MONTANA ADMINISTRATIVE REGISTER

1999 ISSUE NO. 8
APRIL 22, 1999
PAGES 677-931

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 8

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

TABLE OF CONTENTS

Page Number

NOTICE SECTION

Page Number

SPECIAL NOTICE AND TABLE SECTION

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 4.12.3501, 4.12.3503, and 4.12.3504 relating to the grading of certified seed potatoes	) NOTICE OF PROPOSED AMENDMENT))) NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On May 22, 1999, the Montana Department of Agriculture proposes to amend ARM 4.12.3501, 4.12.3503, and 4.12.3504 relating to the grading of certified seed potatoes.

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

4.12.3501 GENERAL REQUIREMENTS (1) The department of agriculture, pursuant to ~~sections~~ 80-3-~~104~~311 and 80-3-~~110~~315 MCA, adopts grade standards and inspection procedures to enforce those grades as further set out in these rules. For the purposes of grading certified seed potatoes, the department hereby adopts by reference the United States Standards for Grades of Potatoes as specified in 7 CFR Part 51 sections 1540 through 1566 of the January 1, 1998 edition with the exceptions specified in ARM 4.12.3501 through 4.12.3504.

(2) through (9) remain the same.

(10) It shall be permissible to use official tags on potatoes containing an excess of oversize, undersize, ~~hollow heart~~ and/or sprouts providing that the official grade certificate indicates that the potatoes exceed the tolerance. It shall be the responsibility of the grower to submit written evidence that the purchaser is willing to accept such a grade.

AUTH: 80-3-303, MCA IMP: 80-3-311 and 80-3-315, MCA

4.12.3503 BLUE TAGS (1) through (1)(d) remain the same.

(e) Sunburn (greening), hollow heart, hollow heart with discoloration, light brown discoloration or brown center shall be permissible.

(f) through (h) remain the same.

(i) Oversized, undersized, and sprouts~~, and hollow heart~~ shall be permissible provided the excess tolerance is indicated on the official grade certificate.

(j) Freezing injury other than the condition of being frozen or affected by soft rot or wet breakdown shall be scored when removal of the affected area causes a loss of more than 10% of the total weight of the tuber.

(k) The tolerance shall be not more than 1% for potatoes which are affected by late blight tuber rot.

AUTH: 80-3-303, MCA IMP: 80-3-303 and 80-3-315, MCA

4.12.3504 RED TAGS (1) through (1)(e) remain the same.

(f) The following blue tag exceptions shall also apply to red tags: air cracks, sunburn (greening), stem-end discoloration, immaturity, sprouts, oversize, undersize, ~~and~~ hollow heart, hollow heart with discoloration, light brown discoloration, brown center, ~~and~~ freezing injury, and the tolerance for late blight tuber rot.

AUTH: 80-3-303, MCA IMP: 80-3-303 and 80-3-315, MCA

Reason: Section 80-3-311 requires the adoption of the United States Standards for Grades of Potatoes. Montana grades for certified seed potatoes have always been based on these standards with the exceptions noted in these rules. This statement clarifies the edition of the CFR and the specific sections being adopted by reference. Seed potatoes are not affected by the occurrence of hollow heart or brown discoloration occurring in the center of the tuber. The Montana Potato Improvement Association has requested this change to the seed potato grading standards. Removal of the requirement will not affect the quality of Montana seed potatoes.

The tolerance for late blight tuber rot in the Montana seed potato grade standards is being reduced to 1 percent to maintain the integrity of Montana seed potatoes and clarify the standard for Montana seed potatoes. The Montana Potato Improvement Association has requested this change to the seed potato grading standards. This tolerance is consistent with recognized standards for late blight in seed potatoes.

3. Interested persons may submit their data, views, or arguments concerning the proposed action in writing to Gary Gingery, Administrator, Department of Agriculture, Agricultural Sciences Division, P.O. Box 200201, Helena, MT 59620-0201, FAX (406)444-5409, or E-mail: agr@state.mt.us, no later than May 20, 1999.

4. If the agency receives requests for a public hearing on the proposed action from either 10% or 25 persons, whichever is less, of the persons who are directly affected by the proposed actions; 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 approximately 8 persons based on approximately 80 seed potato growers.

5. As required by 2-4-302, MCA (HB 389, 1997 Montana legislative session), this notice advises that the department maintains an interested person list for purposes of providing notice on rule making matters. Any person wishing to be on that list must provide to the department, in writing, their name, mailing address and a brief description of the subject matter in which they are interested.

DEPARTMENT OF AGRICULTURE

Ralph Peck, Director
DEPARTMENT OF AGRICULTURE

Timothy J. Meloy, Attorney
Rule Reviewer

Certified to the Secretary of State April 9, 1999.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to prohibited IV therapies	)))	AMENDED NOTICE OF ARM 8.32.1409 PROHIBITED IV THERAPIES

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On April 8, 1999, the Board of Nursing published a notice of proposed amendment of the above-stated rule at page 563, 1999 Montana Administrative Register, issue number 7. On May 22, 1999, the Board of Nursing proposes to amend the above-stated rule.

2. The notice is being amended because the Board inadvertently deleted language which should remain in the current rule. The proposed amendment of ARM 8.32.1409 should have read as follows in the original notice:

"8.32.1409 PROHIBITED IV THERAPIES (1) through (1)(b)(xvii) will remain the same.

(c) performance of sticks, blood draws, flushes of ~~central and~~ arterial lines; or

(d) will remain the same, but will be renumbered (c)."

Auth: Sec. 37-8-415, MCA; IMP, Sec. 37-8-415, MCA

3. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Nursing, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., May 20, 1999.

4. If a person who is directly affected by the proposed amendment wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Nursing, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., May 20, 1999.

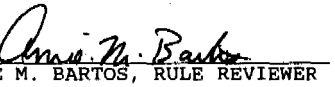
5. If the Board receives requests for a public hearing on the proposed amendment from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Rule Review Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held

at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 330 based on the 3300 licensees in Montana.

6. Persons who wish to be informed of all Board of Nursing administrative rulemaking proceedings, or other administrative proceedings, may be placed on a list of interested persons by advising the Board in writing at 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 or by phone at (406) 444-2071.

BOARD OF NURSING
KIM POWELL, RN, BSN, CEN
PRESIDENT

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


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, April 9, 1999.

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

In the matter of the proposed amendment of ARM 17.58.336, 17.58.342 and 17.58.343 pertaining to review and determination of claims and charges	NOTICE OF PROPOSED AMENDMENT (PETROLEUM BOARD) NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On June 4, 1999, the Board proposes to amend the above-captioned rules.

2. The rules as proposed to be amended appear as follows. Matter to be added is underlined. Matter to be deleted is interlined.

17.58.336 REVIEW AND DETERMINATION (1) and (2) Remain the same.

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

(4) through (7) Remain the same.

AUTH: 75-11-318, MCA, Chapter 259, Laws of 1999; IMP: 75-11-309, MCA

17.58.342 OTHER CHARGES ALLOWED OR DISALLOWED (1) through (3)(b) Remain the same.

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

AUTH: 75-11-318, MCA, Chapter 259, Laws of 1999; IMP: 75-11-318, MCA

17.58.343 REVIEW AND DETERMINATION OF THIRD PARTY DAMAGE COSTS (1) and (2) Remain the same.

(3) The board may delegate to the ~~executive~~ director of the department of environmental quality authority to process and order reimbursement of specified categories of claims upon receipt and review. The ~~executive~~ director of the department of

environmental quality shall report the number of such claims and the amounts obligated or expended at the next meeting of the board.

(4) through (7) Remain the same.

AUTH: 75-11-318, MCA, Chapter 259, Laws of 1999; IMP: 75-11-309, MCA

3. The Board is proposing the change in designation from "executive" director to "director of the department of environmental quality" because Chapter 259, Laws of 1999 has eliminated the authority of the Board to hire its own staff and attaches the Board to the Department of Environmental Quality for administrative purposes. Section 2-15-121, MCA, provides that the department to which a board is attached for administrative purposes shall provide staff for that board.

4. Interested persons may submit their data, views or arguments concerning the proposed action in writing to Debbie G. Allen, Department of Environmental Quality, P.O. Box 200901, Helena, Montana, 59620-0901, no later than May 20, 1999. To be guaranteed consideration, the comments must be postmarked on or before that date.

5. If a person who is directly affected by the proposed amendments wishes to express his/her data, views, and arguments orally or in writing at a public hearing, he/she must make written request for a hearing and submit this request along with any written comments he/she has to Debbie G. Allen, Department of Environmental Quality, P.O. Box 200901, Helena, Montana, 59620-0901. A written request for hearing must be received no later than May 20, 1999.

6. If the agency receives requests for a public hearing on the proposed amendments from either 10 percent or 25 persons, 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 600 persons based on approximately 6,000 tank owners in Montana.

PETROLEUM TANK RELEASE COMPENSATION BOARD

by: *Jean Riley*

JEAN RILEY, Executive Director

Reviewed by:

John F. North

John F. North, Rule Reviewer

Certified to the Secretary of State April 9, 1999.

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

In the matter of the proposed amendment of ARM 24.35.202, 24.35.205, 24.35.213, 24.35.301 and 24.35.303, all related to the independent contractor central unit	) NOTICE OF CANCELLATION OF) PUBLIC HEARING))))

TO ALL INTERESTED PERSONS:

1. On April 8, 1999, at pages 621 through 624 of the 1999 Montana Administrative Register, Issue No. 7, the Department gave notice that it planned to conduct a public hearing on April 30, 1999, at 2:00 p.m. to consider the amendment of ARM 24.35.202, 24.35.205, 24.35.213, 24.35.301 and 24.35.303, all related to the operation of the Department's independent contractor central unit. Due to changes that are anticipated as a result of pending legislation, the Department has cancelled the public hearing and will not be taking any action on the proposed amendments at this time.

2. The Department will publish notice of any future proposed amendments in the manner required by law.

Kevin Braun,
Rule Reviewer

Patricia Haffey, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: April 9, 1999.

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

In the matter of the proposed amendment of ARM 37.80.202 pertaining to child care assistance	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 13, 1999, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rule.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on May 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rule as proposed to be amended provides as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.80.202 INCOME ELIGIBILITY AND COPAYMENTS (1) through (10) remain the same.

[This chart is deleted and the following chart is the new one.]

CHILD CARE SLIDING FEE SCALE

FAMILY SIZE		2	3	4	5	6	7	8
%Poverty	Gross Income	Below 95.5% +$1 of the Federal Poverty Level						
-%Income	CoPay	$5	$5	$5	$5	$5	$5	$5
95.5% + $1	Gross Income	$865	$1,087	$1,309	$1,533	$1,755	$1,977	$2,201
3%	CoPay	$26	$33	$39	$46	$53	$59	$66
100%	Gross Income	$904	$1,138	$1,371	$1,604	$1,838	$2,071	$2,304
4%	CoPay	$36	$46	$55	$64	$74	$83	$92
105%	Gross Income	$949	$1,194	$1,439	$1,684	$1,929	$2,174	$2,419
5%	CoPay	$47	$60	$72	$84	$96	$109	$121
110%	Gross Income	$995	$1,251	$1,508	$1,765	$2,021	$2,278	$2,535
6%	CoPay	$60	$75	$90	$106	$121	$137	$152
115%	Gross Income	$1,040	$1,308	$1,576	$1,845	$2,113	$2,381	$2,650
7%	CoPay	$73	$92	$110	$129	$148	$167	$185
120%	Gross Income	$1,085	$1,365	$1,645	$1,925	$2,205	$2,485	$2,765
-8%	CoPay	$87	$109	$132	$154	$176	$199	$221
125%	Gross Income	$1,130	$1,422	$1,714	$2,005	$2,297	$2,589	$2,880
-9%	CoPay	$102	$128	$154	$180	$207	$233	$259
130%	Gross Income	$1,175	$1,479	$1,782	$2,085	$2,389	$2,692	$2,995
10%	CoPay	$118	$148	$178	$209	$239	$269	$300
135%	Gross Income	$1,221	$1,536	$1,851	$2,166	$2,481	$2,796	$3,111
11%	CoPay	$134	$169	$204	$238	$273	$308	$342
140%	Gross Income	$1,266	$1,593	$1,919	$2,246	$2,573	$2,899	$3,226
12%	CoPay	$152	$191	$230	$270	$309	$348	$387
145%	Gross Income	$1,311	$1,649	$1,988	$2,326	$2,664	$3,003	$3,341
13%	CoPay	$170	$214	$258	$302	$346	$390	$434
150%	Gross Income	$1,356	$1,706	$2,056	$2,406	$2,756	$3,106	$3,456
14%	CoPay	$190	$239	$288	$337	$386	$435	$484

[The following chart is all new material to the rule, but is not shown with underlines to make it easier to read.]

CHILD CARE SLIDING FEE SCALE

FAMILY SIZE		2	3	4	5	6	7	8
%Poverty	Gross Income	Below 95.5% +$1 of the Federal Poverty Level						
%Income	CoPay	$5	$5	$5	$5	$5	$5	$5
95.5% + $1	Gross Income	$882	$1,105	$1,329	$1,553	$1,777	$2,003	$2,227
3%	CoPay	$26	$33	$40	$47	$53	$60	$67
100%	Gross Income	$922	$1,157	$1,392	$1,627	$1,862	$2,097	$2,332
4%	CoPay	$37	$46	$56	$65	$74	$84	$93
105%	Gross Income	$968	$1,215	$1,461	$1,708	$1,955	$2,202	$2,448
5%	CoPay	$48	$61	$73	$85	$98	$110	$122
110%	Gross Income	$1,014	$1,272	$1,531	$1,789	$2,048	$2,306	$2,565
6%	CoPay	$61	$76	$92	$107	$123	$138	$154
115%	Gross Income	$1,060	$1,330	$1,600	$1,871	$2,141	$2,411	$2,681
7%	CoPay	$74	$93	$112	$131	$150	$169	$188
120%	Gross Income	$1,106	$1,388	$1,670	$1,952	$2,234	$2,516	$2,798
8%	CoPay	$88	$111	$134	$156	$179	$201	$224
125%	Gross Income	$1,152	$1,446	$1,740	$2,033	$2,327	$2,621	$2,915
9%	CoPay	$104	$130	$157	$183	$209	$236	$262
130%	Gross Income	$1,198	$1,504	$1,809	$2,115	$2,420	$2,726	$3,031
10%	CoPay	$120	$150	$181	$212	$242	$273	$303
135%	Gross Income	$1,244	$1,562	$1,879	$2,196	$2,513	$2,831	$3,148
11%	CoPay	$137	$172	$207	$242	$276	$311	$346
140%	Gross Income	$1,290	$1,619	$1,948	$2,277	$2,606	$2,935	$3,264
12%	CoPay	$155	$194	$234	$273	$313	$352	$392
145%	Gross Income	$1,336	$1,677	$2,018	$2,359	$2,699	$3,040	$3,381
13%	CoPay	$174	$218	$262	$307	$351	$395	$440
150%	Gross Income	$1,383	$1,735	$2,088	$2,440	$2,793	$3,145	$3,498
14%	CoPay	$194	$243	$292	$342	$391	$440	$490

AUTH: Sec. 52-2-704 and 53-4-212, MCA
IMP: Sec. 52-2-704, 52-2-713, 52-2-721, 52-2-722, 52-2-

723, 52-2-731, 53-2-201, 53-4-211, 53-4-212, 53-4-601, and 53-4-611, MCA

3. This rule change is necessary to update the child care sliding fee scale with the most recent federal poverty level figures. As a result, families may earn more income while remaining eligible for services.

The Montana Department of Public Health and Human Services Early Childhood Bureau administers the Child Care and Development Fund (CCDF). Under the Montana Child Care Act, Mont. Code Ann. 52-2-704, the department is responsible for planning, implementing, and coordinating child care programs. Federal rules, 45 CFR 98.42(a), require lead agencies to establish, and periodically revise, by rule, a sliding fee scale that provides for cost sharing by families that receive CCDF child care services.

The rule change is necessary to implement Montana Legislative statutory intent. The Montana Legislature directed that the amount of the copayment required by the sliding fee scale should not contain huge cliffs for families, either within the income categories for the scale or when families' income increases so that they lose eligibility. Families who receive cash assistance, under Families Achieving Independence in Montana (FAIM/TANF) programs, pay a five dollar copayment for child care services to cover the required Family Investment Activities (FIA). A five dollar copayment also applies to non FAIM families whose income are at, or below, 95.5% of the Federal Poverty Level (FPL). Above 95.5% FPL, families pay an increasing percentage of their gross monthly income (GMI) as they approach 150% FPL. For every five percent increase of GMI, copayment rates increase one percent.

Because wages are low (Avg. $1,586.73/mo. for production workers, Jan. 1999) and the demand for child care in Montana is high, serving families over 150% FPL is problematic. During State FY 1998, Montana faced approximately a 30% child care budget shortfall, while attempting to serve families above 150% FPL. Currently, families pay 14% of their GMI at the upper limit of the sliding fee scale. This approaches the average cost of care ($288.03/mo) for one child. At 150% FPL, without assistance, a single parent with one child will pay 21% of their GMI, and a two parent family with one child will pay 17% of their GMI. This minimizes the cliff that families experience when leaving the upper limits of eligibility.

An alternative option to this rule change would have been to continue the child care sliding fee scale at its current rates. This option was not chosen by the department, however, as the Montana Legislature has clearly indicated, the statutory intent is not to go beyond the "cliffs" which may exist in current rule.

4. 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 Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than May 20, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State April 9, 1999.

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

In the matter of the proposed amendment of ARM 46.12.503, 46.12.505 and 46.12.509 pertaining to inpatient hospitals	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 13, 1999, at 11:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on May 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.503 INPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) through (7) remain the same.

~~(8) "Day outlier" is an extended length of stay case that exceeds the day outlier thresholds as set forth in ARM 46.12.505(6).~~

~~(9)~~ (8) "Cost outlier" is an unusually high cost case that exceeds the cost outlier thresholds as set forth in ARM 46.12.505~~(7)~~ (6).

(10) through (18) remain the same but are renumbered (9) through (17).

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

46.12.505 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

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

(iii) cost ~~or day~~ outliers as set forth in (6) ~~and (7)~~;

(iv) certified registered nurse anesthetist costs as provided in ~~(17)~~ (16);

(1)(a)(v) remains the same.

(vi) disproportionate share hospital payments as provided in ~~(15)~~ (14) and ~~(16)~~ (15).

(b) Inpatient hospital services provided in hospitals located outside the state of Montana, but no more than 100 miles from the border, referred to in these rules as "border hospitals", will be reimbursed under the DRG prospective payment system described in ~~subsection~~ (2). In addition to the prospective rate, border hospitals will be reimbursed for ~~day or~~ cost outliers as set forth in (6), and for capital costs as set forth in (5), but shall not be reimbursed in addition to the DRG payment for medical education costs, neonatal intensive care stop-loss reimbursement or certified registered nurse anesthetist costs or catastrophic cases.

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

(a) For recipients admitted on or after July 1, 199~~6~~ 9, the department assigns a DRG to each medicaid discharge in accordance with the medicare grouper program version ~~13.0~~ 16.0, as developed by 3M health information systems. The assignment of each DRG is based on:

(2)(a)(i) through (2)(b) remain the same.

(c) The department computes a Montana average base price per case. This average base price per case is ~~$1,979.89~~ 2,298.00, effective for services provided on or after July 1, 199~~8~~ 9.

(2)(d) through (2)(d)(ii) remain the same.

(3) For those Montana hospitals designated by the department as of April 1, 1993 as having neonatal intensive care units, reimbursement for neonatal DRG's 385 through 390 shall be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 46.12.509(2). Such facilities shall be reimbursed on an interim basis during each facility's fiscal year. The interim rate shall be a percentage of usual and customary charges, and the percentage shall be the facility-specific cost to charge ratio, determined by the department in accordance with medicare reimbursement principles. Such hospitals shall not receive any ~~day or~~ cost outlier payment or other add-on payment with respect to such discharges or services.

(4) through (4)(a)(i) remain the same.

(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 ~~$222.83~~ 213.69. 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 (5)(a)(ii) remain the same.

~~(6) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may receive payment as provided in this subsection for day outliers for DRGs other than neonatal DRGs 385 through 390 provided by neonatal intensive care units described in (3).~~

~~(a) To receive payment for a day outlier under (1)(a)(iii), the medically necessary portion of the inpatient hospital stay, as determined by the department, must exceed the day outlier threshold established by the department for the DRG.~~

~~(b) The department determines the outlier reimbursement for day outliers for all hospitals and distinct part units, entitled to receive day outlier reimbursement, as follows:~~

~~(i) computing the per diem amount for the DRG by dividing the DRG prospective payment rate by the DRG average length of stay; and~~

~~(ii) multiplying the per diem amount by 60% to establish the day outlier per diem rate for the DRG; and~~

~~(iii) subtracting the number of days at the threshold for the DRG from the actual number of medically necessary inpatient days determined as provided in (6)(a) to establish the number of outlier days; and~~

~~(iv) multiplying the day outlier per diem rate computed in (6)(b)(ii) by the number of outlier days computed in (6)(b)(iii) to establish the day outlier payment.~~

(7) through (7)(b) remain the same but are renumbered (6) through (6)(b).

(i) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in ~~(13)~~ (12);

(7)(b)(ii) through (8)(c) remain the same but are renumbered (6)(b)(ii) through (7)(c).

(i) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in ~~subsection (13)~~ (12); and

(8)(c)(ii) through (10)(a) remain the same but are renumbered (7)(c)(ii) through (9)(a).

(i) a per diem rate 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 ~~subsections~~ (6) ~~or (7)~~, if any, by the statewide average length of stay for the DRG; or

(ii) the sum of the DRG payment for the case as computed in (2) and the appropriate outlier as computed in (6) ~~and (7)~~, if any.

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

(c) designated by the department as a hospital resident as set forth in ~~(12)~~ (11).

(12) through (12)(b)(i) remain the same but are renumbered (11) through (11)(b)(i).

(ii) payment for the first 180 days of inpatient care will be the DRG payment for the case as computed in (2) and any appropriate outliers and catastrophic payments as computed in (6) and (7) ~~or (8)~~; and

(12)(b)(iii) remains the same but is renumbered (11)(b)(iii).

~~(13)~~ (12) The medicaid statewide average cost to charge

ratio equals ~~55~~ 67%.

(14) through (15)(c) remain the same but are renumbered (13) through (14)(c).

~~(16)~~ (15) Disproportionate share hospital payments will be limited to the cap established by the federal health care financing administration for the state of Montana. The adjustment percentages specified in ~~(15)~~(14)(a), ~~(15)~~(b) and ~~(15)~~(c) shall be ratably reduced as determined necessary by the department to avoid exceeding the cap.

(17) remains the same 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, 53-6-113 and 53-6-141, MCA

46.12.509 ALL HOSPITAL REIMBURSEMENT, GENERAL (1) through (5)(b) remain the same.

(c) For isolated hospitals as identified in ARM 46.12.503~~(17)~~ (16), the base year is the facility's cost report for the first cost reporting period ending after June 30, 1993 that both covers 12 months and includes Montana medicaid inpatient hospital costs. Exceptions will be granted only as permitted by the applicable provisions of 42 CFR 413.30 or 413.40 ~~(1992)~~ (1998).

(6) through (8) remain the same.

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

3. The proposed amendment of ARM 46.12.505, Inpatient Hospital Services, Reimbursement is necessary to implement anticipated aggregate funding increases expected from the 1999 Montana legislature. The funding increase is intended to re-base the inpatient diagnosis related groups (DRG) prospective payment system of the Montana medicaid program. If enacted, the increased funding would become available for state fiscal year 2000, and under the proposed rule, the new rates would be effective July 1, 1999.

The proposed rule changes are also necessary to implement an update of the DRG grouper program from version 13.0 to version 16.0.

The proposed rule changes would eliminate day outliers from the list of conditions which are reimbursed in addition to the regular DRG prospective payment system.

The proposed amendments would update references to the department's table of weights and thresholds. The table itself would be modified to update the relative weights and outlier thresholds.

Rate Adjustments

The proposed amendments to ARM 46.12.505 would implement anticipated aggregate funding increases intended to re-base the DRG prospective payment system. One amendment proposes an increase in the average base price per case from $1,979.89 to $2,298.00. Another proposes an increase in the medicaid state average cost/charge ratio from 55% to 67%. These proposals are subject to revision during the rulemaking process, since the anticipated funding increases have not been enacted by the 1999 Montana legislature as of the date of this notice. The department did not consider alternatives, since the amendments are mandatory in order to fulfil legislative intentions.

ARM 46.12.505(6)

The department proposes elimination of the day outlier from the list of conditions for which additional payments may be received because it adds a level of complexity to the payment methodology without adding a significant level of protection from risks to the hospitals. Since the main goal of the existing outlier payments provision is to protect hospitals from unexpected high costs, the cost threshold outliers feature should be sufficient to protect the hospitals from any unfair risk. The cost threshold outlier protection will continue under the proposed amendments.

Elimination of the day outlier payment from the Medicaid program is consistent with the Medicare program, which has also dropped this feature from their payment methodology.

Grouper Update

The department proposes to update the DRG grouper program from version 13.0 to version 16.0. The grouper update will allow claims to be processed more accurately, because version 16.0 reflects recent changes in medical coding and ensuring claims groups to the appropriate DRG. New DRG's have been added since the state of Montana instituted its current grouper version. Maintaining an old system has become administratively expensive for both the department and the hospitals.

Changes in the day outlier payment will improve and simplify administration of the program. Changing the DRG grouper program version to the most current version is necessary to take advantage of the latest technology in matching costs to diagnosis.

Capital-related Costs

The department invites comments on the method of reimbursing inpatient hospital services providers for capital-related costs. The current methodology at ARM 46.12.505(4) relies on audited or

desk-reviewed cost reports. The department seeks public comments and suggestions about methods of efficiently, effectively and accurately determining capital-related costs. In the proposed amendments, the department proposes a reduction in the statewide capital-related cost for out-of-state hospitals from $222.83 to $213.69 per case. The reduction is necessary to allow anticipated funding to match anticipated total reimbursements.

ARM 46.12.503 and 46.12.509

The department found it necessary to amend ARM 46.12.503 and 46.12.509 to reflect the renumbering of ARM 46.12.503 and 46.12.505.

4. 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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59620-4210, no later than May 20, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State April 9, 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 PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 13, 1999, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption and amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on May 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION (1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the health care financing administration (HCFA) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health and human services. Back up tapes of each rate setting period will be maintained for a period of 5 years.

(4) Assessments not containing sufficient in-range data to perform a resource utilization group-III (RUG-III) algorithm will be assigned to the non-classifiable category of BC1. Non-

classifiable assessments may be replaced following the HCFA policy for correction of a prior assessment. This replacement assessment shall be completed and transmitted to the HCFA database maintained by the department prior to the first Friday of the third month of each quarter to be included in the rate calculation. A default case mix index of the lowest index in the state will be assigned to all non-classifiable, BC1, assessments.

(5) All current assessments in the database older than 110 days will be assigned the non-classifiable category of BC1 and given a default case mix index of the lowest index in the state.

(6) 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) Case mix weight 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) 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).

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 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. 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 full assessment. 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) If data reported on the resident listings is in error or if there is missing data, facilities will have until the first Friday of the third month of each quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the HCFA database maintained by the department of public health and human services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with HCFA requirements.

(b) Errors in key field items are corrected following the HCFA key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.

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 III LIEN AND ESTATE RECOVERY FUNDS FOR ONE-TIME EXPENDITURES (1) A one-time appropriation by the 1999 Montana legislature allowed the department to allocate funds from its lien and estate recovery program to the medicaid nursing home program. By the terms of the appropriation, the funds must be used for nursing home staff training, bonuses for direct care staff or one-time benefits for staff.

(2) The department will allocate to each certified nursing facility located within the state of Montana its pro rata share of the total appropriated funds, computed as provided in (3), which submits a qualifying request which is approved by the department. The funds are subject to availability and are a one-time appropriation to the nursing home program to be used only for staff training, bonuses for direct care staff or for other one-time benefits for staff.

(3) The department shall distribute the funds on the basis of medicaid utilization at each nursing care facility. The amount payable to each facility shall be the pro-rata share of total available appropriated funds available based upon collections prior to the end of the state fiscal year ending June 30, 2000 and in subsequent fiscal years. The amount of funds distributed and payable to each facility shall be computed by dividing the total amount of funds available by the total number of medicaid days occupied in the fiscal year for all facilities, to arrive at a per medicaid day amount. Each facility's share will be calculated by multiplying the facility's number of occupied medicaid days for that period by

the per day medicaid amount.

(4) To receive funds under this rule, a nursing care facility shall submit, and have approved, a request form to the department, which specifies how the facility will use these funds for one-time expenditures for staff training, bonuses for direct care staff or for other one-time benefits for staff. The department will review each request and approve qualifying requests prior to making payment. If the cost of a proposal approved by the department exceeds the amount of funds payable to that facility, the department shall not be obligated to and will not reimburse the facility any more than its pro rata share of the available funding.

(5) Facilities that do not submit a qualifying request by the deadline established by the department, shall have their pro rata share of the funds distributed to all other facilities that have submitted a qualifying and approved request for these funds.

(6) A facility that receives funds under this rule shall maintain appropriate records documenting the expenditure of the funds. The documentation shall be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable medicaid record requirements, including but not limited to ARM 46.12.308, 46.12.1258 and 46.12.1260.

(7) The funds distributed under this rule are for one-time expenditures; and facilities will be required to offset these expenditures with the revenue received only under this rule on their annual cost report to the department. These expenses shall not be considered base period costs for the participating facilities.

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 IV ADDITIONAL PAYMENTS FOR DIRECT CARE WAGE AND BENEFITS INCREASES (1) A one-time appropriation by the 1999 Montana legislature authorized the department to distribute to facilities an additional amount for wage and benefits increases for direct care workers in nursing homes.

(2) The department will pay medicaid certified nursing care facilities located in Montana who submit an approved request to the department, an additional amount, computed as provided in (3), as an add-on to their computed medicaid payment rate to be used only for wage and benefit increases for direct care workers in nursing homes.

(3) The department will determine a per day add-on payment, commencing July 1, 1999 and at the beginning of each state fiscal year thereafter, as a pro rata share of appropriated funds allocated for increases in direct care wages and benefits.

(4) To receive the direct care add-on, a nursing facility shall submit for approval a request form to the department which indicates how the direct care add-on will be spent in the

facility. The facility shall submit all of the information required on a form to be developed by the department in order to continue to receive the additional add-on amount for the entire rate year. The form will request information including but not limited to, the number of FTE's employed by category of authorized direct care worker that will receive the benefit of the increased funds, current per hour rate of pay with benefits for each category of worker, projected per hour rate of pay with benefits after the direct wage increase has been implemented, number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit, and number of projected hours to be worked in the budget period.

(5) A facility that does not submit a qualifying request for use of the funds distributed under this rule which includes all of the information that is requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds. The department shall make retroactive adjustment to the payment rate established on July 1, 1999 which will reduce the medicaid per day payment amount by the amount of funds that have been designated for the direct care wage add-on for any non-participating or non-qualifying facility. Any amounts paid by the department up to that time for the direct care wage add-on shall be recovered by the department.

(6) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable medicaid record requirements, including but not limited to ARM 46.12.308, 46.12.1258 and 46.12.1260.

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

3. The rules as proposed to be amended provide as follows. 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 each month, in accordance with the requirements of ARM 46.12.1232 which report to the department the care requirements for each medicaid recipient in the facility on forms provided and according to the patient assessment manual and instructions supplied by the department.~~

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

(2) "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 residents.

(3) through (7) remain the same.

(8) "Licensed to non-licensed ratio" means the ratio computed when the sum of all hourly registered and licensed practical nurse wages, ~~including benefits,~~ paid or accrued by all providers, divided by the total number of registered and licensed practical nurse hours, is divided by the sum of all hourly nurse aide wages, ~~including benefits,~~ paid or accrued by all providers divided by the total number of nurse aide hours.

(a) The licensed to non-licensed ratio will be computed using information from the most recent cost report on file as of April 1 immediately prior to the rate year, or if the hourly component of such information is not available from the cost report, from the staffing reports filed pursuant to ARM 46.12.1232 for the period corresponding to the cost report period from which wage ~~and benefit~~ information is used to set the ratio. If the necessary information for a particular facility is not available from a cost report and/or staffing report, the wages~~, benefits~~ and hours from that facility will not be used to set the ratio.

(9) and (10) remain the same.

~~(11) "Monitor" means a review performed by the department or its agents on a statistical sample of a specific month's medical records, including chart documentation, to determine whether such records support the patient management minutes claimed by the provider for the same month.~~

(11) "Minimum data set (MDS)" means the assessment form approved by the health care financing administration (HCFA), and designated by the department to satisfy conditions of participation in the medicaid and medicare programs.

(12) "Minimum data set RUG-III quarterly assessment form" means the three page quarterly, optional version for RUG-III 1997 update.

(12) through (13)(g) remain the same in text but are renumbered (13) through (14)(g).

(h) nonemergency routine transportation as defined in ~~(12)~~ (13).

(14) through (18) remain the same in text but are renumbered (15) through (19).

(20) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident.

(19) remains the same in text but is renumbered (21).

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

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

(g) A provider holding personal funds of a deceased nursing facility resident who received medicaid benefits at any time

shall, within 30 days following the resident's death, pay those funds ~~to the department's third party liability unit, as required by 53-6-168, MCA~~ as provided by law and regulation.

(1)(h) through (4) remain the same.

AUTH: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113 and 53-6-168, MCA

46.12.1228 RATE EFFECTIVE DATES (1) through (1)(b) remain the same.

(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) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this subchapter, until the earlier of:

(a) the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year;

(b) the effective date of a change in the provider's operating cost component:

(i) as specified in the department's notice of final settlement of a cost report based upon a desk review or audit which results in adjustment of the base period operating costs used by the department to calculate the provider's operating cost component; or

(ii) as provided in ARM 46.12.1243;

(c) the effective date of a change in the provider's direct nursing personnel cost ~~component:~~ limit:

~~(i) as provided in ARM 46.12.1232(7)(a);~~

~~(ii)~~ (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)(iii) remains the same in text but is renumbered (2)(c)(ii).

(2)(d) through (2)(d)(iv) remain the same.

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)(a) remain the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1997~~ 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1996~~ 1998 and December 31, 1998 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

(b) and (c) remain the same.

(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 the same.

(4) The operating cost limit is ~~103%~~ 100% of the day weighted 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 10% of median operating costs or 20% 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) remain the same.

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1997~~ 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1996~~ 1998 and December 31, ~~1996~~ 1998 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

~~(b) "Composite nursing wage rate" means the total base period direct nursing personnel cost divided by the product of the provider's base period average patient assessment score resource utilization group, determined in accordance with ARM 46.12.1232, 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, determined in accordance with ARM 46.12.1232, is the~~

~~average patient assessment score resource utilization group that was previously determined by the department in accordance with ARM 46.12.1232 for purposes of setting the provider's rate for an earlier rate period and which most closely corresponds to the base period.~~

(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.

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

~~(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.~~

(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.

~~(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 most recent average patient assessment score, determined in accordance with ARM 46.12.1232, or the direct nursing personnel cost limit calculated in accordance with (4).~~

(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.

(4) The direct nursing personnel cost limit is ~~107.5%~~ 101% 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 average patient~~

~~assessment score, determined in accordance with ARM 46.12.1232.~~

(5) The facility direct nursing personnel component will be the lower of the facility inflated direct nursing personnel cost per 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 SCORING AND~~ STAFFING AND REPORTING ~~REQUIREMENTS~~ ~~(1) Each provider must report to the department each month the care provided for each medicaid resident in the facility on the forms provided and in accordance with the patient assessment manual and instructions supplied by the department, which contains requirements and instructions for completion of patient abstracts. The patient assessment manual dated September 1991 is hereby adopted and incorporated herein by reference. A copy of this manual is available 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.~~

~~(2) The completed patient (resident) assessment forms and staffing report forms required by this section must be received by the department within 10 days following the end of each calendar month. Each report must be executed by the nursing facility administrator or his designee and must include a certification that the report, to the best of his knowledge and belief, is complete, accurate, and prepared in accordance with all applicable rules and departmental instructions.~~

~~(3) If the complete, accurate and certified forms are not received within the 10 day period, the department may withhold all payments for nursing facility services until such time as the complete, accurate and certified forms are received.~~

~~(4) Based upon the monthly patient (resident) assessment form submitted by the provider in accordance with (2) and considering such hours as are allowable under the patient assessment manual, the department will determine the provider's hourly patient assessment score for the month as follows.~~

~~(a) Using the licensed to non licensed ratio as defined in ARM 46.12.1222, all registered and licensed practical nurse hours, referred to herein as licensed hours, will be converted into non licensed hours. All licensed hours so converted will be added to all nurse aide (nonlicensed) hours. The total of the converted licensed hours and the nonlicensed hours will be divided by the number of residents served in the period. The result is the provider's hourly patient assessment score for the month.~~

~~(5) No more than once a year, for purposes of determining the direct nursing personnel cost component as provided in ARM 46.12.1231, the department will determine the provider's average patient assessment score, using the methodology described in (4)(a), considering such hours as are allowable under the patient assessment manual and based upon all patient assessment~~

~~information for the provider from a survey period consisting of the previous 6 month period of October through March inclusive.~~

~~(a) The department will use the same survey period for all providers.~~

~~(b) The department may determine a provider's average patient assessment score more than once a year and recalculate the provider's direct nursing personnel cost limit according to the provisions of and as required by subsection (7).~~

~~(c) For purposes of determining the provider's direct nursing personnel cost limit as provided in ARM 46.12.1231, the provider's average patient assessment score will be as determined in accordance with subsection (5) or, if applicable, as provided in subsection (6), (6)(c)(i) or (7).~~

~~(6) At least once annually, the department or its agents will monitor the monthly patient assessment abstracts for accuracy and consistency with medical records maintained by the provider. If the department's monitor team finds that the abstracts, as submitted to the department by the provider for the month, are significantly different, as defined in subsection (6)(a), than the abstracts as supported and verified by the provider's medical records, the provider's average patient assessment score, for purposes of determining the direct nursing personnel cost limit under ARM 46.12.1231, will be the provider's hourly patient assessment score for the monitor month, calculated using the methodology described in subsection (4)(a) and based upon the abstracts as verified by the monitor team.~~

~~(a) For purposes of these rules, "significant difference" and "significantly different" mean that the minutes reported in the abstracts as submitted by the provider to the department are ten or more percent greater or less than the minutes as determined by the monitor team.~~

~~(b) Within a reasonable time after completion of the monitor, the department will notify the provider of the monitor results. Such notice will include the provider's patient assessment score as determined by the department from the monitor findings, the provider's patient assessment score for the same month as determined based upon the abstracts submitted by the provider, and a statement of whether or not there is a "significant difference" which will affect the provider's per diem rate.~~

~~(c) Subject to the provisions of subsection (d), if the department determines that a significant difference exists, the provider may request administrative review and fair hearing regarding the determination of significant difference in accordance with ARM 46.12.1268. For purposes of administrative review and fair hearing under ARM 46.12.1268, documentation which was not made available to the monitor team at the time of the initial monitor is inadmissible and may not be considered by the department or the hearing officer.~~

~~(d) For providers who object to the monitor team's sampling technique used to select the abstracts to be monitored, the 100% monitor procedure described in subsection (c) through~~

~~(c)(ii) will be the only appeal available with respect to the sampling technique issue.~~

~~(i) A provider wishing to object to both the sampling technique and to other issues relating to the determination of a significant difference, must first timely request a 100% monitor as provided below. The provider may request administrative review and fair hearing regarding other issues relating to the determination of a significant difference in accordance with ARM 46.12.1268 only after the department has made a determination based upon the 100% monitor as provided in this section.~~

~~(A) For purposes of administrative review regarding other issues after a determination based upon the 100% monitor, the deadline for requesting such review shall begin running on the date of mailing of the department's written determination on the 100% monitor. If the provider does not request a 100% monitor, the deadline for requesting administrative review on issues other than the sampling technique is as provided in ARM 46.12.1268.~~

~~(B) If the provider fails to request a 100% monitor within the time specified in this section, the provider waives the right to object to or appeal the sampling technique used to select the abstracts to be monitored.~~

~~(e) Within thirty (30) days of the department's mailing of the monitor findings as required under subsection (6)(b), a provider which objects to the sampling technique may request a monitor of 100% of the monthly patient assessment abstracts for the month originally monitored.~~

~~(i) If the monitor team finds, based upon the 100% monitor, that the abstracts submitted by the provider are significantly different than the abstracts monitored, the provider must reimburse the department for the cost of the 100% monitor, as determined by the department, and the provider's average patient assessment score will be the provider's hourly patient assessment score for the 100% monitor month, calculated using the methodology described in subsection (4)(a) and based upon the abstracts as verified by the monitor team during the 100% monitor.~~

~~(A) Unless the department receives payment from the provider for the cost of the 100% monitor within 30 days after the department mails to the provider notice of the costs of the monitor, the department may recover such cost by offset against amounts otherwise payable by the department to the provider.~~

~~(ii) If, following a monitor under subsection (6) which resulted in a determination that a significant difference exists, the monitor team finds, based upon the 100% monitor, that the abstracts submitted by the provider are not significantly different than the abstracts monitored, the department will bear the cost of the 100% monitor and the provider's average patient assessment score will be determined in accordance with subsection (5).~~

~~(iii) Documentation which was not made available to the monitor team at the time of the 100% monitor may not be con-~~

~~sidered by the department in an administrative review proceeding or by a hearing officer in a fair hearing regarding the provider's average patient assessment score determination.~~

~~(7) A provider whose direct nursing personnel cost component, effective July 1, has been determined using the provider's average patient assessment score determined in accordance with subsection (6) or (6)(e)(i), may request that a new monitor be performed. In the event of such a request, the monitor will be performed on a month from the period May through October, as selected by the department or its agents.~~

~~(a) If the department determines, based upon the new monitor, that there is no significant difference between the new monitor findings and the abstracts submitted by the provider for the month of the monitor, the provider's direct nursing personnel cost limit shall be recalculated using the provider's average patient assessment score calculated using the methodology described in subsection (5), based upon the average from the entire period May through October and the abstracts as verified by the monitor team. If the recalculated limit changes the provider's direct nursing personnel cost component, as calculated under the provisions of ARM 46.12.1231, the provider's per diem rate shall be revised accordingly, effective January 1 of the rate year, regardless of whether such revision results in an increased or a decreased rate.~~

~~(i) Providers who acquire a new patient assessment score under this subsection must staff in relation to the new patient assessment score as required by subsection (8).~~

~~(b) If the new monitor findings indicate that a significant difference exists, there will be no change in the provider's rate.~~

~~(8) Providers must provide staffing at levels which, at a minimum, equal the staffing requirements indicated by the provider's average patient assessment score, determined in accordance with this section.~~

~~(a) Each provider must report to the department each month, as required in subsection (2), the staffing provided at the facility on forms provided and according to instructions supplied by the department.~~

~~(b) If the department determines that a provider's average patient assessment care requirement was 10% or more in excess of actual provider nursing care staffing for 2 or more consecutive months, the department may:~~

~~(i) schedule and conduct an audit of the provider's cost report within 180 days of receipt of the cost report covering the fiscal year in which the deficiency occurred; and~~

~~(ii) determine allowable costs in accordance with ARM 46.12.1258 and recover, in accordance with ARM 46.12.1261, all amounts paid in excess of allowable medicaid costs, or 10% of the total amount paid to the facility for the period for nursing facility services, whichever is greater.~~

~~(9) Nothing in this rule shall be construed to require the department to revise the provider's rate or establish a new rate based upon an annual monitor or new or revised patient~~

~~assessment score, except as provided in ARM 46.12.1220.~~

(1) 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-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-MA-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) If complete and accurate copies of form DPHHS-MA-015 are not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a).

