01 a.m. to 10:00 a.m.) . $2.75~~
~~(b) lunch (10:01 a.m. to 3:00 p.m.) ..... $3.30~~
~~(c) dinner (3:01 p.m. to 12:00 a.m.) ..... $6.60~~
~~(d) per diem, including lodging ..... $22.44~~

(4) and (5) remain as proposed but are renumbered (3) and (4).

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

46.12.1015 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT (1) The department pays the lower of the following for specialized nonemergency medical transportation services:

(a) the provider's usual and customary charge ~~actual submitted charge for the service not to exceed the rate approved by the public service commission~~; or

(b) the department's fee schedule ~~contained in this rule~~.

~~(2) The department's fee schedule for specialized nonemergency medical transportation is the following:~~

~~(a) Transportation under 16 miles.....$10.47 one way~~
~~(b) Transportation over 16 miles.....$ .66 per mile~~
~~(c) Waiting time for transportation over 16 miles.....$ 5.24 per hour Computed in 15 minute increments or fraction thereof~~

~~(d) Waiting time for under 16 miles.....No payment~~
~~(e) When one way transportation is over 16 miles and the unloaded miles exceed ten percent of the loaded miles, the miles from the departure point to the pick up point plus the miles from the delivery point to the departure point shall be paid for at the rate of.....$ .33 per mile~~

(2) The department hereby adopts and incorporates by reference the department's fee schedule effective July 1, 1999 which sets forth the reimbursement rates for specialized nonemergency medical transportation services and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

46.12.1025 AMBULANCE SERVICES, REIMBURSEMENT (1) Except as provided in ~~(9)~~ (3), the department pays the lowest of the following for ambulance services:

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

(b) the amount allowable for the same service under medicare; or

(c) the amount listed in the department's ~~fees as provided in this section~~ fee schedule.

~~(2) The fees for ancillary ambulance services are the fees provided for in ARM 46.12.806.~~

~~(a) Ancillary ambulance services are those items of durable medical equipment and medical supplies as defined in ARM 46.12.801.~~

(2) The department hereby adopts and incorporates by reference the department's fee schedule effective July 1, 1999 which sets forth the reimbursement rates for ambulance services and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) remains as proposed.

~~(4) The fees for basic life support and advanced life support ambulance services are 90% of the average of all the provider charges submitted to the department for the particular service in fiscal year 1990.~~

~~(a) The fee is adjusted as necessary so that the fees in the aggregate are in accord with adjustments authorized for the particular fiscal year by the legislative appropriation process for that fiscal year.~~

~~(b) The department shall adjust the fee schedule to implement increases or decreases in reimbursement authorized or~~

~~directed by enactment of the legislature.~~

~~(5) The department's fees for ground and air transportation ambulance services mileage are those fees the department determines are authorized for the services in the particular fiscal year by the legislative appropriation process for that fiscal year.~~

~~(6) Except as provided in (9), current fees for ambulance services are published by the department in the June 1999 medicaid ambulance services provider manual, which the department hereby adopts and incorporates by reference. A copy of the department's June 1999 medicaid ambulance services provider manual may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(7) Except as provided in (9), providers must bill for services using procedure codes set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS).~~

~~(8) Copies of the pricing manual, billing codes and HCPCS may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

(9) remains as proposed but is renumbered (4).

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

4. The department has elected to make the following changes to the proposed rules:

46.12.502A

A final State budget enacted by the 1999 legislature and signed into law by the Governor May 10, 1999 allowed the Department to compute the final rate for medical and surgical services. As a result, the proposed rate of $32.40 in subsection (4) was increased to $33.60.

The Department found that the provisions in subsection (7)(c) were an unnecessary duplication of the provisions in subsection (8) and deleted subsection (7)(c).

The Department added language in subsection (8) to make it clear to providers that this subsection was not intended to apply to physician-administered drugs. In order to aid providers in identifying the correct rule, the new language in this subsection includes a reference to ARM 46.12.2003(3), which governs physician-administered drugs.

46.12.515

In subsection (4), the Department deleted references to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) provider manual. This is consistent with the Health

Policy and Services Division's policy of removing fees from its provider manuals and publishing separate fee schedules. The Department intends that this policy will reduce waste, because the entire provider manual would not have to be reprinted each time fees are updated. Compared with the alternative, retaining the fees in a provider manual, a separate fee schedule would allow the Department to update medicaid fee schedule more easily and cost effectively. This would improve the department's ability to timely respond to changing conditions in the health care industry.

A copy of the proposed July, 1999 fee schedule was made available to providers at the time of the public hearing. Furthermore, by applying the proposed changes published in the notice of proposed rulemaking to the existing fees, providers could calculate the proposed fee schedule without contacting the Department.

46.12.542

The Department deleted references to the hearing aid services provider manual and substituted references to the Department's fee schedule. This change is consistent with the policy described in the explanation of the Department's changes to ARM 46.12.515. For a full explanation of the considerations and alternatives, please see the explanation of the Department's changes to that rule.

46.12.806

The Department deleted references to the oxygen systems provider manual and substituted references to the Department's fee schedule in subsection (2)(d). This change is consistent with the policy described in the explanation of the Department's changes to ARM 46.12.515. For a full explanation of the considerations and alternatives, please see the explanation of the Department's changes to that rule.

The Department incorporated diaper and diaper-related supplies in its fee schedule and deleted the separate subsection (2)(e) of this rule setting fees for diapers and diaper-related supplies.

46.12.915

The Department deleted references to the medicaid eyeglass services provider manual and substituted references to the Department's fee schedule in subsection (2)(a)(ii). This change is consistent with the policy described in the explanation of the Department's changes to ARM 46.12.515. For a full explanation of the considerations and alternatives, please see the explanation of the Department's changes to that rule.

46.12.1005

The Department deleted the transportation fee schedule in subsection (2) and the per diem reimbursement schedule in subsection (3). It adopted the Department's fee schedule by reference in subsection (1)(b). This change is consistent with the policy described in the explanation of the Department's changes to ARM 46.12.515, and will give providers a single fee schedule for all medicaid charges. This should simplify billing procedures and result in lower administrative costs for providers. Compared with the alternative, publishing the fees in a provider manual, a separate fee schedule would allow the Department to update medicaid fees as easily as retaining them in the text of the rule. This would improve the Department's ability to timely respond to changing conditions in the health care industry.

46.12.1015

The Department deleted the specialized non-emergency transportation fee schedule in subsection (2) and adopted the Department's fee schedule by reference in subsection (1)(b). This change is consistent with the policy described in the explanation of the department's changes to ARM 46.12.1005. For a full explanation of the considerations and alternatives, please see the explanation of the Department's changes to that rule.

46.12.1025

The Department clarified subsection (1) to provide that the basis for setting ambulance services would be the lower of the provider's usual and customary charge or the rate set in the Department's fee schedule. It will no longer be necessary for providers to report actual costs. This should simplify billing procedures and result in lower administrative costs for providers.

The Department deleted subsections (2) and (4) through (8). It substituted references to the Department's fee schedule in subsection (1)(b). This change is consistent with the policy described in the explanation of the Department's changes to ARM 46.12.515. For a full explanation of the considerations and alternatives, please see the explanation of the Department's changes to that rule.

Subsections (3) and (9) were renumbered, but were otherwise unchanged.

5. No comments or testimony were received.

6. The rules changes will become effective July 1, 1999.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

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

In the matter of the amendment of ARM 46.12.503, 46.12.505 and 46.12.509 pertaining to inpatient hospitals	)))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On April 22, 1999, the Department of Public Health and Human Services published notice of the proposed amendment of the above-stated rules at page 690 of the 1999 Montana Administrative Register, issue number 8.

2. The Department has amended rules 46.12.503 and 46.12.509 as proposed.

3. The Department has amended the following rule as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

(1) through (2)(b) remain as proposed.

(c) The department computes a Montana average base price per case. This average base price per case is ~~$2,298.00~~ 2,075.00, effective for services provided on or after July 1, 1999.

(2)(d) through (4)(a)(i) remain as proposed.

(ii) All out-of-state hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case is ~~$213.69~~ 222.83. Such rate shall be the final capital-related cost reimbursement for facilities' cost reporting periods with respect to which the department waives retrospective cost settlement in accordance with these rules.

(4)(a)(iii) through (7)(a) remain as proposed.

(b) ~~A written request for catastrophic case reimbursement must be mailed or delivered to~~ The department will identify catastrophic cases and notify the provider that additional reimbursement may be available upon medical review. The provider must submit to the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951~~,~~ the following: ~~The request must include:~~

(i) a copy of the claim and remittance advice identifying the DRG reimbursement paid for the same case; and

(ii) a copy of the patient's medical records, including but not limited to admission summary notes, physician orders,

progress notes and discharge summary notes, necessary to document the medical necessity of the length and cost of the inpatient hospital stay. The medical necessity of the days and services of the inpatient hospital stay may be reviewed by the department or its designated agent prior to payment of the catastrophic case.

(7)(c) through (9) remain as proposed.

(a) A transferring hospital reimbursed under the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for each subsequent day ~~for each day~~ of inpatient care determined by dividing the sum of the DRG payment for the case as computed in (2) and the appropriate outlier as computed in (6), if any, by the statewide average length of stay for the DRG; or

(9)(a)(ii) through (11)(b)(iii) remain as proposed.

(12) The medicaid statewide average cost to charge ratio equals ~~67%~~ 61%.

(13) through (16) remain as proposed.

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

4. The Department, in considering the comments received, has elected to do the following:

A final State budget enacted by the 1999 legislature and signed into law by the Governor May 10, 1999 allowed the department to compute the final rates for inpatient hospital services. As a result, the proposed average base price per case of $2,298.00, which included a capital cost component was reduced to $2,075.00, not including capital costs. The proposed statewide average capital cost per case under the reimbursement rate for out-of-state hospitals under the DRG prospective payment system was increased from the proposed $213.69 to $222.83. The proposed statewide average cost to charge ratio was reduced from 67%, which included capital costs to 61%, not including capital costs. These changes were necessary to accommodate the decision to delay prospective payments for capital costs and to allow anticipated expenditures to match the final State budget.

The Department will assess hospitals with the percent of Medicaid births at 55% or greater for additional compensation pending approval from the Health Care Financing Administration Regional Office.

The Department will also assess transportation options for high risk pregnancy cases and neonatal cases.

The Department, through its contractor, will evaluate the types of in-patient cases receiving out-of-state care. It is the Department's intention to devote its limited resources to

Montana hospitals, whenever possible.

Additionally, the Department has left the weight for normal newborn as provided in the current rule.

5. The Department has thoroughly considered all commentary received. The comments received and the department's response to each follow:

COMMENT #1: One Commentor expressed concerns about the long delay between submitting cost reports and getting settlements. The proposed rebase of the inpatient diagnosis related groups (DRG) prospective payment system is based on settlement reports for 1994. The Commentor suggested an interim settlement process to improve the quality of the base cost data.

RESPONSE: The Department acknowledges the Commentor's concerns regarding the data used for rebasing. The Department declines to adopt the Commentor's recommendation. The Department must rely on Medicare's settled cost reports and therefore, the Department has no control over Medicare's work load and Medicare's ability to produce settled cost reports. The Department is currently seeking additional avenues for accessibility to information.

COMMENT #2: One Commentor objected to the inclusion of capital costs (prospective capital payment) in the base, since the Department was relying on 1994 data to project costs for rate years 2000 through 2001. The Commentor recommended delaying adoption of prospective payments for capital expenses until the accuracy of the data is better known.

RESPONSE: The Department concurs with the Commentor's suggestion, and will delay adoption of prospective payments for capital costs. The Department will secure a process for evaluating current capital expense data. It is the Department's intention to implement a prospective payment for capital expenses in a future rule change.

COMMENT #3: One Commentor recommended modification of the payment methodology for transfer cases to provide for two times the average per diem payment amount for the first inpatient day provided to the transferring hospital, plus one per diem payment for each subsequent day up to the full DRG amount (including any qualifying cost outlier amount). The Commentor pointed out that the first few days of inpatient stay typically account for most of the hospital resources provided to patients. A transferring hospital would not have an opportunity to average these costs over the full period of the inpatient stay.

RESPONSE: The Department concurs with the recommendation for transfer cases, and has changed the rule accordingly.

COMMENT #4: One Commentor requested that the Department

develop an automated means of identifying payments for catastrophic cases.

RESPONSE: The Department concurs with the Commentor's recommendation that it develop an automated method for identifying payments for catastrophic cases. Consequently, the former requirement that a written request for reimbursement be initiated by the provider has been deleted from the rule. The new rule requires the Department to monitor catastrophic cases and notify the provider.

COMMENT #5: One Commentor recommended that the Department adopt a medical case management policy for catastrophic cases. The Commentor suggested medical case management would lead to substantial cost savings to the medicaid program.

RESPONSE: The Department concurs with the Commentor's recommendation regarding medical case management of catastrophic cases and will utilize our existing capabilities with a contractor to render medical case management and oversight in those cases.

COMMENT #6: One Commentor questioned whether the Department's automated claims processing system was correctly applying the stop/loss pricing methodology for inpatient hospital services.

RESPONSE: The Department has reviewed the pricing module of its automated claims processing system and determined that the stop/loss pricing methodology is functioning correctly.