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

46.12.1237 CALCULATED PROPERTY COST COMPONENT (1) This rule specifies the method used by the department to calculate the property cost component for a specific provider for rate years beginning on or after July 1, ~~1997~~ 1999. Such property cost component is expressed in dollars and cents per patient day.

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

(i) Except as otherwise specified in ARM 46.12.1243, for rate years beginning on or after July 1, ~~1997~~ 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, ~~1996~~ 1998 and December 31, ~~1996~~ 1998 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least 6 months on file with the department before April 1 immediately preceding the rate year.

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

(e) "~~1998~~ 1999 property component" means the provider's calculated property component determined for rate year ~~1998~~ 1999 in accordance with ARM 46.12.1237.

(2)(e)(i) remains the same.

(3) For rate years beginning on or after July 1, ~~1998~~ 1999, the provider's calculated property cost component is as follows:

(a) If the provider's ~~1998~~ 1999 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's ~~1998~~ 1999 property component or the property rate cap of $11.50.

(b) If the provider's base year per diem property costs exceed the provider's ~~1998~~ 1999 property component by more than $1.86, then the provider's calculated property cost component is

the lesser of the sum of the provider's ~~1998~~ 1999 property component plus $1.86, or the property rate cap of $11.50.

(c) If the provider's base year per diem property costs exceed the provider's ~~1998~~ 1999 property component by $1.86 or less, then the provider's calculated property cost component is the lesser of the provider's base year per diem property costs or the property rate cap of $11.50.

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

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

(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 ~~subsections~~ (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 the same.

(3) For purposes of calculating a per diem rate as provided in ~~subsection~~ (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 ~~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 a ~~patient assessment score~~ medicaid CMI determined as follows:

(i) ~~The department or its agents will monitor the provider's abstracts from a month during the provider's first three months in the medicaid program. If no abstract information is available for the first three months of participation in the medicaid program, the provider's direct nursing personnel cost component shall be calculated using the statewide average patient assessment score.~~ 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.

~~(ii) If the department's monitor team finds that the abstracts, as supported and verified by the provider's chart documentation, are significantly different, as defined in ARM 46.12.1232, than the abstracts as submitted to the department by the provider for the same month, the provider's average patient assessment score, for purposes of calculating the provider's direct nursing personnel cost component, shall be the provider's hourly patient assessment score for the monitor month, calculated using the methodology described in ARM 46.12.1232(4)(a) and based upon the abstracts as verified by the monitor team.~~

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

46.12.1245 SEPARATELY BILLABLE ITEMS (1) and (2) remain the same.

(a) Payment of a per diem nursing services increment under ~~subsection~~ (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's medicaid services division. Approvals will be effective for one month intervals and reapproval must be obtained monthly.

(2)(b) remains the same.

(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 II] 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 subsection (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 the same.

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

46.12.1258 ALLOWABLE COSTS (1) through (3)(j)(ii) remain the same.

(iii) Allowable costs include automobile depreciation calculated on a straight-line basis, subject to salvage value, with a minimum of a 3-year useful life. The total of automobile depreciation and interest, or comparable lease costs will not be allowable in excess of ~~$3200~~ $7,500 per year.

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

46.12.1268 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Within 30 days of mailing of the department's written determination, including a rate ~~or audit~~ determination, a provider aggrieved by the determination may request an administrative review. The request must be in writing, must state the provider's objections in detail and must include any substantiating information and documentation which the provider wishes the department to consider in the administrative review. The request for administrative review and any supporting information or documentation must be mailed to the ~~Administrator, Medicaid Services Division~~ Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) Within the period specified in ~~subsection~~ (1), a provider may request in writing an extension of up to 15 days for submission of an administrative review request. The request for extension must be received by the department within the 30-day period specified in ~~subsection~~ (1).

(1)(b) remains the same.

(c) The provider's request may also include a request for ~~a~~ an informal conference as part of the administrative review. If requested, the conference shall be held no later than 30 days after the department receives the provider's written administrative review request and detailed objections. If a provider requests a conference as part of the administrative review, any substantiating information and documentation the provider wishes the department to consider as part of the review may be submitted no later than the time of the conference. The conference shall be based upon the department's records and determination and the provider's written request, detailed objections and substantiating information and documentation, if any.

(1)(d) remains the same.

(2) In the event the provider does not agree with the department's administrative review determination, the following

fair hearing procedures will apply. The hearings officer may dismiss a fair hearing request if the provider fails to meet any of the requirements set forth in ~~subsections~~ (2)(a) through (e).

(a) The written request for a fair hearing must be mailed or delivered to the ~~Department of Social and Rehabilitation Services, Hearings Officer, P.O. Box 4210, 111 Sanders, Helena, Montana, 59604-4210~~ Department of Public Health and Human Services, Office of Fair Hearings, 616 Helena Avenue, P.O. Box 202953, Helena, MT 59620-2953.

(b) The request must be signed by the provider or ~~his~~ the provider's designee.

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

(e) The provider must serve a copy of the hearing request upon the department's senior and long term care division ~~medicaid services division~~ within 3 working days of filing the request.

(2)(f) remains the same.

(g) The hearings officer will render a written proposed decision within ~~ninety~~ 90 calendar days of final submission of the matter to him.

(3) In the event the provider or department disagrees with the hearings officer's proposed decision, a request for appeal may be made by filing a notice of appeal with the ~~Department of Social and Rehabilitation Services, Office of Fair Hearings, P.O. Box 4210, 111 Sanders, Helena, Montana 59604-4210~~ Department of Public Health and Human Services, Office of Fair Hearings, 616 Helena Avenue, P.O. Box 202953, Helena, MT 59620-2953. The appeal shall be to the board of ~~social and rehabilitative services appeals~~ public assistance.

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

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

4. The proposed changes to the Medicaid nursing facility reimbursement rules are necessary to:

a. Implement mandatory legislative funding increases for nursing facility reimbursement for state fiscal year 2000. Modify reimbursement component percentages and caps on the medians where necessary to assure appropriate payment distribution to nursing facility providers. No other options were considered by the department because legislative intent will mandate an increase in the amount of medicaid reimbursement to nursing homes.

b. Provide a methodology for distribution of increased funding for direct care wage and benefit increases for nursing facility staff. These funds are appropriated separately from the provider rate increases and may only be used for direct care wages and benefits. Not all providers must receive the same rate of increase. No other options were considered by the

department because legislative intent will require distribution of increased funding for direct care wages and benefits.

c. Incorporate rule language, which was adopted through the public notice process in prior years, pertaining to the distribution of grant funds collected from lien and estate recoveries as a one time expenditure based upon approval of a qualifying request for these funds. These funds are subject to availability and are a one time appropriation for staff training, bonuses for direct care staff, or other one-time benefits for staff. This funding cannot become part of the base funding for nursing facilities and as such approved expenditures should be offset for cost reporting purposes with the grant revenue received. No other options were considered by the department because legislative intent will require use of the one-time appropriation be distributed to nursing care facilities.

d. Eliminate requirements for submission of patient assessment abstracts for computation of a medicaid specific patient assessment score for computation of the direct nursing component. Facilities were notified in October that they no longer had to submit monthly patient assessment abstracts for their Medicaid nursing facility residents. The department rejected the alternative, maintaining the patient assessment score methodology. The department believes the use of patient assessment scores would be unnecessarily burdensome and duplicative.

e. Incorporate requirements for utilization of minimum data set (MDS) 2.0, resource utilization group-III (RUG-III) 34 grouper information in the computation of a facility specific and a medicaid specific case mix index for purposes of calculating each facilities direct nursing component.

f. Incorporate case mix components in the rate setting process for direct nursing calculation purposes and define the costs that will be case mix adjusted for rate setting purposes.

g. Rebase to more current base period cost report information in the calculation of rates effective July 1. Base period cost reports will be the fiscal year 1998 cost report or a cost report that is on file with the department of at least six months in a period prior to the fiscal year 1998 cost report if a cost report is not on file at the time of rate setting.

h. Incorporate changes and update the rules where necessary to provide clarifications and to make the rules more understandable where appropriate.

The department does not have available, at this time, all of the information that is necessary to determine the specific changes that will be required to these rules in order to establish

payment levels for nursing facility providers effective July 1, 1999. As of the date of submission for publication of this notice, the legislature is still meeting and the final appropriation funding levels and the final case load growth projection numbers are not available nor will they be final until the legislative session has ended. These rules are the department's best estimate of the funding and case load/bed days that will be adopted by the legislature based upon the information that we have available at this time. The department expects some changes will be necessary to conform these proposed rules to legislative requirements unknown at this time.

The department does not have available the proposed case mix indices for development of an acuity adjustment replacement methodology at this time. The department developed the proposed rules in consultation with a nursing facility reimbursement work group. This notice proposed a change from the patient assessment score (PAS) in the reimbursement methodology to the adoption of a case mix adjustment that is computed from the minimum data set (MDS) information that is submitted by each facility on all of their residents to a Health Care Financing Administration (HCFA) data base on file with the State. The updated case mix information is not available at this time for the development of case mix indices (CMI's) that are being proposed to be developed and used for calculation of the direct nursing component. We do not have available updated private pay surveys, or the bed day allocation to distribute the bed days appropriated across all facilities in proportion to their current utilization at the time of filing of this notice.

The department is proposing that more current cost report information be used to rebase the calculation of the fiscal year 2000 rates. Many of the fiscal year end 1998 cost reports are not on file with the department at the time of the filing of this notice. Based on information that is currently available the department believes, that it will be adjusting the current upper limit percentages on the rate setting variables. The department anticipates that adjustments in the proposed percentages will be necessary when all of the relevant data becomes available in the continuing reimbursement methodology analysis. We expect that there will be additional movement of these percentages and refinement of the components for reimbursement based upon ongoing discussions with the department's nursing facility work group during the course of the next few months. The department will provide rate sheets to all providers in advance of hearing on the proposed rules for verification purposes and in order to facilitate comments when these components and variables become final. The reimbursement analysis provided at the hearing will incorporate the information that is missing at this time and will have percentages that are reflective of that necessary to distribute the funding available, and to meet the department goals for reimbursement distribution for nursing facilities and for state

plan compliance.

Proposed new rule [Rule III] pertains to the distribution of lien and estate recovery funds. These funds have been previously distributed to providers for one-time expenditures based on a process that was established through a public notice process separate from and in addition to the rule making process. The funds appropriated by the legislature are to be used for one-time expenditures based upon submission of a qualifying request for these funds. The funds are to be utilized by nursing facilities to provide staff training, bonuses for direct care staff, or other one-time benefits for staff. Since these costs are to be one-time expenditures, the proposed rules will adopt a procedure where the expenditures incurred for allowable costs will be offset by the revenue received by providers on their annual cost report submission.

Proposed new rule [Rule IV] incorporates a process for distribution of funds appropriated by the legislature to fund wage increases and benefit increases for direct care workers in nursing homes. One purpose of the proposed rule is to provide assurance that the funds are used solely for direct care wage and benefit increases, and not all providers must receive the same rate of increase in each year.

These proposed rule changes will eliminate the requirements for submission of patient assessment abstract information that is included in ARM 46.12.1232 and seek to replace this requirement with the computation of a new acuity adjustment factor to be utilized in calculation of the direct nursing component which is developed by utilizing specific MDS information that is on file in the department HCFA database which will be converted into a medicaid specific case mix index, (CMI) to be utilized in the calculation of the direct nursing component for reimbursement purposes.

The specific changes that are being proposed and why these changes are necessary as well as any other alternatives or options that were considered are listed below:

ARM 46.12.1222

(1) The department proposes elimination of the definition of Abstract from this rule. Abstracts have not been submitted to the department since October 1998, when they were discontinued in order to eliminate duplicate abstract submission requirements for payment purposes when the federal requirements for submission of patient care information became mandated as part of the automated minimum data set submission requirements for nursing facility residents in the state.

(11) Eliminate the definition of Monitor from this rule. Monitors are no longer required because the patient assessment

abstracts have been discontinued. This requirement was duplicative in nature since the federal mandate for automated MDS transmission was implemented.

ARM 46.12.1223

The department proposes amendment of subsection (1)(g) of this rule to conform to the updated state plan by eliminating a specific reference to 53-6-168, MCA, and providing generally, that the money of a deceased resident be distributed according to law.

ARM 46.12.1229

The department proposes revision of the definition of a base period in subsection (2)(a)(i) effective July 1, 1999 as the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive. This change will allow for recognition of more current costs to be included in the computation of rates effective July 1. This change will more appropriately match base period costs with other changes that are being considered in the area of case mix adjustments for acuity utilizing MDS data.

(2)(d) "Median operating costs" computation is redefined to change the weighting of the array calculation from licensed beds to occupied patient days included in the base period. This will result in a more accurate calculation of the median operating cost. This change is necessary and appropriate based upon changes to the calculation of acuity utilizing MDS data, and other changes being proposed in these rule changes.
(4) The department proposes amendment of the operating cost limit to be 100% of the median operating cost. This proposed limit will be adjusted when all of the necessary information has been gathered to determine what the impact will be of including more current base period costs, incorporating the case mix adjustment factor changes and defining which costs will be included in this component for reimbursement. This percentage will most likely decrease from 103% of the median in the current rule, but the extent of this change cannot be determined at this time. This percentage will need to be changed in order to distribute the funding provided by the legislature and to maintain the funding formula within the appropriation guidelines. These components, percentages and caps must be set in combination to assure that the reimbursement system and levels of reimbursement further the goals of the reimbursement system. The department does not have the data available at the time of filing to determine what the exact amount of change will be.

(5) The department proposes adjustment of the providers' operating incentive allowance from the lesser of 10% of the

median operating costs or 20% of the difference between the providers' inflated base year per diem operating cost and the cost limit. This limit may be adjusted from the 20% level based upon the calculation of the median for operating costs and how the department incorporates changes to the computation of the direct care component in the reimbursement calculation. The department does not have the data available to determine what the exact amount of change will be. These percentages will need to be adjusted in order to distribute the funding provided by the legislature and to maintain the funding formula within the appropriation guidelines. The components, percentages and caps must be set in combination to assure that the reimbursement system and levels of reimbursement further the goals of the reimbursement system.

ARM 46.12.1231(2)(a)(i)

The department proposes amendment of the definition of a base period effective July 1, 1999 as the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive. This change will allow for recognition of more current costs to be included in the computation of rates effective July 1. This change will more appropriately match base period costs with other changes that are being considered in the area of case mix adjustments for acuity utilizing MDS data.

ARM 46.12.1231(2)(b)

The department proposes amendment of the composite nursing wage rate to eliminate reference to the patient assessment abstract and incorporate the language that will be developed to compute a medicaid case mix index to be used in the computation of the direct nursing per diem adjusted by the case mix index. This is yet to be determined based upon the incorporation of case mix index calculations from MDS data and the RUG-III 34 grouper computation.

ARM 46.12.1231(2)(b)(i)

The department proposes elimination of the base period patient assessment information and inclusion of language that refers to the calculation of a medicaid specific case mix index to be used in the calculation of the direct nursing per diem calculation.

ARM 46.12.1231(2)(f)

The department proposes changes to the calculation of statewide median average wage. Instead of being weighted by licensed beds it would be weighted by occupied patient days included in the base period. The proposed method would be more accurate in the calculation of the median operating cost. This change is necessary and appropriate based upon other changes that are

being made to these rules.

ARM 46.12.1231(3)

The department proposes amendment of this subsection to be consistent with rule changes being made in ARM 46.12.1232 to accommodate changes from patient assessment score calculation to the calculation of a case mix index used to adjust direct nursing personnel costs for acuity.

ARM 46.12.1231(4)

The department proposes adjustment of the percentage limit on the median for the direct nursing personnel cost limit from 107.5% to 101%. This proposal will most likely be adjusted prior to the final rule depending on the amount of funding and the changes made to the methodology for rate year 2000 in the area of acuity adjustment. As of the date of this notice data were not available to determine what the exact amount of change will be in this component or the changes that will be adopted in the areas of case mix adjustment that will impact the calculation of this component. It is necessary to adjust the percentages that distribute the funding available to achieve the values that the department has placed on the system of reimbursement for nursing facility providers so as to distribute the funding in the most equitable manner. The component percentages must be adjusted in conjunction with each other in order to establish equitable reimbursement levels for nursing facility providers. These components, percentages and caps must be set in combination to assure that the reimbursement system and levels of reimbursement further the goals of the reimbursement system.

ARM 46.12.1232

The department proposes modification of this rule to remove references to the patient assessment scoring requirements and monitor requirements for nursing facility providers. Existing rule subsections (1) through (7) will be deleted because of the department's efforts to eliminate the duplicative reporting requirements for patient assessment abstracts and replace them with the federally mandated submission of minimum data set information to the state. The department no longer requires that patient assessment abstracts be submitted to the senior and long term care program after October 1998. The department consulted with a contractor and a nursing facility reimbursement work group designing changes to the reimbursement system which incorporate a new methodology for acuity adjustment based on the development of case mix indexes for adjustment of direct nursing costs utilizing the automated MDS information that is required to be submitted to the state by nursing facilities in order to comply with federal requirements. A new rule is proposed to explain the case mix calculation process and how this information will be taken from the MDS and converted into a

value for adjustment of costs for acuity differences in each facility. Proposed [Rule I] will explain the case mix weight development for each of the 34 RUG's III groupings and how this will be utilized to develop an acuity adjustment or case mix adjustment for direct nursing cost center payment calculation purposes.

ARM 46.12.1232

The department also proposes to amend ARM 46.12.1232 to change staffing reporting requirements consistent with the elimination of the patient assessment score. Facilities would be required to report staffing levels by the 10th day of the month following the month that they are submitting this information and will be subject to withholding requirements for non-submission of this information. Facilities will be required to staff in accordance with the federal requirement found in 42 CFR 483 in order to meet the needs of the nursing facility residents in their facility.

ARM 46.12.1237(1)(i)

The department proposes that nursing home costs be rebased to a more current cost report period of January 1, 1998 through December 31, 1998, which would become the new base period for property component calculation purposes. This change would allow for recognition of more current costs to be included in the computation of rates effective July 1. This change will more appropriately match base period costs with other changes that are being considered in the area of case mix adjustments for acuity utilizing MDS data.

ARM 46.12.1237(3)

The department proposes an increase in capital rate up to the $11.50 property rate cap by adjusting the rate year in this rule to compare the providers base year capital costs to the fiscal year 1999 rate calculation in order to determine if a rate increase is available. This allows a provider who has higher base year costs than the current 1999 capital rate to receive a rate adjustment up to their base year costs or up to the lower of $1.86 or the capital rate cap. To not adjust this information will not allow a provider to receive a rate increase that is warranted under the rate setting methodology.

ARM 46.12.1243(2)(d)(iv)

The department proposes revision of the calculation for establishment of the median rate for all facilities. Instead of being weighted by licensed beds the median rate would be weighted by occupied patient days to be consistent with other changes in the reimbursement methodology described above and to be more accurate in the calculation of the median operating

cost. This change is necessary and consistent with based upon other changes that are being made to these rules.

ARM 46.12.1243(3)

The department proposes amendment of this subsection to eliminate references to the patient assessment abstract requirements and to replace it with the case mix index calculation requirements. These rules will be modified to define when CMI's will be computed and the method of computation for newly constructed facilities or new providers. Deletes (3)(b)(ii) and (iii) to remove the reference to the department's monitor team, since these requirements no longer exist for nursing facility providers.

ARM 46.12.1245(2)(c)

The department proposes modification of the rules pertaining to the payment for ventilator dependent individuals to accommodate the patient assessment requirement deletion and the changes proposed in the calculation of the direct nursing personnel component.

ARM 46.12.1258(3)(j)(iii)

The department proposes changes in the limit of total allowable automobile depreciation and interest, or comparable lease costs. The rule currently provides that these costs will not be allowed in excess of $3,200 per year. This amount has not been adjusted for many years and is unreasonably low and unrealistic for providers. The department proposes to adopt a new limit of up to $7,500 based upon an analysis of what other states have as a limit in this area or to hold providers to an amount that is supported by documentation and is a reasonable amount in each year that will be subject to audit in order to determine allowability and reasonableness.

ARM 46.12.1268(1)

The proposed amendment is necessary to notify the public that the former Medicaid Service Division is now the Senior and Long Term Care Division. Subsections (2)(a) and (3) clarify that fair hearing requests must be mailed or delivered to the Hearings Office at P.O. Box 202951 Helena MT 59620-2951 in the Department of Public Health and Human Services.

5. 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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than May 20, 1999. The Department also maintains lists of persons

interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State April 9, 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 PUBLIC HEARING ON PROPOSED ON ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On May 13, 1999, at 3:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption and amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on May 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I MEDICAID MENTAL HEALTH SERVICES, AUTHORIZATION REQUIREMENTS (1) Prior authorization is required for all

mental health service provided to a medicaid recipient under the Montana medicaid program, except for those services designated by the department.

(2) The department or its designee will notify providers and recipients of applicable authorization procedures and requirements, and applicable grievance and reconsideration procedures.

(3) Review of authorization requests by the department or its designee will be made with consideration of clinical guidelines published in advance by the department or its designee.

(4) The department may review the medical necessity of services or items at any time either before or after payment in accordance with the provisions of ARM 46.12.306. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements.

(5) The department or its designee may require providers to report outcome data or measures regarding mental health services, as determined in consultation with providers and consumers.

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

RULE II MENTAL HEALTH SERVICES PLAN, AUTHORIZATION REQUIREMENTS (1) The prior authorization, notification and other provisions of [Rule I] apply to the mental health services plan entitled with this subchapter.

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

RULE III 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 LICENSED CLINICAL PSYCHOLOGIST 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 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) 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;

(b) services provided for purposes of discharge planning as required by 42 CFR, part 482.43; and

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

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 LICENSED CLINICAL PSYCHOLOGIST SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request 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) 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% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

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

RULE VI LICENSED CLINICAL SOCIAL WORK SERVICES, DEFINITION (1) Licensed clinical social work services are those services provided by a licensed clinical social worker which are within the scope of practice permitted by Title 37, chapter 22, 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 VII LICENSED CLINICAL SOCIAL WORK 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 social work services are limited to the services designated in the department's Covered Social Work CPT Codes List (April 1999). The department hereby adopts and incorporates herein by reference the Covered Social Work CPT Codes List (April 1999). A copy of the Covered Social Work 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 licensed clinical social worker must have no more than eight individuals participating in the group.

(4) When an eligible child receives licensed clinical social worker services and the provider consults with the parent as part of the child's treatment, the time 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 social worker services must be supported by records as required in ARM 46.12.308.

(6) Telephone contacts are not a licensed clinical social worker service.

(7) Services that can be included under a facility's long term care per diem are not payable as licensed clinical social work services.

(8) Inpatient social work 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 licensed clinical social worker

services. These noncovered services include:

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

(b) services provided for purposes of discharge planning as required by 42 CFR, part 482.43; and

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

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 LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request 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) 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% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

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

RULE IX LICENSED PROFESSIONAL COUNSELOR SERVICES, DEFINITION (1) Licensed professional counselor services are those services provided by a licensed professional counselor which are within the scope of practice permitted in Title 37, chapter 23, MCA and ARM Title 8, chapter 61, subchapter 12, 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 X LICENSED PROFESSIONAL COUNSELOR SERVICES, REQUIREMENTS (1) These requirements are in addition to those contained 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) Licensed professional counselor group counseling services must have no more than eight individuals participating in the group.

(4) When an eligible child receives professional counselor services and the professional counselor consults with the parent as part of the child's treatment, the time 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 professional counselor services must be supported by records as required in ARM 46.12.308.

(6) Telephone contacts are not a professional counselor service.

(7) Services that can be included under a facility's long term care per diem are not payable as licensed professional counselor services.

(8) Inpatient professional counselor 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 licensed professional counselor services. These noncovered services include:

(a) services provided by a licensed professional counselor who is employed or under a contract with a hospital;

(b) services provided for purposes of discharge planning as required by 42 CFR 482.43; and

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

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 LICENSED PROFESSIONAL COUNSELOR SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request 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) 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% of the reimbursement provided in accordance with the methodologies described in ARM 46.12.502A.

(b) For patients who are eligible for both medicare and medicaid, reimbursement is made for the medicare deductible and coinsurance. However, total reimbursement from medicare and medicaid shall not exceed the medicaid fee for the service.

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

RULE XII RESIDENTIAL TREATMENT SERVICES, PURPOSE AND DEFINITIONS (1) The purpose of [Rules XII through XVII] is to specify provider participation and program requirements and to define the basis and procedure the department will use to pay for residential treatment 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 psychiatric care for persons under the age of 21" means a residential treatment facility whose goals, purpose and care are designed for and devoted exclusively to persons under the age of 21.

(b) "Patient day" means a whole 24-hour period that a person is present and receiving residential treatment 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 [RULE XIV], therapeutic home leave days are patient days. The day of discharge is not a patient day for purposes of reimbursement.

(c) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility, under the direction of a physician, to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remediate their condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to a less restrictive level of care at the earliest possible time. Residential psychiatric care includes only treatment or services provided in accordance with all applicable licensure, certification and accreditation requirements and these rules.

(d) "Residential treatment facility" means a 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.

(e) "Residential treatment services" means 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. Residential treatment services are services that comply with the requirements of these rules and the above-cited federal regulations and are provided in a residential treatment facility that is devoted to the provision of residential psychiatric care for persons under the age of 21.

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

(2) Residential treatment 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 residential treatment facility under the rules of the department's quality assurance division to provide 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 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 services;

(d) license and/or register facility personnel in accordance with applicable state and federal laws;

(e) accept, as payment in full for all operating and property costs, the amounts paid in accordance with the reimbursement method set forth in these rules;

(f) for providers maintaining patient trust accounts, insure that any funds maintained in those accounts are used only for those purposes for which the patient, legal guardian or personal representative of the patient has given written authorization. A provider may not borrow funds from these accounts for any purpose;

(g) maintain accreditation as a residential treatment facility by the joint commission on accreditation of health care

organizations (JCAHO) or any other organization designated by the secretary of the United States department of health and human services as authorized to accredit residential treatment facilities for medicaid participation;

(h) submit to the department prior to receiving initial reimbursement payments and thereafter within 30 days after receipt, all accreditation determinations, findings, reports and related documents issued by the accrediting organization to the provider;

(i) provide residential psychiatric care 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) agree to indemnify the department in the full amount of the state and federal shares of all medicaid residential treatment 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 RESIDENTIAL TREATMENT SERVICES, REIMBURSEMENT (1) For residential treatment 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 [RULE XII] and unless all other applicable requirements are met.

(2) For residential treatment services provided 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 services provided by all Montana providers is $262.71 per patient day.

(a) The rate provided in this rule for 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 is an all-inclusive bundled rate. Except as provided in (4)(a), (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), (b) and (c) and are not separately billable.

(a) Subject to (4)(a)(i), 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.

(b) Services and items that are not related to the recipient's psychiatric condition being treated in the residential treatment facility and that are not provided by the residential treatment facility are separately billable in accordance with the applicable rules governing billing for the category of services or items.

(5) Payment for residential treatment services provided outside the state of Montana will be made only under the conditions specified in ARM 46.12.502(3) and these rules. Reimbursement for residential treatment 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) 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). 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) but subsequently obtains additional information necessary to fully apply (5), the department may settle the rates and adjust any overpayment or underpayment in accordance with [RULE XV].

(a) In addition to the requirements of (6), 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) Reimbursement will be made to a 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 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.

(8) No more than 14 days per recipient in each rate year will be allowed for therapeutic home visits.

(9) 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) Providers must bill for residential treatment 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 RESIDENTIAL TREATMENT SERVICES, COST SETTLEMENT AND UNDERPAYMENT (1) For facilities located outside the state of Montana, the department may, as provided in (2), perform cost settlements and correct overpayments and underpayments in accordance with the provisions of ARM 46.12.509.

(2) The department may determine, through the cost settlement process, whether overpayments or underpayments have resulted to out-of-state providers receiving Montana medicaid reimbursements in excess of $50,000 per year. Where the department performs a cost settlement for an out-of-state facility, the provisions of ARM 46.12.509 shall apply.

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

RULE XVI RESIDENTIAL TREATMENT SERVICES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) The right to administrative review and fair hearing shall be in accordance with the provisions of ARM 46.12.509A.

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 RESIDENTIAL TREATMENT SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW AND INSPECTIONS OF CARE (1) Prior to admission and as frequently as the department may deem necessary, the department or its agents may evaluate the medical necessity and quality of services for each

medicaid recipient.

(a) In addition to the other requirements of these rules, the provider must provide to the department or its agent upon request any records related to services or items provided to a medicaid recipient.

(b) The department may contract with and designate public or private agencies or entities or, a combination of public and private agencies and entities, to perform utilization review, inspections of care and other functions under this rule as an agent of the department.

(2) In accordance with 42 CFR, part 456, subpart I, 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 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.

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

(i) be completed, signed and dated within:

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

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

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

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

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

(4) An authorization by the department or its utilization review agent under this rule is not a final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the

medical necessity of services or items at any time.

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

RULE XVIII INSTITUTIONS FOR MENTAL DISEASES, PURPOSE (1) [RULE XVIII] through [RULE XXIV] specify requirements for the provision of and reimbursement for medicaid nursing facility services to medicaid recipients age 65 or older who are residents of an institution for mental diseases. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statutes, rules, regulations and policies.

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

RULE XIX INSTITUTIONS FOR MENTAL DISEASES, DEFINITIONS (1) "Department" means the Montana department of public health and human services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(2) "Institution for mental diseases" means a hospital, nursing facility, or other institution with more than 16 beds which the department has determined is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution for the mentally retarded, including an intermediate care facility for the mentally retarded, is not an institution for mental diseases.

(a) An institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(i) In making a determination of whether an institution is an institution for mental diseases, the department shall consider the guidelines set forth in subsection C of section 4390 of the state medicaid manual, but no single guideline or combination of guidelines shall necessarily be determinative. The state medicaid manual is promulgated by the federal health care financing administration to provide guidance to states on administration of the medicaid program. The department hereby adopts and incorporates herein by reference subsection C of section 4390 of the state medicaid manual (1994). A copy of subsection C of section 4390 of the state medicaid manual may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(3) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(4) "Mental disease" means a disease listed as a mental disorder in the current edition of the Diagnostic and

Statistical Manual of Mental Diseases but does not include mental retardation, senility and organic brain syndrome.

(5) "Nursing facility services" means services defined in ARM 46.12.1222, but not including intermediate care facility services for the mentally retarded.

(6) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(7) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day.

(8) "Provider" means a nursing facility that meets the provider participation requirements specified in [RULE XX].

(9) "Resident" means a person admitted to the provider's facility who has been present in the facility for at least one 24-hour period.

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 INSTITUTIONS FOR MENTAL DISEASES, PROVIDER PARTICIPATION REQUIREMENTS (1) An institution for mental diseases, as a condition of participation in the Montana medicaid program, must be a nursing facility that meets the following requirements:

(a) complies with the requirements set forth at ARM 46.12.1223 for medicaid nursing facility service providers;

(b) has been determined by the department, in accordance with [RULE XIX], to be an institution for mental diseases;

(c) complies with ARM 46.12.1265 regarding utilization review and quality of care for nursing facilities; and

(d) enters into and maintains a written agreement with the department that specifies the respective responsibilities of the department and the provider including arrangements for:

(i) joint planning between the parties to the agreement;

(ii) development of alternative methods of care;

(iii) permission for immediate readmission to the institution when the recipient's need for readmission has been determined to be medically necessary;

(iv) access by the department to the recipient, the recipient's records and the facility;

(v) recording, reporting and exchanging medical and social information about recipients; and

(vi) other procedures necessary to carry out the agreement.

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

RULE XXI INSTITUTIONS FOR MENTAL DISEASES, INDIVIDUAL TREATMENT PLANS (1) Institutions for mental diseases providing services under these rules 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:

(a) an initial review of the recipient's medical, psychiatric and social needs within 30 days after the date of admission;

(b) periodic review of the recipient's medical, psychiatric and social needs;

(c) a determination at least every 90 days of the recipient's need for continued institutional care and for alternative care arrangements;

(d) appropriate medical treatment in the institution; and

(e) appropriate social services.

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

RULE XXII INSTITUTION FOR MENTAL DISEASES, REIMBURSEMENT (1) The Montana medicaid program will not reimburse for services provided in institutions for mental diseases, except:

(a) as provided in [RULE XII] through [RULE XVII] for medicaid recipients under age 21 receiving services in residential treatment facilities; or

(b) as provided in this rule 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 [RULE XIX].

(2) For nursing facility services provided to medicaid recipients age 65 years or over in an institution for mental diseases, the Montana medicaid program will pay a provider:

(a) for each patient day, an interim per diem rate, as specified in (3), minus the amount of the medicaid recipient's patient contribution; and

(b) additional reimbursement for separately billable items as provided in (4).

(3) The final per diem payment rate for:

(a) the nursing facility at Montana state hospital is $325.00; and

(b) the Montana mental health nursing care center at Lewistown is $150.00 for high acuity patients and $100.00 for low acuity patients.

(4) Separately billable items are those items specified in ARM 46.12.1245 and are reimbursable by medicaid according to the provisions of ARM 46.12.1245.

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

RULE XXIII INSTITUTIONS FOR MENTAL DISEASES, BILLING AND PAYMENT (1) Providers must bill for all services and supplies in accordance with the provisions of ARM 46.12.303. The department will pay a provider on a monthly basis the amount determined in accordance with these rules upon receipt of an appropriate billing which reports the number of patient days provided to authorized medicaid recipients during the billing period.

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

RULE XXIV INSTITUTIONS FOR MENTAL DISEASES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES (1) Providers may appeal adverse determinations by the department through the administrative review and fair hearing procedures specified in ARM 46.12.1268.

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 XXV CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, ELIGIBILITY (1) Case management services are available under [Rules XXV through XXX] only to adults (age 18 or over) with severe disabling mental illness.

(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;

(B) the person has a DSM-IV diagnosis of schizophrenic disorder (295); other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82); mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 301.13, 193.83); amnestic disorder (294.0, 294.8); disorder due to a general medical condition (310.1); or pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation; or

(C) the person has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency; and

(ii) the person has ongoing functioning difficulties because of the mental illness, as indicated by one of the following:

(A) medication is necessary to control the symptoms of

mental illness;

(B) the person is unemployed or does not work in a full-time competitive situation because of mental illness;

(C) the person receives SSI or SSDI payments due to mental illness; or

(D) the person maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

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

RULE XXVI CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, DEFINITIONS (1) "Assessment" means an integrated examination of the client's strengths, status, aspirations, needs and goals in the life domains of residence, health, vocation, education, community participation, leisure time and economics.

(2) "Assistance in daily living" means the ongoing monitoring of how a client is coping with life on a day-to-day basis and the activities a case manager performs which support a client in daily life. Assistance with daily living skills includes, but is not limited to, assistance with shopping, monitoring symptoms related to medications, assistance with budgeting, teaching use of public transportation, monitoring and tutoring with regard to health maintenance, and monitoring contact with the family members.

(3) "Case planning" means the development of a written individualized case management plan by the case manager and the client.

(4) "Coordination, referral, and advocacy" means providing access to and mobilizing resources to meet the needs of a client. This may include but is not limited to:

(a) advocating on behalf of a client with a local human services system, the social security system, the disability determination unit, judges, etc.;

(b) making appropriate referrals, including to advocacy organizations and service providers, and insuring that needed services are provided; and

(c) intervening on behalf of a client who otherwise could not negotiate or access complex systems without assistance and support.

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

RULE XXVII 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.