COMMENT #7: One Commentor asked for assurances from the Department that Shodair Hospital and Children's Comprehensive Services and other free standing children's treatment facilities delivering inpatient acute care would be paid using the proposed diagnosis related groups (DRG) rule.

RESPONSE: The Department assures the Commentor that Shodair Hospital and Children's Comprehensive Services and other free standing children's treatment facilities delivering inpatient acute care will be paid according to the proposed DRG rule.

COMMENT #8: One Commentor requested that the Medicare Grouper be updated and kept current.

RESPONSE: The Department agrees that the Medicare Grouper should be updated and kept current and will assess the possibility of annual updates.

COMMENT #9: One Commentor stated that the present inpatient DRG reimbursement methodology for high risk obstetrical cases is woefully inadequate. The Commentor pointed out that such cases require extensive resource consumption,

whether services are provided on an inpatient or outpatient basis. The Commentor requested Medicaid reimbursement on a cost basis.

RESPONSE: The Department is unable to respond to the suggestion during this rulemaking because it does not have sufficient data to project budget considerations for high risk obstetrical cases. However, the Department is willing to gather information about the cost of delivering such services and the current rate of reimbursement. The Department is committed to healthy pregnancy outcomes and is willing to work with the specific hospitals rendering specialized care during high risk pregnancies.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

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

In the matter of the adoption of Rules I through IV and the amendment of rules 46.12.1222, 46.12.1223, 46.12.1228, 46.12.1229, 46.12.1231, 46.12.1232, 46.12.1237, 46.12.1243, 46.12.1245, 46.12.1258 and 46.12.1268 pertaining to nursing facilities	)))))))))))	NOTICE OF ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On April 22, 1999, the Department of Public Health and Human Services published notice of the proposed adoption and amendment of the above-stated rules at page 696 of the 1999 Montana Administrative Register, issue number 8.

2. The Department has adopted the rules III (46.12.1266) and IV (46.12.1267), and amended 46.12.1223, 46.12.1237, 46.12.1258 and 46.12.1268 as proposed.

3. The Department has adopted the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

RULE I (46.12.1233) MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION (1) through (5) remain as proposed.

(6) For purposes of calculating shadow rates, ~~T~~the department will use the RUG-III, 34 category, index maximizer model, version 5.12, ~~to adjust direct nursing costs in the determination of limits and in the rate calculation.~~ The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating shadow rates, ~~c~~case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific case mix ~~and publish it prior to July 1, 1999,~~ utilizing average nursing times from the 1991, 1995 and the 1997 HCFA case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information. ~~The rates will be adjusted using a Montana specific resident case mix distribution.~~

(8) For purposes of calculating shadow rates, ~~T~~the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the

first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a medicaid average case mix index, carried to four decimal places, based on all residents for whom medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment. ~~Any current assessment in the database older than 110 days will be included in the calculation of the averages using the case mix index established in ARM 46.12.1232(4).~~

(9) Facilities will be required to comply with the data submission requirements specified in this rule and ARM 46.12.1234 during the rate year beginning July 1, 1999 for the development of a case mix reimbursement system. The department will utilize case mix data in the computation of quarterly shadow rates for the period July 1, 1999 through June 30, 2000. The department will compute shadow rates in order to determine what each nursing facility's rate would be established at if it was computed utilizing a facility wide case mix, a medicaid case mix index, or any other case mix methodology, as determined appropriate by the department. The shadow rates will be established for comparative purposes only. Facilities will be able to analyze this rate information during this time period in order to become more educated in its use as a reimbursement component for the transition to a case mix reimbursement methodology on July 1, 2000 or subsequent rule years.

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 II (46.12.1234) CORRECTION OF ERRONEOUS OR MISSING DATA (1) The department will prepare and distribute resident listings to facilities on the first Friday of the second month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the first day of the second month of each quarter as reflected in the database maintained by the department. The listings will identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source as reflected on the ~~prior~~ most recent full assessment as of the cut off date. Resident listings will be reviewed for completeness and accuracy. Resident listings shall be signed and returned to the department by the first Friday of the third month of the quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) through (2)(c) remain as proposed.

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

4. The Department has amended the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.1222 DEFINITIONS Unless the context requires otherwise, in this subchapter the following definitions apply:

(1) "Abstracts" mean patient assessment abstracts submitted by providers to the department in accordance with the rules in effect for state fiscal year 1999.

(1) remains as proposed but is renumbered (2).

~~(2)~~ (3) "Case mix index (CMI)" means an assigned weight or numeric score assigned to each RUG-III grouping which reflects the relative resources predicted to provide care to ~~medicaid~~ nursing facility residents.

(3) through (21) remain as proposed but are renumbered (4) through (22).

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

46.12.1228 RATE EFFECTIVE DATES (1) through (1)(b) remain as proposed.

(c) The median operating costs ~~cost limit~~ under ARM 46.12.1229 and the statewide median average wage ~~median direct nursing personnel cost limit~~ under ARM 46.12.1231 used to establish rates for a rate year will be redetermined only as required to set new rates for all providers for a subsequent rate year based upon adoption of further rules or amendments to these rules providing specifically for a rate methodology for a new or a subsequent rate year.

(2) through (2)(b)(ii) remain as proposed.

(c) the effective date of a change in the provider's direct nursing personnel cost component; ~~limit;~~

(i) as specified in the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period direct nursing personnel costs used by the department to calculate the provider's direct nursing personnel cost component; ~~per diem component;~~ or

(2)(c)(ii) remain as proposed.

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

46.12.1229 OPERATING COST COMPONENT (1) through (2)(b) remain as proposed.

(c) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. For the period July 1, 1999 through December 31, 1999, operating costs will be indexed at 75% of the DRI rate of inflation in order to offset the additional funding for the direct care wage add-on as provided in ARM 46.12.1267 which is outside the per diem rate

calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 46.12.1228.

(d) "Median operating costs" means the median amount calculated by arraying the inflated per diem base period operating cost of each provider from low to high, together with the number of licensed beds ~~occupied resident days~~ for the provider during the base period and determining the median so that one-half of the licensed beds ~~occupied resident days~~ in the array have per diem costs less than or equal to the median and one-half of the licensed beds ~~occupied resident days~~ in the array have per diem costs greater than or equal to the median.

(2)(d)(i) through (3)(a) remain as proposed.

(4) The operating cost limit is ~~100%~~ 99% of ~~the day weighted of~~ median operating costs.

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

(5)(a) remains the same.

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

46.12.1231 DIRECT NURSING PERSONNEL COST COMPONENT (1) through (2)(a)(i) remain as proposed.

~~(b) "Per diem nursing personnel costs" means the provider's total direct nursing personnel costs divided by the number of provider's patient days for the base period.~~

(b) "Composite nursing wage rate" means the total base period direct nursing personnel cost divided by the product of the provider's fiscal year 1999 average patient assessment score and the provider's patient days for the base period.

(i) For purposes of calculating the composite nursing wage rate, the provider's base period average patient assessment score is the fiscal year 1999 average patient assessment score that was previously determined by the department in accordance with rules in effect for that period.

(2)(c) through (2)(d) remain as proposed.

(e) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. Direct nursing costs will not be indexed by the DRI rate of inflation for the period July 1, 1999 through December 31, 1999 to offset the additional funding for the direct care wage add-on as provided in ARM 46.12.1267 which is outside the per diem rate calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set,

such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 46.12.1228.

~~(f) "Statewide median case mix adjusted direct nursing personnel cost" means the amount calculated by arraying the inflated base period normalized direct nursing personnel cost, for each provider from low to high, together with the number of occupied resident days for the provider during the base period and determining the median so that one-half of the occupied resident days in the array have average direct nursing personnel cost less than or equal to the median and one half of the occupied resident days occupied in the array have average direct nursing personnel cost greater than or equal to the median. Normalized direct nursing personnel costs are calculated by dividing each nursing facility's direct nursing personnel costs by the quotient resulting from dividing the facility's average medicaid case mix index by the medicaid day weighted average medicaid case mix for all facilities. The medicaid average case mix index is determined by taking a simple average of the quarterly medicaid average case mix indices established in ARM 46.12.1232(8) as of May 1, 1999.~~

(f) "Statewide median average wage" means the amount calculated by arraying the inflated base period average wage rate for each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have average wage rates less than or equal to the median and one-half of the licensed beds in the array have average wage rates greater than or equal to the median.

~~(3) The facility case mix upper limit for direct nursing personnel is computed by dividing the facility specific medicaid CMI, computed from the medicaid case mix determined from the second quarter of the calendar year as established in [Rule II], by the medicaid day weighted average medicaid CMI for all facilities and multiplying that product by the statewide case mix adjusted nursing personnel cost upper limit to determine each facility's upper limit on direct nursing personnel.~~

(3) The provider's direct nursing personnel cost component is the lesser of the provider's inflated base period composite nursing wage rate multiplied by the provider's fiscal year 1999 average patient assessment score or the direct nursing personnel cost limit calculated in accordance with (4).

(4) The direct nursing personnel cost limit is ~~101%~~ 99% of the statewide median average ~~median case mix adjusted direct nursing personnel cost as computed in (2)(f) above~~ wage, multiplied by the provider's ~~most recent~~ 1999 average patient assessment score, determined in accordance with the rules in effect for that period.

~~(5) The facility direct nursing personnel component will be the lower of the facility's inflated direct nursing personnel cost pr day or the medicaid case mix adjusted limit as computed in (3).~~

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

46.12.1232 PATIENT ASSESSMENT, STAFFING AND REPORTING (1) For purposes of determining rate year 2000 rates, the provider's average patient assessment score will be the patient assessment score that was established for fiscal year 1999 rate setting proposes in accordance with the rules in effect during that period.

~~(1)~~ (2) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate form DPHHS-~~MA~~SLTC-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-~~MA~~SLTC-015 may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(b) remains as proposed.

AUTH: Sec. 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-108, 53-6-111 and 53-6-113, MCA,

46.12.1243 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) through (2)(d)(iii) remain as proposed.

(iv) the new provider's interim rate shall be set as follows:

(A) if the previous provider's rate was less than or equal to the bed-weighted ~~day weighted~~ median rate for all facilities for the current year, then the new provider's interim rate shall be the lesser of:

(I) the previous provider's rate adjusted by an amount, if any, determined in accordance with (2)(d)(i) through (iii); or

(II) the bed-weighted ~~day weighted~~ median rate for all facilities for the current year.

(B) if the previous provider's rate was greater than the bed-weighted ~~day weighted~~ median rate for all providers for the current year, then the new provider's interim rate shall be the previous provider's rate.

(2)(e) remains as proposed.

(3) For purposes of calculating a per diem rate as provided in (2)(e), the following shall apply with respect to patient assessment scores ~~medicaid CMI scores~~ used to calculate the direct nursing personnel cost component:

(a) For providers who have received an interim rate under the provisions of this section based upon a change in provider, the provider's direct nursing personnel cost component shall be calculated based upon the fiscal year 1999 average patient assessment ~~medicaid CMI~~ score for the previous provider, as though no change in provider had occurred.

(b) For providers who have received an interim rate under the provisions of this section based upon provision of services in a new facility or as a new provider, the provider's direct nursing personnel cost component shall be calculated based upon the fiscal year 1999 state wide average patient assessment score. ~~a medicaid CMI determined as follows:~~

~~(i) A medicaid average computed in accordance with [Rule I] for the first quarter of participation in the medicaid program. If no medicaid average CMI information is available for the first quarter of participation the provider's nursing personnel cost component will be the statewide average medicaid CMI for all providers.~~

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

46.12.1245 SEPARATELY BILLABLE ITEMS (1) through (2)(b) remain as proposed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current patient assessment score ~~average medicaid CMI used for rate setting (determined under ARM 46.12.1232 [Rule I])~~ from the average itemized hours of licensed and non-licensed nursing hours per day ~~CMI computed~~ for the ventilator dependent resident, determined based upon the facility's time records of nursing services for the 5-day period submitted in accordance with (2)(b), to determine the extraordinary nursing hours for the resident. ~~current MDS information for the resident in order to determine the difference in case mix for this resident from the average case mix for all medicaid residents in the facility.~~ The increment shall be determined by the department by multiplying the number of extraordinary nursing hours per day by an hourly nursing rate determined by the department ~~provider's direct nursing personnel cost component by the ratio of the resident's CMI to the facility's average medicaid CMI to compute an adjusted nursing personnel component~~ for the resident. The department shall determine the hourly nursing rate for the resident based upon the facility's inflated base period composite nursing wage rate determined for the rate year according to ARM 46.12.1231(2)(b) and the mix of licensed and non-licensed nursing staff used to provide the extraordinary nursing hours for the resident. The department will determine the increment for each resident monthly.

(3) through (10) remain as proposed.

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

5. The Department has thoroughly considered all commentary received. The comments received and the department's response to each follow:

COMMENT #1: Many comments were received in support of the elimination of the patient abstract system and the replacement

of this system with a case mix index based upon minimum data set (MDS) information. These commentors believe that the case mix index from the MDS is a better indicator of the acuity of the residents in their facility. Several comments were received in support of the department's proposed reimbursement rules for nursing facilities for fiscal year 2000 using the medicaid case mix index (CMI). Commentors believe that this proposed system will create more reimbursement equalities, by the use of facility specific data from the most recent Medicaid cost reports and the development of a case mix index.

RESPONSE: The department proposed a modification of the current formula methodology to incorporate minimum data set information for reimbursement purposes. The proposed case mix calculation was the result of the elimination of the patient assessment abstract submission requirements which is in keeping with the department's commitment to eliminate duplicative reporting requirements between the abstracts and the minimum data set. The department discontinued these submission requirements in October of 1998 for patient assessment abstracts. The department issued a request for proposal (RFP) for the development of a case mix reimbursement tool using the MDS and established a nursing facility work group which met through the fall and the winter to evaluate case mix adjustments to the reimbursement methodology. The work group felt that recognition of acuity levels in nursing facilities had value and should continue to be recognized in a medicaid reimbursement methodology. The medicaid case mix index methodology was proposed in the first notice of the rule because this model most closely represented how the acuity information was utilized in the previous methodology for establishing the nursing component and is representative of the medicaid population's acuity levels which the department is trying to recognize under a medicaid system of reimbursement.

Based upon comments and resident roster data from all nursing facilities, the department believes that variations in the reliability of medicaid case mix information make that information inaccurate for the establishment of payment rates on July 1, 1999. The resident rosters indicate that many of the medicaid residents needed to be identified and moved to the correct payor classification in order for the medicaid CMI to be accurate for rate setting. There are many reasons that these residents would not be in the correct payor classification, and the only place that the payor classification information is available is from a full assessment or a significant change assessment. The incorporation of this roster information on an ongoing basis will be necessary for the medicaid CMI to be used for payment purposes. Because the data is somewhat unreliable and there is some uncertainty concerning the medicaid case mix information the department will not adopt the rule as first proposed with the medicaid CMI as a component for reimbursement.

Another option that the department considered was the use of the

facility CMI information in the calculation of the direct nursing limit for payment rates on July 1. The calculation is similar to the medicaid CMI formula that was proposed in the first notice, but is not as variable because getting the data into the correct payor classification is not necessary for this model to work. Some facilities found, however, that they did not have all of their residents captured in the HCFA download of MDS information when they reviewed their resident rosters, or that they had unclassifiable MDS's due to transmission problems. Some providers have vendor software problems that they were unaware of and some had incomplete quarterlies because they were submitting the two page rather than the three page quarterly information. The department considered comments received from providers and association representatives, and consulted with contractors concerning the best approach for an acuity measure to utilize on July 1. Based upon the variability in the MDS data, the lack of understanding by the provider community about how this data will be used and a lack of confidence in the provider community that the medicaid CMI or the facility wide CMI data is accurate and reliable for establishment of rates on July 1, the department decided to delay the transition to an MDS acuity adjustment component in the reimbursement methodology for one year.

The rates that will be established on July 1, 1999 for fiscal year 2000 rate setting, will be computed from the six month average patient assessment score that is available and was utilized for fiscal year 1999 rate setting. The department notified all providers when it discontinued the PAS abstract submission requirements that if a case mix methodology was not adopted for fiscal year 2000, that the patient assessment abstract information from fiscal year 1999 would be utilized for rate setting purposes.

While many people supported the proposed transition to a MDS driven acuity measure on July 1, 1999, the department believes that this delay is prudent. At the time of the filing of the second notice for these rule changes, there existed a great deal of uncertainty concerning the validity of the MDS information, and the amount of correction that remains to be done to assure that this acuity data is accurate for rate setting purposes. During the next fiscal year the department will compute quarterly "shadow rates" utilizing medicaid CMI and facility CMI information and will provide this information to providers for validation purposes and to increase understanding of the methodology changes that will be proposed for fiscal year 2001 rate setting. This will allow all providers time to make sure that they are complying with the MDS data submission requirements to the HCFA data base, to work on and resolve vendor software issues, and to familiarize themselves and feel comfortable with the case mix weight calculation process. The resident roster information will be provided on a quarterly basis and will be verified in order to insure that the payor information is accurate prior to the issuance of quarterly

"shadow rates" for comparison purposes. The department will move forward with a case mix adjustment to the reimbursement system during the next fiscal year. The department will use the information that has been gathered during the "shadow rate" computation process and other input that the department solicits from providers in refining a case mix adjustment component for nursing facility reimbursement.

COMMENT #2: Several comments were received in support of rebasing the system of reimbursement using more recent 1998 cost report information. Other commentors believe that there is simply not enough funding provided by the legislature to make rebasing meaningful and that until there is adequate funding the department should not rebase.

RESPONSE: The department agrees that periodic rebasing is desirable to assure that current cost data is sufficiently represented in the system of reimbursement, but also believes that other variables in the rate methodology must be adjusted as a part of and incident to a rebasing to more current cost information. Along with rebasing goes the reestablishment of median costs in the nursing and operating components and the adjustment of the percentage caps on these medians in order to distribute the funding through the reimbursement system. The department has made some modifications to the reimbursement methodology as proposed but has agreed to rebase using fiscal year 1998 cost report information as originally noticed. The department feels that it is important to rebase, even though it is delaying the adoption of the case mix component for July 1, 1999 rate setting and the funding level appropriated for provider rate increases is one percent. Rebasing this year will allow the department to isolate the impact of recognizing more current costs in the system of reimbursement separately from the changes that are occurring in reimbursement due to the movement to a case mix reimbursement system. Providers will be able to see that variability in the rates occurs even without an acuity change because of the impact of rebasing, application of inflation rates, and distribution of the one percent provider rate increase, all of which are factors in the computation of the medians for the rate components. These factors also determine where the percentage caps on the medians must be established to distribute the funding in the most equitable manner while staying within legislatively mandated funding levels.

COMMENT #3: Comments were received concerning the impact that the proposed nursing facility payment rates would have on some of the small rural nursing facilities in the state. Some individuals believe that the proposed payment rates may result in facility closures and movement of residents to distant nursing facilities which have long waiting lists for admission. Commentors are concerned that the department did not consider the impact to rural communities when it proposed payment levels for nursing facilities.

RESPONSE: The department understands the impact that funding levels and medicaid nursing facility reimbursement rates have on the nursing facilities and the communities in which they operate. There are many sizes and types of facilities, with different operational structures and approaches to doing business. While the department is aware of these differences, they are not the department's only consideration when allocating a set amount of Medicaid nursing facility funding to 98 nursing facilities in the state. The payment methodology takes into account, and must consider, many different values in the establishment of payment rates for nursing facilities. The department cannot exceed the legislatively mandated level of funding, and must balance the many different values in the reimbursement methodology, in order to establish payment rates that are fair and equitable for all of the providers participating in the medicaid nursing facility program.

The department is very concerned about access to services for the elderly and disabled in their home communities, and consequently, in the maintenance of rural facilities in Montana. There are many reasons nursing facilities may find themselves wondering if they are going to be able to continue to operate as they have in the past. Nursing facility occupancy is dropping statewide due to the development of optional community-based services such as assisted living and personal care, which are in many cases lower in cost and offer less restrictive environments. Funding levels are not keeping pace with cost increases in these facilities, especially if facilities are trying to spread costs over fewer days due to decreasing occupancy. Medicare has changed to a prospective payment methodology, that in many cases, results in a lower payment amount than in the past. As a result, Medicare is no longer a source of additional funds that facilities can draw from to cover funding shortfalls. Due to the availability of optional services, many facilities cannot or are reluctant to cover shortfalls by shifting costs to private payers by raising private pay rates as they may have done in the past.

The department continues to believe that it should not make distinctions between the types of providers when it establishes reimbursement levels. All facilities must meet the requirements for provision of long term care services to receive reimbursement in the medicaid program. The department believes that the rate system does provide a reasonable degree of freedom for all provider types to participate in the system. The department's analysis shows a great variety in the types and sizes of facilities that receive incentives and that receive rates equaling or exceeding their costs.

The department is confident that the proposed changes for fiscal year 2000 will allow providers sufficient time to understand and adjust to future changes that will occur in the medicaid payment system based upon acuity. The "shadow rate" period will provide the necessary time for managers to plan for their

facilities' future and to assure their ongoing viability.

COMMENT #4: Numerous commentors suggested that the department delay implementation of the proposed changes to the nursing facility rules. As an alternative, they suggest a continuation of the current system with the addition of a one percent provider rate increase, while the department takes the next 12 months to evaluate and confirm that the data systems are accurate and that the case mix methodology, critical to the reimbursement system, is reliable. Some commentors suggested new money infused into the rate array should be allocated to make the overall rate increases in both the nursing component and the operating component equitable. Other commentors suggested a delay in the implementation of the new methodology with an across-the-board rate increase to all facilities at the one percent provider increase amount which would allow them to maintain their current rates with a one percent increase for another year until the system is properly implemented.

RESPONSE: While an across-the-board increase of one percent to each facility payment rate seems attractive to some providers, it would be counter-productive to many other providers. Although administratively simple, and although every provider would receive some amount of increase, an across-the-board increase is not the most prudent approach, nor is it widely lauded at the provider level as an acceptable reimbursement approach. An across-the-board increase to facilities does not recognize changes in costs that have occurred over the past year because new costs are not recognized through rebasing. It does not recognize the increase in inflation, and in some cases, provides an inappropriate increase to some providers that are not entitled to one. It circumvents the methodology and values that the department seeks to promote in the reimbursement calculation system for distribution of funding. Because all providers would get some increase in an across-the-board distribution, it would be even more difficult to transition to a new system because appropriate decreases in payment rates for some providers, due to the recognition of newer costs, or because of median and percentage adjustments with this increased recognition of newer cost and updated inflation rates would have an undue impact. An across-the-board one percent increase from the fiscal year 1999 rates for all providers is not an acceptable approach from the department's perspective. The legislature has never directed that increases in funding should be provided across-the-board at the same rate to all providers. There are values which have been adopted and are represented in the reimbursement system that create the method for the distribution of the funding appropriated by the legislature. The rules which were previously adopted for reimbursement define the distribution methodology and the values inherent in the reimbursement system. An across-the-board approach does not meet the values for the distribution of funding to all providers established by those rules.

All available and appropriated funding will be distributed through the reimbursement methodology, based upon the values that are adopted in the system for the calculation of reimbursement levels. The department originally proposed to set aside $200,000 of the appropriated funding in order to account for rate changes during the fiscal year, but has agreed to distribute this $200,000 through the rate setting methodology on July 1, 1999 in the calculation of payment rates. The department has outlined in response to other comments the changes it is making to the proposed rules for rates that will be established on July 1, 1999. The department decided to delay the implementation of a case mix reimbursement system computed from the minimum data set information and will continue to use the patient assessment information from fiscal year 1999 in the calculation of rates on July 1, 1999.

COMMENT #5: Some commentors were concerned that the residents in the Medicaid case mix index calculation were not representative of the Medicaid residents in the nursing facilities. The assessment date listed on the resident roster was not the most current assessment for the residents. Corrections to the resident roster information would result in a different CMI calculation for these facilities. The information that the department is gathering appears to be inaccurate and there are no checks in place to alert them to invalid data collection. Many commentors believe that there are significant variances in the direct nursing rate component between facilities, and within the same facility from the current rate to the proposed rate computation. The Medicaid CMI is responsible, in these commentors' opinion, for a significant portion of this variance. If the nursing rate is changing dramatically in a high percentage of facilities this indicates that the rate setting formula does not accurately reflect the reality of the direct nursing care needs of residents.

A new system takes time to refine and time to learn. A phase-in period allows providers the time to learn how to accurately use a new system without punishing them for mistakes. The Montana medicaid program is proposing wholesale change even if it involves using flawed data. A lesson should be learned from the State Mental Health Managed Care Program and the department should test and perfect the new reimbursement system before using it.

The department received other suggestions on how to make the case mix data gathering process more fair and more informative for providers. The department should not penalize facilities by using the default CMIs during the initial rate setting process and should establish a process of providing finalized resident listings each quarter after the roster information has been gathered. This would allow providers an opportunity to review that accurate data is being used in the quarterly case mix index calculation for their facility.

RESPONSE: Resident rosters were issued in order to capture accurate payor information for the computation of medicaid CMI's for facilities. This will be an ongoing and necessary task that will occur for case mix computation purposes, since the only time a payor source is listed for a resident is on an annual assessment or a full assessment. The current assessment information would be available for residents that had a complete three page quarterly in the system as of the date of the data extract. These residents would have annual or significant change assessment information as the most current complete information if a new quarterly was not available. The fact that changes need to be made to this data for its use as a reimbursement component does not indicate that the data is inaccurate or flawed, only that there may be a learning curve that has not yet been achieved in the use of this data, because of the newness of the automated MDS information.

The information that has been sent to them on the resident rosters has caused some providers to find that they have vendor software issues of which they were previously unaware. This is not a deficiency in the department's system but rather an issue outside of the Medicaid reimbursement process that needs to be resolved in order for MDS data to be accurate in the HCFA system enough for its use as a reimbursement component. Providers need to understand that many problems are occurring because of the way providers are submitting information to the HCFA data base. The department is only utilizing information as it was submitted to the HCFA data base, and is not creating data from a different source for reimbursement purposes. To the extent this MDS data is being submitted to the HCFA data base accurately and completely, the information used by the department for case mix index computations and rate setting purposes does accurately represent the acuity and direct nursing care needs of nursing facility residents based upon the MDS RUG categories.