(2) Intensive case management services for adults with severe disabling mental illness are case management services provided by a licensed mental health center in accordance with these rules and the provisions of Title 50, chapter 5, part 2, MCA.

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

(a) For purposes of [Rules XXV through XXX], 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 CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, SERVICE REQUIREMENTS (1) Case management services must be supported by narrative documentation of all services provided.

(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.

(3) Objectives in an intensive case management plan must have an identified date of review no more than 90 days after the plan date. Plans will be revised to reflect changes in client goals and needs, and the services provided to the client.

(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.

(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 must include at least three face-to-face contacts with the client per calendar month.

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

RULE XXIX CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, PROVIDER REQUIREMENTS (1) These requirements are in addition to those requirements contained in

rules generally applicable to medicaid providers.

(2) Intensive case management services for adults with severe disabling mental illness must be provided by a licensed mental health center enrolled in the Montana medicaid program as a case management services provider.

(3) Care coordination case management services for adults with severe disabling mental illness must be provided by either a licensed mental health center or a practitioner, as defined in [RULE XXVII], enrolled in the Montana medicaid program as a case management services provider.

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

RULE XXX CASE MANAGEMENT SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS, REIMBURSEMENT (1) Intensive case management services for adults with severe disabling mental illness will be reimbursed on a case rate per month basis as provided in this rule. For purposes of this rule, a month is a calendar month, regardless of the variation in the number of days in each calendar month.

(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 the 15th 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 and discharged on or after the 15th of the month; or

(b) one-half the monthly rate for:

(i) recipients admitted and served beginning on or after the 15th 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 and discharged prior to the 15th of the month.

(3) Care coordination case management services for adults with severe disabling mental illness 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 adults with severe disabling mental illness is limited to a total of 4 hours (16 units of service) per calendar month.

(b) Group care coordination services must include a minimum of 4 participants per group.

(4) The department will pay the lower of the following for case management services for adults with severe disabling mental illness:

(a) the provider's actual submitted charge for services; or

(b) the department fee schedule contained in this rule.

(5) The fee schedule for case management services for adults with severe disabling mental illness is the following:

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

(b) for care coordination case management services for adults with severe disabling mental illness:

(i) for individual care coordination services, $8.50 per 15-minute unit of service; and

(ii) for group care coordination services, $2.50 per 15-minute unit of service per participant.

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

RULE XXXI CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, ELIGIBILITY (1) Case management services are available under [Rules XXXI through XXXVII] only to youth with serious emotional disturbance.

(2) "Serious emotional disturbance (SED)" means with respect to a youth that the youth meets the 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); 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); 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

(iii) for a period of at least 6 months (or for a predicted period over 6 months), the youth consistently and persistently:

(A) has failed to establish or maintain interpersonal relationships appropriate to the youth's developmental stage and cultural environment;

(B) has displayed behavior inappropriate to the youth's developmental stage and culture;

(C) has failed to demonstrate a range of emotion or mood appropriate to the youth's developmental stage and culture;

(D) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings; or

(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 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, DEFINITIONS (1) "Assessment" means the act of identifying the resources and services needed to carry out the therapeutic case plan. Assessment includes identifying the strengths, abilities, potentials, skills and aspirations of the client and the client's family. This is not a psychiatric, medical or other specialized evaluation which is traditionally completed by other qualified professionals. Assessment enables the case manager to determine the nature and extent of brokering, coordination, transportation and advocacy needed.

(2) "Assistance in daily living" means the ongoing monitoring of how a client is coping with life on a day-to-day basis and the provision of assistance by a case manager which supports a client in daily life. Assistance with daily living skills includes but is not limited to:

(a) assistance with shopping and budgeting;

(b) teaching use of public transportation and other

resources;

(c) monitoring and tutoring with regard to health maintenance; and

(d) monitoring contact with family members.

(3) "Case planning" means the development of a written individualized case management plan for the client which is arrived at by the case manager with the participation of:

(a) the parent, legal guardian, or the surrogate parent;

(b) the client advocate;

(c) the client; and

(d) the client's service providers.

(4) "Coordination, referral and advocacy" means providing access to and mobilizing resources to meet the needs of the client. This may include but is not limited to:

(a) monitoring and assessing the impact of services being provided;

(b) identifying services included in the case plan that are not currently being provided, and the reasons the services are not being provided;

(c) ensuring that services identified in the case plan are provided;

(d) making appropriate referrals, including to advocacy organizations and service providers;

(e) enhancing parent or surrogate parent involvement in the planning and delivery of services for a client;

(f) empowering the client to speak or act on the client's own behalf when possible; and

(g) speaking or acting on the client's behalf when the client or others are unable to carry out this role.

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

RULE XXXIII 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.

(2) Intensive case management services for youth with serious emotional disturbance are case management services provided by a licensed mental health center in accordance with these rules and the provisions of Title 50, chapter 5, part 2, MCA, and implementing rules.

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

(a) For purposes of [Rules XXXI through XXXVII], 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 CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, SERVICE REQUIREMENTS (1) Case management services for youth with serious emotional disturbance must be supported by narrative documentation of all services provided.

(2) Intensive case management services for youth with serious emotional disturbance must be provided according to a case management plan which must:

(a) identify and define measurable objectives for the client and the client's family;

(b) 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;

(c) specify strategies for achieving defined objectives;

(d) identify the strengths and potentials of the client and the client's family which will be a base upon which coordinated services will be provided;

(e) identify agencies, service providers and contacts which will assist in achieving the defined objectives and specify how they will assist;

(f) identify natural, family and community supports to be utilized and developed in achieving the defined objectives;

(g) identify the role and duties of the client, the parent or the surrogate parent and all participants in the delivery of a comprehensive and coordinated service to the client and the client's family; and

(h) specify monitoring procedures and time frames.

(3) Objectives in a case management plan must have an identified date of review no more than every 90 days after the plan date. Plans must be kept current and revised to reflect changes in client goals and needs, the services provided to the client, and provider changes of responsibility.

(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.

(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 must include at least three face-to-face contacts with the client per calendar month.

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

RULE XXXV CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, PROVIDER REQUIREMENTS (1) These requirements are in addition to those contained in provisions generally applicable to medicaid providers.

(2) Intensive case management services for youth with serious emotional disturbance must be provided by a licensed mental health center enrolled in the Montana medicaid program as a case management services provider.

(3) Care coordination case management services for youth with serious emotional disturbance must be provided by either a licensed mental health center or a practitioner, as defined in [RULE XXXIII], enrolled in the Montana medicaid program as a case management services provider.

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

RULE XXXVI CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, GEOGRAPHICAL COVERAGE (1) Case management services for youth with serious emotional disturbance are available on a statewide basis.

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

RULE XXXVII CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, REIMBURSEMENT (1) Intensive case management services for youth with serious emotional disturbance will be reimbursed on a case rate per month basis as provided in this rule. For purposes of this rule, a month is a calendar month, regardless of the variation in the number of days in each calendar month.

(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 the 15th 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 and discharged on or after the 15th of the month; or

(b) one-half the monthly rate for:

(i) recipients admitted and served beginning on or after the 15th 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 and discharged prior to the 15th 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 of 4 participants per group.

(4) The department will pay the lower of the following for case management services for youth with serious emotional disturbance:

(a) the provider's actual submitted charge for services; or

(b) the department fee schedule contained in this rule.

(5) The fee schedule for case management services for youth with serious emotional disturbance is the following:

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

(b) for care coordination case management services for youth with serious emotional disturbance:

(i) for individual care coordination services, $8.50 per 15-minute unit of service; and

(ii) for group care coordination services, $2.50 per 15-minute unit of service per participant.

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

Rule XXXVIII MENTAL HEALTH CENTER SERVICES, DEFINITIONS

(1) "Adult" means a person who is not a child or adolescent as defined in this rule.

(2) "Adult day treatment" means a program which provides, in accordance with mental health center license requirements, a variety of mental health services to adults with a mental illness.

(3) "Child or adolescent" means a person 17 years of age and younger, and a person who is older as long as the person remains in secondary school.

(4) "Child and adolescent day treatment" means a program which provides, in accordance with mental health center license requirements, an integrated set of mental health, education and family intervention services to children or adolescents with severe emotional disturbance.

(5) "Community-based psychiatric rehabilitation and support" means service in home, school, workplace, and community setting for adults with severe and disabling mental illness and youth with severe emotional disturbance. Services are provided by trained mental health personnel under the direction of licensed professionals and are designed to assist individuals in developing the skills, behaviors, and emotional stability necessary to live successfully in the community.

(6) "Crisis intervention services" means a program which provides, in accordance with mental health center license requirements, emergency short term 24-hour care, treatment and supervision in a crisis intervention stabilization facility for persons age 18 or older with mental illness experiencing a mental health crisis.

(7) "Day treatment services" means adult day treatment services and child and adolescent day treatment services.

(8) "Foster care for mentally ill adults" means a supervised living environment in a licensed foster home with support services by mental health professionals.

(9) "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 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) "Mental health group home services" means a supported living environment provided under a group home endorsed mental health center license and providing independent living and social skills development services.

(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) "Practitioner services" means services provided by a practitioner which could be covered and reimbursed by the Montana medicaid program if the individual practitioner were enrolled in the program and provided the services according to applicable medicaid requirements.

(14) "Treatment day" means a calendar day, including night, daytime or evening, during which a patient is present at the provider's facility and receiving services according to applicable requirements.

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 MENTAL HEALTH CENTER SERVICES, REQUIREMENTS

(1) These requirements are in addition to those requirements contained in rules generally applicable to medicaid providers.

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

(3) Mental health center services must be provided by, or under the direction of a licensed physician.

(4) Mental health center services must be provided to a recipient in accordance with an individualized treatment plan developed and maintained in accordance with license requirements.

(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.

(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 hours during the treatment day.

(7) For purposes of meeting the minimum hours required in (6)(a) and (6)(b), the provider may not include time during which the recipient is receiving practitioner services which are actually billed separately as practitioner services as permitted under [Rule XL].

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 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;

(e) the therapeutic component of:

(i) crisis intervention services;

(ii) foster care for mentally ill adults; and

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

(4) A mental health center may provide case management services for youth with serious emotional disturbance and adults with severe disabling mental illness if enrolled as a provider of such services and in accordance with the requirement of medicaid rules applicable to those service categories. Case management services will be reimbursed only to the extent allowable and according to the medicaid rules applicable to the particular category of service.

(5) Mental health center services do not include practitioner services, except as specifically provided by and in

accordance with the requirements of these rules. Except as provided by these rules, practitioner services may be covered and reimbursed by medicaid only if the practitioner is enrolled as a provider and according to the medicaid rules and requirements applicable to the practitioner's category of service.

(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 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)(a) or ARM 46.12.2001 through 46.12.2003.

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

(a) family counseling is covered as a mental health center service only if medically necessary for the treatment of the medicaid eligible family member who is involved in the family therapy; and

(b) individual therapy includes diagnostic interviews where testing instruments are not used.

(7) Practitioner 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 mental health center services. These noncovered services include:

(a) practitioner services provided by practitioners who are staff of a mental health center which has a contract with a hospital involving consideration;

(b) services provided for purposes of discharge planning as required by 42 CFR Part 482.43; and

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

(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 MENTAL HEALTH CENTER SERVICES, REIMBURSEMENT

(1) Medicaid reimbursement for mental health center services shall be the lowest of:

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

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

(c) the department's medicaid fee for the service as specified in (2).

(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;

(d) for multi-disciplinary discharge treatment planning (50-60 minutes), $150.00 per meeting, including all participants; and

(e) 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 per treatment day, exclusive of room and board; and

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

(3) For day treatment and crisis intervention services, medicaid will not reimburse a mental health center provider for more than one fee per treatment day per recipient. This subsection does not apply to practitioner services to the extent such services are separately billed in accordance with these rules.

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

3. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.37.105 THERAPEUTIC YOUTH GROUP HOME, APPLICABILITY AND PARTICIPATION (1) ARM Title 37, chapter 37, subchapter 1 applies to services that the department, in its discretion, elects to provide to a youth through a contract between the provider and the department outside the Montana medicaid program provided under ARM Title 46, chapter 12 or the mental health services plan ~~managed care program~~ provided under ARM ~~46.20.103 through 46.20.126~~ Title 46, chapter 20. ~~These rules do~~ This subchapter does not entitle a youth to any of the services described in this subchapter.

(2) remains the same.

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

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

37.37.303 THERAPEUTIC FAMILY CARE, COMPLIANCE WITH APPLICABLE REQUIREMENTS (1) Title 37, chapter 37, subchapter 3 applies to services that the department, in its discretion, elects to provide to a youth through a contract between the provider and the department outside the Montana medicaid program provided in ARM Title 46, chapter 12 or the mental health services plan ~~managed care program~~ provided under ARM ~~46.20.103 through 46.20.126~~ Title 46, chapter 20. ~~These rules do~~ This subchapter does not entitle a youth to any of the services described in this subchapter.

(2) remains the same.

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

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

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

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

(5) and (6) remain the same.

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

46.12.202 SELECTION OF PROVIDER (1) Except as otherwise provided in ARM Title 46, chapter 12 ~~or ARM 46.20.103 through 46.20.126~~ any individual eligible for medical assistance may obtain the services available from any institution, agency, pharmacy, or practitioner, qualified to perform such services and participating under the program, including an organization which provides these services or arranges for their availability on a prepayment basis.

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

46.12.204 RECIPIENT REQUIREMENTS, COPAYMENTS (1) Except as provided in (2) through (4) ~~or ARM 46.20.120~~, each recipient must pay to the provider the following copayments not to exceed the cost of the service:

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

(j) clinic services, other than public health clinic services, $1.00 per visit;

(k) public health clinic services, $.50 per service;

(l)(k) through (1)(t) remain the same but are renumbered (1)(l) through (1)(u).

~~(u)~~ (v) specialized non-emergency medical transportation services, $1.00 per service~~.~~;

~~(v)~~ (w) chiropractor services (for qualified medicare beneficiaries only), $1.00 per service~~.~~;

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

(y) licensed clinical social worker services, $2.00 per service;

(z) licensed professional counselor services, $2.00 per service;

(aa) child and adolescent day treatment or adult day treatment services provided by a mental health center under [Rule XXXVIII through Rule XLI], $1.00 per day; and

(ab) community-based psychiatric rehabilitation and support services provided by a mental health center under [Rule XXXVIII through Rule XLI], $2.00 per 1 hour unit of service.

(2) through (4) remain the same.

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)(y) remain the same.

(z) hospice services; ~~and~~

(aa) licensed clinical psychologist services;

(ab) licensed clinical social worker services;

(ac) licensed professional counselor services;

(ad) residential treatment services;

(ae) mental health center services;

(af) case management services;

(ag) institutions for mental diseases for persons age 65 and over; and

(aa) remains the same in text but is renumbered as (ah).

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

~~(4) Regardless of any other provision of this chapter, mental health services, as defined in ARM 46.20.103, are available to medicaid recipients only as provided in ARM 46.20.103 through 46.20.126.~~

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

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

~~(4) Regardless of any other provision of this chapter, mental health services, as defined in ARM 46.20.103, are explicitly excluded from coverage under the Montana medicaid program, and are available to medicaid recipients only as provided in ARM 46.20.103 through 46.20.126.~~

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

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

(l) licensed clinical psychologists;

(m) licensed clinical social workers;

(n) licensed professional counselors;

(2)(m) through (2)(o) remain the same in text but are renumbered (2)(o) through (2)(q).

(3) through (13) remain the same.

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

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

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

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

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

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

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

(3) Outpatient hospital services are services that would also be covered by medicaid if provided in a non-hospital

setting and are limited to the following diagnostic and therapeutic services furnished by hospitals to outpatients:

(a) diagnostic services, including:

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

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

(iv) psychological tests;

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

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

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

46.12.508 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT

(1) remains the same.

(2) Except for the services reimbursed as provided in (3) through ~~(11)~~ (12), all facilities will be reimbursed on a retrospective basis. Allowable costs will be determined in accordance with ARM 46.12.509(2) and subject to the limitations specified in ARM 46.12.509(2)(a), (b) and (c). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000 for inpatient and outpatient hospital services provided to Montana medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the department waives retrospective cost settlement, the provider's interim payments for the cost report period shall be the provider's final payment for the period.

(2)(a) remains the same.

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

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

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

(5)(e) through (10)(f) remain the same.

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

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

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

(c) The per diem rates specified in (11)(a) and (b) are bundled prospective per diem rates for full-day programs and half-day programs, as defined in ARM 46.12.506. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, biologicals, supplies, equipment, therapies, nurses, social workers, psychologists, licensed professional counselors and other outpatient services, that are part of or incident to the partial hospitalization program, except as provided in (11)(d).

(d) Subject to (d)(i), 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.

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

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

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) remain the same.

(i) Medicaid reimbursement shall not be made unless the provider has obtained authorization from the department or its designated review organization prior to providing any of the following services:

(A) inpatient psychiatric services provided in an acute care general hospital or a distinct part psychiatric unit of an acute care general hospital, as required by [Rule I].

(1)(a)(i)(A) and (B) remain the same in text but are renumbered (1)(a)(i)(B) and (C).

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

(E) outpatient partial hospitalization, as required by [Rule I].

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

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

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

management and federally qualified health center services.

(2) through (6) remain the same.

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

46.12.514 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), PURPOSE AND SCOPE (1) through (5) remain the same.

~~(6) Regardless of the provisions of ARM 46.12.514 through 46.12.517, mental health services, as defined in ARM 46.20.103, are available to recipients under age 21 only as provided in ARM 46.20.103 through 46.20.126.~~

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

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

46.12.516 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (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 [Rule I].

(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 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 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 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.

(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.

(i) The therapeutic portion of medically necessary therapeutic family care treatment is covered for recipients with a primary diagnosis of SED as defined in [RULE XXXII], 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 [Rule I].

(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 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 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) 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.

(2)(g) through (2)(g)(ii) remain the same in text but are renumbered (2)(k) through (2)(k)(ii).

(3) remains the same.

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

46.12.517 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT (1) through (2) remain the same.

(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 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.

(5) For purposes of (3) and (4), "patient day" means a whole 24-hour period that a person is present and receiving therapeutic youth group home or therapeutic family care services. Even though a person may not be present for a whole 24-hour period, the day of admission is a patient day. The day of discharge is not a patient day.

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

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

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

(2) through (6) remain the same.

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

46.12.1708 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, DEFINITIONS (1) through (15) remain the same.

(16) "Visit" means a face to face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services. Encounters with more than one clinic or center health professional, and multiple encounters with the same clinic or center health professional, that take place on the same day and at a single location constitute a single visit, except when ~~one of the following conditions exist:~~

~~(a)~~ after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment~~; or~~.

~~(b) for FQHCs, the patient has a medical visit and a mental health visit as defined in (i) and (ii) of this subsection.~~

~~(i) For purposes of (16)(b), a "medical visit" is a face to face encounter between an FQHC patient and an FQHC health professional for medical services that are not mental health services.~~

~~(ii) For purposes of (16)(b), a "mental health visit" is a face to face encounter between an FQHC patient and an FQHC clinical psychologist, clinical social worker or other health professional for mental health services.~~

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

46.12.1713 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, SERVICE REQUIREMENTS (1) remains the same.

(2) The Montana medicaid program will not reimburse an RHC or FQHC for RHC or FQHC services that are:

~~(a) mental health services as defined in ARM 46.20.103, except as provided in ARM 46.12.1725; or~~

~~(b)~~ services covered by a health maintenance organization for an enrolled recipient, as provided in ARM Title 46, chapter 12, subchapter 48, except as provided in ARM 46.12.1725.

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

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

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

(a) high risk pregnant women;

(b) adults with severe disabling mental illness;

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

(d) youth with serious emotional disturbance;

(1)(c) and (1)(d) remain the same but are renumbered (1)(e) and (1)(f).

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

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

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

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

(p) mental health services provided under the Montana medicaid program or the mental health ~~access~~ services plan provided in ARM Title 46, chapter 20 ~~for the diagnoses specified by the definition of "covered diagnosis" as defined at ARM 46.20.103~~;

(2)(q) through (5) remain.

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

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

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

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

(h) mental health ~~centers~~ center services as provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules XXXVIII through XLI];

(2)(i) remains the same.

(j) licensed clinical psychologists services provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules III through V];

(k) licensed clinical social work services provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules VI through VIII];

(2)(l) remains the same.

(m) licensed professional counselor services provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules IX through XI];

(n) through (v) remain the same.

(w) institution for mental disease services as provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules XVIII through XXIV];

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

(z) case management services as defined in ARM 46.12.1901 et seq. ~~or as provided in ARM 46.20.103 through 46.20.126~~;

(2)(aa) remains the same.

(ab) admission for residential treatment services as provided in ~~ARM 46.20.103 through 46.20.126~~ [Rules XII through XVII];

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

(4) Nothing in this rule reduces or otherwise affects the requirements that must be met under ~~ARM 46.20.103 through 46.20.126,~~ [Rule I] to obtain or access mental health services as ~~defined~~ provided in ~~ARM 46.20.103~~ this chapter.

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 ~~ACCESS~~ SERVICES PLAN, DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) remains the same.

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

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

(d) the Boulder River school ~~Montana youth alternatives campus and wilderness components, only when the youth has been placed in the program by the department or the Montana department of corrections~~;

(3)(e) through (3)(i) remain the same.

(4) "Covered diagnosis" means a diagnosis for which the mental health ~~access~~ services plan provides covered services to members, as specified in ARM 46.20.114.

(a) ~~Prior to April 1, 1999, "covered diagnosis" means for an individual who is medicaid eligible, one of the ICD-9-CM diagnosis codes numbered 290.0 through 291.0, 291.2 through 291.3, 291.5 through 291.9, 292.1 through 292.89, 293, 293.0 through 302, 302.2, 302.4, 302.6, 302.84 through 302.89, 306, 306.0 through 307, 307.1 through 307.3, 307.46, 307.5 through 312.30, 312.32 through 314.9 and 316.~~

~~(b) Beginning April 1, 1999, "covered diagnosis" means for an individual who is medicaid eligible one of the ICD-9-CM~~

~~diagnosis codes numbered 290, 293, 293.0 through 302, 302.2, 302.4, 302.6, 302.84 through 302.89, 306, 306.0 through 307, 307.1 through 307.3, 307.46, 307.5 through 307.80, 307.82 through 312.30, 312.32 through 314.9 and 316.~~

~~(c)~~ A "covered diagnosis" means ~~for an individual who is not medicaid eligible~~ one of the ICD-9-CM diagnosis codes numbered 290, 293, 293.0 through 302, 302.2, 302.4, 302.6, 302.84 through 302.89, 306, 306.0 through 307, 307.1 through 307.3, 307.46, 307.5 through 307.80, 307.82 through 312.30, 312.32 through 314.9 and 316.

(5) and (6) remain the same.

(7) "Federal poverty level" or "FPL" means the ~~1996~~ 1999 poverty guidelines for the 48 contiguous states and the District of Columbia as published under the "Annual Update of the HHS Poverty Guidelines" in the federal register ~~of March 4, 1996~~ on March 18, 1999 and subsequent annual updates.

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

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

~~(10)~~(8) "Medically necessary" is defined as provided in ARM 46.12.102 ~~or "medically necessary services" means services and supplies which are required for diagnosis, prevention or treatment of mental illness and which are:~~

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

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

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

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

(11) remains the same but is renumbered (9).

~~(12)~~(10) "Mental health ~~access~~ services plan" ~~or "MHAP"~~ or "plan" means the mental health services program established ~~access plan described~~ in this subchapter.

(13) remains the same but is renumbered (11).

~~(14)~~(12) "Provider" means a person or entity that has enrolled and entered into a ~~written contract~~ provider agreement with the ~~MCO~~ department in accordance with the requirements of ARM 46.20.110 to provide mental health services to members.

~~(15)~~(13) "Provider ~~contract~~ agreement" means the written ~~contract~~ enrollment agreement entered into between the ~~MCO~~ department and a person or entity to provide mental health services to recipients.

~~(16)~~(14) "Serious emotional disturbance" or "SED" means with respect to a youth that the youth meets the requirements of

(14)(a), (b) or (c), and meets the requirements of (d):

(16)(a) through (16)(c)(iii)(D) remain the same but are renumbered (14)(a) through (14)(c)(iii)(D).

(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.

(17) through (17)(b)(ii)(D) remain the same but are renumbered (15) through (15)(b)(ii)(D).

~~(18)~~(16) "Total family income" means the total annual gross cash receipts, as defined by the bureau of the census and cited in the "Annual Update of the HHS Poverty Guidelines" in the federal register of ~~March 4, 1996~~ March 18, 1999, of all members of a family. Regular and continuing sources of income will be appropriately annualized for purposes of determining the annual income level. Extraordinary and nonrecurring income will be considered only for the 12 month period following receipt.

(18)(a) through (19) remain the same but are renumbered (16)(a) through (17).

~~(20)~~(18) The department hereby adopts and incorporates by reference the ICD-9-CM diagnosis codes with meanings found in the St. Anthony's ICD-9-CM Code Book (1998) effective October 1, 1998 through September 30, 1999, published by St. Anthony Publishing. The department also hereby adopts and incorporates by reference the DSM-IV diagnosis codes with meanings found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), published by the American Psychiatric Association of Washington, DC. These systems of coding provide the codes and meanings of the diagnostic terms commonly used by treating professionals and are incorporated herein in order to provide common references for purposes of the provision of services through the mental health ~~access~~ services plan. Copies of applicable portions of the ICD-9-CM and the DSM-IV 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.

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 ~~ACCESS~~ SERVICES PLAN, MEMBER ELIGIBILITY ~~(1) Individuals that the department has determined eligible for medicaid through the usual medicaid application and eligibility determination processes are not eligible for covered services under the plan. No application or other enrollment is required for an individual who has been determined medicaid eligible by the department.~~

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

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

(1) An individual is eligible for covered services under the plan if:

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

~~(b)~~ the family of which the individual is a member has a total family income, without regard to other family resources, at or below 150% of the most recently published federal poverty level (FPL); ~~or~~ and

~~(c) the individual is a patient of the Montana state hospital or the Montana mental health nursing care center and the family of which the individual is a member has a total family income, without regard to other family resources, at or below 200% of the FPL; and~~

(b) the individual has been denied medicaid eligibility, is ineligible for medicaid by virtue of being a patient in an institution for mental diseases, or has applied for medicaid and the application is pending. An individual who meets medicaid eligibility requirements but does not apply for medicaid is not eligible to receive services under the plan.

(2) If a person who is determined eligible for the plan based upon a pending medicaid application is later determined to be eligible for medicaid:

(a) any payment received by the provider under the plan for services provided during the effective period of medicaid eligibility must be refunded to the department; and

(b) all services provided to the individual during the effective period of medicaid eligibility may be billed to medicaid according to applicable medicaid requirements.

(3) For purposes of determining the total family income under ~~(2)(b)~~ (1):

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

(4) Application forms and information regarding eligibility ~~of non-medicaid individuals~~ for the plan are available at all local county human services departments ~~and from the MCO~~.

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

~~(7) Eligibility and premium payments determinations for non-medicaid individuals are effective for a period of 1 year~~

~~unless the federal poverty level or the member's income or family composition changes before the expiration of the 1-year eligibility period.~~

(7) Eligibility determinations are effective until the earlier of:

(a) 1 year; or

(b) the effective date of any redetermination.

(8) The department may redetermine eligibility at any time.

(a) the department may accept for purposes of initial eligibility under this rule a prior determination of eligibility under the mental health access plan (MHAP), if the individual's eligibility remained effective as of the date of termination of the MHAP. Initial eligibility provided under this subsection must be redetermined in accordance with (8)(b);

(7)(a) remains the same but is renumbered (8)(b).

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

(7)(c) remains the same but is renumbered (8)(d).

~~(d)~~ (e) An individual is liable to the ~~MCO~~ department and the ~~MCO~~ department may collect from the individual the amount of actual ~~MCO~~ payments by the department or its agents to providers for any services furnished to the individual because of misrepresentation of income or a failure to give the required notice of changes in income or family composition.

~~(8)~~ (9) A nonmember receiving covered emergency mental health services, which do not include hospital emergency room or other hospital services, ~~except for a hospital emergency room visit,~~ is ~~presumed~~ eligible on an emergency basis for the plan and may receive covered medically necessary services for a covered diagnosis unless the provider determines that the individual has the means, financially or otherwise, by which to make payment. If the individual is subsequently determined ineligible for the plan or fails to complete an application for plan eligibility within 60 days following completion of emergency treatment, the individual is liable for and may be billed by the provider at its usual and customary private pay charges or by the ~~MCO~~ department for the amount of payments actually made by the ~~MCO~~ department or its agents to the provider for the services provided.

~~(9) In addition to meeting any additional member notification and education requirements under its contract with the department, the MCO must provide all applicants with current, accurate, understandable information regarding covered diagnoses, available services, procedures to access services, financial liability for services obtained outside the plan, and grievance and appeal procedures.~~

(10) Members must comply with the procedures specified by the ~~MCO as necessary~~ department in accordance with [Rule II] to

obtain or access services under the plan.

(11) 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 department may, in its discretion, limit services, rates, eligibility and 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.

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 ~~ACCESS~~ SERVICES PLAN, PROVIDER PARTICIPATION (1) Providers of services may request enrollment in the plan and may participate in the plan only upon approval of enrollment and according to the written ~~contract~~ provider agreement between the provider and the ~~MCO~~ department and the requirements of this subchapter.

(a) The provisions of ARM 46.12.302 shall apply for purposes of provider enrollment in the plan. Providers must enroll with the department's medicaid fiscal agent in the same manner and according to the same requirements applicable under the Montana medicaid program. The department may accept current medicaid enrollment for purposes of enrollment under the plan, if the provider agrees, in a form acceptable to the department, to be bound by applicable plan requirements.

(b) For purposes of enrollment in the plan, providers must be and remain enrolled in the Montana medicaid program for the same category of service and must meet the same qualifications and requirements that apply to the provider's category of service under the Montana medicaid program.

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

~~(a) acute care hospitals;~~

~~(b)~~ (a) residential treatment facilities;

~~(c)~~ (b) therapeutic youth group homes and therapeutic family care providers;

~~(d)~~ (c) ~~community~~ mental health centers;

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

(2)(f) remains the same in text but is renumbered (2)(d).

~~(g)~~ (e) primary care ~~physicians~~ providers, as defined in ARM 46.12.4801(18);

~~(h) advanced practice registered nurses;~~

~~(i) physician assistants;~~

~~(j)~~ (f) licensed clinical psychologists;

(2)(k) and (2)(l) remain the same in text but are renumbered (2)(g) and (2)(h).

~~(m) therapeutic family care providers;~~
~~(n) transitional living group homes;~~
~~(o) federally qualified health centers (FQHCs) which currently provide mental health services;~~
~~(p) home health agencies;~~
~~(q) personal care providers; and~~
~~(r) other categories designated by the MCO~~
(i) outpatient pharmacies; and
(j) outpatient psychiatric partial hospitalization providers.

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

(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.

~~(a)~~ (b) A provider ~~may be~~ who is denied enrollment ~~for good cause, which must be communicated in writing to the provider by the MCO. A participating provider~~ has no right to an administrative review or fair hearing as provided in ARM 46.2.201, et seq., 46.12.409, 46.12.509A, 46.12.1268, 46.20.123 or any other department rule ~~for a denial of enrollment~~.

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

(4) The provisions of ARM Title 46, chapter 12, subchapter 3 ~~46.12.301, 46.12.302, 46.12.304, 46.12.306, 46.12.307, 46.12.309 and 46.12.310~~ and other medicaid program laws, rules and regulations regarding particular categories of service ~~do not~~ apply to participating providers ~~or~~ and the services provided under ~~these rules~~ the plan, except as specifically provided in this subchapter or the provider agreement ~~contract~~.

~~(a) The provisions of ARM 46.12.303 related to payment in full apply to payments by the MCO to providers, except as otherwise provided in this subchapter. The remaining provisions of ARM 46.12.303, relating to claim submission and other matters do not apply to providers with respect to mental health services provided under the plan.~~

(4)(b) through (4)(b)(i) remain the same but are renumbered (4)(a) through (4)(a)(i).

(ii) Upon request, providers must provide complete copies

of medical records to the department or its agents~~, the MCO or the hearing officer~~.

~~(c)~~ (b) For all members, ~~the MCO and~~ providers must comply with the same confidentiality requirements that apply to information regarding medicaid recipients.

(c) The department may collect from a provider any overpayment under the plan as provided with respect to medicaid overpayments in ARM 46.12.303(9) through (10)(b). The department may recover overpayments by withholding or offset as provided in ARM 46.12.408(1).

(i) The notice and hearing provisions of ARM 46.12.407 and 46.12.409 apply to a department overpayment determination under (4)(c).

(d) The department may sanction a provider based upon the same grounds that sanctions may be imposed against a provider under the Montana medicaid program, except that a sanction may not be imposed with respect to a provider's conduct or omission under the plan based upon a medicaid requirement or prohibition that is not applicable to the plan under these rules.

(i) Sanctions imposed under (4)(d) may include termination or suspension from plan participation and required attendance at provider education sessions at the provider's expense.

(ii) The department must consider the factors listed in ARM 46.12.403 in determining whether to impose a sanction and what sanction, if any, to impose. The provisions of ARM 46.12.404 and 46.12.405 shall apply to any sanction imposed under (4)(d).

(iii) The notice and hearing provisions of ARM 46.12.407 and 46.12.409 apply to a department sanction determination under (4)(d).

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

~~(6)~~ (5)(a) An enrolled ~~A participating~~ provider has no right to an administrative review or fair hearing as provided in ARM 46.2.201, et seq., 46.12.307, 46.12.409, 46.12.509A, 46.12.1268 or any other department rule for:

(i) ~~a denial of payment by the MCO to the provider for a service provided to a recipient~~ a determination by the department or its agent that a particular service, item or treatment is not medically necessary;

(ii) a denial of approval, authorization, certification or coverage of a service available from the provider or provided by the provider to a ~~recipient~~ member; or

(iii) any other issues related to the provider agreement ~~contract~~, the provision of services to recipients or the plan, except as specifically permitted by this subchapter.

(b) ~~The provider's sole remedy is as may be provided under the contract or as provided by law based upon the contract.~~ 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 payment by the department to the provider for a service provided to a member if:

(i) the department has determined that the particular service, including the amount, duration and frequency of the service, is medically necessary for the member to treat a covered diagnosis and has authorized the particular service for the member according to applicable requirements; and

(ii) the department has determined that the member is eligible for the plan according the requirements of ARM 46.20.106.

(6) For purposes of applying the provisions of any medicaid rule as required by this subchapter, references in the medicaid rule to "medicaid" or the "Montana medicaid program" or similar references, shall be deemed to apply to the plan as the context permits.

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 ~~ACCESS~~ SERVICES PLAN, COVERED SERVICES (1) ~~Medically~~ Authorized medically necessary mental health services for a covered diagnosis are covered under the plan for members, except as provided in this subchapter.

(2) Covered services include:

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

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

~~(c) treatment planning and service coordination;~~

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

~~(e)~~ (c) psychiatric partial hospitalization services;

~~(f) Montana mental health nursing care center services for extended care of psychiatric conditions;~~

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

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

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

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

~~(k)~~ (g) medication management, including lab services necessary for management of prescribed medications medically necessary with respect to a covered diagnosis;

~~(l)~~ (h) 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;

~~(m)~~ (i) ~~intensive~~ case management services for adults with

~~a serious~~ severe disabling mental illness and for youths with ~~severe~~ serious emotional disturbance;

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

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

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

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

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

~~(s)~~ (l) ~~school based~~ day treatment for children and adolescents with serious emotional disturbance.~~;~~

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

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

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

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

~~(x) lab services; and~~

~~(y) other services, including consumer operated alternatives, designated by the MCO~~.

(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 ~~recipient~~ member may be determined and may be restricted by the ~~MCO~~ 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) The MCO shall make available to members and participating providers its:~~

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

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

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

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

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

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

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

(7)(a) remains the same.

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

~~(8) Regardless of diagnosis, members admitted voluntarily or involuntarily to the Montana state hospital, receive Montana state hospital services under the plan, except for the following members:~~

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

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

~~(c) individuals covered and served under a contract between Montana state hospital and Indian health services; and~~

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

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

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

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

~~(12)~~ (8) The plan covers medically necessary mental health services for any covered diagnosis for a member with a primary diagnosis of mental retardation or developmental disability, but does not cover treatment, habilitation or other services required by the member's mental retardation or developmental disability.

~~(13)~~ (9) The plan does not cover:

(a) any form of transportation services;

~~(b) prescription or other drugs for medicaid eligible recipients, but the plan covers medically necessary psychotropic drugs as provided in (6) of this rule for persons eligible for the plan under ARM 46.20.106(2);~~

~~(c)~~ (b) detoxification, drug or alcohol evaluation, treatment or rehabilitation, regardless of the member's diagnosis; and

~~(d)~~ (c) services provided to a ~~presumptively eligible~~ nonmember who is eligible on an emergency basis during a hospital emergency room visit.

~~(14) The services described in (13)(a), (b) and (c) are covered for medicaid recipients under the medicaid program to the extent provided under applicable medicaid requirements.~~

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

(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.

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 ~~ACCESS~~ SERVICES PLAN, PROVIDER REIMBURSEMENT (1) Reimbursement of enrolled providers for mental health services covered under the plan and provided to plan members ~~under the plan~~ is as provided in ~~the provider contract. Other department rules, including medicaid rules~~ ARM

Title 46, chapter 12 for the same service or category of service under the Montana medicaid program, ~~are not applicable except as specifically provided in this subchapter or the provider contract~~.

(a) For services covered under the plan, reimbursement under the plan is subject to the same requirements, restrictions, limitations, rates, fees and other provisions that would apply to the service if it were provided to a medicaid recipient, except as otherwise provided in these rules. However, if a service is not covered under the plan, the fact that the service is or would be covered by medicaid if provided to a medicaid recipient, does not entitle the provider, member or any other person or entity to coverage or reimbursement of the service under the plan.

(i) For purposes of applying medicaid rules to plan services, a person eligible for the plan under ARM 46.20.106 need not be medicaid eligible.

(2) Provider claims for mental health services provided to members under the plan must be submitted to the ~~MCO for payment as specified in the provider contract. Except for encounter claims submitted to the~~ department's medicaid management information system (MMIS) contractor according to requirements set forth in ARM 46.12.303 ~~as specified in the provider contract, provider claims for mental health services provided under the plan will not be accepted or processed by the department, consultee or other department agents~~. Payments will ~~not~~ be made to the provider through ~~by~~ the department's medicaid MMIS contractor ~~department, consultee or other department contractor, other than the MCO as specified in the provider contract~~.

(3) Providers must accept the amounts payable under ~~the provider contract~~ 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 ~~and for purposes of applying such provisions the term "MCO" shall be substituted for "department"~~.

(4) The provisions of ARM 46.12.304 apply with respect to ~~MCO is responsible for investigating and collecting member's~~ third party resources and seeking payment from these sources~~, as provided in the provider contract~~.