Other factors contribute to movement or variances in the direct nursing component, besides the change from the patient assessment system to a CMI calculation for acuity. Some of these other factors include rebasing to more current costs, the reduction of the level of inflation being made to account for the adjustment for the direct care wage add-on, the adjustment of the medians and the percentage caps on these medians to recognize rebased costs and the added inflation.

The department does not agree that the changes proposed to the reimbursement system indicate that the proposed case mix adjustments do not capture acuity changes or do not accurately reflect the reality of the direct nursing care needs of residents in nursing facilities. The department believes that through the development of "shadow rates" during the next fiscal year it will be able to analyze the case mix component more thoroughly and will understand better the real acuity of residents living in nursing facilities today.

The department has previously explained in responses to other comments, that it will delay the transition to a case mix system for one year and will utilize the current methodology with the Patient Assessment Information from fiscal year 1999 in the computation of the direct nursing component for the rate year beginning July 1, 1999. The department will continue to refine the system for case mix calculation and will provide ongoing provider education and "shadow rates" to providers to show the computation of payment rates utilizing a facility wide, as well as a medicaid case mix index component in the establishment of payment rates. Quarterly downloads of data from the HCFA data base and quarterly resident roster information will be reviewed and validated prior to the establishment of "shadow rates" during the year. This one year delay will allow providers ample time to resolve issues with vendors, data submission and payor classification so that a smooth transition to a case mix system can occur on July 1, 2000. The department will use this next year to formalize a process for the gathering and validating of MDS information for use as a component in reimbursement.

COMMENT #6: A better way of calculating the MDS data would be obtained by doing a six month average, not a snapshot of the case mix data of the medicaid residents in the facility. A snapshot is less likely to accurately reflect a facility's true case mix than if assessments over a period of time are used.

RESPONSE: The data obtained from the HCFA data base is representative of a quarter of acuity information for any resident that has had a complete, three page quarterly submitted during the period that the data extract occurred. Even though this is a point-in-time extract of data, it is clearly representative of acuity for the entire quarter for most residents. For those residents who do not have a complete quarterly in the extract, the case mix index is computed from the most recent annual or full assessment that is sufficiently complete and resides in the HCFA system. If there were significant changes in these residents' acuity they should be reflected by a significant change assessment, which would be captured in this data extract process. Over the course of the next year, the department will have several quarters of MDS information from which to compute CMIs. The department will be able to develop a trend over time, and will be able to utilize the changes in the CMIs over a three or four quarter period when establishing payment rates in the future. When these rules were proposed, the department only had a one quarter snapshot of data from which to compute the CMIs that were issued in the draft rate sheets. The department used the best data available when estimating payment rates utilizing a case mix index during the first notice of the rate setting methodology. The department is proposing to capture MDS information on a quarterly basis and to compute both facility wide CMI and medicaid only CMI during the next fiscal year so that providers become familiar with the process for calculation and validation of case mix information. The department will issue "shadow rates" during the year so that

providers will be able to monitor the impact that a change to the case mix system will have on their payment rate calculation. The department will propose use of a CMI value in the establishment of payment rates effective on July 1, 2000. The department will use this next year to learn the new system and to validate and refine the process for capturing and computing case mix indexes utilizing MDS data.

COMMENT #7: Several commentors expressed concern that the reduction in the percentage caps in the spreadsheets sent to providers during the rulemaking period was greater than originally proposed. The department should fund rates at the level originally proposed in the first notice. Setting caps at levels which are below the statewide median level appears arbitrary and without correlation to the economic reality of caring for residents.

If the rates are modified with percentages below the statewide medians, each facility will see a rate decrease over those currently in place. It is unreasonable to expect that facilities will be able to lower their costs in the future to live within the reimbursement level. At a time when Medicare is cutting their rates and costs are increasing due to regulatory and data collection mandates, the department is arbitrarily cutting the caps in the various components.

Another commentor disagreed with the many providers who blamed the new case mix system for the reduction in the nursing and operating limits and the payment rates. This commentor believes that there are multiple reasons for the fluctuation in rates, such as a one percent provider rate increase, rebasing to more current costs, and application of inflation from the midpoint of the cost report period to the midpoint of the rate year. Setting aside the changes that are being proposed in the acuity adjustment, these other variables have historically caused rates to fluctuate every time the department rebases rates in conjunction with limited levels of funding. The commentor believes that the median caps would have decreased with or without any other changes to the system. The issue is not the formula, but rather the inadequacy of the funds appropriated.

RESPONSE: The rationale which accompanied the first notice of the rule clearly stated that specific percentages on the cost components and specific changes to payment levels for providers were unavailable at that time. It warned that there would most likely be adjustments prior to the final rule adoption. It notified providers that adjustments would occur based upon the final level of funding appropriated by the legislature, which was still in session at the time of the first notice, and based upon incorporation of more current cost information and other data that was not available when the first notice was filed. The department's spreadsheet, issued to providers prior to the rule hearing, had the medians recalculated and the percentages lowered to ninety-five percent of operating costs with an eight

percent incentive allowance. It also had a direct nursing cost median at ninety-six percent based upon the new data that became available between the first notice and the time of the rule hearing.

Because the reimbursement components must be set in conjunction with each other, when new data is incorporated into the system of reimbursement, all of the components are adjusted to account for these increases or decreases in costs. Base period costs are inflated to bring them forward to the midpoint of the rate year recognizing cost increases during the next rate year prior to the establishment of the medians for each of the reimbursement components. When the medians are adjusted in each of the cost components, the percentages on these medians may also be modified in order to distribute a set amount of funding though the reimbursement process in the fairest way possible. Annual rate setting has always generated a set of winners and losers. Depending on individual provider changes in the areas of cost or acuity, the winners and losers vary from year to year. A change to a new acuity measure in conjunction with rebasing will generate variations in the level of rates that are set for providers. It will generate a new set of providers that are either advantaged or disadvantaged by the change. It is difficult for the department to ascertain to what extent the changes in reimbursement are due to rebasing or other changes, and how much is due to the effects of changing to a new acuity measure.

The department agrees with the commentor that the only real change being proposed was the substitution of the medicaid CMI in place of the Medicaid PAS score. When the department is rebasing to recognize more current costs and more current inflation levels, the funding level appropriated plays a role in the determination where the percentages on those median costs can be adjusted to. Historically, costs have increased faster than the level of funding provided by the legislature. Even with the change back to the use of patient assessment information for fiscal year 2000 rate setting purposes, the percentages on the medians will be lower than they were in fiscal year 1999.

In responses to other comments, the department outlined that it will not move forward with the change to an MDS based acuity measure for this rate setting period. The department will rebase to more current cost information and will utilize the fiscal year 1999 patient assessment information in the establishment of rates for fiscal year 2000. This results in changes to the methodology from that originally proposed. With this change, the percentages for the operating cost limit will be increased to ninety-nine percent of the median operating costs, the incentive allowance will be the lesser of five percent of the median operating costs or five percent of the difference between the provider's inflated base year per diem operating cost and the operating cost limit. The direct nursing

personnel cost component limit will be ninety-nine percent of the statewide median average wage. The percentages, caps and medians used in setting rate components must be established in conjunction with each other in order to distribute funding in the most equitable and appropriate manner to all providers participating in the medicaid nursing home program. The percentages are not required to be maintained at any particular level to distribute funding equitably through the reimbursement system. Percentages and caps must be part of a reasoned decision-making process that evaluates all of the information in the system and cannot be looked at in isolation to determine whether the system meets legal requirements. All reimbursement factors must be considered to determine the adequacy of reimbursement levels. Analysis may not be limited to one component of reimbursement. In addition to the one percent provider rate increase that is being distributed through the rate formula, each provider will receive an additional $2.14 added to their per diem rate on July 1, for direct care wage increases in fiscal year 2000. With this funding added to each providers per diem payment rate, few providers will see a rate decrease over their prior year's level of funding.

COMMENT #8: One provider commented that it didn't appear that the department was recognizing inflation on new base period costs.

RESPONSE: Inflation is being applied to costs in the same manner that it has historically been applied. Costs are indexed from the midpoint of the cost report period to the midpoint of the rate year utilizing the DRI-HC McGraw Hill inflation rates. If a provider has a newer cost report, more recent than the fiscal year 1998 cost reports that are the base period, they will receive inflation at a lesser rate because the period of time from the midpoint of their cost reporting period to the midpoint of the rate year is a shorter amount of time.

COMMENT #9: Comments were received concerning the increases that are available for the direct care wage add-on. There were concerns raised over the time period that could be used to meet the department's requirements for provision of these increases. Is it only available for wage and benefit increases for periods subsequent to July 1, 1999, or will increases effected between December 31, 1998 and June 30, 1999 be eligible? Some providers have increased wages and benefits to nurses and other employees prior to the July 1, 1999 date that these funds are available.

Other providers commented that the department needs to make provisions in the rule to keep the direct care wage and benefit increases from being rolled into direct nursing and operating costs that are already capped. How can providers be sure that these wage increases will be recognized by the department in future years?

An alternative method for providing the funds for direct care wages could be to allow a facility to retain the direct care salary add-on when the facility already has an average direct care salary cost that is well above the statewide average hourly wage, basically they are already paying higher wages, so there is no need to push costs up artificially to attract the increased direct care add-on funds.

One commentor recommended that the department provide a definition of direct care to include, at a minimum, all nurses and nurse aides as well as activity, social services, dietary, housekeeping and laundry staff.

RESPONSE: The direct care wage add-on of $2.14 per medicaid day will be added to the per diem payment rate established effective July 1, 1999, for all providers. This funding was made available by the legislature and is outside of the one percent that the legislature provided for rate increases. If wage increases have occurred since the time the legislature has adjourned, the department will consider these increases as meeting the legislative intent. Facilities will be able to report increases in wages that have occurred from the period May 1, 1999 through the end of the state fiscal year and the department will consider such reports as meeting the documentation requirements for use of these funds. If increases occurred prior to May 1, 1999 the department will not consider them as meeting the intent of the legislature and they cannot be used as documentation in support of receiving the $2.14 add-on to the payment rate.

In order to receive the direct care wage funds, a provider will need to submit to the department an itemized form that shows how the $2.14 per medicaid day add-on will be utilized by the provider for increases in wages and benefits for staff in the facility. The department will develop and provide a form to be utilized by providers to submit the request for approval. The eligible categories of workers who can participate in the direct care wage add-on will be included in the form that is developed by the department. A completed request form will need to be on file with the department as of September 30, 1999 in order for a facility to be considered for continuation of the $2.14 add-on for fiscal year 2000. Providers that do not choose to participate will have the $2.14 recovered from their payments retroactively. If providers can only document use of a portion of the $2.14 add-on, they will be entitled to a pro rata amount of the direct care add-on and any excess funds that have been paid over this amount up to the $2.14 will be recovered by the department retroactively.

The increases in wages and benefits provided by facilities will be allowable and reportable on the medicaid cost report, and will become part of the cost base. The funding for the direct care wage add-on is being provided outside the provider rate increase for the next two years. In the future it will be

necessary to remove these costs from the base, if a rebasing occurs, prior to establishing payment rates and to continue the funding outside the reimbursement formula/provider rate increase process.

COMMENT #10: Nursing facilities are struggling to survive under tighter scrutiny, reduced reimbursement from Medicare and ever-expanding oversight. The present, as well as, the proposed reimbursement scheme is causing facilities to reduce much needed staff and services at a time when residents are needing it more than ever.

RESPONSE: The provision of direct care wage add-on funds in the amount of $2,858,031 in fiscal year 2000, separate from the provider rate increase, is a recognition by the legislature that adequate staffing levels are critical to the provision of quality nursing facility care. The legislative intent clearly indicates that these funds are to be used to provide increases in wages and benefits for direct care workers, especially those that traditionally earn lower wages or are classes of employees that are typically harder to recruit and retain without adequate wages and benefits. These funds should go a long way in assisting facilities to maintain staffing levels and to lessen the turnover rate of staff by providing more wage and benefit options.

COMMENT #11: Many providers commented that the department should consider limiting the inflation index or rate of inflation because of the direct care add-on. Because the department is already recognizing inflation for wage costs through the add-on for direct care wages the provision of an inflationary adjustment to costs from July 1, 1999 through December 31, 1999 in the reimbursement calculation pays for the same costs more than once.

RESPONSE: The department believes that this argument has merit. The department provided in the final rules a mechanism to reduce the rate of inflation applied to the nursing facility costs for the period July 1, 1999 through December 31, 1999. This will account for the increased funding for the direct care wage add-on that is in addition to the formula computation for reimbursement.

No inflation will be provided to direct nursing costs for the six month period July 1, 1999 through December 31, 1999, when the direct care add-on first becomes available. Seventy-five percent of the inflation rate attributed to this six month period will be applied to the operating cost component. All of the nursing staff costs included in the direct care wage component of the reimbursement calculation can qualify for the increase in funds provided by the direct care add-on. The operating component consists of more than salaries and benefits costs for the types of workers that could participate in the direct care wage add-on. Based upon an analysis of cost report

information, the department determined that wage and benefits costs for activities, social services, housekeeping, dietary/food service and laundry workers as a percentage of all other operating costs averages twenty-five percent. Based upon this data, it seems reasonable that the costs in the operating component not related to wages and benefits for qualifying workers should have inflation applied at the rate of seventy-five percent of the inflation rate for the period July 1, 1999 through December 31, 1999.

COMMENT #12: The department proposes to change the manner in which the licensed to non-licensed ratio is calculated by excluding "benefits" from the calculation. A commentor believes "benefits" are part of the cost of employees and are an important part of this calculation. The commentor recommended that both wages and benefits continue to be used in the calculation.

RESPONSE: The department proposed the elimination of benefits costs from the licensed to non-licensed ratio calculation because it was computing the benefits costs as a percentage of the reported wages. The wage and benefit information is gathered from the cost reports submitted by providers. Wages are easily identified by category of direct care employees. Benefits are typically lumped together on the cost report and are allocated through the step down process based upon salary information. In order to calculate benefits, the department estimates benefits for all providers at the same percentage of reported wages. This benefits estimate is then added to the reported wage information by each category of direct care worker and then divided by the number of hours reported in the year by category to compute each facility's RN, LPN and Nurse Aide wage rate. These hourly rates by facility, with or without benefits, are summed to compute a statewide average wage for each category of worker. A ratio is then computed by dividing the RN statewide average wage by the Nurse Aide statewide average wage to determine the relationship between the difference in wages by category of worker. For example, RN wages are 1.23 times Nurse Aide wages. This computation was historically utilized in the computation of the individual facility patient assessment scores and to compute the relationship between licensed time and non-licensed time for staffing report purposes.

Because the purpose of this computation is to determine the relative relationship of wage rates among these categories of direct care workers in total, statewide, the addition of benefits to this computation will not change this overall relationship among these wages. This is especially true if the department computes benefits as a percent of wages for each category of worker and at the same rate for each facility. The bottom line total would be different, but the relationship among the totals would be the same.

The licensed to non-licensed ratio, as proposed in the first

notice rule, was to be used to derive the relationship of RN's, LPN's and Nurse Aides to each other in the development of the case mix weights under the new acuity measure. These ratios are used to make the adjustment for Montana specific wage rates in the computation of the case mix weights for the 34 grouper. Nurse aides are equal to a value of 1, RN's and LPN's are equal to an amount greater than 1 based on the relative wage rate that is computed on a statewide average. The department does not believe the inclusion or exclusion of benefits will change the overall relationship in this ratio computation because we are using this data in an aggregate manner and are not using it on an individual facility basis.

COMMENT #13: The department proposes elimination of language requiring nursing facilities to pay personal funds belonging to a deceased medicaid resident to the department's third party liability unit and to replace it with language "as required by law and regulation". One commentor recommended that the current language be retained because it provides clearer guidance as to what is required.

RESPONSE: While the department believes that the language was clear as it was originally written, the proposed language provides adequate guidance as to this requirement. Providers have been provided ample information as to the proper process for the disposal of personal funds belonging to deceased medicaid residents and we believe that the language proposed "as required by law and regulation" is appropriate and adequate.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State June 4, 1999.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the protocol of air agitated saline in trans-thoracic echo-cardiograms	)))))	NOTICE OF PETITION FOR DECLARATORY RULING

TO: All Concerned Persons:

1. On July 15, 1999, at 8:00 a.m., in the conference room of the Division of Professional and Occupational Licensing, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana, the Board of Nursing will consider a petition for declaratory ruling on protocol of air agitated saline in trans-thoracic echocardiograms (commonly called contrast echocardiogram).

2. This petition is filed and requested by Meridee A. Lieberg, of the Community Medical Center in Missoula, Montana, for clarification of the parameters of nursing practice and to eliminate a perception of endemic confusion within the medical community.

3. The Credentials and Nursing Practice Committee determined that this would be an appropriate administrative procedural exercise because of potential air embolisms if improperly performed and of different treatments of this procedure in different medical institutions. (Some institutions require that a physician be present for this procedure while other institutions do not.)

Petitioner wants to know whether this is within a nurse's scope of practice and avers that Community Medical Center is in favor of this.

4. The administrative rule upon which Petitioner requests the declaratory ruling is ARM 8.32.1403 which provides:

8.32.1403 STANDARDS RELATED TO THE REGISTERED NURSE'S RESPONSIBILITY TO APPLY THE NURSING PROCESS The registered nurse shall:

(1) conduct and document nursing assessments of the health status of individuals and groups by:

(a) collecting objective and subjective data from observations, examinations, interviews and written records in an accurate and timely manner. The data includes, but is not limited to:

(i) biophysical, emotional and mental status;

(ii) growth and development;

(iii) cultural, spiritual and socio-economic background;

(iv) family health history;

(v) information collected by other health team members;

(vi) client knowledge and perception about health

status and potential, or maintaining health status;
(vii) ability to perform activities of daily living;
(viii) patterns of coping and interacting;
(ix) consideration of client's health goals;
(x) environmental factors (e.g. physical, social, emotional and ecological); and
(xi) available and accessible human and material resources.
(b) sorting, selecting, reporting and recording the data;
(c) validating, refining and modifying the data by utilizing available resources, including interactions with the client, family, significant others and health team members.
(2) establish and document nursing analysis which serves as the basis for the strategy of care;
(3) develop the strategy of care based upon data gathered in the assessment and conclusions drawn in the nursing analysis. This includes:
(a) identifying priorities in the strategy of care;
(b) collaboration with the client to set realistic and measurable goals to implement the strategy of care;
(c) prescribing nursing intervention(s) based on the nursing analysis;
(d) identifying measures to maintain comfort, to support human functions and positive responses, to maintain an environment conducive to teaching to include appropriate usage of health care facilities.
(4) implement the strategy of care by:
(a) initiating nursing interventions through;
(i) giving direct care;
(ii) assisting with care;
(iii) assigning and delegating care;
(iv) collaboration and/or referral when appropriate.
(b) providing an environment conducive to safety and health;
(c) documenting nursing interventions and responses to care to other members of the health team;
(d) communicating nursing interventions and responses to care to other members of the health team.
(5) evaluate the responses of individuals or groups to nursing interventions. Evaluation shall involve the client, family, significant others and health team members.
(a) Evaluation data shall be documented and communicated to appropriate members of the health care team.
(b) Evaluation data shall be used as a basis for reassessing client health status, modifying nursing analysis, revising strategies of care and prescribing changes in nursing interventions.
(c) Research data shall be utilized in nursing practice.

5. Petitioner requests that the Board of Nursing declare that it is within the scope of practice for a nurse to inject air agitated saline solution in trans-thoracic echocardiograms (commonly called contrast echocardiogram).

6. Interested persons may submit their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Nursing, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., July 15, 1999.

7. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in this action and need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Commerce no later than 5:00 p.m., on July 6, 1999, to advise us of the nature of the accommodation that you need. Please contact Dianne Wickham, Executive Director, Board of Nursing, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-2071; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-7759.

BOARD OF NURSING
KIM POWELL, RN, BSN, PRESIDENT

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

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, June 4, 1999.

NOTICE OF FUNCTIONS OF ADMINISTRATIVE RULE REVIEW COMMITTEE

Interim Committees and the Environmental Quality Council

Administrative rule review is a function of interim committees and the Environmental Quality Council (EQC). These interim committees and the EQC have administrative rule review, program evaluation, and monitoring functions for the following executive branch agencies and the entities attached to agencies for administrative purposes.

Business and Labor Interim Committee:

- Department of Agriculture;
- Department of Commerce;
- Department of Labor and Industry;
- Department of Livestock;
- Department of Public Service Regulation; and
- Office of the State Auditor and Insurance Commissioner.

Education Interim Committee:

- State Board of Education;
- Board of Public Education;
- Board of Regents of Higher Education; and
- Office of Public Instruction.

Children, Families, Health, and Human Services Interim Committee:

- Department of Public Health and Human Services.

Law, Justice, and Indian Affairs Interim Committee:

- Department of Corrections; and
- Department of Justice.

Revenue and Taxation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

State Administration, Public Retirement Systems, and Veterans' Affairs Interim Committee:

- Department of Administration;
- Department of Military Affairs; and
- Office of the Secretary of State.

Environmental Quality Council:

- Department of Environmental Quality;
- Department of Fish, Wildlife, and Parks; and
- Department of Natural Resources and Conservation.

These interim committees and the EQC have 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. They also 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, amend, or repeal a rule.

The interim committees and the EQC welcome comments and invite members of the public to appear before them or to send written statements in order to bring to their attention any difficulties with the existing or proposed rules. The mailing address is PO Box 201706, Helena, MT 59620-1706.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1. Consult ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.
Statute Number and Department	2. Go to cross reference table at end of each title which lists MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1999. This table includes those rules adopted during the period April 1, 1999 through June 30, 1999 and any proposed rule action that was pending during the past 6-month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1999, 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 1998 and 1999 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.

GENERAL PROVISIONS, Title 1

1.2.419 Filing, Compiling, Printer Pickup and Publication of the Montana Administrative Register, p. 2701, 3138
1.2.519 Basic Format Instructions for the Montana Administrative Register, p. 2856, 3223
1.3.101 and other rules - Model Rules of Procedure - Amendment of the Sample Forms Attached to the Model Rules, p. 600, 1225

ADMINISTRATION, Department of, Title 2

I Acquiring Services to Operate the State Charitable Giving Campaign, p. 561
2.21.812 and other rules - Sick Leave Fund, p. 2133, 53

(Public Employees' Retirement Board)
2.43.403 and other rules - Membership, Service Credit, and Service Purchases in Retirement Systems Administered by the Board - Service Purchases - Social Security Coverage for the Employees of the State and Its Political Subdivisions, p. 932

(State Compensation Insurance Fund)
2.55.321 Calculation of Experience Rates, p. 2643, 3267

2.55.327 and other rules - Construction Industry Premium Credit Program - Definitions - Individual Loss Sensitive Dividend Distribution Plan, p. 2776, 3268

AGRICULTURE, Department of, Title 4

I-IX Pesticide Reporting, Cleanup, and Pesticide Containment, p. 2924, 54
4.10.1001 and other rules - Pesticide Enforcement, p. 1, 404
4.12.1428 Assessment Fees on All Produce, p. 2934, 507
4.12.3501 and other rules - Grading of Seed Potatoes, p. 677

STATE AUDITOR, Title 6

6.6.503 and other rules - Medicare Supplement Insurance, p. 2325, 3269
6.6.801 and other rules - Annuity Disclosures, p. 16, 508
6.6.3101 and other rules - Long-term Care, p. 2193, 3271
6.6.4001 Valuation of Securities, p. 205, 639
6.6.5090 Rate Manual and Rate Restriction Guidelines, p. 2781, 3276
6.10.101 and other rules - Registration - Unethical Practices - Financial Requirements - Bonding - Books and Records Requirements in the Business of Securities, p. 2527, 56

(Classification Review Committee)
6.6.8301 Updating References to the NCCI Basic Manual for Workers Compensation and Employers Liability Insurance, 1996 Edition, p. 3174, 509

COMMERCE, Department of, Title 8

8.2.208 Renewal Dates, p. 3178, 274

(Board of Alternative Health Care)
8.4.301 Fees, p. 431, 1121

(Board of Athletics)
8.8.2806 Fees, p. 433

(Board of Barbers)
8.10.405 Fee Schedule, p. 435

(Board of Clinical Laboratory Science Practitioners)
8.13.303 and other rule - Fees - Renewal, p. 437

(Board of Cosmetologists)
8.14.814 Fees - Initial, Renewal, Penalty and Refund Fees, p. 439

(Board of Dentistry)
8.16.409 and other rules - Dentist Mandatory CPR - Screening Panel - Dental Hygiene Mandatory CPR - Continuing Education in Anesthesia - Requirements and Restrictions - Denturist Applications - Denturist

Examination - Denturist Intern - Renewal - Requirements and Restrictions - Inspections-Sanitary Standards - Screening Panel - Out-of-State Applicants - 90-Day Guarantee, p. 2541, 3237, 209

(State Electrical Board)
8.18.407 Fee Schedule, p. 441, 1200

(Board of Hearing Aid Dispensers)
8.20.402 Fees, p. 443
8.20.408 and other rule - Unprofessional Conduct - Continuing Educational Requirements, p. 2350, 343
8.20.417 Definitions, p. 207

(Board of Landscape Architects)
8.24.409 Fee Schedule, p. 445, 1122

(Board of Medical Examiners)
I Curriculum Approval for Applicants for Acupuncture License, p. 2936, 276
8.28.403A Graduate Training Requirements for Foreign Medical Graduates, p. 2786, 275
8.28.420 and other rules - Fee Schedule - Fees, p. 447
8.28.1501 and other rules - Definitions - Fees - Unprofessional Conduct - NCCPA Certification, p. 2783, 277
8.28.1508 Quality Assurance of Advanced Practice Registered Nurse Practice, p. 22

(Board of Funeral Service)
8.30.402 and other rules - Applications - Licensure of Out-of-State Applicants - Examination - Fee Schedule - Sanitary Standards - Transfer or Sale of Mortuary License - Crematory Facility Regulation - Processing of Cremated Remains - Board Meetings - Disclosure of Funeral Arrangements - Methods of Quoting Prices - Itemization - Disclosure Statement - Cemetery Regulation - Federal Trade Commission Regulations - Disclosure Statement on Embalming, p. 1228, 1833, 2959, 66
8.30.407 Fee Schedule, p. 450, 1201