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

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

AUTH: Sec. 53-2-201 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 ~~ACCESS~~ SERVICES PLAN, PREMIUM

PAYMENTS, AND MEMBER COPAYMENTS (1) A ~~non-medicaid~~ member of the plan must pay to the provider the following copayment not to exceed the cost of the service; ~~a monthly premium payment to the MCO determined from the table below. The premium payment that a member must pay is the corresponding payment for the percentage range of the federal poverty level that is within the member's total family income.~~

~~Percent of federal poverty level.~~	~~Premium payment per month.~~
~~0-25%~~	~~$ 0~~
~~26-50%~~	~~$ 10~~
~~51-100%~~	~~$ 25~~
~~101-150%~~	~~$ 35~~
~~151-200%~~	~~$ 50~~

~~(2) A family with more than one non-medicaid member of the plan must pay a monthly premium payment to the MCO~~ department ~~determined from the table below. The premium payment a family must pay is the corresponding payment for the percentage range of the federal poverty level that is within the family's total family income.~~

~~Percent of federal poverty level.~~	~~Premium payment per month.~~
~~0-25%~~	~~$ 0~~
~~26-50%~~	~~$ 20~~
~~51-100%~~	~~$ 50~~
~~101-150%~~	~~$ 70~~
~~151-200%~~	~~$100~~

~~(3) The MCO department may waive payment of a premium payment for purposes of managing risk.~~

~~(4) Copayments may be charged to and collected from members by providers or the MCO only as provided in this rule.~~

~~(5) Medicaid eligible members may not be charged or required to pay copayments for mental health services provided under the plan. A resident of a state institution, however, remains obligated to pay charges for the cost of care as provided in Title 53, chapter 1, part 4, MCA and implementing rules.~~

~~(6) A pharmaceutical provider may charge a copayment on the purchase of a prescription by a non-medicaid member of the plan subject to the following limitations.~~

~~(a) The copayment may not exceed for each filling of a prescription the lesser of the cost of that particular filling or $10.~~

(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, or a lesser amount designated by the department; and

(c) for each inpatient admission, $50 or a lesser amount designated by the department.

~~(b) The total of copayments paid per month by a member may not exceed $50.~~

~~(c) The total of copayments paid per month by a family with more than one non medicaid member may not exceed $100.~~

~~(7) The MCO may refuse to provide services under the plan, except emergency services or services provided by the Montana state hospital or the Montana mental health nursing care center, to any member who has accumulated unpaid premiums and copayments more than 90 days in arrears, if:~~

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

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

~~(8) Residents of the Montana state hospital and the Montana mental health nursing care center, whether or not medicaid eligible, are liable to the institution for amounts assessed by the department pursuant to Title 53, chapter 1, part 4, MCA and implementing rules. Residents of the Montana state hospital and the Montana mental health nursing care center are not responsible in addition for such amounts for the premium payments specified in this rule. Pharmacy copayments required by this rule are not charged to inpatients of the Montana state hospital and the Montana mental health nursing care center.~~

~~(9)~~ (2) The medicaid copayment provisions of ARM 46.12.204 are not applicable to mental health services provided under the plan.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-131, MCA
IMP: Sec. 53-1-405, 53-1-601, 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-131, MCA

46.20.123 MENTAL HEALTH SERVICES PLAN, MEMBER NOTICE, GRIEVANCE AND ~~APPEAL~~ RECONSIDERATION RIGHTS (1) The department or its designee must notify the member or the member's designated representative in writing of a decision denying eligibility or a request for services. The requirements of ARM 46.2.204 do not apply to the notice. The notice will state:

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

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

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

(d) an explanation of how to request a grievance or reconsideration regarding the determination.

(2) If the department fails to provide notice or fails to timely provide notice or if a notice required by (1) fails to comply substantially with the requirements of (1), the remedy is the provision of a new notice which does comply substantially with (1) and a new opportunity to request a reconsideration regarding the decision specified in the notice. A failure to

give adequate or timely notice under (1) does not entitle the member to an authorization for the services that were denied.

~~(1)~~ (3) A member has the right to any applicable grievance processes provided by the department's review designee referred to in [Rule II] and, following exhaustion of such grievance processes, ~~a fair hearing~~ an informal reconsideration as provided ~~for claimants at ARM 46.2.201, et seq.,~~ in ARM 46.2.208(5)(a) regarding a denial or termination of plan eligibility, a denial of authorization or coverage of services, a determination that a member is liable to the department as provided in ARM 46.20.106 based upon a misrepresentation or failure to provide notification of changes in income or family composition, or a determination that a member is liable to the provider as provided in ARM 46.20.106 based upon failure to apply for plan eligibility within 60 days following completion of emergency treatment.

~~(2) Subject to the requirements of this rule, a member has the right to a fair hearing as provided for claimants at ARM 46.2.201, et seq., regarding:~~

~~(a) a denial of service by the MCO;~~

~~(b) a determination that a member is liable to the MCO as provided in ARM 46.20.106(7)(c) based upon a misrepresentation or failure to provide notification of changes in income or family composition; and~~

~~(c) a determination that a member is liable to the MCO as provided in ARM 46.20.106(8) based upon failure to apply for plan eligibility within 60 days following completion of emergency treatment.~~

~~(3) The MCO must notify the member or the member's designated representative in writing of a decision denying a request for services. The notice must be provided within 10 days after a decision is made by the MCO. The requirements of ARM 46.2.204 do not apply to the notice. The notice must state:~~

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

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

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

~~(d) the legal authority supporting the decision; and~~

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

~~(4) If the MCO fails to provide notice or fails to timely provide notice or if a notice required by (3) fails to comply substantially with the requirements of (3), the remedy is the provision of a new notice which does comply substantially with (3) and a new opportunity to contest the decision specified in the notice. A failure to give adequate or timely notice under (3) does not entitle the member to an authorization for the services that were denied.~~

~~(5) The MCO must provide a written procedure for resolution of grievances and appeals brought by a member or the member's representative. A member may submit a grievance or appeal to the MCO within 30 days after mailing of notice of the~~

~~decision to the member or the member's designated representative. A member must exhaust the MCO's grievance or appeal procedure before exercising the administrative review panel procedure specified in (6).~~

~~(6)~~ (4) The department or its designee may request additional supporting information or documentation from the member~~,~~ or the provider ~~or the MCO~~ for purposes of ~~reviewing and deciding the~~ a grievance or informal reconsideration ~~administrative review panel case~~.

(a) ~~The administrative review will be conducted informally.~~ The department will consider the written materials submitted and the rationale for the decision ~~provided by the MCO~~. In its discretion, if the department finds that resolution of the issues would be aided, the department may contact persons involved in the case, interested agencies or mental health professionals and may request that the member, the member's representative, a mental health professional, ~~a representative of the MCO,~~ a provider representative or other appropriate persons to appear in person or by telephone conference to discuss the case.

(b) The department must make a decision on the ~~administrative review~~ informal reconsideration and notify the member or the member's representative in writing of the decision.

~~(7) The administrative review decision is final and binding on the MCO. The MCO is not entitled to a fair hearing as provided in ARM 46.2.201, et seq., 46.12.409, 46.12.509A, 46.12.1268 or any other department rule to contest an adverse administrative review decision.~~

~~(8) A member has the right of appeal as provided at ARM 46.2.201, et seq., to contest an adverse administrative review decision regarding an action described in (2)(a) through (d) of this rule, but must exhaust the administrative review procedure before a fair hearing may be requested from the department under the provisions of ARM 46.2.201, et seq. A member does not have a right of appeal under ARM 46.12.201, et seq. to contest an adverse decision regarding a matter not described in (2) of this rule.~~

(5) A member must request a grievance according to the requirements specified by the department's designee.

(6) A member must request an informal reconsideration within 30 days after receiving notice of the grievance decision.

~~(9)~~ A member that does not timely ~~submit a grievance or appeal or a request for an administrative review~~ request an informal reconsideration is deemed to have accepted the ~~agent's~~ determination and is not entitled to any further notice or ~~appeal~~ review opportunity.

~~(10) For purposes of ARM 46.2.202(1)(c), the 90 day appeal period starts on the day the department mails to the member or the member's representative a written notice of the administrative review decision.~~

~~(11) The administrative review process provided in ARM 46.2.208 does not apply to a member request for a fair hearing~~

~~to contest an administrative review panel decision under (8).~~

~~(12) The member and the MCO are the parties to an appeal brought by a member regarding any matters subject to appeal as specified in (2) of this rule. The department is not a party to an appeal brought by a member regarding any matters subject to appeal as specified in (2) of this rule.~~

~~(13) The provisions of this rule apply in addition to the applicable provisions of ARM 46.2.201, et seq., except that the provisions of this rule shall control in the event of a conflict with the provisions of ARM 46.2.201, et seq. The provisions of ARM 46.12.409, 46.12.509A, 46.12.1268 or any other department appeal or hearing provision do not apply to a review or hearing under this rule.~~

~~(14)~~ (7) A member is not entitled to continuation of benefits under these rules. ARM 46.2.206 or 42 CFR, part 431, subpart E~~, unless the decision at issue is a rescission by the MCO of a specifically granted approval for a particular service for a specific period of time. The member is not entitled to a continuation of benefits where the MCO granted approval for a service for a period of time or number of units but the MCO denies approval for additional periods or units of service~~.

(8) A provider is not entitled to payment for services provided after the effective date of a denial of authorization.

(9) A member is entitled only to the processes specifically provided in this rule to contest an adverse decision by the department or its designee. A member is not entitled to any administrative review or hearing procedure under ARM 46.2.201, et seq., or other department rule, regarding a denial or termination of plan eligibility, a denial of authorization or coverage of services, or any other issue arising under the plan.

(10) A member is not entitled to any grievance, reconsideration, review, hearing or other appeal process with respect to changes in eligibility coverage or other plan benefits which result from generally applicable changes in eligibility requirements, coverage provisions, rates, imposition of limitations or other changes.

AUTH: Sec. 2-4-201, 53-2-201, 53-6-113 and 53-6-706, MCA
IMP: Sec. 2-4-201, 53-1-601, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-706 and 53-21-202, MCA

46.20.126 MENTAL HEALTH ~~ACCESS~~ SERVICES PLAN, TRANSITION FROM RULES IN EFFECT PRIOR TO ~~APRIL 1, 1997~~ JULY 1, 1999

(1) Notwithstanding any provision of this subchapter, under no circumstances will the plan cover services provided prior to ~~April 1,1997~~ July 1, 1999.

~~(2) Individuals receiving mental health services prior to April 1, 1997 under any state program including but not limited to medicaid, managing resources Montana, a state mental health program, or a state child and family services program, will not be entitled under any such program to further mental health services provided on or after April 1, 1997. This rule applies~~

~~regardless of whether the member has completed any prescribed course of treatment, whether admission occurred, or continued stay or services were approved for any particular period of time under such program. Continued state funding will be available for mental health services provided on or after April 1, 1997 only as provided in this subchapter.~~

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

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-1-601, 53-1-612, 53-2-201 and 53-21-202, MCA

3. The proposed rule changes implement a joint federal and state funded program of mental health service coverage under the Montana medicaid program and a state-funded Mental Health Services Program (MHSP). Services currently are provided to eligible individuals under the Mental Health Access Plan (MHAP). The current MHAP system is operated under a waiver of certain federal medicaid requirements approved by the federal Department of Health and Human Services under section 1915 of the Social Security Act. Under the waiver, funding from several programs, including medicaid and certain general fund programs was combined and administered under a single program that served both medicaid-eligible and certain other low income individuals. Under the waiver and MHAP, the department contracts with a managed care organization to operate the program.

A subcommittee of the Montana legislature recently voted to require the department to terminate its contract with the current managed care organization. The managed care organization then notified the department that it would terminate the contract. The contract will terminate on June 30, 1999. As a result of contract termination, the waiver necessary to operate the MHAP program will also terminate. Accordingly, the department will no longer have waiver authority to operate the MHAP program.

Action by the Montana Legislature to require the department to terminate its contract with Montana Community Partners (MCP), the department's contractor for the Mental Health Access Plan (MHAP), actual notice of contract termination received from MCP, and the termination of the section 1915(b) waiver which allows the department to operate the MHAP all combined to effectively preclude the possibility of continuing operation of the MHAP in its present form. The department considered continuation of the MHAP under a new contractor but determined that option was not available. Selection of another contractor would require an extended procurement process, a period of time for the selected vendor to develop systems, procedures and processes consistent with current MHAP rules, and a possible delay in implementation while the department tested and certified the contractor's

readiness to adequately perform all necessary functions. The department will, in fact, follow this procedure in implementing a new mental health managed care system over the next year. For the present, it is necessary to define and implement an interim method to assure the continuation of mental health services to medicaid beneficiaries and other low-income persons with a serious mental illness. Because the department's 1915(b) waiver has been extended only through April, 1999, that method must be in accord with Health Care Financing Administration regulations.

The department must select approaches to service coverage and rate structures that can be implemented in the relatively short amount of available time, that work within existing systems and processes, that minimize reliance upon untested approaches and that can be implemented within the appropriations provided by the Montana legislature. Considering the concerns of providers and consumers under MHAP regarding the levels of rates, timeliness of payment and other issues, the department believes that an interim system based upon familiar systems and processes and a generally predictable level and timeliness of payment will facilitate stability in the service delivery system. Such a system will also provide a sound foundation upon which to develop and implement a new managed care system in the next biennium. Accordingly, the department has selected the option of basing the proposed rules in large part upon the medicaid rules that were in effect prior to MHAP, with particular changes necessary to address the circumstances of the interim system and changes in medicaid systems and processes that have occurred since MHAP implementation.

Given the complexity and scope of the task of implementing a comprehensive statewide system of mental health services for medicaid and other low income individuals, the department believes that the only feasible option is to implement a system of coverage and reimbursement similar to the medicaid system in place immediately prior to MHAP implementation. This option allows the department to adopt systems and processes familiar to the department, providers and consumers. The department believes that this is the only option that can be successfully implemented by July 1, 1999.

The department intends that the programs established under the proposed rule changes will be implemented on a temporary interim basis. The department anticipates that it will be working over the course of the next 15 months to establish a new mental health managed care system under the final version of a proposal currently under consideration in the Montana legislature.

The proposed rules establish both medicaid and MHSP coverage of mental health services. The proposed rules specify the mental health services that will be covered under medicaid and MHSP, the requirements and limits applicable to various medicaid and MHSP mental health services, the rates to be paid for particular

medicaid and MHSP mental health services, copayments required for medicaid and MHSP eligible individuals, recipient and provider grievance, reconsideration and hearing rights under MHSP, eligibility requirements for individuals to receive services under MHSP and other program definitions and requirements.

The department considered the option of developing a completely separate system for providing mental health services coverage to low income individuals not eligible for medicaid. However, the department did not select this approach because sufficient time was not available to fully consider or develop such a system and because such an approach would be inefficient for the department, providers and consumers. There are significant advantages to adopting a program as similar as possible to the proposed medicaid system. Accordingly, the department has selected the option of proposed rules that apply the same requirements, procedures, rates and other rules to both medicaid and non-medicaid mental health service coverage insofar as practicable. Although complete uniformity between the two programs is not possible for various reasons, the department believes that the proposed rules minimize unnecessary differences between the programs and unnecessary duplication in paperwork or other requirements.

The department weighed several reimbursement methodologies, including those in effect for providers prior to MHAP implementation, those currently used by MCP to reimburse providers, and those currently in effect for medicaid providers. In several cases the first and last of these are identical. In some cases the present methodology for MCP and for medicaid are identical. The department examined a number of options for setting reimbursement rates for services under the proposed rules. Several facility- or provider-specific methodologies were utilized for both medicaid and non-medicaid mental health services prior to implementation of the MHAP. The department determined that these methodologies were overly complicated and would require the accumulation and analysis of data that would be burdensome to both the providers and the department and would not allow for a sufficiently timely process. The department is proposing rates that will be uniform across any given provider type in order to eliminate inequities that existed in reimbursements prior to MHAP and to promote the efficient delivery of services within the constraints of the available budget.

Within each provider type, the department contemplated a range of possible reimbursement rate options. All rate decisions were made to be as consistent as possible, considering changes in the billing and reimbursement methodology, with the medicaid rates that were in effect prior to the MHAP while taking into consideration the present reimbursement rate being paid to that provider type by Montana Community Partners. The final

determinant of the rates specified in the proposed rules was the need for the mental health program to operate within appropriated funding levels while avoiding future reductions in either services or eligibility. The proposed reimbursement rates will provide reimbursement consistent with efficiency, economy and quality of care and sufficient to provide access to services for covered individuals, while allowing for coverage of the widest possible array of services within available funding.

In all cases, the department determined that the billing and payment processes currently in place for the Montana medicaid program would be used. This promotes consistency between provider types, reduces confusion, and precludes expensive and time consuming systems changes for both providers and for the department's fiscal intermediary.

Medicaid service coverage. With the establishment of MHAP, the administrative rules applicable to medicaid were amended to exclude coverage of mental health services. Rules providing for medicaid coverage and reimbursement of mental health services were repealed, and various rules were amended to eliminate references to excluded mental health services. Under MHAP, mental health services were provided to both medicaid and other low income recipients under the MHAP rules codified at ARM title 46, chapter 20.

The proposed changes to 46.12.501, 46.12.502, 46.12.514, 46.12.1713 are necessary to assist persons with mental health needs. The changes remove language specifically excluding medicaid coverage of mental health services, and to include covered mental health service categories in the list of medicaid covered services in 46.12.501.

The department considered service coverage options providing for more restrictive as well as less restrictive coverage than was provided under medicaid prior to MHAP implementation. The department did not select the option of restricting coverage beyond pre-MHAP coverage because it believed that at least the pre-MHAP array of services was necessary to adequately meet the needs of recipients needing mental health services.

The department also considered providing more services than were provided under the pre-MHAP medicaid program, such as coverage of inpatient psychiatric services to children in freestanding psychiatric hospitals and coverage of a wider array of community treatment services. The department did not select coverage of inpatient psychiatric services to children in freestanding psychiatric hospitals because the high cost of such services would consume a disproportionate share of available funding and would require corresponding reductions in other services categories affecting a significant number of recipients.

Other services that could have been covered for medicaid

eligible individuals under MHAP are not proposed for coverage because sufficient appropriations are not available to cover them or they cannot be provided under federal medicaid service categories. Accordingly not all services that could have been covered under MHAP are included in the proposed list of medicaid covered services.

The department selected the option of covering the categories of covered mental health services covered under medicaid prior to MHAP, with coverage of certain additional community services provided by mental health centers. The department recognizes that one advantage of MHAP was greater flexibility to provide services based upon individual needs rather than rigid service categories. The department intends to maintain a degree of coverage flexibility beyond the pre-MHAP coverage categories by submitting state plan amendments to allow coverage for mentally ill adults of community-based psychiatric rehabilitation and support, and multi-disciplinary discharge treatment planning, as well as the therapeutic components of adult foster care and mental health group home services. The proposed rule proposes medicaid and MHSP coverage of these services as mental health center services. If the state plan amendments are approved, the department will retain coverage of these services for medicaid eligible individuals. If state plan amendments are not approved, the department will consider providing discretionary coverage of these services under MHSP for medicaid eligible individuals.

The department has proposed, within the constraints of program requirements and available funding, an array of mental health services that it believes will address the needs of consumers. This proposal contains the department's best current estimate of the array of services that can be covered and funded under the interim system. The department does not consider the proposed array of services under medicaid or MHSP to be conclusive or final, and invites comment regarding the service coverage to be provided. The department also invites comment regarding what other mechanisms might be employed so that services can be offered without incurring costs in excess of available appropriations.

Hospital mental health services. The proposed changes to ARM 46.12.506, 46.12.507 and 46.12.508 are necessary to assist persons with acute mental health needs. These amendments provide medicaid coverage of psychiatric partial hospitalization services and coverage of psychologist and psychological testing services in the outpatient hospital setting. The proposed rule generally reinstates this coverage as available prior to MHAP, and provides for reimbursement at the pre-MHAP medicaid rates. The scope and definition of partial hospitalization services is generally the same as before MHAP, and additional details are set forth in the department's medicaid partial hospitalization policy, available upon request from the department's Health

Policy and Services Division.

Proposed ARM 46.12.508(11)(d)(i) is necessary to impose a limit of one visit per week upon the number of separately billable psychiatric physician visits for recipients in partial hospitalization programs. This limit is necessary to prevent abuse of the separate billing opportunity for physician visits in this setting and to assure the cost effective use of the funds available for coverage of mental health services. The department believes that the services necessary for recipients can be provided within this limit by the physician and by other staff under the physician's direction.

The proposed partial hospitalization rates are the pre-MHAP medicaid rates inflated by 3% to account for cost increases.

Residential treatment services. Rules XII through XVII are necessary to assist persons needing mental health treatment in a residential setting. The proposed rules establish medicaid coverage and reimbursement of residential treatment services. The definition and scope of this medicaid service coverage and the provider participation requirements are the same as prior to MHAP. As before MHAP, medicaid will not cover inpatient psychiatric hospitalization in freestanding psychiatric hospitals.

Reimbursement for residential treatment services provided by in-state facilities will be a single statewide prospective rate of $262.71 per patient day. At the time MHAP was implemented, medicaid reimbursement for residential treatment services was made under a facility-specific prospective rate per patient day, but was midway through a transition to a single statewide per diem rate. The proposed reimbursement rate adopts the statewide rate approach, proposing a rate that is the average of specific facility rates in effect immediately prior to implementation of MHAP. The adoption of a single specific rate for the anticipated interim period renders unnecessary adoption of the complicated rate methodology and cost reporting and settlement rules that were used prior to MHAP.

As before MHAP, the per diem rate is a bundled rate and covers all services, therapies and items related to the patient's psychiatric condition while the patient is admitted to the residential treatment facility, except as specified in the rule. Proposed Rule XIV (4)(a)(i) is necessary to impose a limit of one visit per week upon the number of separately billable psychiatric physician visits for recipients in residential treatment facilities. This limit is necessary to prevent abuse of the separate billing opportunity for physician visits in this setting and to assure the cost effective use of the funds available for coverage of mental health services. The department believes that the services necessary for recipients can be provided within this limit by the physician and by other

staff under the physician's direction.

Rule XVII is necessary to ensure that reimbursement is made only for medically necessary services. The proposed rules specify the department's authority regarding utilization review and inspection of care in residential treatment facilities, and to establish the federally mandated certificate of need requirements. Prior to MHAP, residential treatment services were subject to a utilization review process separate from other service categories. Under the proposed rules, residential treatment services will be subject to prior authorization by the department's utilization review contractor under Rule I. The department does not anticipate that a separate contractor or utilization review process will be established for residential treatment services during the interim period.

Institutions for Mental Disease. Proposed Rules XVIII through XXIV are necessary to assist persons needing institutional treatment. The proposed rules establish medicaid coverage and reimbursement of services provided in institutions for mental diseases (IMD) for persons over age 65. The definition and scope of this medicaid service coverage and the provider participation requirements are the same as prior to MHAP. Federal medicaid law prohibits reimbursement of services provided in IMDs except for persons age 65 or over in an IMD (in Montana, the nursing facility unit at Montana State Hospital and Montana Mental Health Nursing Care Center at Lewistown), or persons under age 21 in inpatient psychiatric facilities (in Montana, residential treatment facilities).

Reimbursement for IMD services provided to persons age 65 or over will be a prospective rate of $350 per patient day for the nursing facility unit at Montana State Hospital and $150 per patient day for high acuity and $100 per patient day for low acuity for the Montana Mental Health Nursing Care Center at Lewistown. At the time MHAP was implemented, medicaid reimbursement for IMD services was a per diem rate determined retrospectively based upon the providers' actual costs. Providers were reimbursed an interim rate and rates were settled after filing of cost reports. The adoption of the specific rates in effect prior to MHAP renders unnecessary adoption of the complicated rate methodology and cost reporting and settlement rules that were used prior to MHAP. As was the case before MHAP, providers will be permitted to bill in addition for separately billable items as provided in ARM 46.12.1245.

Therapeutic Youth Group Home and Family Care Services. The proposed changes to 46.12.516 and 46.12.517 are necessary to assist persons needing therapeutic youth group home and family care services. The proposed amendments provide medicaid coverage of the therapeutic component of therapeutic youth group home services and therapeutic family care services. Medicaid will cover only the therapeutic component of these services, and

under federal restrictions cannot cover the room and board portion of these services. For children in state custody who are placed in these levels of care, room and board will be paid outside medicaid and MHSP by the department's child and family services division (CFS). Room and board in these service settings will not be covered under medicaid or MHSP.

The therapeutic component of therapeutic youth group home and family care services will be covered by medicaid according to requirements similar to those that existed prior to MHAP. In contrast to pre-MHAP coverage, these services must be prior authorized in accordance with Rule I by the department's mental health services utilization review contractor, rather than by CFS. For purposes of this prior authorization, the particular medical necessity criteria for these services that were codified in CFS rules prior to MHAP are included in the proposed medicaid rules to specify the degree of need that must exist to access these services.

CFS will not perform prior authorization for these services, and no contract with CFS is required for medicaid or MHSP coverage of these services. CFS may in its discretion contract for the provision of these services outside medicaid or MHSP. The proposed changes to ARM 37.37.105 and 37.37.303 are necessary to replace references to MHAP with references to medicaid and MHSP.

The proposed changes to ARM 46.12.517 are necessary to specify the reimbursement rates for the therapeutic component of these services. The proposed reimbursement rates are $156 per patient day for the therapeutic component of intensive level therapeutic youth group home services, $84.16 per patient day for the therapeutic component of campus based or moderate level therapeutic youth group home services, $59.27 per patient day for the therapeutic component of intensive level therapeutic family care services and $39.75 per patient day for the therapeutic component of moderate level therapeutic family care services. These rates are based upon the rates in effect prior to MHAP implementation adjusted for subsequent medicaid provider rate increases.

Mental health center services. Proposed Rules XXXVIII through XLI are necessary to provide for medicaid coverage and reimbursement for those persons needing mental health center services. These services will be reimbursed under a category of services separate from clinic services. The proposed changes to 46.12.570 are necessary to specify that mental health center services are not reimbursed as clinic services, as they were prior to MHAP.

Mental health center services may be provided by facilities licensed by the department as a mental health center. For purposes of medicaid coverage and reimbursement, all services must be provided in accordance with applicable licensure

requirements and the requirements of the proposed rules. Medicaid covered mental health center services include adult day treatment, child and adolescent day treatment, community-based psychiatric rehabilitation and support, and multi-disciplinary discharge treatment planning, and the therapeutic components of crisis intervention services, foster care for mentally ill adults and mental health group home services. Mental health centers and their staff may also provide case management services according to proposed Rules XXV through XXXVII, but to do so must enroll as case management service providers.

Practitioners (physicians, mid-level practitioners, licensed clinical psychologists, licensed clinical social workers and licensed professional counselors) and mental health centers will be required to enroll individually and directly in the appropriate medicaid category of service. Generally, the mental health centers will not be reimbursed for practitioner services as mental health center services. Practitioners employed by or under contract with a mental health center may assign their medicaid payments to the mental health center, but their services will be reimbursed only as provided in the proposed rules.

The proposed rules will permit the mental health center to elect to either include practitioner services for purposes of billing for mental health center services, as permitted by the proposed mental health center services rules, or to not include the practitioner services as mental health center services and to have the practitioner bill under their respective category of service, as permitted by the rules applicable to the particular service. However, the same practitioner services cannot be billed as both mental health services and as services under the practitioner's category of service. Except as separate billing is permitted by the rules, the mental health center reimbursement provided in the rules covers and includes all services provided by the mental health center and its staff.

The proposed rules include documentation requirements that for day treatment services are more extensive than required by licensure rules. For day treatment services, the proposed rules require that the provider make and maintain attendance records and daily notes concerning the recipient's participation and progress in the program. These requirements are necessary to assure that recipients are actually in attendance and participating in a service that will achieve the goals of the program.

For day treatment services, the proposed rules also require attendance for minimum numbers of hours in order to receive either half-day or full-day reimbursement. In addition, day treatment services will be limited to 15 treatment days per month for adults and 20 treatment days per month for children and adolescents. These limits are necessary to enable the

department to cover the widest possible array of mental health services for the greatest number of needy individuals.

Reimbursement for mental health center services is according to a schedule of fees for defined units of service. These rates are based upon the rates in effect prior to MHAP implementation, where available, and upon the department's assessment of the reimbursement level sufficient to ensure adequate access to services consistent with the need to assure the availability of the broadest possible array of mental health services.

Psychologist, Social Worker and Professional Counselor Services. Proposed Rules III through V, VI through VIII, and IX through XI, respectively, are necessary to assist persons needing mental health services in non-residential settings. The proposed rules provide for medicaid coverage and reimbursement of licensed clinical psychologist services, licensed clinical social worker services and licensed professional counselor services.

Services in each of these three categories will be limited to services that are within the scope of practice permitted under state licensure law and that are included on the department's list of covered CPT codes for each service category. The lists of covered CPT codes are incorporated by reference in the respective rules for each service category, and copies of these lists are available upon request from the department's Addictive and Mental Disorders Division.

Some of the limitations that were imposed on these services under medicaid prior to MHAP are included, as they are considered necessary to assure that service utilization is necessary and appropriate. However, the 22 hour annual limit has not been included in this proposal. The 22-hour limit was difficult for providers to follow and for the department to administer and enforce. Under the proposed rules, service utilization will be reviewed and controlled under the prior authorization and review procedures that will be established pursuant to Rule I.

Reimbursement of licensed clinical psychologist services, licensed clinical social worker services and licensed professional counselor services will be at 59%, 47% and 47% respectively of the reimbursement determined under the resource based relative value scale (RBRVS) methodology provided in ARM 46.12.502A. The proposed changes to ARM 46.12.502A are necessary to include these services in the list of services reimbursed under the RBRVS methodology set forth in that rule.

This reimbursement methodology is consistent with the methodology in effect for all other practitioners under the Montana medicaid program and will not require these providers to modify their current billing procedures. Use of CPT codes will allow providers a greater range of reimbursable service than

would be possible utilizing the "local codes" in effect prior to MHAP implementation while allowing the department to make comparisons with MHAP data. The rates specified are designed to be consistent with the level of reimbursement paid to most providers prior to MHAP implementation while considering the present MHAP rates.

Case management services. The proposed changes to ARM 46.12.1902 and proposed Rules XXV through XXXVII are necessary to assist persons needing intensive case management services and care coordination services. The proposed rules provide for medicaid coverage and reimbursement of case management services for adults with severe disabling mental illness (SDMI) and youth with serious emotional disturbance (SED). Under the proposed rules, these services will be available on a statewide basis.

For both SDMI adults and SED youth, the proposed rules will provide coverage of two categories of case management services - intensive case management and care coordination case management services. The components of services covered under both categories is the same as covered under pre-MHAP medicaid rules. The differences between the two case management categories are the providers that may provide the service and the intensity of the service. Intensive case management may be provided only by a licensed mental health center, which must enroll as a case management service provider.

The less intensive care coordination services may be provided by a licensed mental health center or by clinicians, such as physicians, mid-level practitioners, psychologists, social workers and professional counselors. To obtain medicaid coverage and reimbursement, practitioners must enroll in the program as a case management service provider. The care coordination category is designed to provide a flexible approach for patients whose condition does not require the degree of involvement provided by intensive case management, but who need a minimal level of case management service. The various practitioners may provide needed care coordination services, or otherwise are expected to contact a mental health center or other provider who can provide the more intensive service. Care coordination services are limited to 4 hours (16 15-minute units) of service per month per recipient.

For both categories of case management services, the provider must make and maintain narrative documentation to support the services provided. For intensive case management services, care must be provided in accordance with a case management treatment plan and according to applicable licensure requirements. For intensive case management, case workers cannot have a case load that exceeds 22 clients for adults or 20 clients for youth at any given time. Services must be provided according to the recipient's individual need, but must include at a minimum 3 face to face contacts per month. These requirements are

necessary to assure that recipients receive a sufficient degree of attention and service, and that the services are supported and demonstrated by documentation.

Case management reimbursement rates are based upon a monthly rate for intensive case management services and based upon a 15 minute unit of service for care coordination services, for either individual or group services. This approach is consistent with the current MCP methodology and is preferred by providers in that it offers greater flexibility and eliminates unnecessary paperwork. The rates specified are designed to be consistent with the level of reimbursement paid to most providers prior to MHAP implementation while considering the present MHAP rates.

Medicaid freedom of choice. The proposed change to ARM 46.12.202 is necessary to reinstate the same degree of freedom of choice of providers that existed prior to MHAP. The waiver under which MHAP is operated includes a waiver of the federal medicaid freedom of choice provisions, and with the expiration of the waiver medicaid freedom of choice must be reinstated. As was the case prior to MHAP, the recipient's right to choose a provider will be subject to applicable medicaid requirements, e.g., the provider must be enrolled in the medicaid program and must comply with applicable prior authorization, service and billing requirements.

Medicaid copayments. The proposed changes to ARM 46.12.204 are necessary to assist the department in providing mental health services within its limited legislative appropriation. The proposed amendments specify the copayments applicable to categories of mental health services that will be provided under medicaid. The proposed copayments are nominal in amount and similar to the copayment amounts in effect prior to MHAP. In addition, the proposed changes to ARM 46.12.204(1)(j) and (k) are necessary to provide for separate copayment provisions for public health clinics. Public health clinic services are reimbursed as a separate category, subject to a $.50 per service copayment and other clinic services are subject to a $1.00 per visit copayment.

Miscellaneous medicaid changes. The proposed changes to ARM 46.12.1708 are necessary to remove language that differentiates between physical health and mental health visits in federally qualified health centers and rural health clinics. This distinction was necessary under MHAP because medicaid paid these facilities only for physical health services, and not for mental health services. The distinction will not be necessary under these rules because medicaid will pay these providers for both physical and mental health services. The proposed changes to ARM 46.12.4810 are necessary to replace references to MHAP with references to the current program names. The proposed changes to ARM 46.12.5007 are necessary to update service category names

and rule references.

Mental Health Services Program (MHSP). The proposed changes to ARM 46.20.103 through 46.20.126 are necessary to eliminate the MHAP program and replace it with a program of mental health service coverage paid on a fee for service basis for certain eligible low income individuals. MHSP will provide coverage and reimbursement of mental health services only for individuals who are not eligible for medicaid.

The department desires to provide the widest array of services to the greatest number of needy individuals under this program, within available appropriation levels. The department has proposed as broad an array of service coverage as it currently believes possible. The department invites comments regarding service coverage and will consider coverage of additional categories within the limits of available funding.

To make the most efficient and effective use of available funds to provide the services most needed to the individual most in need, it is necessary to impose some limits on the categories of services available, the amount of services available within covered categories and otherwise to limit various aspects of the program.

MHSP is not an entitlement program and the establishment of the program and the services offered does not entitle any individual, provider or other person or entity to eligibility, to any type, amount or level of service, to participate in the program, or to receive any particular number of patients or amount of reimbursement. While the department has offered the widest service coverage it considers possible, actual service utilization or other factors arising after program implementation may require adjustments in eligibility requirements, the number of individuals that can be served under the program, the services that will be covered, the reimbursement rates that will be paid, the number of providers that will be enrolled or other aspects of the program.

MHSP eligibility. The proposed amendments to ARM 46.20.106 are necessary to provide mental health services for low income persons not eligible for medicaid. The proposed amendments specify the eligibility requirements for the MHSP. In setting parameters for non-medicaid eligibility for the interim program described in the proposed rules, the department examined several options, including a higher income limit and a resource limitation. Due to budgetary constraints and to achieve the benefits of simplicity and stability for the people presently served under MHAP, the department determined to maintain eligibility criteria and procedures consistent with the present MHAP non-medicaid eligibility process.

To be eligible, an individual must be an adult with severe

disabling mental illness or a youth with serious emotional disturbance, and the individual must have total family income at or below 150% of the federal poverty level, without regard to other assets or financial circumstances. The proposed rules follow the MHAP rules regarding what is considered income. Adoption of these eligibility rules are necessary to assure continuation of service for individuals already enrolled in MHAP and receiving services.

The eligibility category for state facility residents is not continued because services at Montana State Hospital and the Montana Mental Health Nursing Care Center will be funded directly through by the state rather than through the MHSP. This will not result in an interruption of services to residents of these institutions. These services will be funded by appropriations and/or collections under existing state law from residents able to pay and from liable third parties.

Only persons ineligible for medicaid and who otherwise meet eligibility requirements will be eligible under the MHSP. As a condition of eligibility, an individual must apply for and be denied medicaid eligibility, have a pending medicaid application, or must be ineligible because the individual is an inmate in a public institution. For otherwise eligible individuals, MHSP coverage will be available while a medicaid application is pending. If a person obtains services under the plan and is later determined eligible for medicaid for this period, the provider may be required to refund the plan payment and bill medicaid. The department is considering whether an alternative approach can be fashioned that would not require a refund and rebilling for these services, and if a satisfactory process can be identified will revise this provision in the final adoption notice. These requirements are necessary to maximize the benefit of funding available for the non-medicaid portion of the plan, by assuring that medicaid is used where available under applicable requirements.

MHSP eligibility will be determined by the department or its county human services offices. For purposes of the transition from MHAP to MHSP, the department intends to rely initially upon eligibility determinations made under MHAP for those persons who remain MHAP eligible as of June 30, 1999. Eligibility may be redetermined at any time and will be redetermined no more than one year after the last determination was made. Individuals must notify the department within 30 days of any changes in income or family composition that would affect eligibility. The proposed rules regarding provisions are necessary to assure continuity of eligibility during the transition period. A complete redetermination of eligibility for purposes of the plan would be difficult to complete within the available time, and could cause interruptions in service.

Member copayments. The proposed amendments to ARM 46.20.120 are

necessary to ensure services for persons within 150% of the federal poverty level and at the same time allow the program to keep expenditures within the amounts appropriated by the Montana legislature. The proposed amendments specify copayments applicable to services under the MHSP. Copayments will be no more than $10 per outpatient service, no more than $10 (or the amount of the prescription) for each prescription filled, and no more than $50 for each inpatient admission. Depending upon service utilization and the availability of funding, the department may reduce these copayment amounts by notifying providers and consumers of the reductions. Based upon the funding available, copayments higher in amount than charged to medicaid recipients will be necessary to allow coverage of an adequate array of services.

For non-medicaid recipients, the department has received substantial public comment on previously-proposed copayment and premium requirements. On balance, sentiment has favored recipient financial participation. Copayment is less burdensome for the recipient and the department while being less likely to deter persons with a mental illness from seeking needed services. Collection of copayments will allow the department to fund a wider array of services, including a limited pharmacy benefit, within the funding appropriated for mental health services.

Covered services. The proposed amendments to ARM 46.20.114 are necessary to specify the services that will be covered under the MHSP. Covered services include those listed in the rule when medically necessary to treat a covered diagnosis, and the list of covered diagnoses remains the same as under MHAP for non-medicaid eligible individuals. The proposal includes a wide array of outpatient services, including mental health center services, partial hospitalization, and psychotropic medications, and also includes residential treatment services, and the therapeutic component of therapeutic youth group homes and therapeutic family care. The department also contemplated additional services for the non-medicaid population but determined it was not possible to further expand the array of services to be provided within the anticipated available funding. As one option, the department considered an array of mental health services much more attenuated than is presented in the proposed rules. The department originally proposed limiting non-medicaid reimbursed mental health services to those services provided to this population prior to the MHAP in order to ensure expenditures will not exceed appropriated funding. That option would have precluded reimbursement of all out-of-home services and prescription drugs. The department believes, however, that it will be possible to fund essentially all of the services provided to non-medicaid eligible MHAP members, with the exception of acute inpatient services, within the appropriation currently specified in HB2. The department believes it has proposed the most extensive coverage possible under available

funding, but invites comment regarding the proposed list of covered services.

Services under the MHSP must be provided according to the requirements applicable to the same category under medicaid. General medicaid requirements and medicaid requirements applicable to particular service categories apply to services under the plan except where otherwise specified. Overpayments and instances of fraud and abuse will be handled according to the corresponding medicaid requirements and processes, and providers will be entitled to notice and hearing regarding overpayment and sanction determinations. Application of medicaid requirements to services under the MHSP is necessary to standardize requirements, avoid unnecessary duplication of systems, processes and provider requirements, and to enable the department to establish a system within existing time and funding limitations.