(Board of Nursing)
8.28.1508 Quality Assurance of Advanced Practice Registered Nurse Practice, p. 22
8.32.1409 Prohibited IV Therapies, p. 563, 680

(Board of Nursing Home Administrators)
8.34.414 and other rule - Examinations - Fee Schedule, p. 453, 1123
8.34.414 and other rule - Examinations - Fees, p. 2139, 2964, 67

(Board of Optometry)
8.36.601 and other rule - Continuing Education Requirements - New Licensees, p. 3180, 511

8.36.804 Approved Drugs, p. 1187

(Board of Outfitters)
8.39.508 and other rules - Licensure--Renewal - Guide or Professional License - Safety Provisions - Standards for Outfitters, Guides and Professional Guides - Unprofessional Conduct and Misconduct, p. 241, 809

(Board of Pharmacy)
8.40.401 and other rules - Practice of Pharmacy, p. 2353, 3103, 3200, 344
8.40.404 Fee Schedule, p. 455, 1124

(Board of Professional Engineers and Land Surveyors)
8.48.1105 Fee Schedule, p. 457

(Board of Private Security Patrol Officers and Investigators)
8.50.437 Fee Schedule, p. 459

(Board of Psychologists)
8.52.605A and other rules - Minimum Standards - Examination - Continuing Education Program Options, p. 3182, 211
8.52.616 Fee Schedule, p. 461, 1125

(Board of Public Accountants)
8.54.410 and other rule - Fee Schedule - Statement of Permit Holders, p. 463, 1203
8.54.410 and other rules - Fee Schedule - Inactive Status and Reactivation - Basic Requirement - Alternatives and Exemptions, p. 2369, 212

(Board of Real Estate Appraisers)
8.57.101 and other rule - Board Organization - Continuing Education, p. 1189
8.57.412 Fees, p. 465

(Board of Realty Regulation)
8.58.301 and other rules - Definitions - Applications - Fees - Inactive Licenses - Trust Account Requirements - Continuing Education - Grounds for License Discipline - General License Administration Requirements - Pre-licensing Education - License Renewal - Inactive Licenses-Reactivation - Continuing Property Management Education - Trust Account Requirements for Property Management - Grounds for License Discipline for Property Management Licensees - Foreign Land Sales Practices Act, p. 24, 405
8.58.419 and other rules - Grounds for License Discipline - General Provisions - Unprofessional Conduct - Grounds for License Discipline of Property Management Licensees - General Provisions - Unprofessional Conduct, p. 2788, 3277

(Board of Respiratory Care Practitioners)
8.59.402 Definitions, p. 997

(Board of Sanitarians)
8.60.410A and other rule - Examinations - Sanitarian-in-training, p. 2939, 278
8.60.413 Fees, p. 999

(Board of Speech-Language Pathologists and Audiologists)
8.62.402 and other rules - Definitions - Supervisor Responsibility - Schedule of Supervision - Non-allowable Functions of Speech Aides - Functions of Audiology Aides, p. 3239, 408

(Board of Veterinary Medicine)
8.64.401 and other rules - Definitions - Continuing Education - Unprofessional Conduct, p. 3185, 411
8.64.402 Fee Schedule, p. 467, 1126
8.64.508 and other rule - Unprofessional Conduct - Record-keeping Standards, p. 565

(Building Codes Division)
8.70.101 and other rules - Building Codes Division, p. 1001

(Weights and Measures Bureau)
8.77.103 Weights and Measures Bureau - NIST Handbook 44, p. 469
8.77.103 Weights and Measures Bureau - NIST Handbook 44, p. 325
8.77.103 and other rule - NIST Handbook 44 - Receipt to be Left at Time of Delivery, p. 3188, 68

(Local Government Assistance Division)
I Administration of the 1999 Federal Community Development Block Grant Program, p. 3245, 1204

(Board of Investments)
8.97.1101 and other rules - Board of Investments, p. 1018

(Travel Promotion and Development Division)
8.119.101 Tourism Advisory Council, p. 471
8.119.101 Tourism Advisory Council, p. 327

EDUCATION, Title 10

(Superintendent of Public Instruction)
10.16.1101 and other rules - Procedures for Evaluation and Determination of Eligibility for Special Education and Related Services, p. 2233, 69

(Board of Public Education)
I-CCLXXXIV and other rules - Content and Performance Standards for Literature, Writing, Speaking and Listening, Media Literacy, Science, Health, Technology, World Languages, Reading and Mathematics, p. 1030

(State Library)
10.102.4001 Reimbursement to Libraries for Interlibrary Loans, p. 1563, 3104

FISH, WILDLIFE, AND PARKS, Department of, Title 12

12.6.1501 and other rules - Game Farms, p. 2646, 79

(Fish, Wildlife, and Parks Commission)
I-IX Creating "Primitive Fishing Access Site Designation" Where Site Development and Maintenance are Limited, p. 1991, 91
12.6.901 Limiting the Use of Motor-propelled Water Craft on Various Bodies of Water Within the Thompson Chain of Lakes Area, p. 1996, 3278
12.9.801 Creating Game Damage Hunt Rosters, p. 473

(Fish, Wildlife, and Parks Commission and Department of Fish, Wildlife, and Parks)
12.3.123 and other rule - License Refunds, p. 43, 413

ENVIRONMENTAL QUALITY, Department of, Title 17

I-VI CECRA - Listing, Delisting and Ranking Rules for Comprehensive Environmental Cleanup and Responsibility Act (CECRA) Facilities, p. 1264, 2941, 837
17.56.1001 and other rule - Underground Storage Tanks - Tank Fee Schedule - Upgrading of Existing UST Systems, p. 2547, 3108

(Board of Environmental Review)
I and other rules - Public Water Supply - Public Water and Sewage System Requirements, p. 578
I Water Quality - Temporary Water Quality Standards for Daisy Creek, the Stillwater River, and Fisher Creek, p. 482, 1218
I & II and other rules - Air Quality - Air Quality Transportation - General Conformity Determinations, p. 244, 1216
17.8.102 and other rules - Air Quality - Air Quality Incorporation by Reference Rules, p. 1191
17.8.301 and other rules - Air Quality - Maximum Achievable Control Technology (MACT) Approval for Hazardous Air Pollutants, p. 572
17.8.302 and other rule - Air Quality - Adopting and Incorporating by Reference Emission Guidelines for Hospital/Medical/Infectious Waste Incinerators, p. 2373, 3106
17.8.321 Air Quality - Opacity Limits and Other Requirements for Kraft Pulp Mills, p. 2398, 279
17.8.601 and other rules - Air Quality - Open Burning, p. 568
17.8.705 and other rules - Air Quality - De Minimis Changes that May Be Made to a Facility Without an Application to Revise the Facility's Air Quality Permit, p. 261, 1206

17.24.101 and other rules - Hard Rock - Hard Rock Mining Reclamation, p. 2376, 2994, 640
17.24.301 and other rules - Coal and Uranium Mining Program Rules for the Industrial and Energy Minerals Bureau, p. 2995, 811
17.30.602 and other rules - Water Quality - Montana Surface Water Quality Standards - Nondegradation - Ground Water Pollution Control System, p. 477
17.30.602 and other rules - Water Quality - Montana Surface Water Quality Standards - Nondegradation Rules - Ground Water Pollution Control System Rules, p. 1835, 94
17.30.1341 Water Quality - Permit Requirements of Lagoons, p. 1198
17.38.215 Public Water Supply - Bacteriological Quality Samples for Public Water Supply Systems, p. 257, 1222

(Petroleum Tank Release Compensation Board)
17.58.331 Assent to Audit Requirements, p. 2245, 3112
17.58.336 and other rules - Review and Determination of Claims and Charges, p. 682

TRANSPORTATION, Department of, Title 18

I-III Setting Policy for Waiver and Suspension of Motor Fuel Penalties, p. 2666, 513
I-III and other rules - Alcohol Tax Incentive Program, p. 2144, 3113
I-IV and other rules - Special Fuel Users Tax, Dealers and LPG Tax, p. 2797, 645
I-V Procedures for Dealers of Compressed Natural Gas (CNG) and Liquefied Petroleum Gas (LPG), p. 2671, 515, 651

CORRECTIONS, Department of, Title 20

I-VI Parole of a Youth Confined in a State Youth Correctional Facility, p. 2943, 214
I-XI Siting, Establishment, and Expansion of Prerelease Centers in the State of Montana, p. 2675, 3114
20.9.501 and other rules - Licensure of Youth Detention Facilities, p. 2813, 121

(Board of Pardons and Parole)
20.25.101 and other rules - Board of Pardons and Parole, p. 3248, 290

JUSTICE, Department of, Title 23

I-IV Permitting the Referral of Department of Justice Debts to the Department of Administration or Other Agency Designated by Law, p. 399, 984
1.3.101 and other rules - Model Rules of Procedure - Amendment of the Sample Forms Attached to the Model Rules, p. 600, 1225

LABOR AND INDUSTRY, Department of, Title 24

24.16.9003 and other rule - Incorporation by Reference to Federal Davis-Bacon Wage Rates, p. 611
24.16.9007 Montana's Prevailing Wage Rates - Non-construction Services, p. 615
24.16.9007 Incorporation by Reference of Federal Davis-Bacon Wage Rates, p. 3249
24.30.102 Occupational Safety and Health Standards for Public Sector Employment, p. 617
24.35.202 and other rules - Independent Contractor Central Unit, p. 621, 684

(Human Rights Commission)
I-XIV and other rules - Organization and Functions of the Montana Human Rights Commission, p. 1851, 3201

LIVESTOCK, Department of, Title 32

I & II Inspector Examination - Certification, p. 47
I-XXV Regulation of Game Farms in the State of Montana, p. 2681, 136
(Board of Livestock)
I Emergency Adoption - Chronic Wasting Disease and Importation Restrictions on Game Farm Animals, p. 3115
I-XI Chronic Wasting Disease, p. 265, 652
32.8.101 Incorporation by Reference of the Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration Program for Certification of Interstate Milk Shippers, p. 2699, 144

MILITARY AFFAIRS, Department of, Title 34

I-VI Administration of the Education Benefit Program for the Montana National Guard, p. 49

PUBLIC HEALTH AND HUMAN SERVICES, Department of, Title 37

I & II and other rules - State Facility Reimbursement, p. 492
I-III and other rules - Transfer from the Department of Family Services - Child Care Assistance, p. 2408, 3117
I-IV and other rules - Nursing Facilities, p. 696
I-XV and other rules - Families Achieving Independence in Montana (FAIM), p. 1592, 3284
I-XXV and other rules - AFDC Foster Care, p. 964
I-XXV and other rules - Standards for Licensing of Laboratories Conducting Analyses of Public Water Supplies, p. 3080, 291
I-XLI and other rules - Coverage and Reimbursement of Mental Health Services for Medicaid Eligible and Certain Other Low Income Individuals, p. 723
11.5.901 and other rules - Transfer from the Department of

BOARD APPOINTEES AND VACANCIES

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

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

In this issue, appointments effective in May 1999, appear. Vacancies scheduled to appear from July 1, 1999, through September 30, 1999, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a board should refer to the bill that created the board for details about the number of members to be appointed and necessary qualifications.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of June 4, 1999.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES FROM MAY, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Clinical Laboratory Science Practitioners (Commerce)			
Sen. Walter L. McNutt Sidney Qualifications (if required): clinical laboratory science practitioner	Governor	Schneider	5/25/1999 4/16/2003
Ms. Susan Pullman Butte Qualifications (if required): clinical laboratory science practitioner	Governor	Crull	5/25/1999 4/16/2003
Ms. Doris Knox Winifred Qualifications (if required): public member	Governor	Flynn	5/25/1999 4/16/2003
Board of Nursing Home Administrators (Commerce)			
Mr. Lee Jockers Billings Qualifications (if required): public member 55 years of age or older	Governor	Rabenberg	5/28/1999 5/28/2004
Board of Real Estate Appraisers (Commerce)			
Mr. Roger Jacobson Kalispell Qualifications (if required): real estate appraiser	Governor	not listed	5/1/1999 5/1/2002
Board of Realty Regulation (Commerce)			
Mr. John Beagle Sidney Qualifications (if required): real estate broker	Governor	reappointed	5/25/1999 5/9/2003
Ms. Teddye Beebe Libby Qualifications (if required): public member	Governor	Noe	5/25/1999 5/9/2003

BOARD AND COUNCIL APPOINTEES FROM MAY, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Veterans' Affairs (Military Affairs)			
Mr. Johnny Buck	Governor	not listed	5/18/1999
Glendive			5/18/2004
Qualifications (if required): veteran			
Children's Trust Fund Board (Public Health & Human Services)			
Mr. Chuck Hunter	Governor	Garrity	5/26/1999
Helena			1/1/2001
Qualifications (if required): Department of Public Health and Human Services representative			
Low Income Energy Programs Advisory Council (Public Health and Human Services)			
Mr. Carl Visser	Director	not listed	5/1/1999
Billings			0/0/0
Qualifications (if required): none specified			
Rep. Royal C. Johnson	Director	not listed	5/1/1999
Billings			0/0/0
Qualifications (if required): none specified			
Mr. Mike Billings	Director	not listed	5/1/1999
Helena			0/0/0
Qualifications (if required): none specified			
Mr. John Hines	Director	not listed	5/1/1999
Helena			0/0/0
Qualifications (if required): none specified			
Mr. Glen Phelps	Director	not listed	5/1/1999
Butte			0/0/0
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Low Income Energy Programs Advisory Council (Public Health and Human Services) cont.			
Mr. Lorene Zackuse Pablo Qualifications (if required): none specified	Director	not listed	5/1/1999 0/0/0
Montana State Veterans Cemetery Advisory Council (Military Affairs)			
Mr. John "Jack" McGlynn Butte Qualifications (if required): United Veterans Committee	Director	not listed	5/1/1999 5/1/2001
Mr. Mickey Nelson Helena Qualifications (if required): Lewis and Clark County coroner	Director	not listed	5/1/1999 5/1/2001
Ms. Alma Dickey Helena Qualifications (if required): prisoners of war	Director	not listed	5/1/1999 5/1/2001
Ms. Alma Dickey Helena Qualifications (if required): Disabled American Veterans Auxiliary	Director	not listed	5/1/1999 5/1/2001
Ms. Irma Paul Helena Qualifications (if required): Veterans of Foreign Wars Auxiliary	Director	not listed	5/1/1999 5/1/2001
Ms. Rose Marie Storey Helena Qualifications (if required): American Legion Auxiliary	Director	not listed	5/1/1999 5/1/2001
Mr. Herb Ballou Helena Qualifications (if required): Military Order of the Purple Heart	Director	not listed	5/1/1999 5/1/2001

BOARD AND COUNCIL APPOINTEES FROM MAY, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana State Veterans Cemetery Advisory Council (Military Affairs) cont.			
Mr. George Paul	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Military Order of the Cooties			
Mr. Jim Heffernan	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Marine Corps League			
Mr. Ruddy Reilly	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): 40 and 8			
Mr. Ray Read	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Vietnam Veterans of America			
Mr. M. Herbert Goodwin	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): First Special Service Force			
Mr. Robert C. McKenna	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): consulting engineer			
Mr. Al Kirkeby	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Veterans of Foreign Wars			
Mr. Hugh "Tony" Cummings	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): American Legion			

BOARD AND COUNCIL APPOINTEES FROM MAY, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana State Veterans Cemetery Advisory Council (Military Affairs)			cont.
Major Steve Martinka	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Department of Military Affairs			
Mr. George Poston	Director	not listed	5/1/1999
Helena			5/1/2001
Qualifications (if required): Disabled American Veterans			
Rangeland Resources Committee (Natural Resources and Conservation)			
Mr. Steve Hedstrom	Governor	Lee	5/25/1999
Raynesford			0/0/0
Qualifications (if required): rancher			
State Library Commission (Education)			
Ms. Dorothy Laird	Governor	reappointed	5/22/1999
Whitefish			5/22/2002
Qualifications (if required): public member			
Mr. Alvin Randall	Governor	Stearns	5/22/1999
Troy			5/22/2002
Qualifications (if required): public member			

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Aging Advisory Council (Public Health and Human Services)		
Ms. Vi Thomson, Missoula Qualifications (if required): public member	Governor	7/18/1999
Ms. Mary Alice Rehbein, Lambert Qualifications (if required): public member	Governor	7/18/1999
Ms. Pauline Nikolaisen, Kalispell Qualifications (if required): public member	Governor	7/18/1999
Ms. Dorothea C. Neath, Helena Qualifications (if required): public member	Governor	7/18/1999
Agriculture Development Council (Agriculture)		
Mr. Everett Snortland, Conrad Qualifications (if required): actively engaged in agriculture	Governor	7/1/1999
Mr. John Swanz, Judith Gap Qualifications (if required): actively engaged in agriculture	Governor	7/1/1999
Ms. Julie Burke, Glasgow Qualifications (if required): actively engaged in agriculture	Governor	7/1/1999
Alfalfa Leaf-Cutting Bee Advisory Committee (Agriculture)		
Mr. Tim Wetstein, Joliet Qualifications (if required): member of the Montana Alfalfa Seed Association	Governor	7/1/1999
Alternative Health Care Board (Commerce)		
Dr. Kathleen Stevens, Billings Qualifications (if required): medical doctor	Governor	9/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Alternative Health Care Board (Commerce) cont.		
Dr. Nancy Dunne-Boggs, Missoula Qualifications (if required): naturopath	Governor	9/1/1999
Board of Banking (Commerce)		
Mr. Loren Tucker, Virginia City Qualifications (if required): public member	Governor	7/1/1999
Mr. Robert T. Baxter, Thompson Falls Qualifications (if required): state bank officer	Governor	7/1/1999
Board of Barbers (Commerce)		
Ms. Adeline Fisher, Butte Qualifications (if required): public member	Governor	7/1/1999
Ms. Monica Eisenzimer, Columbia Falls Qualifications (if required): licensed barber	Governor	7/1/1999
Board of Cosmetology (Commerce)		
Mr. John Reichelt, Billings Qualifications (if required): cosmetologist	Governor	7/1/1999
Board of Funeral Services (Commerce)		
Mr. David G. Fulkerson, Plentywood Qualifications (if required): licensed mortician	Governor	7/1/1999
Board of Hearing Aid Dispensers (Commerce)		
Mr. Ed VanTighem, Great Falls Qualifications (if required): public member	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Board of Hearing Aid Dispensers (Commerce) cont.		
Ms. Lee Micken, Bozeman	Governor	7/1/1999
Qualifications (if required): hearing aid dispenser		
Board of Medical Examiners (Commerce)		
Dr. Lawrence McEvoy, Clancy	Governor	9/1/1999
Qualifications (if required): doctor/surgeon		
Dr. Faust Alvarez, Helena	Governor	9/1/1999
Qualifications (if required): doctor		
Board of Nursing (Commerce)		
Ms. Nancy Heyer, Missoula	Governor	7/1/1999
Qualifications (if required): registered professional nurse		
Ms. Terry Buhre, Lewistown	Governor	7/1/1999
Qualifications (if required): LPN		
Board of Pharmacy (Commerce)		
Ms. Shirley Baumgartner, Glasgow	Governor	7/1/1999
Qualifications (if required): licensed pharmacist		
Board of Physical Therapy Examiners (Commerce)		
Mr. Jeff Pallister, Great Falls	Governor	7/1/1999
Qualifications (if required): physical therapist		
Board of Private Security Patrol Officers and Investigators (Commerce)		
Mr. Gary Boyer, Great Falls	Governor	8/1/1999
Qualifications (if required): member of the Peace Officers' Standards and Training Advisory Council		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Board of Private Security Patrol Officers and Investigators (Commerce) cont.		
Ms. Mariann Calnan, Montana City Qualifications (if required): public member	Governor	8/1/1999
Board of Professional Engineers and Land Surveyors (Commerce)		
Dr. Fred Walter, Butte Qualifications (if required): professional engineer	Governor	7/10/1999
Mr. David E. Bowman, Ennis Qualifications (if required): professional land surveyor	Governor	7/1/1999
Mr. Warren P. Scarrah, Bozeman Qualifications (if required): engineering instructor	Governor	7/1/1999
Ms. Paulette Ferguson, Missoula Qualifications (if required): public member	Governor	7/1/1999
Board of Psychologists (Commerce)		
Dr. Paul Silverman, Missoula Qualifications (if required): licensed psychologist engaged in teaching of psychology	Governor	9/1/1999
Board of Public Accountants (Commerce)		
Mr. Curtis Ammondson, Great Falls Qualifications (if required): certified public accountant	Governor	7/1/1999
Board of Radiologic Technologists (Commerce)		
Ms. Debbie Sanford, Lewistown Qualifications (if required): radiologist technologist	Governor	7/1/1999
Dr. Dennis S. Yutani, Glasgow Qualifications (if required): radiologist	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Board of Radiologic Technologists (Commerce) cont.		
Ms. Cynthia L. Smith, Billings	Governor	7/1/1999
Qualifications (if required): radiologist technologist		
Mr. Alan Sevier, Glendive	Governor	7/1/1999
Qualifications (if required): public member		
Board of Sanitarians (Commerce)		
Mr. John Shea, Anaconda	Governor	7/1/1999
Qualifications (if required): public member		
Board of Veterinary Medicine (Commerce)		
Dr. Don Smith, Livingston	Governor	7/31/1999
Qualifications (if required): licensed veterinarian		
Burial Preservation Board (Indian Affairs)		
Mr. Clarence Wagner, Browning	Governor	8/22/1999
Qualifications (if required): representative of the Blackfeet Tribe		
Mr. Carl Fourstar, Poplar	Governor	8/22/1999
Qualifications (if required): representative of the Assiniboine Tribe		
Mr. David Schwab, Polson	Governor	8/22/1999
Qualifications (if required): representative of the State Historic Preservation Office		
Ms. Juanita Stovall, Billings	Governor	8/22/1999
Qualifications (if required): representative of the public		
Mr. Francis Auld, Elmo	Governor	8/22/1999
Qualifications (if required): representative of the Salish Kootenai Tribe		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Burial Preservation Board (Indian Affairs) cont.		
Dr. Randall Skelton, Missoula	Governor	8/22/1999
Qualifications (if required): physical anthropologist		
Ms. Jennie Parker, Ashland	Governor	8/22/1999
Qualifications (if required): representative of the Northern Cheyenne Tribe		
Committee on Telecommunications Services for the Handicapped (Public Health and Human Services)		
Mr. Edward VanTighem, Great Falls	Governor	7/1/1999
Qualifications (if required): deaf		
Ms. Cathy Brightwell, Helena	Governor	7/1/1999
Qualifications (if required): member from an interLATA interexchange carrier		
Ms. Flo Ellen Hippe, Great Falls	Governor	7/1/1999
Qualifications (if required): handicapped		
Community Services Advisory Council (Governor)		
Mr. Charles McCarthy, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Department of Public Health and Human Services		
Ms. Sherry Stevens Wulf, Kalispell	Governor	7/1/1999
Qualifications (if required): representing a non-profit agency		
Ms. Norma Bixby, Lame Deer	Governor	7/1/1999
Qualifications (if required): representative of tribal government		
Electrical Board (Commerce)		
Mr. Ron VanDiest, Helena	Governor	7/1/1999
Qualifications (if required): licensed electrician		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Family Education Savings Program Oversight Committee (Commissioner of Higher Education)		
Mr. Patrick P. Davison, Billings	Governor	7/1/1999
Qualifications (if required): presiding officer of the Board of Regents		
Ms. Sarah Kelly, Helena	Governor	7/1/1999
Qualifications (if required): public member		
Game Farm Advisory Council (Livestock and Fish, Wildlife and Parks)		
Dr. Anne Johnson, Malta	Governor	7/19/1999
Qualifications (if required): veterinarian		
Mr. Chris Marchion, Anaconda	Governor	7/19/1999
Qualifications (if required): representing sportspersons of Montana		
Mr. David Simpson, Hardin	Governor	7/19/1999
Qualifications (if required): representing the Department of Fish, Wildlife and Parks		
Mr. Duane Braaten, Kalispell	Governor	7/19/1999
Qualifications (if required): representing the Board of Livestock		
Mr. Bill Nyby, Antelope	Governor	7/19/1999
Qualifications (if required): representing the game farm industry		
Information Technology Managers Council (Administration)		
Mr. Tony Herbert, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Steve Colberg, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Mike Billings, Helena	Director	7/1/1999
Qualifications (if required): none specified		