Provider requirements and reimbursement. The proposed amendments to ARM 46.20.110 are necessary to specify the requirements that must be met by providers to participate in the MHSP. To participate in MHSP, providers must be enrolled in medicaid for the same category of service and must also sign an agreement for enrollment in the MHSP. The enrollment requirements and process are the same as for medicaid. Providers already enrolled as medicaid providers will be required merely to sign an addendum to their medicaid provider agreement in order to enroll. Application of medicaid provider requirements to the MHSP is necessary to standardize requirements, avoid unnecessary duplication of systems and processes, and to enable the department to establish a system within existing time and funding limitations.

Reimbursement for services provided to MHSP eligible individuals will be the same reimbursement available under the proposed medicaid rules. Medicaid rules regarding claims submission, third party liability and payment in full will also apply. Claims will be submitted to and processed by Consultec, the medicaid claims processing agent. Use of the medicaid reimbursement and claim provisions is necessary to avoid unnecessary duplication of effort and to insure the same level of access to services for eligible members under both programs. Use of medicaid rules will avoid requiring providers, department staff and department contractors having to develop and learn new systems, rules and processes. Providers are generally familiar with many these rules, which will facilitate a smooth transition from the MHAP program to the fee for service program.

Definitions. The proposed amendments to ARM 46.20.103 are necessary to conform the MHSP definitions to the program changes discussed above. In addition, the proposed amendment to ARM 46.20.103(3)(d) is necessary to add the Boulder River School, which is the girls correctional facility corresponding to Pine

Hills, and delete Montana youth alternatives from to the list of detention and correctional facilities in which members are not covered.

The proposed amendments to ARM 46.20.103(7) and 46.20.103(18) are necessary to take into account rising costs of living. The proposed amendments update the Federal Poverty Level to the most current federal publication. The proposed amendments to 46.20.103(10) is necessary to apply the medicaid definition of medical necessity to the MHSP, so that a single definition applies to both programs, in order to avoid conflicting and inconsistent definitions.

The proposed amendments to ARM 46.20.103(15)(d) are necessary to clarify that a youth does not meet the definition of seriously emotionally disturbed if the primary problem is one of a developmental disability, substance abuse, sex offender or criminal nature. This is necessary to assure that services are provided only when medically necessary to treat psychiatric or mental health needs, rather than physiological, social or other problems.

Prior Authorization and Review of Services. The interim mental health services system established under the proposed rule changes is not a managed care system. However, under the proposed system the department generally will require prior authorization of mental health services and may review the necessity of mental health services prospectively or retrospectively. Rules I and II are necessary to impose prior authorization and related requirements on services under medicaid and MHSP.

The department contemplated several options in determining how to ensure that services under the proposed rules would be provided to those most in need and would be the most effective use of public funds. Among the options examined were the possibility of having no restrictions on services beyond the criteria that the services be medically necessary. Prior experience in the fee-for-service arena has demonstrated the futility of this approach in precluding the delivery of unnecessary and ineffective services, and such a course would be irresponsible on the part of the department.

The department considered establishing a system of uniform, a priori limitations such as the limit of twenty-two hours of outpatient treatment per fiscal year that was in effect for the medicaid program prior to the MHAP. Such a system is irrational, does not consider individual circumstances, is difficult both to comply with and to administer, and is largely ineffective in ensuring the most appropriate use of limited mental health funds.

Consequently, the department will implement a utilization review

system for mental health services as provided for in the proposed rules.

The department will operate a prior authorization program through a contract with an established Montana review organization. All services will be subject to authorization, but the department may designate various services by notification to providers and consumers for which prior authorization will not be required. This system is contemplated to include required prior authorization for all out-of-home placements, continued care reviews for those same services, and selective retrospective review of the medical necessity and effectiveness of outpatient services. All services will be subject to retrospective review for compliance with medical necessity, documentation and other program requirements. Providers and consumers will be notified in writing of the applicable procedures, clinical guidelines that will be used to evaluate authorization requests, and grievance and reconsideration procedures.

The proposed changes to ARM 46.12.509 are necessary to include medicaid covered hospital mental health services to the list of hospital services subject to prior authorization by the department's designated review organization. The provisions of this rule are intended to work in conjunction with the provisions of Rule I to require a single prior authorization process for hospital mental health services.

In addition, the department or its contractor may require providers to report outcome data or measures regarding mental health services, after determining in consultation with providers and consumers the data or measures to be requested.

The prior authorization and related requirements imposed by and to be established under Rules I and II are necessary to assure that only medically necessary and appropriate services are covered and reimbursed with scarce public funds.

Grievance, reconsideration and appeal. The department will require that its utilization review contractor provide timely, written notice to consumers and providers of authorization determinations and applicable grievance or reconsideration processes. The primary avenue for consumers and providers to obtain review of adverse decisions will be a grievance process that the department will require its mental health utilization services contractor to provide. The department will require that the process be specified in writing and made available to consumers and providers.

If the grievance and reconsideration processes available through the contractor do not resolve the issue, further review is available depending upon whether the issue arises under medicaid or the MHSP. If the issue arises under medicaid, the same

administrative review and hearing rights will be available as under the medicaid program generally. This includes the right to administrative review and a contested case hearing. For services provided under medicaid, the proposed rule changes provide the same provider administrative review and hearing rights as under medicaid generally.

In this regard, the proposed changes to ARM 46.2.202, 46.12.509A and Rules XVI and XXIV are necessary to re-establish medicaid administrative review and hearing procedures for residential treatment centers and/or institutions for mental diseases.

The proposed amendments to ARM 46.20.123 are necessary to specify the notice and reconsideration rights available to MHSP members. Members must be notified of any decision denying eligibility or authorization of services. After exhausting any available grievance and reconsideration procedures with the review contractor, the member may request an informal reconsideration process. The purpose of this process is to assure that decisions are not based upon mistakes or misunderstandings regarding the facts of the case. However, consistent with the nature of the program as a non-entitlement program, the proposed rule does not extend the right to formal litigation-type hearing procedures. In addition, payment will be made only for authorized services, and payment will not be made during the pendency of a grievance or reconsideration.

These provisions are necessary to assure that members have an opportunity to correct mistakes by the department or its contractor and present their response to the decision at issue. However, formal hearing procedures are not proposed because the program does not entitle a member to eligibility or benefits.

The proposed amendments to ARM 46.20.110 are necessary to specify the reconsideration and hearing right available to providers under the MHSP. Consistent with the provision that the MHSP does not create entitlement to services or other benefits, the proposed rule provides for an informal reconsideration process rather than formal contested case hearings for providers with respect to denial of enrollment, denial of service authorization and related issues. The proposed rules do provide for administrative review and contested case hearings if payment to a provider is denied after the department or its agent have authorized services for an eligible member. This provision is necessary to assure that providers will be willing to provide services in reliance upon service authorizations. In addition, notice and hearing rights are included for providers in the event of an overpayment determination or imposition of sanctions based upon alleged program fraud or abuse. This provision is necessary to protect providers' interests in payments received and regarding the adverse effect of fraud and abuse allegation upon their reputation interests.

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

The estimated budgetary impact of these proposed rule changes are as follows. Total medicaid expenditures for FY 1998 were approximately $48,304,979 and for FY 99 are expected to total approximately $49,500,000. Under the propsoed rules, expenditures for medicaid mental health services for FY 2000 will be approximately $49,230,243, including $13,705,700 in state general funds and $35,524,543 in federal funds and for FY 2001 will be approximately $51,602,747, including $14,046,268 in state general funds and $37,556,479 in federal funds. Funds expended for services to non-medicaid eligible individuals in FY 1998 were $25,030,716, which includes $871,537 in mental health block grant funds. The department estimates expenditures for services to non-medicaid eligible individuals in FY 2000 in the amount of $25,762,228, which includes $871,537 in mental health block grant funds, and for FY 2001 $26,014,829, which includes $871,537 in mental health block grant funds.

4. The proposed rules and amendments will become effective July 1, 1999 and will apply to services provided on or after July 1, 1999. The proposed rules and amendments do not apply to services provided before July 1, 1999.

5. 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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than May 20, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State April 9, 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 PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 13, 1999, at 9:30 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on May 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rules as proposed to be amended provide as follows. 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 (1)(d) remain the same.

(e) "Resource based relative value scale (RBRVS)" means the most current version of the medicare resource based relative value scale contained in the physicians' medicare fee schedule adopted by the health care financing administration of the U.S. department of health and human services and published in the Federal Register annually, as amended through ~~July 1, 1997~~ November 2, 1998 which is hereby adopted and incorporated by reference. A copy of the medicare 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. The RBRVS reflects RVUs for estimates of the actual effort and
expense involved in providing different health care services.

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

(3) Except as set forth in (8), (9) and (10) the fee for a covered service provided by any of the provider types specified in (2) is determined by multiplying the relative value units determined in accordance with (7) by the conversion factor specified in (4), and then multiplying the product by a factor of one plus or minus the applicable policy adjustor as provided in (5), if any; provided, however, that rates for procedure codes included in the conversion to the RBRVS reimbursement methodology are:

(a) for state fiscal year 1998, no less than 85% of and no more than 140% of the medicaid fee for that procedure in state fiscal year 1997;

(b) for state fiscal year 1999, no less than 80% of and no more than 145% of the medicaid fee for that procedure in state fiscal year 1997~~;~~

(c) for state fiscal year 2000:

(i) those codes paid at 80% of the level of state fiscal year 1997 reimbursement in state fiscal year 1999 shall be frozen at that level;

(ii) those codes restricted to 145% of the medicaid fee of the level of state reimbursement in state fiscal year 1997 which were at the lowest percentage of medicare reimbursement in state fiscal year 1999 shall receive a 1% increase in provider fees.

(d) for state fiscal year 2001:

(i) those codes paid at 80% of the level of state fiscal year 1997 reimbursement in state fiscal year 1999 shall be frozen at that level;

(ii) those codes restricted to 145% of the medicaid fee of the level of state reimbursement in state fiscal year 1997 which were at the lowest percentage of medicare reimbursement in state fiscal year 2000 shall receive a 1% increase in provider fees.

(4) The conversion factor used to determine the medicaid payment amount for the services covered by this rule for state fiscal year ~~1999~~ 2000 is:

(a) ~~$34.40~~ $32.40 for medical and surgical services, as specified in (2); and

(b) remains the same.

(5) and (6) remain the same.

(7) The RVUs for a medicaid covered service provided by any of the provider types specified in (2) are calculated as follows:

(a) if medicare sets RVUs, the medicare RVUs are applicable;

(b) if medicare does not set RVUs but medicaid sets RVUs, the medicaid RVUs are set in the following manner:

(i) convert the existing dollar value of a fee to an RVU value;

(ii) evaluate the RVU of similar services and assign an RVU value; or

(iii) convert the average by report dollar value of a fee to an RVU value; or

(c) remains the same.

(8) and (8)(a) remain the same.

(b) For state fiscal year ~~1998~~ 2000, the "by-report" rate is ~~58%~~ 57% of the provider's usual and customary charges.

(9) through (13) remain the same.

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 the same.

(4) The department hereby adopts and incorporates herein by reference the department's EPSDT manual, published ~~July, 1998~~ June 1999. 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. 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 the same.

(2) Reimbursement for outpatient chemical dependency treatment, nutrition, and private duty nursing services is specified in the department's 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 EPSDT provider manual, published ~~July, 1998~~ June 1999. A copy of the manual 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 the same.

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

46.12.541 HEARING AID SERVICES, REQUIREMENTS AND LIMITATIONS (1) and (2) remain the same.

(3) A hearing aid may be covered under the medicaid program if:

(a) the recipient has been referred by a physician or mid-level practitioner for an audiological examination and the physician or mid-level practitioner has determined that there is

no medical reason for which a hearing aid would not be effective in correcting the recipient's hearing loss;

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

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

46.12.542 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lower of the following for covered hearing aid services and items:

(1)(a) remains the same.

(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 medicaid hearing aid services provider manual (~~July 1998~~ June 1999). The manual contains requirements and instructions related to medicaid coverage and reimbursement of hearing aids. A copy of the 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 the same.

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)(d) remain the same.

(i) For all oxygen systems, portable and stationary, reimbursement will be made in accordance with the department's oxygen fee schedule dated ~~May 1, 1998~~ June 1999, which is hereby adopted and incorporated by reference. A copy of the oxygen 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 ~~July 1998~~ June 1999, which the department hereby adopts and incorporates by reference. A copy of the department's ~~July 1998~~ 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) through (4)(b) remain the same.

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

46.12.915 EYEGLASSES, REIMBURSEMENT (1) remains the same.

(2) Reimbursement for contact lenses ~~is as follows~~ or

dispensing fees is as follows:

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

(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 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 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 5920-2951.

~~(ii) the department's fee schedule maintained in accordance with the methodology described in (2)(c); or~~

~~(iii) the amount allowable for the same service under medicare, if the services are also covered by medicare for the recipient.~~

~~(b) For all purposes under this rule, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.~~

~~(c) The department's fee schedule for contact lenses includes fees set and maintained according to the following methodology:~~

~~(i) At least annually the department will review billings for services, other than those services for which a specific fee has been set under the provisions of (2)(c)(ii), to determine the total number of times each service has been billed by all providers in the aggregate within the previous 12 month period.~~

~~(ii) Upon review of the aggregate number of billings as provided in (2)(c)(i), the department will establish a fee for each service which has been billed at least 50 times by all providers in the aggregate during the previous 12 month period. The department shall set each fee at 90% of the average charge billed by all providers in the aggregate during the previous 12 month period. For purposes of determining the number of billings and the average charge, the department considers only those billings that comply with ARM 46.12.915(2)(b).~~

~~(iii) Once the department has established a fee as provided in (2)(c)(ii), the fee will not be adjusted except as provided in (2)(c)(iv).~~

~~(iv) Except as provided in (2)(c)(v), for all services for which no fee has been set under the provisions of (2)(c)(ii), the department's fee schedule amount shall be 90% of the provider's usual and customary charge. For purposes of (5), the provider's usual and customary charge may not exceed the limit specified in (2)(c).~~

~~(v) For new procedure codes where a medicare fee is available, the department's fee schedule amount shall be the medicare allowable charge, until the department sets a fee based upon 50 billings for the procedure code as provided in (2)(c)(ii).~~

~~(3) Reimbursement for dispensing fees is as follows:~~
~~(a) the department pays the lowest of the following:~~
~~(i) the provider's usual and customary charge for the service; or~~
~~(ii) the department's fee schedule maintained in accordance with the methodologies described in ARM 46.12.502A.~~
~~(4) The department may contract for coverage of contact lenses through a volume purchasing arrangement with a supplier of materials.~~

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

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT (1) through (1)(b) remain the same.

(2) The department's fee schedule for transportation is the following:

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

(c) commercial ground transportation, including taxi and limousine service for trips up to 16 miles total - usual fee not to exceed a total of ~~$10.37~~ $10.47 for a one way trip;

(d) commercial ground transportation, including taxi and limousine service for trips exceeding 16 miles - ~~$.65~~ $.66 per mile that a person is a passenger.

(3) through (5) remain the same.

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

(2) The department's fee schedule for specialized nonemergency medical transportation is the following:

(a) Transportation under 16 miles.....$~~10.37~~ 10.47 one way

(b) Transportation over 16 miles.....$ ~~.65~~ .66 per mile

(c) Waiting time for transportation over 16 miles.....$ ~~5.20~~ 5.24 per hour

Computed in 15 minute increments or fraction thereof

(2)(d) and (2)(e) remain the same.

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) through (5) remain the same.

(6) Except as provided in (9), current fees for ambulance

services are published by the department in the ~~July 1998~~ June 1999 medicaid ambulance services provider manual, which the department hereby adopts and incorporates by reference. A copy of the department's ~~July 1998~~ 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) through (9) remain the same.

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

3. In ARM 46.12.502A(1)(e), 1997 is changed to 1999 to reflect the most current version of the RBRVS contained in the Federal Register which is the basis for the medicaid RBRVS reimbursement methodology.

In ARM 46.12.502A(3), (c) and (d) are added to describe reimbursement in state fiscal years 2000 and 2001 for codes which were restricted in reimbursement in state fiscal year 1999. These subsections are added to describe reimbursement methodology as specified by legislative intent.

In ARM 46.12.502A(4), 1999 is changed to 2000 to reflect the new fiscal year for which the conversion factors are effective. The conversion factors are updated in ARM 46.12.502A(4)(a) from $34.40 to $32.40 and (b) remains the same. These changes are required to implement the provider funding for RBRVS authorized by the 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999) and are in accordance with the legislative intent as implemented in accordance with ARM 46.12.502A(4)(b), (c) and (d). Since the legislature has specified the reimbursement methodology for RBRVS, no other options were considered.

In ARM 46.12.502A(8)(b), state fiscal year 1998 is changed to 2000 to reflect the new fiscal year for which the "by-report" rate is effective. The "by report" rate is updated from 58% to 57% based on the RBRVS reimbursement methodology.

In ARM 46.12.515(4), July, 1998 is changed to June 1999 to reflect the new fiscal year for which the EPSDT provider manual is effective. The changes to this ARM implement the 1% provider increase authorized by the 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). These changes are necessary to ensure that these fee schedules are updated as intended by legislative action. The option of leaving the rule unchanged may result in consumers lacking access to these services or receiving products that are of less than adequate quality.

In ARM 46.12.517(2), July, 1998 is changed to June 1999 to reflect the new fiscal year for which the EPSDT provider manual is effective. The changes to this ARM implement the 1% provider

increase authorized by the 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). These changes are necessary to ensure that these fee schedules are updated as intended by legislative action. The option of leaving the rule unchanged may result in consumers lacking access to these services or receiving products that are of less than adequate quality.

In ARM 46.12.541(3)(a), the term mid-level practitioner is inserted twice to include the ability of a mid-level practitioner to refer a recipient for an audiological examination, providing the necessary clearance that there is no medical reason for which a hearing aid would not be effective in correcting the recipient's hearing loss. The proposed rule language provides more latitude for recipients and is less restrictive. It is also in alignment with federal regulation. The option of leaving the rule unchanged would leave the rule unaligned with federal regulation and could jeopardize federal financial participation in the medicaid program.

In ARM 46.12.542(1)(b), 1998 is changed to 1999 to reference the hearing aid services provider manual dated June 1999. The hearing aid services provider manual dated June 1999 will provide an updated fee schedule in accordance with legislative action whereby providers received a 1% increase, 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). This change is necessary to ensure that these fee schedules are updated as intended by legislative action. The option of leaving the rule unchanged may result in consumers lacking access to these services or receiving services that are of less than adequate quality.

In ARM 46.12.806(2)(d)(i), May 1, 1998 is changed to June 1999 to reflect the new fiscal year for which the oxygen fee schedule is effective. In ARM 46.12.806(2)(e), 1998 and 1998 are changed to 1999 and 1999 to reflect the new fiscal year for which the diaper fee schedule is effective. The changes to this ARM implement the 1% provider increase authorized by the 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). These changes are necessary to ensure that these fee schedules are updated as intended by legislative action. The option of leaving the rule unchanged may result in consumers lacking access to these products or receiving products that are of less than adequate quality.

In ARM 46.12.915(2)(a)(ii), the text on the fee schedule process is deleted and replaced with text referencing the department's Eyeglass Services Provider Manual dated June 1999. This change is necessary to provide the department flexibility to update fee schedules in accordance with legislative action whereby providers received a 1% increase, 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). This change is necessary to ensure that these fee schedules are updated as

intended by legislative action. The option of leaving the rule unchanged may result in consumers lacking access to these services or receiving services that are of less than adequate quality.

In ARM 46.12.1005(2)(c), $10.37 is changed to $10.47 and in ARM 46.12.1005(2)(d), $.65 is changed to $.66 to indicate the new rate. In ARM 46.12.1015(2)(a), $10.37 is changed to $10.47 and in ARM 46.12.1015(2)(b), $.65 is changed to $.66 to indicate the new rate. In ARM 46.12.1015(2)(c), $5.20 is changed to $5.24 to indicate the new rate. In ARM 46.12.1025(6), July 1998 and July 1998 are changed to June 1999 and June 1999 to reflect the new state fiscal year.

The proposed changes to ARM 46.12.1005(2), 46.12.1015(2) and 46.12.1025(6) are necessary to implement the provider increases authorized by the 1999 General Appropriations Act (Chapter 551, Laws of Montana, 1999). These rates were calculated to reflect the 1% increase for July 1, 1999. The option of leaving the rules unchanged is not being selected because that option would compromise the intent of the legislative directive as well as the integrity of the program.

4. 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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than May 20, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laura Thomas
Director, Public Health and Human Services

Certified to the Secretary of State April 9, 1999.

BEFORE THE BOARD OF OUTFITTERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to licensure--renewal, guide or professional guide license, safety provisions, standards for outfitters, guides and professional guides - unprofessional conduct and misconduct	)	NOTICE OF AMENDMENT OF 8.39.508 LICENSURE--RENEWAL, 8.39.514 LICENSURE - GUIDE OR PROFESSIONAL GUIDE LICENSE, 8.39.704 SAFETY PROVISIONS, 8.39.709 STANDARDS FOR OUTFITTERS, GUIDES AND PROFESSIONAL GUIDES - UNPROFESSIONAL CONDUCT AND MISCONDUCT

TO: All Interested Persons:

1. On February 11, 1999, the Board of Outfitters published a notice of public hearing on the proposed amendment of the above-stated rules at page 241, 1999 Montana Administrative Register, issue number 3. The hearing was held in Helena, Montana on March 10, 1999.

2. The Board has amended ARM 8.39.514, 8.39.704 and 8.39.709 exactly as proposed, and has amended ARM 8.39.508 as proposed, but with the following changes:

"8.39.508 LICENSURE--RENEWAL (1) and (1)(a) will remain the same as proposed.

(b) ~~an affidavit~~ signed ~~and notarized~~ statement verifying that the licensee has current first aid training and is able to produce a current first aid card upon request;

(1)(c) through (4) will remain the same as proposed."

Auth: Sec. 37-1-131, 37-47-201, MCA; IMP, Sec. 37-47-201, 37-47-302, 37-47-303, 37-47-304, 37-47-306, 37-47-307, 37-47-312, MCA

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 commentor stated that dropping the CPR requirement was in direct conflict with safeguarding the public's health, safety and welfare.

RESPONSE: CPR is not a better method of protecting public health. Information received by the board does not support the assertion that CPR in the wilderness is effective.

COMMENT NO. 2: Three commentors raised the issue that requiring notarized statements are much too difficult to obtain and, therefore, should not be required.

RESPONSE: The board agrees with the comment and has amended the rule as shown above.

COMMENT NO. 3: One commentor suggested requiring outfitters to review first aid with guides and delete the first aid qualification.

RESPONSE: The first aid requirement is essential to the outfitting operation. As a result, the training needs to be accomplished by a certified first aid trainer.

COMMENT NO. 4: One commentor was concerned that summary first aid requirements are not found in the temporary guide rules.

RESPONSE: The board agrees and will correct this in a future rulemaking proceeding.

BOARD OF OUTFITTERS
ROBIN CUNNINGHAM, CHAIRMAN

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

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, April 9, 1999.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the AMENDMENT OF ARM 17.24.301, 17.24.302, 17.24.303, 17.24.304, 17.24.305, 17.24.306, 17.24.313, 17.24.315, 17.24.321, 17.24.324, 17.24.327, 17.24.401, 17.24.403, 17.24.404, 17.24.405, 17.24.413, 17.24.415, 17.24.416, 17.24.501, 17.24.503, 17.24.505, 17.24.507, 17.24.510, 17.24.520, 17.24.522, 17.24.601, 17.24.603, 17.24.605, 17.24.607, 17.24.623, 17.24.625, 17.24.632, 17.24.633, 17.24.634, 17.24.639, 17.24.640, 17.24.642, 17.24.645, 17.24.646, 17.24.647, 17.24.652, 17.24.702, 17.24.711, 17.24.713, 17.24.716, 17.24.724, 17.24.725, 17.24.726, 17.24.728, 17.24.733, 17.24.762, 17.24.815, 17.24.821, 17.24.823, 17.24.825, 17.24.901, 17.24.903, 17.24.911, 17.24.924, 17.24.925, 17.24.927, 17.24.932, 17.24.1001, 17.24.1002, 17.24.1003, 17.24.1005, 17.24.1006, 17.24.1010, 17.24.1014, 17.24.1017, 17.24.1018, 17.24.1104, 17.24.1111, 17.24.1112, 17.24.1116, 17.24.1132, 17.24.1143, 17.24.1221, 17.24.1222, 17.24.1223, 17.24.1224, 17.24.1225, 17.24.1226, 17.24.1228, 17.24.1261, and 17.24.1262; REPEAL OF 17.24.501A, 17.24.514, 17.24.519A, 17.24.604, 17.24.606, 17.24.1103, and 17.24.1116A; and ADOPTION OF NEW RULE I relating to coal and uranium mining program rules for the Industrial and Energy Minerals Bureau	)	NOTICE OF AMENDMENT, REPEAL AND ADOPTION OF RULES (Coal)

TO: All Interested Persons

1. On November 19, 1998, the Board of Environmental Review published notice of public hearing on the proposed amendment, repeal, and adoption outlined above on page 2995 of the 1998 Montana Administrative Register, Issue No. 22.

2. The Board has amended rules 17.24.302, 17.24.303, 17.24.304, 17.24.306, 17.24.313, 17.24.315, 17.24.324, 17.24.327, 17.24.403, 17.24.404, 17.24.405, 17.24.413, 17.24.415, 17.24.416, 17.24.503, 17.24.507, 17.24.510, 17.24.520, 17.24.522, 17.24.601, 17.24.603, 17.24.605, 17.24.607, 17.24.623, 17.24.625, 17.24.632, 17.24.633, 17.24.639, 17.24.640, 17.24.642, 17.24.645, 17.24.646, 17.24.647, 17.24.652, 17.24.702, 17.24.711, 17.24.713,

17.24.716, 17.24.724, 17.24.725, 17.24.726, 17.24.728, 17.24.733, 17.24.762, 17.24.815, 17.24.823, 17.24.825, 17.24.903, 17.24.924, 17.24.925, 17.24.927, 17.24.932, 17.24.1001, 17.24.1002, 17.24.1003, 17.24.1005, 17.24.1006, 17.24.1010, 17.24.1014, 17.24.1017, 17.24.1018, 17.24.1104, 17.24.1111, 17.24.1112, 17.24.1116, 17.24.1132, 17.24.1143, 17.24.1221, 17.24.1222, 17.24.1223, 17.24.1224, 17.24.1225, 17.24.1228, 17.24.1261, and 17.24.1262 as proposed; the Board has repealed rules 17.24.501A, 17.24.514, 17.24.519A, 17.24.604, 17.24.606, 17.24.1103, and 17.24.1116A as proposed; the Board has adopted RULE I (17.24.826) as proposed.

3. The Board has amended the following rules as proposed with the following changes. Matter to be added is underlined. Matter to be deleted is interlined.

17.24.301 DEFINITIONS (1) through (63) Remain as proposed.

(64) "Material damage" means, with respect to subchapter 9 rules on underground mining operations:

(a) any functional impairment of surface lands, features, structures or facilities;

(b) any physical change that has an ~~significant~~ adverse impact on the capability of the affected land to support any current or reasonably foreseeable uses or causes ~~significant~~ loss in production or income; or

(c) any ~~significant~~ change in the condition, appearance or utility of any structure or facility from its pre-subsidence condition.

(65) through (106) Remain as proposed.

(107) "Sedimentation pond" means a sediment control structure, including a barrier, dam, or excavated depression, which slows down runoff water to allow sediment to settle out. The term does not include sedimentation control ~~structures~~ practices, such as straw dikes, riprap, check dams, ~~and~~ mulches, dugouts, in-pit sumps, and other similar measures that reduce overland flow velocity, reduce runoff volume, or trap sediment.

(108) through (141) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-203, MCA

17.24.305 MAPS (1) and (2)(a) Remain as proposed.

(b) Maps, plans, and cross-sections required under (1)(l), (m), (o), (s), and (t) of this rule must be prepared by, or under the direction of, and certified by a qualified ~~registered~~ licensed professional engineer, with assistance from experts in related fields, except that:

(i) maps and cross-sections required under (1)(l), (m), (o), (s), and (t) of this rule may be prepared by, or under the direction of, and certified by a qualified licensed professional land surveyor with assistance from experts in related fields; and

(ii) maps, plans, and cross-sections for sedimentation ponds and spoil disposal facilities may be prepared only by a qualified licensed professional engineer.

(2)(c) and (3) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-222, MCA

17.24.321 TRANSPORTATION FACILITIES PLAN (1) Remains as proposed.

(2) Plans for low-water crossings ~~must contain drawings~~ of ~~the~~ perennial and intermittent stream channels must be submitted and must demonstrate that protection of such stream channels will be maximized in accordance with ARM 17.24.602, 17.24.631, 17.24.633, 17.24.638, and any other applicable rules.

(3) and (4) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-222, MCA

17.24.401 FILING OF APPLICATION AND NOTICE (1) An applicant for an operating permit, a test pit prospecting permit, a renewal of an operating permit or test pit prospecting permit, a major revision to an operating permit or test pit prospecting permit, or an amendment (other than an incidental boundary revision) to add acreage to an operating permit or a test pit prospecting permit shall file the application with the department's main office in Helena and, ~~as~~ if directed by the department, ~~and~~ with the federal coal regulatory authority.

(2) through (6) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-222, 82-4-226, 82-4-231, 82-4-232, 82-4-233, MCA

17.24.501 GENERAL BACKFILLING AND GRADING REQUIREMENTS (1) through (6)(a) Remain as proposed.

(b) Backfilling and grading must be completed within 2 years after coal removal from each pit has been concluded. For the purpose of this provision, "each pit" means any continuous dragline pass within a particular permit area.

(c) and (d) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-231, 82-4-232, MCA

17.24.505 BURIAL AND TREATMENT OF EXPOSED MINERAL SEAMS AND WASTE MATERIALS (1) Remains as proposed.

(2) Acid, acid-forming, toxic, toxic-forming, combustible, or other undesirable waste materials or fly ash identified by the department that are exposed, used, or produced during mining or mineral preparation must be covered in accordance with ARM 17.24.501(2) with the best available nontoxic and noncombustible material. The method and site of final disposal must be approved by the department. If necessary, these materials must be tested to determine necessary mitigations to neutralize acidity, to nullify toxicity, to prevent water pollution and sustained combustion, or to minimize adverse effects on plant growth and land uses.

If necessary to protect against upward migration of salts or exposure by erosion, to provide an adequate depth for plant growth or to otherwise meet local conditions, the department may specify thicker amounts of cover using noncombustible and nontoxic material or the use of special compaction and isolation techniques to prevent contact of these materials with groundwater. Acid, acid-forming, toxic, toxic-forming or other deleterious materials must not be buried or stored in proximity to a drainage course so as to cause or pose a threat of water pollution.

(3) through (8) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-231, MCA

17.24.634 RECLAMATION OF DRAINAGES (1) Construction of reclaimed drainages must ~~emphasize~~ exhibit channel and floodplain dimensions that approximate the premining configuration and that will blend with the undisturbed drainage system above and below the area to be reclaimed. The average channel gradient must be maintained with a concave longitudinal profile and the channel and floodplain must be constructed to:

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

AUTH: 82-4-204, MCA; IMP: 82-4-231, MCA

17.24.821 ALTERNATE RECLAMATION: SUBMISSION OF PLAN (1) Each operator who desires to conduct alternate reclamation pursuant to 82-4-232~~(7) and (if alternate revegetation is proposed) (8)~~, MCA, shall submit his plan to the department. The plan must contain appropriate descriptions, maps and plans that show:

(1)(a) through (2) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-233, MCA

17.24.901 GENERAL APPLICATION AND REVIEW REQUIREMENTS (1) through (1)(d) Remain as proposed.

(e) In the event the survey shows such structures, renewable resource lands, or water supplies exist, and that subsidence could cause material damage or diminution of value or foreseeable use of the land or contamination, diminution, or interruption of such water supplies, or if the department determines that such damage or diminution or contamination, diminution, or interruption could occur, the application must include the following information:

(i) a detailed description of the measures to be taken to prevent ~~or minimize~~ subsidence and subsidence-related damage, including:

(A) the anticipated effects of planned subsidence, if any, and a map of the proposed underground mine workings which shows the location and extent of the areas in which planned-~~subsistence~~ subsidence mining methods will be used and that identifies all areas where the measures in (1)(e)(i)~~(B) and~~ (C) below will be taken to prevent ~~or minimize subsidence and~~ subsidence-related damage~~, and to mitigate such damage~~;

(B) measures, if any, to be taken in the mine to prevent ~~or minimize~~ subsidence, including, but not limited to, such measures as backstowing or backfilling of voids, leaving support pillars of coal, and areas in which no coal removal is planned, including a description of the overlying area to be protected by leaving coal in place;

(C) measures to be taken on the surface to prevent ~~or minimize~~ material damage or ~~lessening~~ diminution of the value or the reasonably foreseeable use of structures or the surface, including such measures as reinforcement of sensitive structures or features, installation of footers designed to reduce damage caused by movement, change of location of pipelines, utility lines, or other features, relocation of movable improvements to sites outside the angle-of-draw, and monitoring to determine the commencement and degree of subsidence so that other appropriate measures can be taken to prevent~~, minimize, or mitigate~~ material damage in accordance with ARM 17.24.911. For areas where planned subsidence is proposed, written consent or request by the owners of non-commercial buildings and occupied residential dwellings and structures related thereto that material damage ~~minimization~~ prevention measures should not or need not be taken may be provided in lieu of a description of ~~minimization~~ prevention measures to be taken;

(e)(ii) through (2) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-222, MCA

17.24.911 SUBSIDENCE CONTROL (1) Remains as proposed.

(2) If the operator utilizes planned and controlled subsidence in the mining operation, all necessary measures must be taken to ~~minimize~~ prevent material damage to non-commercial buildings and occupied residential dwellings and all structures related thereto~~, to the extent technologically and economically feasible~~. Such measures are not required if the operator has the written consent of the owners of such structures.

(3) through (8) Remain as proposed.

(9) Within a schedule approved by the department, the operator shall submit a detailed plan of the underground workings. The plan shall include maps and descriptions of significant features of the underground workings, including the size, configuration, and approximate location of pillars and entries, extraction ratios, measures taken to prevent ~~or minimize~~ subsidence and related damages, areas of full extraction, and other information required by the department.

(10) Remains as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-227, 82-4-231, MCA

17.24.1226 SMALL OPERATOR ASSISTANCE PROGRAM: QUALIFICATION OF LABORATORIES, CONSULTANTS, AND CONTRACTORS (1) The department shall designate qualified laboratories, consultants, and contractors. To receive such a designation, ~~laboratories~~ firms shall apply to the department

and provide ~~such~~ the information ~~as is~~ necessary to establish the qualifications required by (2) of this rule.

(2) and (3) Remain as proposed.

AUTH: 82-4-204, 82-4-205, MCA; IMP: 82-4-221, MCA

4. The Board received the following comments; the Board's responses follow. Some comments have been combined or grouped together to promote efficiency in the description of comments and in the responses. Also, comments made on rules or portions of rules that were not part of or related to this proposed rulemaking or comments of a general nature not specifically related to any of the proposed rules have not been responded to in what follows, because they are outside of the scope of this rulemaking.

COMMENT #1: Eliminating the phrase "...including any terracing or access roads..." and the last sentence in ARM 17.24.301(13) would eliminate terraces, access roads, and permanent water impoundments from the definition of approximate original contour (AOC) and thus from consideration in final reclamation. In addition, allowing a reference to depressions and an associated ARM in the definition of AOC is inconsistent with striking these two portions of the definition which also have supporting ARM sections.

RESPONSE: Striking the two indicated portions of this definition will not preclude the features described from being part of final reclamation, because they may be allowed under ARM 17.24.601(11), 17.24.504, and 17.24.642. The language proposed to be added regarding depressions is text (with some qualification) being moved from ARM 17.24.501(4)(a). Permanent water impoundments are not prohibited because they are not depressions and the requirement to eliminate depressions does not apply to them.

COMMENT #2: The deletion of the last sentence in ARM 17.24.301(13) may prohibit the approval of final pit impoundments in final reclamation. The proposed rule does not provide a mechanism to approve final pit impoundments or wetlands in reclamation.

RESPONSE: Any proposed permanent pond must meet the requirements of ARM 17.24.504 and 17.24.642, irrespective of the definition of AOC. A proposed final pit impoundment would of course need to meet the basic criteria in the definition of AOC, irrespective of the proposed deleted language in ARM 17.24.301(13). Furthermore, permanent water impoundments are not prohibited because they are not depressions and the requirement to eliminate depressions does not apply to them. Wetland restoration is required in ARM 17.24.751(2)(f) and (g). Wetlands as enhancement features could also be considered in relation to ARM 17.24.503(1) and proposals for permanent impoundments (see rule citations in response to

COMMENT #1). Thus wetland reclamation is required or can be considered irrespective of the proposed deleted language in the definition of AOC.

COMMENT #3: The use of the word "significant" in the proposed definition of "material damage" in ARM 17.24.301(64) does not adequately address the damage issues of a landowner subject to material damage from mining. Any damage is significant to the affected landowner.

RESPONSE: The Board agrees. The Board has made this change. (See ARM 17.24.301(64) under part 3 of this notice.)

COMMENT #4: Proposed ARM 17.24.301(71), definition for "Non-commercial building", is out of alphabetical order. It should be inserted before "Noxious plants".

RESPONSE: The proposed definition for "Non-commercial building" does in fact come before "Noxious plants". The November 9, 1998, rule notice indicated on page 3 that section (68), which in the current rules is the definition of "Noxious plants", would be renumbered to (72), which is after (71) "Noncommercial building".

COMMENT #5: The proposed changes to ARM 17.24.301(107) remove the clear distinction between sediment control structures that need to be designed and those that do not. It also has the effect of expanding the definition of "sedimentation pond" beyond the scope of ARM 17.24.639. Deleting the reference to ARM 17.24.639 in the first sentence is a mistake, because it provides a relevant reference to the details of sedimentation ponds. In addition, there is a need to recognize the use of in-pit sumps as a sediment control option. (Some of these comments were accompanied by proposed revisions to the Board's language for the definition of "sedimentation pond".)

RESPONSE: The qualifier that referenced ARM 17.24.639 has not been reinserted because, with that qualifier, the definition would be circular. However, the Board has modified the definition by expanding the exclusions. This should alleviate the concern in a manner that does not create a circular definition.

COMMENT #6: The proposed deletion of "registered land surveyor" from ARM 17.24.305(2)(b) is not consistent with state law at 37-67-101(6) and (8), MCA, which define "practice of land surveying" and "professional land surveyor", respectively. These definitions imply that licensed professional land surveyors can prepare and certify mine maps and cross-sections, but not plans. Also, the term "registered" for both engineers and land surveyors should be changed to "licensed" to recognize the term now used by state

law. (These comments were accompanied by proposed revisions to the Board's proposal in ARM 17.24.305(2)(b)).

RESPONSE: The Board agrees with these comments and has made appropriate changes to the affected rule, although differently than proposed in the comment, to more clearly preserve the distinctions between what a licensed professional land surveyor will be allowed to prepare and certify as compared with a licensed professional engineer (see ARM 17.24.305 under part 3 of this notice).

COMMENT #7: Deletion of the last part of the sentence in ARM 17.24.321(2) seems to remove any reason for the indicated plans for low water crossings to be submitted.

RESPONSE: The deleted phrase is a vague performance standard located in a rule which consists of application requirements. Performance standards for water resource protection or mitigation are found in subchapters 5 and 6. The Board does agree that some connection of the provision in ARM 17.24.321(2) with appropriate performance standards would be desirable for clarity of purpose. Thus, the Board has added a phrase that references the appropriate performance standards in the rules (consistent with federal rules) and will also make one further change for clarification of text. (See ARM 17.24.321(2) under part 3 of this notice).