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
Mr. Terry Johnson, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Barney Benkelman, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Hank Voderberg, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Robert LaRue, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Bob Meismer, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Gary Wulf, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Larry DeFrance, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Tripp Hammer, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Jim Frahm, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Patti Jacques, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Dana Corson, Helena Qualifications (if required): none specified	Director	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
Mr. Art Pembroke, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. David Nagel, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Tori Hunthausen, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Hank Trenk, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Karen Hruska, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Kipp Riebe, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Kathy James, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Homer Young, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Carleen Layne, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Bob Auer, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Dulcy Hubbert, Helena Qualifications (if required): none specified	Director	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
Mr. Bob Morris, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Joel Oelfke, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Ms. Judy Jones, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Gregg Wheeler, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Eivind Nilsen, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Michael Randall, Helena	Director	7/1/1999
Qualifications (if required): none specified		
Mr. Ken Stolz, Missoula	Director	7/1/1999
Qualifications (if required): none specified		
Interagency Coordinating Council/State Prevention Programs (Public Health and Human Services)		
Ms. Trudy Miller, Helena	Governor	7/1/1999
Qualifications (if required): representing prevention programs and services		
Ms. DeAnn Thomas, Kalispell	Governor	7/1/1999
Qualifications (if required): representing prevention programs and services		
Judicial Standards Commission (Justice)		
Ms. Patty Jo Henthorn, Big Timber	Governor	7/1/1999
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Mental Disabilities Board of Visitors (Commerce)		
Mr. Robert W. Visscher, Livingston	Governor	8/1/1999
Qualifications (if required): professional person		
Mr. Wallace A. King, Helena	Governor	8/1/1999
Qualifications (if required): professional person		
Mr. John Sampsel, Miles City	Governor	8/1/1999
Qualifications (if required): consumer		
Ms. Jennifer Pryor, Boulder	Governor	8/1/1999
Qualifications (if required): representative of organization concerned with welfare of the mentally retarded		
Mr. Steve Cahill, Clancy	Governor	8/1/1999
Qualifications (if required): representative of organization concerned with welfare of mentally ill		
Montana Geographic Information Council (Administration)		
Ms. Lois A. Menzies, Helena	Governor	9/9/1999
Qualifications (if required): director of the Department of Administration		
Ms. Mary Bryson, Helena	Governor	9/9/1999
Qualifications (if required): director of a state agency		
Ms. Karen Strege, Helena	Governor	9/9/1999
Qualifications (if required): state librarian		
Mr. Jon Sesso, Butte	Governor	9/9/1999
Qualifications (if required): representative of local government		
Mr. Harold Blattie, Columbus	Governor	9/9/1999
Qualifications (if required): representative of local government		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Montana Geographic Information Council (Administration) cont.		
Mr. Steve Hellenthal, Billings Qualifications (if required): representative of local government	Governor	9/9/1999
Mr. Lance Clampitt, Denver, CO Qualifications (if required): federal representative	Governor	9/9/1999
Mr. Dan Mates, Billings Qualifications (if required): federal representative	Governor	9/9/1999
Mr. Dan Sullivan, Butte Qualifications (if required): representative of public utilities	Governor	9/9/1999
Mr. Stuart Blundell, Helena Qualifications (if required): representative of private business active in land information systems	Governor	9/9/1999
Mr. Steve Fourstar, Billings Qualifications (if required): representative of Native American Tribes of Montana	Governor	9/9/1999
Mr. Richard Aspinall, Bozeman Qualifications (if required): representative of the University System	Governor	9/9/1999
Mr. Chris Smith, Helena Qualifications (if required): designee of a director of a state agency	Governor	9/9/1999
Ms. Pam Case, Missoula Qualifications (if required): federal representative	Governor	9/9/1999
Montana Historical Society Board of Trustees (Historical Society)		
Ms. Susan McDaniel, Miles City Qualifications (if required): public member	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Montana Historical Society Board of Trustees (Historical Society) cont.		
Mr. William MacKay, Roscoe Qualifications (if required): public member	Governor	7/1/1999
Mr. Ed Henrich, Anaconda Qualifications (if required): public member	Governor	7/1/1999
Ms. Lee Rostad, Martinsdale Qualifications (if required): public member	Governor	7/1/1999
Montana Mint Committee (Agriculture)		
Mr. John Ficken, Kalispell Qualifications (if required): mint grower	Governor	7/1/1999
Montana Special Education Advisory Panel (Office of Public Instruction)		
Mr. Wallace Melcher, Helena Qualifications (if required): business concerned with transition	Director	7/1/1999
Rep. Royal C. Johnson, Billings Qualifications (if required): legislator	Director	7/1/1999
Ms. Judith Oberst, Helena Qualifications (if required): parent of a child with disabilities	Director	7/1/1999
Ms. Mary Ann Akers, Helena Qualifications (if required): state agency	Director	7/1/1999
Ms. Mary Susan Fishbaugh, Billings Qualifications (if required): higher education	Director	7/1/1999
Ms. Kim Miller, Lewistown Qualifications (if required): regular classroom teacher	Director	7/1/1999

Board/current position holder	Appointed by	Term end
Montana Special Education Advisory Panel (Office of Public Instruction) cont.		
Ms. Crystal Dreese, Billings Qualifications (if required): individual with a disability	Director	7/1/1999
Mr. Ed Heiser, Eureka Qualifications (if required): general educator	Director	7/1/1999
Superintendent Maria Harrison, Shelby Qualifications (if required): county superintendent	Director	7/1/1999
Ms. Sondra Strong, Kalispell Qualifications (if required): special education program administrator	Director	7/1/1999
Ms. Laurie Pipinich, Great Falls Qualifications (if required): teacher of children with disabilities	Director	7/1/1999
Ms. Vicki LaFond-Smith, Helena Qualifications (if required): parent of a child with disabilities	Director	7/1/1999
Ms. Julie Traver, Bozeman Qualifications (if required): parent of a child with disabilities	Director	7/1/1999
Ms. Judy Jonart, Butte Qualifications (if required): regular classroom teacher	Director	7/1/1999
Ms. Linda Adelson, Bozeman Qualifications (if required): private school representative	Director	7/1/1999
Ms. Carol Damm, Miles City Qualifications (if required): representative from juvenile and adult corrections	Director	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Motorcycle Safety Advisory Committee (Office of Public Instruction)		
Mr. Dal Smilie, Helena	Governor	7/1/1999
Qualifications (if required): representing motorcycle riding groups		
Mr. William Henne, Hamilton	Governor	7/1/1999
Qualifications (if required): peace officer		
Noxious Weed Seed Free Forage Advisory Council (Agriculture)		
Mr. W. Ralph Peck, Helena	Director	7/24/1999
Qualifications (if required): director of the Department of Agriculture		
Mr. Harry Woll, Kalispell	Director	7/24/1999
Qualifications (if required): forage producer		
Mr. LaMonte Schnur, Townsend	Director	7/24/1999
Qualifications (if required): forage producer		
Mr. Kerry Kovanda, Columbus	Director	7/24/1999
Qualifications (if required): forage producer		
Mr. Don Walker, Glendive	Director	7/24/1999
Qualifications (if required): forage producer		
Mr. Dennis Perry, Choteau	Director	7/24/1999
Qualifications (if required): feed pellets and cube products		
Ms. Marjorie Schuler, Carter	Director	7/24/1999
Qualifications (if required): livestock/agriculture		
Mr. Robert Carlson, Butte	Director	7/24/1999
Qualifications (if required): weed districts		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Noxious Weed Seed Free Forage Advisory Council (Agriculture) cont.		
Mr. Bob McNeill, Dillon	Director	7/24/1999
Qualifications (if required): outfitters/guides		
Mr. Dennis Cash, Bozeman	Director	7/24/1999
Qualifications (if required): extension service/ex officio		
Mr. Ray Ditterline, Bozeman	Director	7/24/1999
Qualifications (if required): agricultural experiment station/ex officio		
Mr. Con Donvan, Sidney	Director	7/24/1999
Qualifications (if required): weed districts		
State Emergency Response Commission (Military Affairs)		
Dr. Drew Dawson, Helena	Governor	8/10/1999
Qualifications (if required): representing state medical response		
Mr. Paul Spengler, Helena	Governor	8/10/1999
Qualifications (if required): representing a local emergency planning committee		
Ms. Linda Williams, Fort Benton	Governor	8/10/1999
Qualifications (if required): representing local medical response		
Mr. Pat Keim, Helena	Governor	8/10/1999
Qualifications (if required): representing Burlington Railroad		
Mr. Thomas Ellerhoff, Helena	Governor	8/10/1999
Qualifications (if required): representing the Department of Environmental Quality		
Mr. Bill Rhoads, Butte	Governor	8/10/1999
Qualifications (if required): representing a Montana utility company		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
State Emergency Response Commission (Military Affairs) cont.		
Sheriff Cliff Brophy, Columbus	Governor	8/10/1999
Qualifications (if required): representing local law enforcement		
Mr. Seldon Weedon, Great Falls	Governor	8/10/1999
Qualifications (if required): representing a state fire organization		
Mr. Jim Greene, Helena	Governor	8/10/1999
Qualifications (if required): representing Disaster and Emergency Services		
Mr. Pat Brannon, Helena	Governor	8/10/1999
Qualifications (if required): representing the Department of Transportation		
Mr. Gary Hindoien, Clancy	Governor	8/10/1999
Qualifications (if required): representing the Montana National Guard		
Mr. Bill Gianoulias, Helena	Governor	8/10/1999
Qualifications (if required): representing the Department of Administration		
Mr. Lloyd Jackson, Pablo	Governor	8/10/1999
Qualifications (if required): representing Native Americans		
Mr. Tim Murphy, Missoula	Governor	8/10/1999
Qualifications (if required): representing the Department of Natural Resources and Conservation		
Mr. Andrew Malcolm, Helena	Governor	8/10/1999
Qualifications (if required): representing the Governor's Office		
Mr. Donald Skaar, Helena	Governor	8/10/1999
Qualifications (if required): Department of Fish, Wildlife and Parks representative		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
State Emergency Response Commission (Military Affairs) cont.		
Lt. Randy Yaeger, Helena	Governor	8/10/1999
Qualifications (if required): representative of state law enforcement		
Mr. Larry Barton, Helena	Governor	8/10/1999
Qualifications (if required): representing motor carriers		
Mr. Terry Phillips, Helena	Governor	8/10/1999
Qualifications (if required): representative of the Department of Justice		
Captain David Martinson, Great Falls	Governor	8/10/1999
Qualifications (if required): representative of Malstrom Air Force Base		
Mr. Jim Hirose, Great Falls	Governor	8/10/1999
Qualifications (if required): representative of a local fire organization		
Mr. Brent Erickson, Helena	Governor	8/10/1999
Qualifications (if required): railroad representative		
SummitNet Executive Council (Administration)		
Ms. Lois A. Menzies, Helena	Governor	7/1/1999
Qualifications (if required): director of the Department of Administration		
Mr. Bob Person, Helena	Governor	7/1/1999
Qualifications (if required): information technology advisory council representative		
Mr. William Salisbury, Helena	Governor	7/1/1999
Qualifications (if required): representative of a state agency		
Mr. Scott Buswell, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Office of Public Instruction		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
SummitNet Executive Council (Administration) cont.		
Ms. Janet Kelly, Miles City	Governor	7/1/1999
Qualifications (if required): local government representative		
Mr. Richard A. Crofts, Helena	Governor	7/1/1999
Qualifications (if required): Commissioner of Higher Education		
Ms. Mary Bryson, Helena	Governor	7/1/1999
Qualifications (if required): information technology advisory council representative		
Teachers' Retirement Board (Administration)		
Mr. Joseph Cross, Billings	Governor	7/1/1999
Qualifications (if required): teacher		
Telecommunications Access Services for Disabilities (Public Health and Human Services)		
Mr. Jack Sterling, Billings	Governor	7/1/1999
Qualifications (if required): representative of independent local exchange companies		
Tourism Advisory Council (Commerce)		
Mr. Larry McRae, Kalispell	Governor	7/1/1999
Qualifications (if required): public member representing Glacier Country		
Ms. Thelma M. Baker, Missoula	Governor	7/1/1999
Qualifications (if required): public member representing Glacier Country		
Mr. Carl Kochman, Great Falls	Governor	7/1/1999
Qualifications (if required): public member representing Russell Country		
Mr. Kelly Flynn, Townsend	Governor	7/1/1999
Qualifications (if required): public member representing Gold West Country and outfitters		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Vocational Rehabilitation Advisory Council (Public Health and Human Services)		
Mr. Ben Longie, Dillon	Director	8/25/1999
Qualifications (if required): none specified		
Wheat and Barley Committee (Agriculture)		
Mr. Lanny Christman, Dutton	Governor	8/20/1999
Qualifications (if required): Republican from District IV		
Mr. Leonard Schock, Vida	Governor	8/20/1999
Qualifications (if required): Republican from District VII		
Yellowstone River Task Force (Fish, Wildlife and Parks)		
Mr. Tom Lane, Livingston	Governor	7/1/1999
Qualifications (if required): rancher who lives along the river		
Mr. John Bailey, Livingston	Governor	7/1/1999
Qualifications (if required): representative of local businesses		
Mr. Joel Marshik, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Department of Transportation		
Mr. Bob Wiltshire, Livingston	Governor	7/1/1999
Qualifications (if required): representative of the angling community		
Mr. Mike Atwood, Livingston	Governor	7/1/1999
Qualifications (if required): representative of local businesses		
Ms. Michelle Goodwine, Livingston	Governor	7/1/1999
Qualifications (if required): representative of local businesses		
Mr. Jerry O'Hair, Livingston	Governor	7/1/1999
Qualifications (if required): rancher who lives along the river		

VACANCIES ON BOARDS AND COUNCILS -- JULY 1, 1999 through SEPTEMBER 30, 1999

Board/current position holder	Appointed by	Term end
Yellowstone River Task Force (Fish, Wildlife and Parks) cont.		
Mr. Roy Aserlind, Livingston	Governor	7/1/1999
Qualifications (if required): representative of property owners		
Mr. Rod Siring, Livingston	Governor	7/1/1999
Qualifications (if required): representative of property owners		
Mr. Brant Oswald, Livingston	Governor	7/1/1999
Qualifications (if required): representative of conservation groups		
Ms. Ellen Woodbury, Livingston	Governor	7/1/1999
Qualifications (if required): representative of Park County		
Mr. Ken Kastelitz, Livingston	Governor	7/1/1999
Qualifications (if required): representative of the City of Livingston		
Mr. Doug McDonald, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Corps of Engineers and an ex-officio member		
Mr. Laurence Siroky, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Department of Natural Resources and Conservation		
Mr. Stuart Lehman, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Department of Environmental Quality		
Mr. Joel Tohtz, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Department of Fish, Wildlife and Parks		
Mr. Martin Davis, Livingston	Governor	7/1/1999
Qualifications (if required): representative of the Conservation District		