COMMENT #8: The proposed change in ARM 17.24.401(1) does not express the idea, as indicated in the rationale for the change, that the Department will direct whether an application must also be submitted to OSM.

RESPONSE: The comment is correct; a mistake was made in the transcription of the intended language. This mistake has been corrected and the language further clarified (see ARM 17.24.401(1) under part 3 of this notice.)

COMMENT #9: The proposed change in ARM 17.24.404(7)(b) is not an updating to federal rules, but is a lowering of state standards because it extends the violation resolution process out over a longer period of time than the current rule allows.

RESPONSE: The Board agrees that this change is a lowering of state standards, but this change is in fact a reflection of the federal rules (30 CFR 773.15) and is being required by the Office of Surface Mining (OSM). In its letter of October 17, 1995, to the Department, OSM indicated that this change must be made by the state, because this change grants rights and remedies to the mine permit applicant, and OSM would not consider the state's rule as effective as the counterpart federal rule unless these same rights and remedies are granted in the state rule. Thus, the Board will not deviate from the change as originally proposed.

COMMENT #10: The proposed deletion of language from ARM 17.24.501(1), consisting of a revised time table for reclamation if the operator for good cause shown cannot complete backfilling and grading within set time limits, removes flexibility which is not found in ARM 17.24.501(6), contrary to what the Board asserts.

RESPONSE: The Board disagrees, because the plain reading of ARM 17.24.501(6) clearly indicates that the operator has flexibility to receive a variance from the requirements for current backfilling and grading if adequate justification is provided.

COMMENT #11: The sentence ("Additional bonding may be required...") proposed to be deleted from ARM 17.24.501(1) is a flag to the operator regarding the consequences of his action; thus, this sentence should be added to ARM 17.24.501(6), or a reference to ARM 17.24.1102 should be made there.

RESPONSE: The Board disagrees that this is necessary, because there are potentially a number of kinds of proposed changes in mining or reclamation operations that may trigger a need to adjust the bond or at least examine it. A reference to the possible need to adjust the bond is not found in all rules where various changes of mining and reclamation plans would need to be addressed. The bottom line is that, pursuant to ARM 17.24.1102, the Department is responsible for insuring that the bond is adequate or upgraded as necessary to cover all approved changes in mining or reclamation plans.

COMMENT #12: In deleting ARM 17.24.501(3)(c) and moving some of the language from ARM 17.24.501(3)(c) to (3)(b), the phrase "before the acid, toxic, acid-forming, or toxic-forming materials are covered" should have been retained and not deleted from the rule. The revised requirement will allow operators to handle these kinds of materials as they wish before the Department approves of a handling plan.

RESPONSE: The Board disagrees with this comment, because the plain interpretation and understanding of this language as revised is that the operator must submit a plan and receive approval for handling of such materials prior to any final disposal. There would be no purpose for the Department to receive a plan after final disposal had taken place. Additionally, pursuant to application requirements in subchapter 3 (ARM 17.24.313(3)(a), (4), and (4)(a)) operators must submit plans for handling of overburden and other materials, which would include acid, toxic, etc., materials; this is required before any final disposal of such materials can occur.

COMMENT #13: In ARM 17.24.501(6), the phrase "upon adequate written justification and documentation provided by the operator" should be deleted, because it is superfluous and redundant. All revisions and variances are predicated on Department review of proposals by operators.

RESPONSE: The Board disagrees, because a standard to be met to receive a variance from the provisions of ARM 17.24.501(6) needs to be stated to provide consistency of evaluation of proposals for such a variance.

COMMENT #14: The revision of ARM 17.24.501 and the repeal of ARM 17.24.501A does great harm to the standard in the law of reclaiming as "rapidly, completely and effectively" as possible. The deletion of ARM 17.24.501A(3)(a), specifically the sentence "Rough backfilling and grading must be completed within 180 days following coal removal", and replacing it with ARM 17.24.501(6)(b), i.e., "Backfilling and grading must be completed within 2 years after coal removal from each pit has been concluded" amounts to no time limit at all.

RESPONSE: The Board disagrees with these comments. The reclamation standard in state law that is referred to (82-4-231(1), MCA) requires some judgment on the part of the Board (and the Department) as to what this means and how to apply it in the form of administrative rules. The Board believes it has exercised that judgment. The proposed change will not reduce the current rate of reclamation. The current 180-day rule contains the option for the Department to grant a variance for legitimate operational reasons. The Department has found that more than 180 days is often legitimately required for prudent mine and reclamation operations to meet operational and coal marketing constraints, and has granted variances in those cases under the current rules. Because at least four spoil ridges frequently optimize effective construction of a post-mine topographic surface, and coal mines in Montana generally complete less than two pits (and spoil ridges) in 180 days, it follows that allowance for an extended time frame can benefit reclamation in certain cases. (As a side note, in making this rule change, the Board has eliminated the term "rough" as a qualifier to "backfilling and grading", because it is ambiguous and thus creates uncertainty regarding what is required to meet the backfilling and grading timeliness standard.) Thus, this change in the rule will result in a more realistic reflection of on-the-ground mining and reclamation factors that influence reclamation timing.

COMMENT #15: In ARM 17.24.501(6)(b), what is the definition of "each pit"? Is it the whole permit area or one pass of the dragline? If it is the whole permit area, this could result in a scenario that is contrary to 82-4-231(1), MCA.

RESPONSE: The Board didn't intend for "each pit" to mean the entire permit area. Thus, the Board agrees that clarification of what "each pit" means in the context of this provision is warranted. A definition of this term will be adopted as shown in ARM 17.24.501(6)(b) under part 3 of this notice.

COMMENT #16: Why was the language of ARM 17.24.501A(3)(a) not included in the strikeout portions of proposed changes as everything else was?

RESPONSE: All of ARM 17.24.501A was proposed to be repealed as indicated in the rulemaking notice on page 3077, 1998 Montana Administrative Register, Issue No. 22. The Office of the Montana Secretary of State requires that notice of proposed repeal of an entire rule be written in this manner, i.e., not showing strikeouts of the entire text of the rule.

COMMENT #17: The language of ARM 17.24.501A(3)(a) is central to the timing of when, and if, reclamation will be completed.

RESPONSE: The text of ARM 17.24.501A(3)(a), with modification, was moved to ARM 17.24.501(6)(a) and (b). The primary aspects of this modification consisted of changing the 180-day requirement to a 2-year requirement and eliminating "rough" from "backfilling and grading". See the response to COMMENT #14 for further discussion of this modification.

COMMENT #18: The deletion of ARM 17.24.501A is a big mistake. This rule provides for the determination of approximate original contour and standards for achieving successful repair. Striking the entire paragraph results in the Department relying upon various standards at various operations, which may or may not be effective, and makes reclamation depend solely upon company personnel competence.

RESPONSE: The Board does not agree. As indicated in the rationale for the repeal of this rule (page 3077, 1998 Montana Administrative Register, Issue No. 22), language, with modifications, in sections (1)(a), (2), and (3) of ARM 17.24.501A was relocated to ARM 17.24.501 and 17.24.301(13). Also, text on approximate original contour is now found in ARM 17.24.501(4). Text in ARM 17.24.501A(1)(b) and (c) has no practical application. The Department uses premining and postmining topography (PMT) maps to determine compliance of a reclamation plan with approximate original contour, as defined in ARM 17.24.301(13), and any other PMT requirements.

COMMENT #19: The Department is deleting ARM 17.24.501A and substituting it with ARM 17.24.501, as revised, to deflect criticism for lack of currency of reclamation at most of the mines. If there is no effective rule, there is no failure to enforce.

RESPONSE: The first statement is incorrect. The reasons for the changes have been stated in the original notice of rulemaking and in response to COMMENT #14 above. Furthermore, the Board does not agree with the premises that there is a lack of currency of reclamation at most of the mines and that the new rule will be ineffective.

COMMENT #20: The state has not been requiring companies to comply with the rules. This rule rewrite aids in further circumvention.

RESPONSE: Assuming that these statements refer to the rule changes relative to ARM 17.24.501 and 501A, the Board disagrees that the state has not been requiring companies to comply. No evidence is presented by the commentor supporting this contention. As pointed out in the response to COMMENT #14, the Board has presented reasons for these rule changes and why reclamation progress will not diminish as a result of the amendments.

COMMENT #21: These rule changes (relative to ARM 17.24.501 and 17.24.501A) will set the Department up for Pegasus-like events at the coal mines. The state can no longer rely on performance bonds to provide security for insuring reclamation is done. Due to creditors, the state only received 18 cents on the dollar in the bankruptcy of Glacier General Assurance Company. The best protection against bond forfeitures is to proceed apace with reclamation in conjunction with mining. It is poor policy to leave the bulk of the work until the last years of mining. Montana would be put in the position of paying for reclamation bills and letting the companies go free through bankruptcy.

RESPONSE: The Board does not agree with the premise of these statements, i.e., that these rule changes will delay major reclamation efforts to the point that companies will forfeit their bonds rather than perform the required reclamation. The Board does believe that reclamation needs to proceed with mining, the pace of which may vary depending upon the specifics of the mine. The Board explained in the response to COMMENT #14 why reclamation progress will not be diminished by these rule changes. In addition, performance bonds undergo periodic review and update which reflect changing conditions at the mines and changing costs. Bonds are designed to reflect the costs of reclaiming the total areas of disturbance at specified points in time. Bonds are still the best ultimate method that the state has to insure that the reclamation will be accomplished. Also, surety bonds, which are the type that most of the state's coal mine operators use, are still the best kind of bond, short of a cash bond. According to information received from the State Insurance Department, there has been only one failure of a surety company in the U.S.A. in the last 6 years. To manage the risk

of using surety bonds, ARM 17.24.1106 requires, among other things, that a specific surety bond not exceed 10% of the surety company's capital surplus account; also, ARM 17.24.1101(1) requires a surety company to be licensed for business in Montana. There is no absolute 100% guarantee of the availability of a bond, as the reference to Glacier General Assurance indicates. However, other than the Glacier General situation, the state has forfeited only two coal mine company bonds in the history of coal mining under the present statute, and has received payment in full in both cases. In conclusion, the possibility that the state will be put in the position of paying for reclamation bills with respect to coal mining operations is remote.

COMMENT #22: Two commentors proposed to retain ARM 17.24.501A, but also that (3)(a) of this rule be revised by adding language regarding the redirecting of groundwater as part of the backfilling and grading process, by imposing fees on the operator to insure that requirements for reclamation in this rule, including timeliness, are met, by allowing a third party to conduct reclamation on a mine site if the operator does not meet the prescribed requirements, and by the imposition of penalties with respect to the bond and the fees if the operator does not comply.

RESPONSE: The premises of and assertions underlying this proposal are found in COMMENT #14, #20, and #21, with which the Board does not agree and to which the Board has responded, accordingly. Thus, the Board does not agree with the need for the commentor's proposed rule revisions regarding backfilling, grading, fee imposition, and third party reclamation contractors. Furthermore, these proposed changes are beyond the scope of this rulemaking; the Board may not consider new proposed substantive rulemaking at this point in this rulemaking process because the public has not been afforded an opportunity to comment on them.

The proposed rule change regarding the redirecting of groundwater as part of the backfilling and grading process is also beyond the scope of this rulemaking.

COMMENT #23: The term "exposed mineral seam" should be added to the title of ARM 17.24.505 to better identify the activities covered by the rule.

RESPONSE: The Board agrees and will revise the title to read "BURIAL AND TREATMENT OF EXPOSED MINERAL SEAMS AND WASTE MATERIALS". (See ARM 17.24.505 under part 3 of this notice.) In addition, the Board has corrected a typographical error in the rule by changing the word "sustain" to "sustained".

COMMENT #24: In ARM 17.24.505(1), the phrase "upon demonstration by the operator that a lesser cover depth will

afford the same protection against combustion and other undesirable properties or effects of the mineral seam" should be deleted, because it is unnecessary. All revisions and variances are predicated on departmental review of proposals submitted by operators.

RESPONSE: See response to COMMENT #13.

COMMENT #25: The word "undesirable" in the quoted phrase of ARM 17.24.505(1) in COMMENT #24 above should be deleted and replaced with the word "waste", because "undesirable" is undefined, whereas "waste" is defined.

RESPONSE: The Board disagrees. "Undesirable" is already present in ARM 17.24.505(2) and its meaning appears clear from the context in which it is used. If "waste" were used, the meaning of the resulting term "waste properties or effects" would be unclear and certainly different from what is intended. The point of using "undesirable" is to protect against acid-forming, toxic, etc., properties that a coal seam might have.

COMMENT #26: Regarding ARM 17.24.505(1), the use of 4 feet of material to cover the exposed coal seam is not a whole lot of protection in erosive conditions. The risk would be higher with less material.

RESPONSE: Whether the use of less than 4 feet of material would be acceptable is a site-specific determination, which is why an operator must demonstrate that a lesser depth will afford the same protection as the proposed rule reads.

COMMENT #27: What is the rationale for removing the term "suitable" from the language in ARM 17.24.520(2), which is language, with modification, that was moved from ARM 17.24.519A? Also, the fill discussion in ARM 17.24.520 is not as detailed as that in 30 CFR 816.71(e) and 816.74.

RESPONSE: The reason for deleting "suitable" is to be consistent with ARM 17.24.505. ARM 17.24.505 allows for placement of such materials in the mined out area if certain procedures or practices are followed to protect water resources and plant growth and to prevent sustained combustion. ARM 17.24.520(2) does not relate to how to handle wastes (suitable or unsuitable); it relates to the need to consider the volume of all wastes (suitable and unsuitable) that are to be disposed of on the mine (pursuant, of course, to ARM 17.24.505) for the purpose of demonstrating (if it can be demonstrated) that the total volume of materials (spoils and wastes) available "is more than sufficient to restore the disturbed area to the approximate original contour".

In the comment that the fill discussion in ARM 17.24.520 is not as detailed as in the federal counterpart rules, it is not clear what the commentor is specifically referring to. OSM has not indicated to the state any deficiencies in the state rule compared to the current federal rules.

COMMENT #28: In ARM 17.24.601(1), the phrase "for documented and justified reasons related to the needs of the mining operation or improved reclamation" should be deleted, because it is unnecessary and redundant. The Department is expected to approve variances only if necessary and justified.

RESPONSE: See the response to COMMENT #13.

COMMENT #29: Some of the road requirements in ARM 17.24.601, 17.24.603, 17.24.605, and 17.24.607 that would affect the safety of mine workers are being stricken.

RESPONSE: This comment is non-specific as to what provisions are being referenced. Much of the deleted text that may fit the context of the comment are items that do not relate to the Department's area of responsibility and authority in coal mine regulation, which is primarily environmental protection, land reclamation, and health and safety of the public. Mine worker safety is the province of the Mine Safety and Health Administration (MSHA), the Occupational Safety and Health Administration (OSHA), and the Safety Bureau of the Montana Department of Labor and Industry. The only area of the Department's authority which clearly involves worker safety is blasting, although the Department would never knowingly engage in or require any action or practice that was obviously unsafe to workers.

COMMENT #30: Does MSHA have rules on miner safety with respect to some of these rules on roads proposed for deletion? Does OSM have equivalent standards for road construction?

RESPONSE: The Board is not aware of how MSHA's rules relate to mine roads. OSM does not have standards on mine roads equivalent to Montana's; OSM's rules are very general with respect to roads (see 30 CFR 816.150 and 816.151).

COMMENT #31: I think ARM 17.24.605 is the first time "BTCA" is encountered. It is not written out anywhere.

RESPONSE: In subchapter 6, "BTCA" is first encountered in ARM 17.24.601(3), where it is written out: "best technology currently available". The term is defined in ARM 17.24.301(19).

COMMENT #32: The people at Colstrip who are living with a seismograph in their basement because of blasting will miss the 8-hour per day rule, i.e., part of the deleted portion of

ARM 17.24.623(2)(b)(iii). At least the reference to ARM 17.24.624 should be retained.

RESPONSE: ARM 17.24.623(2)(b)(iii) concerns the information on days and time periods that blasting will be conducted that must be in the required published blasting schedule, which is what ARM 17.24.623 addresses. The published blasting schedule must, of course, comply with many requirements of ARM 17.24.624, including any imposed restrictions on time, area covered, and sequence of blasting, requirements for access control to blasting areas, and requirements for warning and all-clear signals. Thus, there are many requirements in ARM 17.24.624 besides time of blasts that must be reflected in the blasting schedule. Retaining a reference to ARM 17.24.624 in the indicated provision of this rule serves no purpose. The Department retains the authority under ARM 17.24.624 to limit blasting to 8 hours per day or any other limit necessary to protect public health, safety, or welfare.

COMMENT #33: Deleting the referenced rule text in COMMENT #32 will render the Montana standards less stringent than the federal rules. 30 CFR 816.64 prescribes blasting in daylight hours from sunrise to sunset. If you are living in a place that can have blasting 24 hours a day, maybe you don't want to be living there.

RESPONSE: ARM 17.24.624(2) imposes the same limitation as the federal rule (30 CFR 816.64), that is, blasting must be conducted between sunrise and sunset. The rule also authorizes the Department to impose more restrictive time periods if warranted.

COMMENT #34: In ARM 17.24.633(1), changing the word "appropriate" to "approved" is a weakening of the standard, because it is now possible to approve a pond in an inappropriate place.

RESPONSE: The rule, as proposed to be amended, references ARM 17.24.638 and 17.24.639. These rules require these structures to be located in appropriate locations and provide more specific criteria for determining appropriate locations.

COMMENT #35: The changes in ARM 17.24.633(4) seem to indicate that if you have implemented your discharges from your disturbed areas, have control of them with your BTCA standards, that's all that is required if you have an MPDES permit, and the federal rules are not applicable. I would hope that the federal rules are applicable. The changes to (4) make this section far less definite regarding the circumstances to which it was designed to apply.

RESPONSE: ARM 17.24.633(4), as revised, provides: "All discharges which include water from areas disturbed...must be

in compliance with all federal and state laws and regulations" (key words underlined). The deleted portion at the beginning of (4), "Whenever a sedimentation pond...shall achieve the following criteria...", is now covered in much more simplified language in the first line of the new (4). The deleted text at the end of old (4)(a) is covered by the added text: "applicable effluent limitations". Old (4)(b) is not necessary, because the special circumstance described in (4)(b) is now covered by the all-encompassing language of revised (4).

COMMENT #36: ARM 17.24.633(6) should not be deleted, if you're going to comply with the rules other than BTCA, and in order for the rest of the changes in ARM 17.24.633 to make sense. Deleting this provision significantly weakens and obfuscates the standard which sedimentation structures must meet under BTCA.

RESPONSE: All of the requirements in ARM 17.24.633(6) are covered in ARM 17.24.633(1), (3) as revised, and (4) as revised.

COMMENT #37: Omitting "Design" from the first line of ARM 17.24.634(1) should not be done, because there should be some forethought about how to construct a channel before any construction begins.

RESPONSE: As indicated in the rulemaking notice on page 3029, 1998 Montana Administrative Register, Issue No. 22, the purpose of replacing "design" with "construction" in (1) was to convert (1) to a performance standard only. The Board agrees that designs are necessary; designs are still required under (2) as revised.

COMMENT #38: The provisions on how to determine approximate original contour, which the Department wants to strike, would aid in designing stream channels bearing a resemblance to the premining condition.

RESPONSE: There is nothing in the deleted text of ARM 17.24.301(13), the definition of approximate original contour, that relates to reclaimed channel design.

COMMENT #39: A few commentors proposed revised language in various parts of ARM 17.24.634(1) and (2). Proposed changes in (1) would replace the term "emphasize" with "exhibit", and would eliminate "channel and floodplain" where found and replace it in one instance with "drainages". Proposed changes in (1)(f) in addition to those of the Board are shown as follows: "establish or restore the ~~channel~~ drainage to include, where appropriate, a diversity of ~~aquatic~~ habitats ~~(generally a series of riffles and pools)~~ that approximates the premining characteristics . . ." In (2), the commentors

have proposed substantially revised text that would confine the need to submit drainage designs to channels "dominated by fluvial processes". The commentors indicate that the rationale for all of these proposed changes is that designs for ephemeral channels are unnecessary and that the proposed language ties detailed channel designs to quantifiable premining conditions that can be measured by proven scientific methods.

RESPONSE: With one exception, the above proposed changes are beyond the scope of this rulemaking; the Board may not consider new proposed substantive rulemaking at this point in this rulemaking process. The one exception is that the Board has replaced the word "emphasize" with "exhibit" in ARM 17.24.634(1), because it clarifies the intent of (1), which is now a performance standard only.

COMMENT #40: In ARM 17.24.634(2), leaving the definition of "habit or characteristic pattern" as the only standard for channel designs fails to minimize erosion. A channel in the process of reaching equilibrium may still be eroding severely.

RESPONSE: The referenced definition is not the only standard for channel designs. As shown at the bottom of page 3029, 1998 Montana Administrative Register, Issue No. 22, parts (1)(b) through (1)(e), which are also standards for channels, are still in the rule. Also, part (1)(f) as revised is a channel standard. Stability (as related to erosion) is still covered, in similar or identical language as it was before, in ARM 17.24.634(1)(a) in conjunction with ARM 17.24.301(46) and in (1)(c) and (1)(e) of ARM 17.24.634.

COMMENT #41: The text in ARM 17.24.634(2) regarding state-of-the-art stream designs and the submitting of channel designs at least 120 days before channel reclamation should not be stricken. Regarding state-of-the-art, repetition is not a bad thing; a little reminder does not hurt the Department or the operator. The 120-day requirement should be of help to the Department and the operator. Otherwise the Department may have people dropping off the design asking for immediate approval.

RESPONSE: See the Board's rationale for these changes in the rulemaking notice. Some repetition is not necessarily a bad thing. However, if "state-of-the-art" is retained here, it should also be placed in many other locations in the rules, because state-of-the-art is required on all reclamation (82-4-231(1), MCA). Regarding the 120-day requirement, it is possible that the Department may get pressure to approve a design "by yesterday". The bottom line is that channel construction may not begin until the design is approved (ARM 17.24.634(2)).

COMMENT #42: Removing the last sentence of ARM 17.24.634(2) removes an important safeguard for the successful reconstruction of a channel. Topsoil is not so plentiful that it can be wasted on an improperly constructed area. Design and construction of drainage channels ought to be one of the more important aspects of reclamation. Before topsoiling you would be better off having an inspection of the channel. Department employees should be able to inspect constructed channels before resoiling, presumably because they are on the mines for inspections anyway.

RESPONSE: See the rationale for this deletion in the rulemaking notice. The Board concurs that design and construction of channels is a key aspect of reclamation and that wasting of soil is undesirable. The Department can inspect many reconstructed channels prior to resoiling, but with the resources and workload in the Coal and Uranium Program, and in light of the need and desire of many operators to continue reclamation progress in accordance with their scheduling of reclamation activities, to require that all reconstructed channels be inspected prior to resoiling is impractical. The Department has the authority to take enforcement action if a company does not comply with design requirements in constructing channels; this would include loss of soil if a violation of applicable subchapter 7 rules is identified.

COMMENT #43: Although the proposed revised language in ARM 17.24.634 allows for greater flexibility, the rule is still burdensome to our reclamation efforts. Submitting designs for every channel is not practical. The Department may exempt all or portions of drainage channels from the need for designs, but this process is cumbersome at best. In the late 1980's, this rule contained language indicating that significant channels required designs but insignificant ones did not. Perhaps we should step back and consider the intent of this rule.

RESPONSE: This comment does not specifically address the proposed changes, but calls for some consideration that is beyond the scope of this rulemaking; state rulemaking procedures do not allow the Board to consider new proposed substantive rulemaking at this point in this rulemaking process.

COMMENT #44: In ARM 17.24.639(1)(a)(i)(A), the phrase "generally accepted method" should be substituted for "method approved by the department", because there are many methods available which provide reasonable estimates of sediment volume. The operator should not be required to use a method preferred by the Department. The review and approval process is the mechanism to express any concerns about the method used.

RESPONSE: The term "generally accepted method" is too vague to be satisfactorily enforceable. The last sentence of the comment seems to agree that the Department should be the ultimate authority in determining the acceptability of methods, which is what the rule provides; and the Board agrees that the Department must have ultimate authority to determine design methods to insure the adequacy of pond design. The suggested amendment has not been made.

COMMENT #45: ARM 17.24.639(1)(c)(i)(B) should not be changed, because reducing by nearly half the capacity of the sedimentation pond will leave the pond under capacity to hold the 10-year, 24-hour precipitation event. The original version of this rule allows for smaller sedimentation ponds if the circumstances justify it. The only result of this change may be the construction of more sedimentation ponds.

RESPONSE: Subsection (1)(c)(i) of this rule involves only design for sediment loading, not the 10-year, 24-hour precipitation event. Design for 10-year 24-hour precipitation event is also required under ARM 17.24.639(2). Subsections (A) and (B) under (1)(c)(i) provide two alternatives, one of which must be chosen to design the pond for sediment loading. Subsection (B) is an option that could be characterized as a quicker, but worst case approach to designing for sediment. The Department's experience in working with sediment volume estimation and how ponds have actually functioned at the coal mines over many years indicates that the original requirement in option (B) of 0.035 ac-ft per acre (which was in the original program rules of OSM and which OSM repealed many years ago) is overdesign and may result in unnecessarily large ponds and unnecessary land disturbance to build such large ponds. The revised value of 0.02 ac-ft per acre for option (B) is more reasonable and adequate. Finally, contrary to the last sentence in the comment, the result of this change will not be more sediment ponds, but smaller ones in certain cases, which may reduce land disturbance.

COMMENT #46: Deleting ARM 17.24.639(6) has significantly weakened and obfuscates the standard which sedimentation structures must meet under BTCA.

RESPONSE: This deleted provision is completely covered by the requirements in ARM 17.24.633(4) as revised.

COMMENT #47: The second sentence as revised in what is now ARM 17.24.639(6), "With the approval of the department, additional storage may be provided for sediment and water above the total design requirement", should be deleted. This is an operational decision that should be reserved for the operator to make. The review and approval process is the

mechanism for the Department to voice any concerns it may have with a plan that provides for additional storage volume.

RESPONSE: This comment is beyond the scope of this rulemaking, because it proposes a substantive change in the process (deleting a key provision, "approval by the department") regarding provision for additional storage capacity. Also, it appears as if the last sentence of the comment contradicts the first two sentences, because the review and approval process would allow the Department to exercise authority over a proposal for additional storage, which is what the rule as revised provides for. Approval by the Department is necessary to limit land disturbance that could occur because of excessive pond storage capacity.

COMMENT #48: Considering the life of some mines, some sedimentation ponds could be in place for 35 or 40 years. Embankments on some of the dams of that age on our ranch have settled in the middle, and unless there is adequate freeboard there is a real risk of breaching in the middle of the dam. This is something to keep in mind regarding new ARM 17.24.634(9).

RESPONSE: The Board agrees that maintaining adequate freeboard on sedimentation ponds is necessary. Section (9) of this rule states: "The minimum elevation at the top of the settled embankment must be 1 foot above the water surface in the pond..." (emphasis added).

COMMENT #49: We have a concern with the proposed revision of ARM 17.24.639(27)(a) and (b) involving the deletion of "primary" in the first line of both (a) and (b). This concern relates to COMMENT #5 regarding ARM 17.24.301(107).

RESPONSE: Please see the response to COMMENT #5, which addresses this concern, and therefore, the concern with ARM 17.24.639(27)(a) and (b).

COMMENT #50: In ARM 17.24.639(27)(a), removing the text which indicates that slopes of sedimentation ponds that are excavations must be 3h:1v or less could endanger wildlife or people. On a 3:1 slope, wildlife might be able to get out, if they can get to one end or the other. The major danger would be in winter with the pond ice unstable or covered with snow; if something goes through the ice, it's going to be dead. There was a case in Colorado where a person fell through the ice in one of these in an oil shale mine and he drowned because he couldn't get out from under the ice.

RESPONSE: The objective of this rule is slope stability of excavations, and the rationale for the change is from that perspective and for operational and land disturbance reasons. The response to Comment #29 about worker safety is pertinent

here as well. In addition, regarding both wildlife and human safety, most such excavations would not have vertical or near-vertical slopes all around, because it is anticipated they would primarily be constructed with dozers or scrapers. Dozers and scrapers require entrance and exit points to do the work, which means that slopes for entrance and exit cannot be extremely steep. Draglines could be used but only in rare instances where mining happened to be occurring at a point and at a time where an excavated pond needed to be constructed. Finally, risks to wildlife and humans are minimal, even on the steeper slopes.

COMMENT #51: Since these rules are meant to be read by engineers and the public, as well as lawyers, even if it is redundant, the reference to "Standard Methods for Examination of Water and Wastewater, 15th edition" in ARM 17.24.645(6) should be retained, because it gives the reader a shortcut of what to look for without having to hunt up a copy of the federal regulations which may not be available.

RESPONSE: "Standard Methods..." is not a stand-alone reference for groundwater data collection methods, whereas 40 CFR Part 136 is. In other words, there are methods in the federal citation that may be applicable to groundwater, but that are not found in "Standard Methods..." The public is certainly free to consult "Standard Methods...", because it is applicable in most cases. If there are questions about its applicability in specific instances, persons may consult with the Department. Also, 40 CFR Part 136 is available on the internet.

COMMENT #52: In ARM 17.24.716(2), the term "by establishing sod plugs" should be deleted from the first sentence, because this is not a common method of revegetation in Montana and would be covered by "other methods" in this sentence.

RESPONSE: This is listed only as an option, even if uncommon, and as such presents no difficulty to operators.

COMMENT #53: The sentence in ARM 17.24.716(2), "Mixed seedings must be conducted in a manner and at a time that will avoid deleterious competition of different vegetal types or to avoid seed distribution problems due to different seed sizes", is unnecessary, because the second sentence in ARM 17.24.716(2) states that all revegetation methods must be approved by the Department.

RESPONSE: The second sentence does not require or imply the performance standard in the quoted sentence. Thus, the sentence must be retained.

COMMENT #54: Regarding the changes in ARM 17.24.733(3), it shouldn't be any more difficult to arrive at the height

measurement for these kinds of plants [trees, shrubs, and half-shrubs] than it would be to measure their density. The stricken standard may not be an appropriate one, but there probably is a way.

RESPONSE: The deleted provision is not about height measurement, but is about the counting of stems of clonal species (e.g., snowberry). For many years baseline data have not been collected using the method presently required by 17.24.733(1) for reclaimed areas. By deleting the language in (3)(b), the density of clonal species on reclamation may be determined in the same way that it has been determined for many years in the baseline/reference area situation so that the data may be properly compared.

COMMENT #55: The change in ARM 17.24.821(1) is just as sloppy as in the previous version. Splitting the legal reference with a parenthetical phrase is very confusing. The longer and clearer way to say the thought is: "Each operator who desires to conduct alternate reclamation pursuant to 82-4-232(7) and/or alternate reclamation pursuant to 82-4-232(8) MCA shall submit his plan to the department".

RESPONSE: To eliminate confusion, the Board has deleted the references to subsections (7) and (8). (See ARM 17.24.821 under part 3 of this notice.)

COMMENT #56: Regarding the changes in ARM 17.24.901 to comply with the federal rule that came out of the energy bill, the protection for people living over subsidence has been reduced. The old wording was to prevent material damage; now you're only going to minimize it. There is also an inherent conflict in this, because the Montana law is stronger on protection of structures over underground mining than is the Federal Energy Act, which only protected domestic habitations and had no respect for businesses that operate in coal mining areas other than coal mining.

RESPONSE: Section 82-4-243, MCA, was adopted by the 1997 legislature on the advice of OSM regarding the need to comply with new section 720 of the Surface Mining Control and Reclamation Act (SMCRA). This new section of SMCRA was adopted as part of the 1992 Federal Energy Policy Act. The language in 82-4-243, MCA is virtually identical to section 720 of SMCRA. The changes proposed in ARM 17.24.901 and also in 17.24.911 were an attempt to bring the state program up to federal rule standards, also on the advice of OSM.

Section 82-4-243, MCA, requires that material damage that has occurred as a result of subsidence must be mitigated. When the rule implements this statute, use of the term "minimize" is correct.

Section 82-4-231(10)(f) also pertains to subsidence. It provides that the operator must prevent subsidence. As is pointed out by the commentor, use of "minimize" in the portions of the rule that implement this statute is improper. The Board has made the necessary amendments in ARM 17.24.901 by deleting the term "minimize" in appropriate places.

In addition to the change in ARM 17.24.901, other changes in ARM 17.24.901 and in other rules are necessary. In ARM 17.24.901(1)(e)(i)(A), "(B) and" are stricken in the reference to (1)(e)(i)(B) and (C), because "(B)" now involves measures to prevent subsidence, which must be disassociated from (1)(e)(i)(A), which involves allowance for planned subsidence. In proposed ARM 17.24.911(2), the phrase "to the extent technologically and economically feasible" in the context of preventing material damage to buildings, dwellings, etc. from planned subsidence is not consistent with 82-4-231(10)(f); therefore, this phrase will be deleted. Finally, in ARM 17.24.911(9), the term "or minimize", which currently exists and was heretofore not subject to any changes, will be struck for the same reasons as above. See ARM 17.24.901 and 17.24.911 under part 3 of this notice for all of these changes.

COMMENT #57: Regarding ARM 17.24.1001(2)(l) and 17.24.1018(4), the proposed additional requirements are burdensome to the operators. Notifying the landowner that the Department must make investigations and inspections to insure compliance of prospecting operations on the landowner's property does not mean that the landowner will be amenable to the Department conducting such investigations and inspections. What happens if the Department is denied access? How will these rules be enforced? Are these rules simply permit application requirements?

RESPONSE: ARM 17.24.1001(2)(l) is merely an application requirement. ARM 17.24.1018(4) is merely a requirement for the notice of intent to prospect that the operator must submit. In both cases, the only responsibility of the operator is to document that the affected landowner on whose property the prospecting operations are proposed to take place has been notified of the Department's responsibilities to carry out investigations and inspections on the property. Whether the landowner agrees or not with the idea of the Department accessing his/her property or denies the Department access are not issues in these rules for the operator.

COMMENT #58: Regarding proposed new ARM 17.24.1104(2), considering the fact that Montana law requires underground mines to be responsible for reclamation on the entire area to be undermined, and damages to water and structures should be covered under the original bonding, this new section could be interpreted to relieve the operator of responsibility until

damage has occurred. Not only is subsidence predictable and planned, but the damages that follow to surface structures and water installations are not unanticipated. This section undermines Montana's reclamation bonding for damages caused by underground mining.

RESPONSE: This new section does not supersede or preclude the requirements for "up-front" bonding in Montana rules (ARM 17.24.1102). To the extent that material damage from controlled subsidence is predictable and the costs for repair can be estimated during the permit application stage, these costs must be included in the initial bond. If unanticipated damage or consequences occur, however, amended ARM 17.24.1104(2) requires that additional bonding must be obtained according to the procedures prescribed. It does not preclude or preempt the requirements of ARM 17.24.911(7)(a) through (d) to repair, restore, rehabilitate, compensate, replace, etc., the structures or resources that have been damaged. ARM 17.24.1104(2) indicates that, in addition to those requirements, the operator must also submit additional bond to insure that the restoration, rehabilitation, compensation, etc., will occur.

COMMENT #59: Regarding new ARM 17.24.1104(2), drafters of this section need to go without water for 90 days some time.

RESPONSE: The new language is an adoption of a federal rule. It does not allow the operator to take up to 90 days to resupply a damaged water source. The performance standards for resupplying water are in ARM 17.24.911(7)(a) and (d), which have no 90-day time frame attached ((7)(a) states "promptly replace, etc."). New ARM 17.24.1104(2) relates to submitting additional bond to insure repair, restoration, etc., due to subsidence-related damage, and allows for the possibility of various time frames to resupply, restore, etc., before requiring the submittal of additional bond.

COMMENT #60: Regarding new ARM 17.24.1104(2), does the extension beyond 90 days to waive water resupply also extend to the need for putting up bond? This new section does not say that if the operator meets the terms of the extension, he shall put up additional bond until the water is resupplied.

RESPONSE: Regarding the first statement in the comment, the new section does not waive water resupply. Regarding both statements, if the operator meets the terms of extension (to 90 days or to a maximum of 1 year) for not having to submit additional bond, by definition the operator will have resupplied the water, repaired the damage, etc. Otherwise the operator will not have met the terms for an extension not to submit the additional bond.

COMMENT #61: At some point in these subsidence amendments to ARM 17.24.901, 17.24.903, 17.24.911, and 17.24.1104, the Department should make it clear that an operator cannot destroy water, and leave the landowner without water for up to a year at least. There must be a specifically stated requirement for a temporary water supply from the landowner if requested.

RESPONSE: The rules do not allow the operator to destroy water. ARM 17.24.901 and 17.24.911 are extensive (made even more so with the proposed revisions) in their coverage of application and performance standard requirements regarding subsidence, material damage, and protective and mitigative measures related thereto. See the response to COMMENT #59 for reference to performance standards regarding resupply of water. Although the rules do not specifically state that temporary water supplies must be provided if requested, 82-4-243(1)(b), MCA, requires prompt replacement of water supplies. No rule amendment is necessary.

COMMENT #62: The implications from the Energy Act rules bring implications to the Montana rules that do not arise from the original rules; therefore, the water supply question needs to be clarified, as well as the bonding.

RESPONSE: See response to COMMENT #56.

5. The Board has adopted several other miscellaneous amendments to the rules to conform them to current rule drafting style, to correct typographical and other clerical errors, and to make the rules easier to read and more understandable. These editorial amendments do not change the meaning or requirements of the rules.

Reviewed by: BOARD OF ENVIRONMENTAL REVIEW

David Rusoff by: *Russell H. Hudson*
David Rusoff RUSSELL H. HUDSON,
Rule Reviewer Acting Chairperson

Certified to the Secretary of State April 9, 1999.

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I through VI promulgating listing, delisting, and ranking rules for CECRA facilities	))))	NOTICE OF ADOPTION OF RULES (CECRA)

TO: All Interested Persons

1. On May 14, 1998, the Department of Environmental Quality published notice of public hearing on proposed adoption of the rules outlined above at page 1264 of the 1998 Montana Administrative Register, Issue No. 9. On November 5, 1998, the Department published notice of a supplemental comment period on the proposed adoption of new Rule VI at page 2941 of the 1998 Montana Administrative Register, Issue No. 21.

2. The Department has adopted Rule I (17.55.101) 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 II (17.55.102) DEFINITIONS In this subchapter the following terms have the meanings indicated below and are supplemental to the definitions in 75-10-701, MCA:

(1) "Beneficial use" means a use of ~~groundwater~~ water designated under the appropriate classification in ARM ~~17.30.1003~~ 17.30.621 through 17.30.629 and ARM 17.30.1006.

(2) "Free product" means a hazardous or deleterious substance or a ~~substance~~ material containing a hazardous or deleterious substance that is present as a non-aqueous phase liquid.

(3) and (4) Remain as proposed.

(5) ~~"Risk-based concentrations" means chemical concentrations corresponding to a level of risk deemed appropriate by the department for a particular facility.~~

~~(6)~~ "Sensitive environment" means:

(a) a terrestrial or aquatic resource, including wetlands, with unique or highly valued environmental or cultural features;

(b) an area with unique or highly valued environmental or cultural features; or

(c) a fragile natural setting.

AUTH: 75-10-702, MCA; IMP: 75-10-702, MCA

RULE III (17.55.105) CECRA PRIORITY LIST (1) Remains as proposed.

(2) Inclusion on the CECRA priority list or the rank of a facility on that list is not a precondition to department action under CECRA or any other applicable law.

(3) Delisting a facility on the CECRA priority list pursuant to ARM 17.55.114 does not relieve a person liable or

potentially liable under 75-10-715, MCA, from the responsibility to conduct remedial actions, including operation and maintenance, required by the department.
AUTH: 75-10-702 and 75-10-704, MCA; IMP: 75-10-702 and 75-10-704, MCA

RULE IV (17.55.108) FACILITY LISTING (1) through (2)(b) Remain as proposed.

(c) The department shall notify the county commissioners, local boards of health created pursuant to 50-2-104 through 50-2-107, MCA, and governing bodies of cities, towns, and consolidated local governments in the community most likely to be threatened by the facility that is proposed for listing.

(2)(d) through (3) Remain as proposed.

(4) Any person may submit a request to the department to list a facility on the priority list. The request must be in writing and contain the rationale for the proposed listing and documentation or confirmation of the release or threat of a release. If the department determines listing may be appropriate, compliance with the provisions of this rule is required.
AUTH: 75-10-702, MCA; IMP: 75-10-702, MCA

RULE V (17.55.111) FACILITY RANKING (1) through (2)(a) Remain as proposed.

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997)~~ in a public drinking water supply~~; or

(ii) through (2)(b) Remain as proposed.

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997)~~ in a public drinking water supply~~; or

(ii) Remains as proposed.

(c) documented release into a drinking water line that is part of a public drinking water supply, with:

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards"(~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997)~~ in a public drinking water supply~~; or

(ii) Remains as proposed.

(d) documented release to surface water in a drinking water intake that is a ~~private~~ domestic or commercial drinking water supply, with:

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular

WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997) ~~in a domestic or commercial drinking water supply~~; or

(ii) Remains as proposed.

(e) documented release to groundwater in a drinking water well that is a ~~private~~ domestic or commercial drinking water supply, with:

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997) ~~in a domestic or commercial drinking water supply~~; or

(ii) Remains as proposed.

(f) documented release into a drinking water line that is a ~~private~~ domestic or commercial drinking water supply, with:

(i) a documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997) ~~in a domestic or commercial drinking water supply~~; or

(ii) Remains as proposed.

(g) presence of explosive vapor levels or concentrations of vapors that could cause acute health effects in a structure or utility corridor;

(h) indications of an imminent danger of fire or explosion or a release of dangerous levels of vapors ~~outdoors~~ in ambient air; or

(i) Remains as proposed.

(3) A high priority designation must be given to a facility whose release does not exhibit any of the characteristics provided in (2) but exhibits one or more of the following characteristics:

(a) documented release to surface water ~~in a drinking water intake~~ that is a drinking water source with:

(i) no documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997) in a drinking water supply intake; and

(ii) for substances whose parameters for human health are not listed in WQB-7 or 40 CFR 141 (1997), no concentration at levels that render the water harmful, detrimental, or injurious to a beneficial use in a drinking water supply intake;

(b) documented release to groundwater ~~in a drinking water well~~ that is a drinking water source with:

(i) no documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~December 1995~~ November 1998 edition) or a standard

established as drinking water maximum contaminant level listed at 40 CFR 141 (1997) in a drinking water supply well; and

(ii) for substances whose parameters for human health are not listed in WQB-7 or 40 CFR 141 (1997), no concentrations at levels that render the water harmful, detrimental, or injurious to a beneficial use in a drinking water supply well;

(c) ~~documented release into a water line which is a drinking water source with:~~

~~(i) no documented or probable exceedance of a Montana water quality human health standard listed in department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (December 1995 edition) or a standard established as a drinking water maximum contaminant level listed at 40 CFR 141 (1997); and~~

~~(ii) for substances whose parameters for human health are not listed in WQB-7 or 40 CFR 141 (1997), no concentrations at levels that render the water harmful, detrimental, or injurious to a beneficial use;~~

~~(d)~~ documented release to ambient air that poses a threat to public health;

~~(e)~~ (d) documented release of friable asbestos-containing material on the ground surface that ~~may pose~~ poses a threat to public health;

~~(f)~~ (e) migration of contamination ~~above risk based concentrations~~ to ~~third party property currently in use or~~ a utility corridor currently in use;

(g) Remains as proposed, but is renumbered (f).

~~(h)~~ (g) documented and extensive contamination of exposed shallow soil or exposed sediment ~~above risk based concentrations~~ with uncontrolled facility access;

(i) Remains as proposed, but is renumbered (h).

~~(j) free product release impacting third party property, or~~

~~(k)~~ (i) documented impact to a sensitive environment.

(4) A medium priority designation must be given to a facility that does not exhibit any of the characteristics provided for in (2) or (3) but exhibits one or more of the following characteristics:

(a) documented or probable release to surface water that is not a drinking water source but is used for ~~another purpose~~ a beneficial use;

(b) documented or probable release to groundwater that is not a drinking water source but is used for ~~another purpose~~ a beneficial use;

(c) documented or probable release into a water line that is not used as a drinking water source but is used for ~~another purpose~~ a beneficial use;

(d) and (e) Remain as proposed.

(f) potential for migration of contamination to ~~third party property currently in use or~~ a utility corridor currently in use;

(g) documented contamination to ~~third party property not in use or~~ a utility corridor not in use;

(h) documented or probable localized contamination of soil ~~above risk-based concentrations~~;

(i) through (5)(d) Remain as proposed.

(e) minimal potential for release to ~~third party property or~~ a utility corridor; or

(f) Remains as proposed.

(6) An operation and maintenance designation must be given to a facility on the CECRA priority list at which remedial actions are complete but which is undergoing operation and maintenance, including but not limited to revegetation monitoring, surface water monitoring, groundwater monitoring, or waste repository maintenance. Facilities with an operation and maintenance designation will be maintained on the CECRA priority list in a separate category.

(7) and (8) Remain as proposed.

AUTH: 75-10-702 and 75-10-704, MCA; IMP: 75-10-702 and 75-10-704, MCA

RULE VI (17.55.114) DELISTING A FACILITY ON THE CECRA PRIORITY LIST (1) Except as provided in (3), ~~T~~the department ~~may~~ shall delist a facility from the CECRA priority list if:

(a) the department determines that all requirements of CECRA have been fully met, including the requirement that conditions at the facility assure present and long term protection of public health, safety and welfare, and the environment;

(b) the department determines that the facility should not have been listed based on subsequent investigation; or

(c) another state program assumes jurisdiction of the facility and that state program is addressing all the releases and threatened releases of all hazardous or deleterious substances at the facility.

(2) In determining whether to delist a facility from the CECRA priority list, the department shall consider whether:

(a) documented investigations or facility-specific risk analysis demonstrate that taking additional remedial actions is not appropriate to address the release or threatened release of hazardous or deleterious substances;

(2)(b) and (c) Remain as proposed.

(3) The department may not delete ~~a facility~~ from the CECRA priority list ~~if~~ a facility that is subject to continuing engineering controls or institutional controls ~~related to a remedial action, including but not limited to alternate water supply, caps, or security measures, are needed to assure present and long term protection of public health, safety and welfare, or the environment~~ unless the engineering or institutional controls consist of:

(a) deed restrictions or restrictive covenants that run with the land and that have been approved by the department and duly recorded;

(b) zoning restrictions; or

(c) a designated controlled groundwater area as provided for in 85-2-506, MCA.

~~(4) The department may require that all the state's outstanding remedial action costs, including remedial action costs associated with delisting the facility from the CECRA priority list, and penalties be paid to the department by liable persons prior to delisting the facility from the CECRA priority list.~~

(5) through (7)(b) Remain as proposed, but are renumbered (4) through (6)(b).

(c) The department shall notify the county commissioners, local boards of health created pursuant to 50-2-104 through 50-2-107, MCA, and governing bodies of cities, towns, or consolidated local governments in the community most likely to be threatened by the facility that is proposed for delisting.

(d) through (f) Remain as proposed.

(7) Any person may submit a request to the department to delist a facility on the priority list. The request must be in writing, contain the rationale for the delisting, and indicate with specificity how the requirements of this rule have been met. If the department determines delisting is appropriate, compliance with (6) is required.

AUTH: 75-10-702, MCA; IMP: 75-10-702, MCA

4. The Department received the following comments; Department responses follow:

RULE I (17.55.101)

COMMENT #1: Rule I (17.55.101) - Procedures for listing, delisting, and ranking facilities under the Comprehensive Environmental Cleanup and Responsibility Act (CECRA) should be at least as rigorous as procedures for listing, delisting, and ranking sites on the National Priorities List (NPL) under the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), 42 USC § 9605. CERCLA requires the promulgation of amendments to the Hazard Ranking System (HRS) to assure that the HRS accurately assesses the relative degree of risk to human health and the environment posed by sites and facilities subject to CERCLA review. HRS procedures are applied to any site facility to be listed under CERCLA in making listing decisions. DEQ's proposed rules should require an examination and ranking of these factors for the purpose of listing a facility.

RESPONSE: CECRA is designed to address sites that are not being addressed under CERCLA and therefore the criteria for listing a CECRA site may not be the same as the criteria under CERCLA. Under CERCLA, listing and ranking occur simultaneously. Under CECRA, a site is listed and then ranked. Using the HRS package on CECRA sites is unnecessary and would be expensive and overly burdensome at such an early stage in the process. The Department (DEQ) believes it appropriate to focus its resources on cleanup rather than burdensome investigations which would be necessary under the proposal to list and rank sites. Section

75-10-702, MCA, specifically states which facilities are eligible for listing under CECRA: those that have "a confirmed release or substantial threat of a release of a hazardous or deleterious substance that may pose an imminent and substantial threat to public health, safety, or welfare or the environment." At the time of listing, it is likely that DEQ will not have complete information about the extent of the release at the facility. Listing the site allows DEQ to prioritize the need for remedial action and allocate resources to sites. DEQ should not be required to wait to list a site and initiate actions until the exhaustive list of information has been acquired. Much of this information will not be obtained until a remedial investigation has been completed. DEQ does not believe it should be the entity conducting such an investigation prior to the listing or ranking of a site. The costs of such an investigation would be high and DEQ would be obligated to cost-recover these expenses.

RULE II (17.55.102)

COMMENT #2: The definition of "risk-based concentrations" in Rule II (17.55.102) is too arbitrary; the definition should be much more specific and should provide the criteria for such a determination.

RESPONSE: DEQ has carefully reviewed all comments it received regarding this definition and has come to the conclusion that the definition should be removed from the rules. Subsections of Rule V (17.55.111) that rely on the definition for ranking purposes have also been deleted.

COMMENT #3: Rule II(2) (17.55.102) - The definition of "free product" should include terms that address mobility in the environment or should be otherwise clarified. Non-aqueous phase liquids can be tightly held by physical forces in the void spaces in soils and will not flow to wells or other potential accumulation points under the influences of gravity. The generally accepted definition of "free product" typically states that the product can flow under the influences of gravity or is otherwise reasonably mobile in the environment.

RESPONSE: DEQ disagrees that terms relating to mobility should be added to the definition. Regardless of the mobility of the free product, it will act as a continuing source of contamination as long as it is present in the subsurface. Therefore, it should be addressed to minimize risk to public health, safety, welfare and the environment. In response to the comments regarding the definition of "free product", DEQ amended the proposed definition in order to ensure clarity.

COMMENT #4: The commenter submitted modified definitions for "primary contact activities" for inclusion into Rule II (17.55.102).

RESPONSE: The proposed definitional change for "primary contact activities" would limit the definition to activities conducted in surface water which is unnecessarily restrictive. For example, it would not cover the situation where contaminated groundwater was used to fill a swimming pool.

COMMENT #5: Rule II(4) (17.55.102) - An explicit definition of "sensitive environment" should be provided. One commenter suggested the definition from 40 CFR 112.2. Other commenters expressed concern that the term "sensitive environment" is not used in the statute and the definition used in the proposed rule is subjective.

RESPONSE: DEQ has reviewed the provided definition which included many specific types of sensitive environments and believes that the definition in the rule covers the specific areas discussed in the definition tendered by the commenter. In addition, CECRA is designed to protect public health, safety, and welfare, and the environment. Therefore, DEQ is authorized to rank sites with threats to the environment and it is appropriate to differentiate ranking based on the types of environments affected by a release. The use of the term "sensitive environment" is for the purpose of ranking based on magnitude of risk. The fact that the definition is not included in statute does not preclude DEQ from defining it in rule.

RULE III (17.55.105)

COMMENT #6: The need to rank facilities appears to be driven by the need to prioritize the allocation of state special revenue account monies for application to remedial actions. Accordingly, it would not appear to be necessary to list or rank facilities where a party has assumed responsibility for the entire cleanup, or no orphan share exists. One commenter suggested amending the rule to provide that facilities being remediated by the facility owner or operator could not be listed.

RESPONSE: Section 75-10-704, MCA, requires DEQ to prioritize sites "for remedial action based on potential effects on human health and the environment" and § 75-10-702, MCA, uses the same language. The prioritization is risk based. Under the commenter's reasoning, a maximum priority site with a liable party who has assumed responsibility for cleanup would not be listed. DEQ disagrees that this is appropriate; listing serves an important role in providing notice to the public of the potential human health and environmental threats. It also assists DEQ in allocating its resources and determining when DEQ must initiate action. The existence or lack of an orphan share is irrelevant in making a listing decision.

COMMENT #7: The listing or delisting of a facility should be

subject to the rulemaking process as provided under the Montana Administrative Procedure Act. Once the proposed rulemaking process is complete, the determination to list or delist a facility should be judicially reviewable as a final agency action. In addition, approval of the governor of the state of Montana should be required before a facility is listed. A commenter suggested that DEQ evaluate the current CECRA list within 120 days and propose a new CECRA list which would be subject to notice, rulemaking, approval by the governor, and judicial review.

RESPONSE Section 75-10-702, MCA, requires that DEQ provide a mechanism for the re-evaluation of facilities on the existing priorities list. DEQ has done so in Rule V(7) and (8) (17.55.111) and through the amendment to Rule VI (17.55.114). The statute does not require DEQ to propose an entirely new CECRA Priority List, nor does it require the listing decision to go through a rulemaking process. The determination that an action is a final agency action subject to judicial review, and the availability of that review, is determined by statute. CECRA does not contain provisions for such judicial review. The legislature has designated DEQ as the agency responsible for carrying out the provisions of CECRA and CECRA specifically gives listing authority to DEQ. Therefore, it would be inappropriate to require governor approval over the decisions made by an executive state agency.

COMMENT #8: Include language that makes it clear that the relative ranking of a site is not a precondition to DEQ's action. If DEQ needs to act on a site it should not be limited because it is a medium priority site.

RESPONSE: Rule III(2) (17.55.105) has been amended to address this comment.

RULE IV (17.55.108)

COMMENT #9: Rule IV (17.55.108) - Listing a facility as a CECRA priority is a very serious decision, and listing results in severe business impacts for those properties listed. Private property rights need to be respected in handling all CECRA sites.

RESPONSE: Comment noted. DEQ strives to respect property rights while carrying out its statutory duty to protect public health, safety, and welfare and the environment.

COMMENT #10: Rule IV (17.55.108) - It is not clear if a "confirmed" release means it should be an observed confirmed release.

RESPONSE: DEQ considers a confirmed release to mean the same thing as an observed or documented release.

COMMENT #11: Rule IV (17.55.108) - The criteria should be based on actual risk to people and the environment.

RESPONSE: As provided in § 75-10-702, MCA, DEQ is authorized to adopt rules addressing releases "that may pose an imminent and substantial threat to public health, safety, or welfare or the environment." Therefore, the criteria are statutorily based.

COMMENT #12: Rule IV (17.55.108) - Requests for public hearings should also be allowed at the request of a potentially liable person (PLP).

RESPONSE: A PLP is considered a member of the community and may request a public meeting pursuant to Rule IV(2)(e) (17.55.108). Section 75-10-702, MCA, requires that DEQ provide the opportunity for a public meeting but not a hearing. See also §75-10-713, MCA.

COMMENT #13: Rule IV (17.55.108) - The listing decision should not be based on safety or welfare considerations. Only effects on "human health and the environment" should be considered in listing and delisting decisions under CECRA.

RESPONSE: CECRA specifically provides protections to the "public health, safety, or welfare or the environment." See §§75-10-702 and 75-10-711, MCA. The rulemaking authority in §75-10-702, MCA, authorizes DEQ to list a facility that may pose a threat to "public health, safety, or welfare or the environment".

COMMENT #14: Rule IV (17.55.108) - Threshold factors for listing should be defined. Suggestions for the threshold factors to be established as basic requirements to be considered in facility listing decisions under CECRA include: confirmed, observed release; population actually at risk; threat to ecological function of sensitive environment; nature of release material; pathway for exposure; mobility of waste material; volume, area, and concentration of waste material; and potential for contamination of current drinking water supplies.

RESPONSE: Section 75-10-702, MCA, specifically states which facilities are eligible for listing under CECRA: those that have "a confirmed release or substantial threat of a release of a hazardous or deleterious substance that may pose an imminent and substantial threat to public health, safety, or welfare or the environment". At the time of listing, it is likely that DEQ will not have complete information about the extent of the release at the facility. Listing the site allows DEQ to prioritize the need for remedial action and allocate resources to sites. DEQ should not be required to wait to list a site and initiate actions until the exhaustive list of information has been acquired. Much of this information will not be obtained until a remedial investigation has been completed. DEQ does not

believe it should be the entity conducting such an investigation prior to the listing or ranking of a site. The costs of such an investigation would be high and DEQ would be obligated to cost-recover these expenses. DEQ believes it more appropriate to get the site listed and ranked and then allow the potentially liable persons the opportunity to properly and expeditiously perform the required remedial actions.

COMMENT #15: Rules IV (17.55.108) and V (17.55.111) are not in logical sequence. It makes more sense to first rank a site to see whether the listing is appropriate.

RESPONSE: Before a site can be listed, a determination that a release or threat of a release must be made as provided in Rule IV (17.55.108). Once that determination has been made, the relative risk of that release or threat of release must be prioritized. It is often not possible to rank a site before it becomes a site through the listing process.

COMMENT #16: Rule IV(1) and (2) (17.55.108) - The rulemaking authority granted under §75-10-702, MCA, requires DEQ to "provide a written description of the nature and severity of the threat" that may be posed to public health, safety, or welfare or the environment. This requirement is not included in Rule IV (17.55.108) but should be a prerequisite to proceeding with the notification and public comment steps.

RESPONSE: The requirement described in §75-10-702, MCA, is addressed in Rule IV(2)(a) (17.55.108).

COMMENT #17: Rule IV(2) (17.55.108) - DEQ should keep a list of parties who have expressed an interest in a site and notify those people when a change is proposed at that site, including listing, delisting, or changing the rank, and DEQ should notify adjacent landowners when a change is proposed at the site. DEQ should be required to provide written notice to the facility owner of a proposed listing or delisting.

RESPONSE: Currently DEQ gives notice to interested parties of significant activities at many sites and will continue doing so. However, DEQ does not believe it is necessary to include additional notification requirements not included in the statute which would result in potential delays in initiating remedial actions. DEQ will attempt to locate property owners and provide notice to them but there are many instances where ownership may not be determined prior to initiating the listing process. This is particularly true where the property owner is in absentia or on mining properties where there are numerous deeds with overlapping ownership, mineral interests, and boundaries.

COMMENT #18: Rule IV(2)(c) and (7)(e) (17.55.108) - One commenter requested that city, county, city-county or district boards of health, created pursuant to §§50-2-104 to 50-2-107,

MCA, be added to the list. Because city-county boards of health have specific responsibilities for protecting public health, pursuant to state law, they should be notified of proposed listings or be able to request a public meeting on a proposed listing.

RESPONSE: DEQ believes it is appropriate to notify county health boards when DEQ is considering a listing decision and has amended (2)(c) of the rule accordingly. After the health boards have been notified, it is appropriate that those health boards work through their governing bodies in requesting a public meeting; therefore, DEQ has determined it is not necessary to amend (2)(e) of the rule.

COMMENT #19: Rule IV(2)(d) (17.55.108) - It is unclear why the rule provides in one section that DEQ "may conduct" a meeting and yet in another section it provides that DEQ "shall conduct" a meeting. Regardless, the meeting should be held in the interested community.

RESPONSE: The rule provides that DEQ may hold a public meeting without a specific request for one but must hold a public meeting upon request of ten or more persons, a group composed of ten or more members, or by a governing body of a city, town, or county. The meeting would be held in the community most likely to be threatened by the facility that is proposed for listing.

COMMENT #20: Rule IV(3) (17.55.108) - One commenter requested that this be amended as follows: "If the department lists a facility on the CECRA priority list and remedial actions to address the release or facility are required by another state, federal or local program, the department shall provide a written rationale for listing the facility on the CECRA priority list". Because other federal or local programs may regulate a site proposed for listing, the rationale for listing should justify why listing is appropriate to protect public health and the environment.

RESPONSE: Section 75-10-702(1)(a)(ii), MCA, provides for the delisting of a facility when another state program assumes jurisdiction of the facility. The language used in the rule is identical to that used in the statute and DEQ declines to expand the language to include federal or local programs.

COMMENT #21: The rules as proposed are vague, arbitrary, and are not statutorily based. The proposed rules seek to list facilities that do not pose an imminent or substantial risk to public health or the environment, and are therefore inappropriate.

RESPONSE: DEQ cannot respond to the first sentence without more specificity. Rule IV(1) (17.55.108) clearly states the requirement for listing a site, which includes the existence of

an imminent and substantial threat to public health, safety, or welfare or the environment.

COMMENT #22: Before listing a site, there must be some scientific evidence of a risk greater than 1 times 10 to the negative 4 for industrial property.

RESPONSE: If the site poses an imminent and substantial threat to public health, safety, or welfare or the environment, it may be listed. The suggested risk level may not be protective of these concerns and is not a level that DEQ would accept regardless of the proposed land use.

COMMENT #23: One commenter indicated it may be inappropriate to list a facility simply because DEQ confirms a release or threat of a release of a hazardous or deleterious substance. This language which effectively establishes the threshold for listing facilities is overly vague. In addition, listing on that basis ignores considerable other statutory authority of that agency to respond to releases or potential releases and to do so in a much more timely manner than could be accomplished with these proposed rules. The listing process as outlined in these rules should only be used for those facilities where reasons exist that cleanup cannot be reasonably anticipated under other statutory authority. The listing effort should also focus on public health and the environment rather than safety and welfare. Another commenter indicated that DEQ should be required to list a site if a substance poses an imminent or substantial threat to public health.

RESPONSE: Section 75-10-702, MCA, authorizes DEQ to list a facility with "a confirmed release or substantial threat of a release of a hazardous or deleterious substance that may pose an imminent and substantial threat to public health, safety, or welfare or the environment". It is not appropriate for DEQ to change the statutory language in its rules. Also, please note the language of Rule IV (17.55.108): DEQ "may" list a facility under the outlined criteria. Such a listing is not required and, if a new release is being addressed by other statutory authority, DEQ does not anticipate the need to go through the listing process for that release. For example, if a tanker truck spills a large volume of diesel on the highway, that release would need to be addressed immediately. While the release could potentially be listed, in reality such a listing would likely not occur because by the time the public participation requirements of the listing process were satisfied the release would likely be cleaned up. Because DEQ can anticipate a situation where cleanup would be done quickly and completed before the comment period ends, retaining "may" is appropriate. DEQ will make a determination that CECRA is the appropriate enforcement and cleanup authority before proposing to list a site according to these rules. In addition, DEQ has delisted a number of sites which are being addressed by other

statutory authority.

COMMENT #24: The rules should provide that the following releases will not be placed on the CECRA Priority List. These releases should be expressly exempted from CECRA listing coverage:

(a) releases excluded from the definition of release in §75-10-701(18), MCA;

(b) permitted releases, including but not limited to releases permitted under:

(i) the National Pollutant Discharge Elimination System, 33 USC § 1342;

(ii) the dredge and fill provisions of the Clean Water Act, 33 USC § 1344;

(iii) the Solid Waste Disposal Act, 42 USC § 6925(a) to (d);

(c) the pretreatment requirements for the introduction of any pollutant into a publicly owned treatment works, 33 USC §1317(b) or (c) and 33 USC §1342;

(d) releases being addressed in a voluntary cleanup action;

(e) naturally occurring releases;

(f) releases not in excess of background concentrations;

(g) de minimus releases or releases of less than a reportable quantity; and

(h) releases that may or will be addressed under authorities other than CECRA, including other State programs.

RESPONSE: As to permitted releases, §75-10-715, MCA, provides a defense to liability for permitted releases and therefore it is not necessary for DEQ to provide an exemption for these releases. Section 75-10-701(18), MCA, provides a definition of "release" and provides exclusions from the definition. Therefore, an occurrence excluded from the definition of release is already excluded. DEQ may list facilities undergoing voluntary cleanup to track resource allocation but is not required to list these sites and may not do so if cleanup occurs quickly. In addition, liable persons conducting a voluntary cleanup may want the site listed in order to be eligible for the allocation process provided for in the Controlled Allocation of Liability Act contained in CECRA. As to listing a facility subject to a voluntary cleanup action, §75-10-704, MCA, requires DEQ to prioritize sites "for remedial action based on potential effects on human health and the environment" and §75-10-702, MCA, uses the same language. The prioritization is risk based. Under this reasoning, a maximum priority site with a liable party who is conducting a voluntary cleanup would not be listed. DEQ disagrees that this is appropriate; listing serves an important role in providing notice to the public of the potential human health and environmental threats. It also assists DEQ in allocating its resources and determining when DEQ must initiate action. Therefore, DEQ believes it appropriate to retain the ability to list these sites. De micromis and de

minimus releases are addressed in §75-10-719, MCA, and provide DEQ flexibility in settling with persons responsible for a small amount of a release. As to releases from a facility that may be addressed by other authorities than CECRA, §75-10-702, MCA, indicates that DEQ may still list the facility but must explain, in writing, its rationale for the listing. This concept has been incorporated into Rule IV(3) (17.55.108). Section 75-10-702, MCA, governs the involvement of other state programs at potential or actual CECRA sites as follows: If remedial actions to address the site are required by another program, DEQ must explain its rationale for listing the site. DEQ is not prohibited from listing the site. The statute also provides that if another state program assumes jurisdiction, DEQ must delist the site. However, there are certain facilities where one state program handles remediation efforts for a portion of the facility or for certain constituents of concern before transferring it back for further remediation under CECRA. Therefore, to address both situations, Rule VI (17.55.114) has been amended to provide that if another state program assumes jurisdiction of the entire facility for all releases of hazardous or deleterious substances, DEQ will delist the facility. If less than the entire facility is being addressed by that program (and thus jurisdiction is not assumed) DEQ will retain the discretion to keep that facility on the list.

RULE V (17.55.111)

COMMENT #25: Rule V (17.55.111) - The use of "probable" with respect to exceedances of standards [(a)(i), (b)(i), (c)(i), (d)(i), (e)(i), and (f)(i)] should be omitted or, alternatively, a scientific/statistical criterion should be stated. Similarly, the use of "concentrations that render the water harmful, detrimental, or injurious to beneficial use" has no precise quantitative definition and should not be used: in place of this phrase, specific standards should be proposed.

RESPONSE: CECRA requires DEQ to address sites with a release or threat of a release. See §§75-10-702 and 75-10-711, MCA. The concept of "probable" encompasses "threat of a release" which is covered by CECRA. Also, there appears to be some confusion over ranking a site versus listing a site. Rule V (17.55.111) pertains to the ranking of sites once they have been placed on the CECRA priority list; Rule IV (17.55.108) pertains to listing. In this case, the site has already been listed because of a confirmed release or substantial threat of a release pursuant to §75-10-702, MCA. The "probable" notion assists DEQ in prioritizing the site because of its greater potential threat. The language "concentrations that render the water harmful, detrimental, or injurious" is the standard used under the Water Quality Act (ARM 17.30.1006) and DEQ believes it is appropriate to use a similar standard in its CECRA ranking process. For example, CECRA defines petroleum products (i.e., total petroleum hydrocarbons [TPH]) as hazardous or deleterious

substances but there are no specific water quality standards for TPH. The rule language describes how DEQ ranks sites with TPH contamination.

COMMENT #26: Rule V (17.55.111) - Almost no consideration is given to documented or probable violations of aquatic life standards in state waters. The only mention of aquatic life are found in Rule V(3)(k) and (4)(k) (17.55.111), which says that documented and potential "impacts to a sensitive environment" shall be considered. DEQ should modify the definition of two terms used in the proposed rules to assure impacts to aquatic life and the environment are adequately considered in the ranking process. DEQ should also consider impacts to state waters in the ranking process. Therefore, "all state waters" should be inserted into the proposed definition. CECRA was written to assure protection of public health, safety, and welfare and the environment. Second, the proposed rules should define "impact" or clarify exactly how DEQ will determine if an "impact" has occurred. DEQ should use compliance with the aquatic life standards in Circular WQB-7 as the "test" for impacts to the environment. If violations of those standards occur, impact must be assumed.

RESPONSE: DEQ believes that an impact to an aquatic resource (included in the definition of "sensitive environment") would be indicated if an aquatic life standard was exceeded. An "aquatic resource" includes "state waters". Under this ranking criteria, DEQ also has the ability to address contaminated sediments for which there are no standards.

COMMENT #27: Rule V (17.55.111) - References to third-party property should be deleted. This matter should be between private parties.

RESPONSE: DEQ agrees and the rule has been amended accordingly to remove references to third-party property.

COMMENT #28: Rule V (17.55.111) - The proposed Rule V (17.55.111) provides that ranking decisions will be based on exceedances of specified environmental quality standards. Multiple sample analyses should be required for ranking purposes and the proposed rules should require that there be an exceedance in at least three consecutive samples collected over a reasonable period of time in order to substantiate a ranking decision. A single sample analysis should never be an adequate basis for listing or ranking decisions.

RESPONSE: DEQ disagrees with this comment. There are some instances in which one sample might be adequate for ranking purposes. For example, if a DEQ staff member inspects a site, sees hazardous substances leaking onto the ground, and takes a sample which confirms the presence of hazardous substances in the soil, DEQ does not believe that multiple sample analyses

would be necessary to rank the site. Therefore, DEQ does not believe it necessary to proscribe multiple sample analyses. As more information is obtained about the site it can be re-ranked under Rule V (17.55.111).

COMMENT #29: Rule V (17.55.111) - Priority ranking increases should be subject to notice and comment proceedings.

RESPONSE: The public will be given the opportunity to comment on listing, delisting, and relisting decisions. However, ranking decisions are made to allow DEQ to prioritize sites for remedial actions based on potential effects on human health and the environment. This assists DEQ in allocating its resources to address the sites posing the greatest risk first. Through this rulemaking process, DEQ has provided the public with the opportunity to comment on the various objective criteria DEQ must use in making ranking decisions. Further public input on individual site rankings is not needed because such input would not change a ranking decision which must be made according to the objective criteria set forth in the rules.

COMMENT #30: Rule V(2)(a) (17.55.111) - Please revise as follows: "documented release to surface water ~~in a drinking water intake~~ that is a public drinking water supply, with...." Listing should not be contingent upon a release at the point of drinking water intake. A release many miles away from the intake may affect the quality of water diverted for drinking water uses at the point of the intake.

RESPONSE: The maximum priority designation is when contamination above standards has reached the intake because actual drinking water supplies are impacted. A high priority designation is appropriate for the situation described by the commenter where releases into the water source have occurred but the release has not yet reached the intake; thus the water supply is threatened but not yet impacted. Rule V(3)(a) (17.55.111) has been amended to clarify this ranking criteria; (2)(a) and (2)(b) have also been amended in response to this comment to ensure clarity and consistency.

COMMENT #31: Rule V(2)(b)(i) and (2)(f)(i) (17.55.111) - Insert "public" after "as a" and before "drinking water".

RESPONSE: DEQ disagrees that modification is necessary as it does not add to the clarity of the rule. Rule V(2)(b) (17.55.111) already refers to "public drinking water" and Rule V(2)(f) (17.55.111) is referencing a domestic or commercial water supply.

COMMENT #32: Rule V(2)(c) (17.55.111) - Please revise as follows: "Documented release into a water line that is part of a public drinking water supply".

RESPONSE: The rule has been amended to include the suggested language and to clarify that "water line" is a "drinking water line".

COMMENT #33: Rule V(2)(e) (17.55.111) - Insert "in a drinking water well" after "groundwater" and before "that is".

RESPONSE: The rule has been amended for clarity by including the referenced language and clarifying that "private" means "domestic or commercial".

COMMENT #34: Rule V(2)(e) (17.55.111) - A release to groundwater should be documented to affect a water supply. It could be argued that essentially all groundwater is potentially a drinking water supply and an actual threat to the designated use of drinking water should be documented.

RESPONSE: DEQ agrees with this comment and is amending (2)(e) to "documented release to groundwater in a drinking water well that is a domestic or commercial drinking water supply". In order to ensure related sections are consistent, (2)(e)(i), (2)(d), and (2)(f) have also been amended.

COMMENT #35: Rule V(2)(g) (17.55.111) - Should scientifically qualify the "health effects" terminology. Also, insert "adverse public" after "could cause" and before "health effects".

RESPONSE: The term "health effects" has been qualified by including the term "acute" in the rule. In order to rank as a maximum priority site, the potential health effects must be acute. DEQ did not include the language "adverse public" because it is redundant. Rule IV (17.55.108) requires that, before a site can be listed, there must be a release or threat of a release of a hazardous substance that poses a threat to public health, safety, welfare, or the environment. Therefore, if a site is being ranked the determination that there is a risk of an adverse public effect has already been made.

COMMENT #36: Rule V(2)(g) (17.55.111) - The language in (2)(g) is the same as (3)(g) and needs to be clarified.

RESPONSE: Subsection (2)(g) has been amended to clarify that a maximum priority rank will be given to sites with the potential to cause "acute" health effects while a lower ranking is appropriate if the potential health effects are less severe.

COMMENT #37: Rule V(2)(h) (17.55.111) - The language in (2)(h) and (3)(d) should be more consistent. It should be clear that you're talking in both locations about ambient air quality.

RESPONSE: Both the references are referring to ambient air and Rule V(2)(h) (17.55.111) has been amended accordingly.

COMMENT #38: Rule V(2)(i) (17.55.111) - The inclusion of "free product in significant quantities in the groundwater" under the maximum priority ranking is inappropriate. Free product in the subsurface (on groundwater) does not necessarily pose the same immediate threat as that posed by free product released to surface water. Further, the priority assigned to free product releases to groundwater fails to differentiate between releases of various petroleum products, some of which are soluble, volatile, and more mobile due to their physical properties (e.g., fuel oils) that may remain on the groundwater in the subsurface for years and pose little or no threat to human health or the environment. Free product releases to groundwater need to be classified on the Priority Ranking Sheet according to specific attributes that govern the actual threat(s) that may be posed by such releases (e.g., location, depth, product type, geologic formation, permeability, etc.).

RESPONSE: If free product is present in significant quantities, DEQ believes a maximum priority ranking is appropriate. Free product presents a greater threat to public health, safety, welfare and the environment because of the potential for migration and direct contact exposure. For surface water releases, there are acute effects to aquatic species which also justify the maximum priority ranking. If unaddressed, free product has the potential to greatly increase the risk to public health, safety, and welfare and the environment. Free product acts as a continuing source of contamination as long as it is present in the subsurface. In addition, at the time of initial ranking, DEQ may not have the type of information suggested by the commenter. As more information becomes available, DEQ can change the ranking of a facility pursuant to (7).

COMMENT #39: Rule V(3) (17.55.111) - This section is confusing: it is not clear what a release must consist of to meet this classification. Shouldn't this be releases of hazardous or toxic substances in amounts that would affect beneficial uses and that are higher than natural levels?

RESPONSE: DEQ has made changes to this section to clarify which releases would result in a high priority ranking. Pursuant to Rule IV (17.55.108), in order be listed, there must be a confirmed release or substantial threat of a release of a hazardous or deleterious substance that may pose an imminent and substantial threat to public health, safety, or welfare or the environment. Rule V (17.55.111) prioritizes facilities which have been listed based on magnitude of risk.

COMMENT #40: Rule V(3) (17.55.111) - The criteria provide for a high priority designation where a release to a drinking water source is documented but where there are no exceedances of applicable state and federal water quality standards. A release that results in no exceedances of applicable standards cannot be

designated high risk. Provisions defining high priority criteria, based on non-exceedance of applicable drinking water standards, should be deleted from Proposed Rule V (17.55.111).

RESPONSE: DEQ agrees that clarification of the high priority ranking criteria is needed and has amended the rule accordingly. For example, it has been clarified that a high priority ranking is appropriate where there are documented releases to surface water or groundwater that are drinking water sources but where the contamination has not reached the intake (see (3)(a) and (3)(b)). Proposed Rule V(3)(c) (17.55.111) has been deleted entirely and (3)(d) has been amended by changing "may pose" to "poses" to make it affirmative.

COMMENT #41: Rule V(3) (17.55.111) - Delete the entire high priority designation criteria.

RESPONSE: No justification for this suggestion was provided. However, DEQ notes that §75-10-746(7), MCA, refers to maximum and high priority sites. The high priority category was contemplated by the legislature and is therefore appropriate in the rules.

COMMENT #42: Rule V(3)(a)(i) (17.55.111) - In (3)(a)(i), the high priority site would be listed if the site had no documented or probable exceedance of the Montana Water Quality Standard. That does not make any sense. The same problem exists in (3)(b)(i) and (3)(c)(i).

RESPONSE: The rule has been amended to clarify that a high priority ranking is appropriate if there has been a documented release to surface water or groundwater that are drinking water sources but no exceedances of water quality standards has been found in either the intake or the well. Rule V(3)(c) (17.55.111) has been deleted because, with the corrections made as a result of this comment, its language is duplicative of that found in Rule V(3)(a) and (b) (17.55.111).

COMMENT #43: Rule V(3)(d) (17.55.111) - A site with a documented release to ambient air that poses a threat to public health should probably be a maximum priority site, and be included under Rule V(2) (17.55.111).

RESPONSE: A release to ambient air will rank as a maximum priority site under Rule V(2)(h) (17.55.111). Rule V(2)(h) (17.55.111) has been amended to clarify that "outdoor" means "ambient air".

COMMENT #44: Rule V(3)(k) (17.55.111) - Impact to a sensitive environment should not solely be used to establish a high priority designation.

RESPONSE: Section 75-10-702, MCA, authorizes DEQ to list a

facility with "a confirmed release or substantial threat of a release of a hazardous or deleterious substance that may pose an imminent and substantial threat to public health, safety, or welfare or the environment". Based on statutory guidance, DEQ believes impacts to sensitive environments warrant a high priority ranking. The statutory requirement to protect public health, safety, or welfare applies equally to protecting the environment; therefore, DEQ has provided a mechanism to prioritize sites based on risk to different types of environments.

COMMENT #45: Rule V(4)(a) and (c) (17.55.111) - Delete "another purpose" and insert "a beneficial use".

RESPONSE: DEQ has amended the rule, including (4)(b), to include the proposed language. As a result of this comment, DEQ has also amended the definition of beneficial use to include beneficial uses of surface water.

COMMENT #46: Rule V(4)(d) (17.55.111) - "Imminent threat" needs to be defined on a scientific basis that considers the specific contaminants involved, the site-specific environmental conditions, and whether the transfer from soil to water could lead to the exceedances of a water quality standard or risk-based concentration.

RESPONSE: CECRA uses the term "imminent threat" and what constitutes this type of threat differs on a site-by-site basis. For example, soil contamination in sandy soils is a greater threat to groundwater than soil contamination in clay soils. DEQ must have the ability to rank sites based on what is known about site conditions.

COMMENT #47: Rule V(4)(d), (f), (h), (i), and (k) (17.55.111) - Delete.

RESPONSE: DEQ is unsure of the commenter's rationale for suggesting the deletion of these ranking criteria but, upon review, DEQ does not believe such deletion is appropriate.

COMMENT #48: Rule V(4)(e) (17.55.111) - Change "potential" to "documented" and "may pose" to "is".

RESPONSE: A documented release to ambient air that poses a threat to public health ranks as a high priority under Rule V(3)(d) (17.55.111) so amending this subsection in the medium priority section would be duplicative because it is already listed in the high priority section. DEQ does not believe it is appropriate to reduce this to a medium priority rank because of the level of risk presented when there is a documented release to ambient air.

COMMENT #49: Rule V(4)(j) (17.55.111) - Change "or probable

extensive contamination of" to "release to" and insert "that poses a risk greater than 1 x 10^{-4} after "soil" and before "with controlled".

RESPONSE: Rule IV (17.55.108) requires that, before a site can be listed, there must be a release or threat of a release of a hazardous substance that poses a threat to public health, safety, welfare, or the environment. Therefore, if a site is being ranked, the determination that a release has occurred has already been made and including similar language in the ranking rule is unnecessary. As to including language regarding the level of risk, DEQ does not accept this suggested risk level regardless of whether access to the facility is controlled.

COMMENT #50: Rule V(5) (17.55.111) - Low priority sites should not be listed in the first place. The criteria define a low priority site as one having minimal potential for release to migration pathways. Such sites should not be listed under CECRA.

RESPONSE: Although sites are ranked low priority, they still may pose a threat to public health, safety, welfare, or the environment and still require remedial action. The listing threshold must be met before ranking even occurs. The fact that one site does not pose as much risk as another is not a reason for failing to list a site.

COMMENT #51: Rule V(6) (17.55.111) - Sites where remedial actions are complete should be delisted, not redesignated for priority. Section (6) should be changed to eliminate the requirement that facilities at which remedial actions are complete but which are undergoing operation and maintenance (O&M) should be given operation and maintenance designations. Instead, the proposed rule should require that such sites be removed from the CECRA priority list as soon as construction of remedial action is complete.

RESPONSE: DEQ has carefully considered whether sites undergoing O&M should be designated as such and thus remain listed. Many sites undergoing O&M are exceeding applicable standards, such as those contained in WQB-7, and therefore may pose a threat to public health, safety or welfare or the environment. Consultants performing environmental assessments rely on DEQ for accurate information regarding potential threats to adjoining properties. In addition, the success of remedial actions at some sites in O&M is being monitored and, if the actions fail, further remediation would be required. DEQ needs to be able to allocate resources to monitor O&M activities. For these reasons, the continued listing of some sites undergoing O&M is justified. However, DEQ also recognizes that there may be sites where all the requirements of CECRA have been met, in which case continued listing of a site undergoing O&M is not warranted. For those sites undergoing O&M that do remain on the list, the Department

has therefore amended Rule V(6) (17.55.111) to remove the implication that no sites undergoing O&M can be deleted and to provide a separate category on the CECRA priority list to clarify the status of O&M sites remaining on the list (see Rule V [17.55.111]). Rule III (17.55.105) has also been amended to make it clear that delisting does not preclude the Department from requiring remedial actions, including O&M, at delisted sites.

COMMENT #52: Rule V(6) (17.55.111) - The O&M designation would include such minor activities that a site could never be delisted even though some minor monitoring or maintenance is required. This defeats the purpose of having a delisting process for most sites. The EPA allows NPL sites with ongoing O&M to be deleted. Many site cleanups with O&M requirements do not require further remedial actions.

RESPONSE: See response to comment #51. As to the EPA policy regarding NPL sites, that policy provides that EPA will consider three criteria when considering whether to delist a site from the NPL: (1) whether the responsible parties have implemented all required response actions; (2) whether all appropriate fund-financed response under CERCLA has been implemented and no further response action by responsible parties is appropriate; or (3) whether the remedial investigation has shown that the release poses no significant threat to public health or the environment and therefore it is not appropriate to take response measures. It also provides that if monitoring to determine the need for a future response action is ongoing at the site, delisting is premature. EPA retains the ability to maintain sites on the NPL that are undergoing O&M and retains discretion to delist sites undergoing O&M on a site-by-site basis. The policy considers whether or not more remedial actions are necessary at a site and whether or not the actions that have been taken are protective when making a delisting decision. Using EPA's policy as a guide, DEQ has determined that, if all the requirements of CECRA are met, a site undergoing O&M will be delisted.

COMMENT #53: Rule V(7) and (8) (17.55.111) - Delete in the entirety.

RESPONSE: Because no rationale was provided for deleting these subsections, it is difficult to respond to the comment in a meaningful manner. However, DEQ believes it is appropriate to provide for the re-ranking of a facility as new information becomes available. It is also appropriate to allow someone to petition for re-ranking and the rules provide for this.

COMMENT #54: Rule V(7) (17.55.111) - Under (7), DEQ must be required to provide documentation of its reason for a change in site listing. It is not enough that DEQ is just re-evaluating. There must be documentation in the files that the public can

look at to know that the decision was not arbitrary.

RESPONSE: Section (7) speaks to re-ranking the site. The additional information that may cause a change in rank will be placed in DEQ's files which are open to the public and the rule has been amended accordingly to indicate that information which may change the rank of a facility must be documented.

COMMENT #55: The tiered system as proposed in the rules is inappropriate. If there is not an objective, scientifically based imminent or substantial threat to public health or the environment a facility should not be listed.

RESPONSE: Section 75-10-746(7), MCA, refers to maximum and high priority sites and the use of the tiered system conforms with legislative intent. In addition, Rule IV (17.55.108) requires an imminent and substantial threat as a threshold requirement to listing.

RULE VI (17.55.114)

COMMENT #56: Rule VI (17.55.114) - Provisions should also be included to allow for a person to submit a request for delisting a facility similar to the provision that allows a person to request a facility be evaluated for listing. Another commenter suggested providing a formal mechanism for a company to petition to get off the list.

RESPONSE: DEQ agrees with this comment and has amended the rule accordingly.

COMMENT #57: Rule VI (17.55.114) - The delisting decision should not be based on safety or welfare considerations. References to safety and welfare should be deleted from Proposed Rule VI (17.55.114), section (1)(a).

RESPONSE: CECRA specifically provides for protection of the "public health, safety, or welfare or the environment" and therefore it is appropriate to base delisting decisions on these criteria.

COMMENT #58: Rule VI (17.55.114) - Straightforward criteria for delisting should be defined. Proposed Rule VI (17.55.114) should be modified to provide the following criteria for delisting:

(i) the facility should not have been listed in the first place;

(ii) all appropriate response actions (excluding O&M) have been implemented;

(iii) the release poses no significant threat to public health or the environment;

(iv) the release is being addressed by another state or federal program;

(v) the boundaries of the site were improperly determined;
(vi) the release is being addressed under a voluntary cleanup action (no need to wait until closure); or
(vii) other relevant information or conditions exist that support delisting of the facility from the CECRA list.

RESPONSE: DEQ responds as follows:
(i) covered under Rule VI(1)(b) (17.55.114);
(ii) covered under Rule VI (1)(a) and (2)(b) (17.55.114) except for O&M [see responses to comments # 51 and 52];
(iii) covered under Rule VI(1)(a), (2)(a), and (2)(b) (17.55.114);
(iv) covered under Rule VI(1)(c) (17.55.114). The language used in the rule is identical to that used in the statute and DEQ declines to expand the language to include federal programs. Also, §75-10-702, MCA, governs the involvement of other state programs at potential or actual CECRA sites as follows: If remedial actions to address the site are required by another program, DEQ must explain its rationale for listing the site. DEQ is not prohibited from listing the site. The statute also provides that if another state program assumes jurisdiction, DEQ must delist the site. However, there are certain facilities where one state program handles remediation efforts for a portion of the facility or for certain constituents of concern before transferring it back for further remediation under CECRA. Therefore, to address both situations, Rule VI (17.55.114) has been amended to provide that if another state program assumes jurisdiction of the entire facility for all releases of hazardous or deleterious substances, DEQ will delist the facility. If less than the entire facility is being addressed by that program (and thus jurisdiction is not assumed) DEQ will retain the discretion to keep that facility on the list;
(v) DEQ has the ability to change the definition of a "facility" without the necessity of delisting the facility;
(vi) Section 75-10-704, MCA, requires DEQ to prioritize sites "for remedial action based on potential effects on human health and the environment" and §75-10-702, MCA, uses the same language. The prioritization is risk based. Under this reasoning, a maximum priority site with a liable party who is conducting a voluntary cleanup would be delisted. DEQ disagrees that this is appropriate; maintaining the listing serves an important role in providing notice to the public of the potential human health and environmental threats. It also assists DEQ in allocating its resources and determining when DEQ must initiate action. Therefore, DEQ believes it inappropriate to delist these sites; and
(vii) covered under Rule VI(2)(c) (17.55.114).

COMMENT #59: Rule VI (17.55.114) - Partial deletion of facilities should be allowed under any of the criteria discussed above for site deletion.

RESPONSE: DEQ has the ability to change the definition of a

"facility" which results in severing a portion of the facility and DEQ has, in fact, redefined facilities in this manner. DEQ has determined that it is appropriate to continue to address portions of facilities in this way but the rule, as written, does not need to be changed.

COMMENT #60: Rule VI (17.55.114) - This states that one option to stay off the list is completing a remedial action under the voluntary cleanup process then DEQ grants a petition for closure. The proposed rule requires a separate process. If it is conducted under VCRA the delisting should be somewhat automatic.

RESPONSE: This rule does not provide a mechanism to stay off the list by completing a voluntary cleanup. Rather, it indicates that a site can be delisted after the petition for closure provided for in §75-10-738, MCA, has been granted. If all the requirements of Rule VI (17.55.114) are met, DEQ will issue a "no further action" letter and delist the site.

COMMENT #61: Rule VI(1) (17.55.114) - Insert two more criteria for delisting: the risk to the public is 1×10^{-4} or less and access to the facility is controlled.

RESPONSE: The suggested risk level is not a level that DEQ would accept for any site. In addition, the fact that access to the facility is controlled does not mean that public health, safety, or welfare or the environment are protected and does not justify delisting.

COMMENT #62: Rule VI(1) (17.55.114) - The word "may" should be changed to "shall" to provide stronger incentive to accomplishing the remedial action. A facility and its owners may be economically impaired if the property remains on the list because a listing designation carries with it a stigma.

RESPONSE: DEQ believes that the delisting rules provide a clear set of procedures for delisting. DEQ has carefully reviewed all comments it received regarding the "shall delist" versus "may delist" issue and has determined that the rule is appropriately written. It is appropriate to leave a site on the CECRA Priority List for the reasons discussed herein. However, a site subject to institutional controls may still be eligible for a no further action letter which should alleviate concerns that the listing is inhibiting development opportunities for the property.

COMMENT #63: Rule VI(1)(a) (17.55.114) - This rule should address and be limited to the "conditions" for which the facility was listed under CECRA.

RESPONSE: DEQ will have much less information about a site at the time it is listed than it will have at the time of

delisting. Limiting the conditions to those known at the time of listing is inappropriate.

COMMENT #64: Rule VI(1)(a) (17.55.114) - The language "assure...long-term protection" is very subjective since "long-term" is not defined. Given the lack of a definition it is perceivable that delisting would never occur for some facilities.

RESPONSE: Section 75-10-721, MCA, requires remedial actions to be effective and reliable in the long term; therefore, the proposed rules use identical language. It is anticipated that determining what constitutes "long-term" will, to a certain extent, be site-specific. For example, at one site monitoring the performance of a remedy might be necessary for 5 years to establish long-term protection while at another site similar monitoring might be necessary for 50 years.

COMMENT #65: Rule VI(1)(b) (17.55.114) - Where it provides that DEQ determines that the facility should not have been listed, additional language should be added such as "based on subsequent investigation or additional information in the file." Documentation of the reason should be done so people understand that it was not an arbitrary decision.

RESPONSE: The information will be placed in DEQ's files which are open to the public. The rule has been amended accordingly to indicate that the information must be documented.

COMMENT #66: Rule VI(1)(c) (17.55.114) - Please amend as follows: "another state federal or local program assumes jurisdiction of the facility, and the department determines that conditions at the facility will assure present and long-term protection of public health, safety and welfare and the environment." Assumption of jurisdiction by a local or federal program may justify delisting a CECRA site. Whether a site is regulated by another state, local or federal program, it should not be delisted unless DEQ can determine that such regulation will provide long-term protection of public health and the environment.

RESPONSE: Section 75-10-702(1)(a)(ii), MCA, provides for the delisting of a facility when another state program assumes jurisdiction of the facility. The language used in the rule is identical to that used in the statute and DEQ declines to expand the language to include federal or local programs. See also §75-10-702(1)(a)(iv), MCA. Rule VI (17.55.114) requires that long-term protection of public health, safety, welfare and the environment are assured before delisting.

COMMENT #67: Rule VI(2) (17.55.114) - The consideration of "other relevant information or conditions" referred to in (c) should be deleted. Site delisting should be based on successful

completion of appropriate remedial actions and compliance with human health and aquatic life standards. Consideration of "other relevant data" (with no definition of what that information may include) will likely lead to more debate and less timely cleanup of contaminated sites.

RESPONSE: It is difficult to anticipate every situation that may arise when DEQ is determining whether to delist a facility; therefore DEQ included the term "other relevant information or conditions" to give DEQ the flexibility to consider such information when making a delisting determination. Other relevant information could encompass the criteria discussed in Rule VI (17.55.114) (1), (3), and (4).

COMMENT #68: Rule VI(2), (5), and (6) (17.55.114) - Delete in their entirety.

RESPONSE: No rationale was provided to justify the deletion of these subsections and, based upon DEQ's review, deletion is not justified.

COMMENT #69: Rule VI(2)(a) (17.55.114) - The investigation or facility-specific risk analysis needs to be documented and needs to be in the file.

RESPONSE: The rule has been amended to indicate that the information must be documented. Site documents received by DEQ are placed in the files and are open to the public.

COMMENT #70: Rule VI(3) (17.55.114) - The rule should address delisting of portions of the facility where a remedial action has been completed.

RESPONSE: DEQ has the ability to change the definition of a "facility" which results in severing a portion of the facility and DEQ has, in fact, redefined facilities in this manner. DEQ has determined that it is appropriate to continue to address portions of facilities in this way but the rule, as written, does not need to be changed.

COMMENT #71: Rule VI(3) (17.55.114) - The justification for capping and institutional controls is to provide long-term protection of public health and the environment. If a site cannot be delisted even if an engineered cap or a deed restriction or zoning ordinance is included in the remedy, there is reduced incentive to implement long-term protection. This is an overly restrictive and unreasonable restriction on the delisting process. Institutional controls are often an integral component of cleanup action and insure the long term protection of human health and the environment.

RESPONSE: See responses to comments #51 and #52. As to deed restrictions or zoning ordinances, DEQ agrees that these

controls used as a part of a final remedy at a site do not warrant the continued listing of that site and has amended Rule VI (17.55.114) accordingly. DEQ also believes that a site with a designated groundwater control area does not warrant continued listing, so long as all other remedial actions required at the site have been undertaken. However, there are other sites with institutional controls such as caps or fencing which do warrant the continued listing of a site because these types of institutional controls require continued monitoring to ensure their integrity. DEQ also notes that institutional controls do not have to be part of a final remedy and often, if a more aggressive remedy is selected, institutional controls are not necessary. In addition, institutional controls address the protectiveness of public health but do not typically protect public safety, welfare, or the environment. Therefore, the continued listing of sites with certain institutional controls is warranted.

COMMENT #72: Rule VI(4) (17.55.114) - Requirement of payment of DEQ costs regardless of liability or appropriateness of the costs is not a reasonable condition to delisting.

RESPONSE: DEQ has carefully evaluated all comments it received on this subject and has deleted this subsection of the rule. However, it is important to note that § 75-10-722, MCA, requires DEQ to keep a record of its remedial action costs and allows DEQ to require "a person liable under 75-10-715, MCA, to pay" these costs. Section 75-10-704, MCA, provides that DEQ shall "recover costs and damages incurred by the state." The Environmental Quality Protection Fund is a revolving fund used to carry out the provisions of CECRA. If it is not replenished through the payment of DEQ's costs, DEQ's ability to carry out CECRA's provisions is seriously jeopardized. Therefore, although DEQ has removed this criteria as a consideration in the delisting process, it should not be interpreted in any manner to mean that DEQ will not use other authorities available to it to seek recovery of costs and damages incurred by the State.

COMMENT #73: Rule VI(5) (17.55.114) - It should be clarified that DEQ must go through a public process when it decides to relist a site, and relisting is basically listing.

RESPONSE: Section (5) states that in relisting, DEQ must comply with the requirements of Rule IV (17.55.108) which are the listing rules. Therefore, the public process requirements in Rule IV (17.55.108) will be met in relisting a site.

COMMENT #74: Rule VI(7) (17.55.114) - The rules should require that adjacent property owners, and other interested parties, be notified (with an opportunity for comment) for all delisting, relisting, and prioritization decisions made by DEQ pursuant to the proposed rules. Public participation is critical to the

CECRA process, and the proposed rules should assure it happens in a timely and meaningful manner.

RESPONSE: The public will be given the opportunity to comment on listing, delisting, and relisting decisions and the notice given to the public will provide notice to adjacent property owners. In addition, currently DEQ provides notice to interested parties on significant activities at many sites and will continue to do so in the listing and delisting context. However, DEQ does not believe it is necessary to provide for public comment when making ranking decisions, as these decisions are made to allow DEQ to prioritize sites for remedial actions based on potential effects on human health and the environment. This assists DEQ in allocating its resources to address the sites posing the greatest risk first. Through this rulemaking process, DEQ has provided the public with the opportunity to comment on the various objective criteria DEQ must use in making ranking decisions. Further public input on individual site rankings is not needed because such input would not change a ranking decision which must be made according to the objective criteria set forth in the rules.

COMMENT #75: Rule VI(7)(c) (17.55.114) - Delete.

RESPONSE: Section 75-10-702, MCA, requires DEQ to provide a mechanism for delisting sites that includes a provision for public participation. In the rules, DEQ has developed such a mechanism and has based the public participation provisions on §75-10-713, MCA, which provide for specific notice to county commissioners and governing bodies of cities, towns, and consolidated local governments.

COMMENT #76: Rule VI (7)(e) (17.55.114) - Revise as follows: "The department shall notify the county commissioners and governing bodies of cities, towns, or consolidated local governments, and the City, County, City-County, or District Board of Health, in the community most likely to be threatened by the facility that is proposed for delisting."

RESPONSE: DEQ believes it is appropriate to notify county health boards when DEQ is considering a delisting decision and has amended (7)(c) [now (6)(c)] of the rule accordingly. After the health boards have been notified, it is appropriate that those health boards work through their governing bodies in requesting a public meeting; therefore, DEQ has determined it is not necessary to amend (7)(e) [now (6)(e)] of the rule.

COMMENT #77: Rule VI(7)(f) (17.55.114) - Insert "within 30 days" after "in writing" and before "to relevant".

RESPONSE: DEQ will be as responsive as possible in responding to comments but declines to put in the proposed timeline. DEQ needs the ability to allocate its resources to high priority

work and it is possible that responding to these comments would have to be given a lower priority in some instances.

COMMENT #78: The commenter noted that all federal Superfund and CECRA sites require some engineering or institutional controls once the cleanup is done. If DEQ requires that a site that has engineering or institutional controls cannot be delisted, DEQ will never delist a site in the state of Montana. There are options to continue to inform the public that institutional controls remain on the site via notifications in the public record. You could transfer the requirements on a site for continued maintenance to another program. If the control at issue is something like a cap and maintaining vegetation so weeds don't take over the site and cause erosion, that just falls into what people should be doing on their land anyway, best management practices.

RESPONSE: See response to comment #71. DEQ agrees that some sites with institutional controls should be delisted. DEQ notes that to date, over 70 sites have been delisted under CECRA. At 30 of those sites, remediation has been completed. At the other 40 sites, delisting occurred because the sites were referred to other state programs or it was determined that the initial listing was inappropriate. At the 30 sites that have been cleaned up, some institutional controls (such as deed restrictions) are in place. At many of the sites, no institutional controls were required. DEQ does not believe it is appropriate to rely on best management practices to maintain a cap when maintenance of that cap is critical to the success of a CECRA remedy. In many instances, a more aggressive remedy might eliminate or minimize reliance on O&M and institutional controls to assure long-term protection and, if a PLP does not want to be responsible for ongoing O&M or institutional control enforcement, it should propose the more stringent remedy which does not require these controls. The commenter did not specify what other options were available to inform the public that institutional controls remain on the site via notifications in the public record or what other program might be able to handle the maintenance requirements for a site. DEQ's evaluation indicates it is the entity responsible for these obligations and it has the requisite authority to carry out the obligations.

COMMENT #79: Delisting sites should be mandatory if delisting criteria are met. Since facilities are to be prioritized for remedial action based on the effects of a release on human health and the environment and there is a requirement that a facility must actually present a substantial and imminent threat to be listed on the CECRA priority list then, logically, delisting should be mandatory.

RESPONSE: DEQ agrees and Rule VI (17.55.114) has been amended accordingly.

COMMENT #80: Since the term "long-term protection" is not defined, state that if no significant threat to public health or the environment exists, the facility shall be removed from the CECRA priority list?

RESPONSE: Section 75-10-721, MCA, requires remedial actions to be effective and reliable in the long term; therefore, the proposed rules use identical language. It is anticipated that determining what constitutes "long-term" will, to a certain extent, be site-specific. For example, at one site monitoring the performance of a remedy might be necessary for 5 years to establish long-term protection while at another site similar monitoring might be necessary for 50 years. CECRA also requires protection of public safety and welfare; see §§75-10-702 and 75-10-711, MCA.

COMMENT #81: The rule should mandate that a facility be removed from the CECRA priority list for any of the following reasons:

(a) the facility was improperly listed in the first place;

(b) all appropriate response actions (excluding operation and maintenance) have been implemented;

(c) the release poses no significant threat to public health or the environment;

(d) the release is being addressed by another State or Federal program;

(e) the boundaries of the facility were determined improperly;

(f) the release is being addressed under a voluntary cleanup program (no need to wait until completion or closure of the cleanup action);

(g) other relevant information or conditions exist that support delisting of the facility from the CECRA list;

(h) the site no longer meets the listing requirements;

(i) the site does not pose a risk which is greater than 10^{-5};

(j) the final remedy or cleanup plan has been approved;

(k) the site was listed without notice or comment rulemaking; or

(l) the expenditure of state superfund money is not required to remediate the property.

RESPONSE: (a) See rule VI(1)(b) (17.55.114) which addresses an improper listing;

(b) see responses to comments #51 and 52;

(c) see rule VI(1) (17.55.114) [if requirements of CECRA are met, there will be no significant threat to public health or the environment]. Also, the CECRA specifically provides protections to the "public health, safety, or welfare or the environment." See §§75-10-702 and 75-10-711, MCA. The rulemaking authority in §75-10-702, MCA, authorizes DEQ to list a facility that may pose a threat to "public health, safety, or welfare or the environment.";

(d) if remedial actions to address the site are required by

another program, DEQ must explain its rationale for listing the site. DEQ is not prohibited from listing the site. The statute also provides that if another state program assumes jurisdiction, DEQ must delist the site. However, there are certain facilities where one state program handles remediation efforts for a portion of the facility or for certain constituents of concern before transferring it back for further remediation under CECRA. Therefore, to address both situations, Rule VI (17.55.114) has been amended to provide that if another state program assumes jurisdiction of the entire facility for all releases of hazardous or deleterious substances, DEQ will delist the facility. If less than the entire facility is being addressed by that program (and thus jurisdiction is not assumed) DEQ will retain the discretion to keep that facility on the list. Section 75-10-702(1)(a)(ii), MCA, provides for the delisting of a facility when another state program assumes jurisdiction of the facility. The language used in the rule is identical to that used in the statute and DEQ declines to expand the language to include federal programs;

(e) DEQ has the ability to change the definition of a "facility" if the boundaries were determined improperly and DEQ does not believe delisting the facility is appropriate in this situation;

(f) see response to comment #24;

(g) see Rule VI(2)(c) (17.55.114);

(h) see Rule VI. Section 75-10-702, MCA, provides the statutory criteria for listing and delisting sites. In accordance with its provisions, Rule VI provides a mechanism for delisting a site if all the requirements of CECRA have been met, including the protection of public health, safety, and welfare and the environment. As to the mandatory delisting of a facility, see response to comment 62;

(i) the stated level addresses risks to human health but does not address risk to public safety, welfare, or the environment. Thus, DEQ does not believe including it as a delisting criteria is appropriate;

(j) there is no justification for delisting a site with an approved cleanup plan, because DEQ cannot assure long term protection of public health, safety and welfare and the environment until completion of the remedy;

(k) there are many sites on the CECRA list that did not go through the notice or comment period contemplated by these rules because no similar requirements existed. Section 75-10-702(2), MCA, specifically indicated that the listing of these sites was not invalid. After the effective date of these rules, DEQ will comply with the listing requirements contained herein. As to sites listed prior to these rules, see Rule VI(2)(c) and (8) which allow a person to petition for delisting based on other relevant information. Therefore, if a site does not belong on the list a person can petition for its removal; and

(l) the listing and prioritization of sites is risk based. Maintenance of a site listing serves an important role in providing notice to the public of the potential human health and

environmental threats. It also assists DEQ in allocating its resources and determining when DEQ must initiate action. The potential expenditure of state money is not an appropriate consideration when making a delisting decision.

GENERAL COMMENTS:

COMMENT #82: In general, the proposed rules lack any scientific or objective criteria. By failing to rely on objective scientific criteria the rules put the regulated community in a listing/delisting/ranking process bound to be arbitrary. The rules do not provide the regulated community with statutorily based criteria on which to rely, but at the same time the rules seek to require a facility owner to meet standards that are arbitrarily established for each facility.

RESPONSE: DEQ disagrees that the rules are arbitrary and believes the rules provide a basis for consistently addressing listing, delisting, and ranking decisions. The rules describe a process by which potential sites may be listed and requires that all potential sites undergo public comment before listing. Once listed, the rules describe how sites will be ranked for prioritization. The rules reflect statutory criteria and provide predictability. The commenter also states that the rules require a facility owner to meet arbitrary standards; upon review DEQ is unable to ascertain which rule is establishing standards for facility owners. Rather, the rules are mandating standards that DEQ must meet when listing and ranking sites.

COMMENT #83: The proposed rules provide that "the standards are intended to ensure that the Department consistently follows certain criteria when listing or delisting a facility to allow public participation in the process." However, the rules contain ambiguous terms leading to arbitrary determinations which are not adequately based in law or fact.

RESPONSE: In general, DEQ disagrees with this comment. However, DEQ does believe that some clarification of the rules is appropriate as specified herein and has made the changes deemed appropriate. For example, DEQ has removed the definition of "risk-based concentrations" and has removed rankings based on this definition from the rules in order to provide more objective criteria.

Reviewed by: DEPARTMENT OF ENVIRONMENTAL QUALITY

John F. North by: *Mark A. Simonich*

John F. North, MARK A. SIMONICH, Director
Rule Reviewer

Certified to the Secretary of State April 9, 1999.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the management of continuous infusion of epidural catheters for analgesia in the obstetric setting.	DECLARATORY RULING

1. On March 26, 1998, the Board of Nursing (Board) published a Notice of Petition for Declaratory Ruling in the above-entitled matter at page 767, 1998 Montana Administrative Register, issue number 6.

2. On April 30, 1998, the Board presided over a hearing in this matter to consider written and oral testimony from interested individuals. On that date the Board made a motion to issue a declaratory ruling.

3. While considering the draft ruling, the Board discovered that copies of the declaratory ruling notice had not been provided to all interested persons. Therefore, the Board held a second hearing, with proper notice to all interested persons, on November 5, 1998. The Board received written and oral testimony from interested persons and deliberated the issue. Based upon the testimony received and deliberations, the Board voted to issue this declaratory ruling.

Issue

4. Petitioners requested a ruling on whether it is within the scope of practice of a registered nurse to manage continuous infusion analgesia via epidural catheter in the care of pregnant women clients.

Summary of Comments

5. The Board received eight written comments as well as testimony during the hearing held on April 30, 1998. Petitioners submitted additional information for the November 5, 1998, hearing as did several opponents.

6. Four commentors noted the physiological differences between a woman post-surgical patient and a pregnant woman in delivery. Commentors specifically referred to greater risk of catheter migration due to enlarged veins, heightened sensitivity of the sympathetic nervous system and rapid onset and extended duration of analgesia. Four commentors mentioned the difficulties which may occur as a result of sympathetic nervous system blocks.

7. Five commentors provided input regarding the fact that registered nurses providing nursing care to a pregnant woman are responsible, in essence, for two patients: mother and fetus. Commentors noted that the fetus is susceptible to blood pressure changes, high blood concentrations of analgesia agents, and the fetus' reliance upon the maternal physiological functions for

survival. Commentors state that if the health of the mother is compromised by the administration of epidural analgesia, the fetus is the first to suffer.

8. One commentor referenced the availability of alternative pain management therapies which are appropriate for administration by registered nurses.

9. Two commentors suggested allowing registered nurses to manage epidural analgesia under the guidelines promulgated by the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN). Both commentors stated that management of epidural analgesia is outside the training received by licensed registered nurses in preparation for licensure and, therefore, should not be relied upon to establish whether registered nurses as a matter of course are qualified for this task. Included within the guidelines and referenced by one commentor were requirements that registered nurses managing epidural analgesia obtain additional training beyond that mandated by mere licensure, adoption of facility policies providing for assistance where the patient experiences adverse results, written orders for dosage and administration, and the staffing of a qualified analgesia provider to place the catheter, administer the test dose, and be readily available for consultation by the registered nurse.

10. Comments provided from opponents focused on the issue of current practice by many RNs. Several commentors noted that obstetric nurses administer other medications which are potentially much more harmful than epidural analgesia. Commentors also note that declaring such actions as outside the scope of practice for an RN would delay interventions which would otherwise reduce or eliminate pain.

Analysis

11. Mont. Code Ann. § 37-8-102(5) (1997), defines "professional nursing," to include the "administration of medications and treatments prescribed by physicians, [and] advanced practice registered nurses . . . authorized by state law to prescribe medications and treatments."

12. Administrative Rule of Montana 8.32.1404 states, "The registered nurse shall: . . . obtain instruction and supervision as necessary when implementing nursing techniques or practices; . . . [and] consult with other members of the health team to provide optimum client care . . . ."

13. The Board addressed administration of regional analgesia through epidural catheter by non-anesthetist registered nurses in a declaratory ruling published at page 89, 1997 Montana Administrative Register Issue No. 1, January 16, 1997. The Board declared that it was within the scope of practice for registered nurses to administer regional analgesia via existing epidural catheter upon a physician or qualified anesthetist's written order. The Board tempered such administration, however, by specifying that the performance is

contingent on "documented education, certification, and annual competency evaluations." MAR 1-1/16/97 page 90. Additionally, the Board stated that administration was appropriate in all settings. *Id.*

14. The Board did not directly address the issue regarding epidural administration of analgesia during labor and delivery while deliberating on the initial declaratory ruling petition. It was specifically noted that several states did not permit registered nurses to administer analgesia via epidural catheter during labor and delivery, however, no information regarding such practice was presented for the Board's consideration. From the deliberation record, it is clear the Obstetric setting was at least contemplated as being appropriate although there is no discussion that it should be specifically included.

15. The final declaratory ruling was based upon findings of fact addressed to pre- and post- operative procedures in the hospital and home health care settings. Therefore, it is within the Board's ability to now address the labor and delivery setting.

16. The Board received information regarding the physiological differences between a post-operative patient and a patient in labor. Much testimony focused on these differences and the assertion of a higher risk of complications arising through the use of an epidural catheter with a laboring patient that simply are not often present in the post-operative patient. However, the Board notes that many individuals impacted by this declaratory ruling are post-operative cesarean section patients who will be in need of pain management via epidural administration.

17. The administration of analgesia, both by statute and by the Board's prior declaratory ruling, is within the scope of practice of a registered nurse. However, the registered nurse is responsible for receiving instruction and supervision regarding the administration and to work toward providing optimum patient care.

18. Regarding the care of the pregnant woman, the registered nurse is responsible for not only monitoring the mother's status, but also the fetus' status. In addition to monitoring tasks, RNs will often be assigned the additional task of attending an epidural analgesia catheter with its additional risks. It is also clear from the testimony received that the assignment of epidural attendance is done with some oversight by a licensed anesthesia provider giving instructions relative to the use of the epidural. Such oversight is not only useful, it must be mandatory.

Conclusion

19. After consideration of the comments presented in this matter and the information submitted by the petitioners, the Board makes the following declaratory ruling.

20. Management of an analgesia in the pregnant woman via epidural catheter is in the scope of practice of the registered nurse provided that qualified anesthesia personnel are in-house and immediately available to the unit.

BOARD OF NURSING

BY: Kim Powell RN BSN CEN
KIM POWELL, RN, BSN, CEN
PRESIDENT

DATED 3/25/99

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 December 31, 1998. This table includes those rules adopted during the period January 1, 1999 through March 31, 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 December 31, 1998, 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, p. 2856

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
2.21.6401 and other rules - Performance Appraisal, p. 1452, 2258

(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
4.3.602 and other rules - Rural Assistance Loan Program to Assist Substandard Income, p. 2188, 2704

4.5.102 and other rules - Ranking of Weed Grant Projects - Identifying New Noxious Weeds, p. 1986, 2472
4.10.1001 and other rules - Pesticide Enforcement, p. 1, 404
4.12.1428 Assessment Fees on All Produce, p. 2934, 507

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

(Board of Athletics)
8.8.2802 and other rules - Definitions - Prohibitions - Physical Examinations - Physician Requirements - Elimination-type Events - Point System - Scoring - Promoter-Matchmaker - Medical Advisor, p. 1053, 2858, 2958
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
8.13.303 and other rules - Fees - Renewal - Inactive Status - Reactivation of License, p. 2136, 2860

(Board of Cosmetologists)
8.14.803 and other rules - Applications for Examination - Temporary Permits - Application of Out-of-State Cosmetologists, Manicurists, Estheticians - Transfer Students - Continuing Education - Salons - Booth Rental Licenses - Restrictions of Temporary Permits, p. 1456, 2261
8.14.814 Fees - Initial, Renewal, Penalty and Refund Fees, p. 439

8.34.414 and other rule - Examinations - Fees, p. 2139, 2964, 67

(Board of Occupational Therapists)
8.35.408 and other rule - Unprofessional Conduct - Continuing Education, p. 1551, 2266

(Board of Optometry)
8.36.601 and other rule - Continuing Education Requirements - New Licensees, p. 3180, 511

(Board of Outfitters)
8.39.505 and other rules - Outfitter Applications and Renewals - Guide or Professional Guide Licenses and Qualifications - Safety Provisions - Unprofessional Conduct, p. 816, 2560
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
8.39.804 Review of New Operations Plan and Proposed Expansion of Net Client Hunting Use Under an Existing Operations Plan, p. 1463, 2267

(Board of Pharmacy)
8.40.401 and other rules - Practice of Pharmacy, p. 2353, 3103, 3200, 344
8.40.404 Fee Schedule, p. 455

(Board of Professional Engineers and Land Surveyors)
8.48.1105 Fee Schedule, p. 457

(Board of Private Security Patrol Officers and Investigators)
8.50.428 and other rules - Experience Requirements - Fees - Private Investigator Trainee, p. 2230, 2705
8.50.437 Fee Schedule, p. 459
8.50.505 and other rule - Employers' Responsibility - Type of Firearm, p. 2366, 2965

(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

(Board of Public Accountants)
8.54.410 and other rule - Fee Schedule - Statement of Permit Holders, p. 463
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)
8.57.412 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

8.58.411 and other rules - Fees - Continuing Education - Unprofessional Conduct, p. 2141, 2861

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)

8.59.506 and other rules - Fees - Continuing Education - Unprofessional Conduct, p. 1553, 2276

(Board of Sanitarians)

8.60.410A and other rule - Examinations - Sanitarian-in-training, p. 2939, 278

(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

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. 1310, 2563

(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

(Consumer Affairs Division)

I Notice of Resale of Returned Vehicle, p. 1989, 2476

(Banking and Financial Institutions Division)
8.80.110 Fees for the Approval of Point-of-Sale Terminals, p. 1556, 2478
8.80.307 Dollar Amounts to Which Consumer Loan Rates are to be Applied, p. 1558, 2479

(State Banking Board)
8.87.401 and other rule - Organization of the State Banking Board, p. 1560, 2480, 2706

(Local Government Assistance Division)
I Administration of the 1999 Federal Community Development Block Grant Program, p. 3245
8.94.3714 Administration of the 1998 Federal Community Development Block Grant Program, p. 706, 2481

(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)
10.55.602 and other rules - Content and Performance Standards for Reading and Mathematics, p. 1358, 2707
10.57.220 Teacher Certification - Recency of Credit, p. 830, 1920, 2753

(State Library)
10.102.4001 Reimbursement to Libraries for Interlibrary Loans, p. 1563, 3104

(Montana Historical Society)
I-XVI Procedures That State Agencies Must Follow to Protect Heritage Properties and Paleontological Remains - General Procedures Which the State Historic Preservation Office Must Follow in Implementing its General Statutory Authority, p. 411, 2022, 2483

FISH, WILDLIFE, AND PARKS, Department of, Title 12

I-III Angler Education Events, p. 626, 2277
12.3.202 Establishing a New Class of License Agent Who May Receive Compensation from Clients for Preparation of Hunting License and Permit Applications, p. 629, 2485
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 and other rules - Water Treatment System Operators - Approved Providers of Training for Water Treatment System Operators - Definitions - Updating Classification of Water and Wastewater Treatment Systems - Continuing Education Requirements for Operators, p. 2248, 2966
I-VI CECRA - Listing, Delisting and Ranking Rules for Comprehensive Environmental Cleanup and Responsibility Act (CECRA) Facilities, p. 1264, 2941
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
I & II and other rules - Air Quality - Air Quality Transportation - General Conformity Determinations, p. 244
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
17.8.504 and other rule - Air Quality - Application and Operation Fees, p. 1574, 2486
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
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

17.30.502 Water Quality - Montana Mixing Zone - Definitions, p. 847, 2487
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
17.30.610 Water Quality - Montana Surface Water Quality Standards, p. 857, 2489
17.38.215 Public Water Supply - Bacteriological Quality Samples for Public Water Supply Systems, p. 257

(Department of Environmental Quality and Board of Environmental Review)
17.36.1101 and other rules - Water Quality - Administrative Enforcement Procedures Under the Public Water Supply Act, p. 2754

(Petroleum Tank Release Compensation Board)
17.58.331 Assent to Audit Requirements, p. 2245, 3112

TRANSPORTATION, Department of, Title 18

I-III and other rules - Agriculture Refunds Standard Deduction (60%), p. 2791
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
18.9.102 Bonding Requirements for Gasoline, Special Fuel or Aviation Fuel Distributors, p. 2669

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

Availability for Inspection - Sample Collection - Identification Methodology, p. 1589, 2756

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

(Board of Milk Control)

32.24.301 Butter Component Used in the Pricing Structure of Milk to Establish the Class I, II and III Producer Prices, p. 2255, 2760

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-VIII and other rules - Rural Health Clinics and Federally Qualified Health Centers, p. 886, 2045

I-XV and other rules - Families Achieving Independence in Montana (FAIM), p. 1592, 3284

I-XXIII and other rules - Child Support Enforcement Guidelines, p. 317, 447, 2066, 2598

I-XXV and other rules - Standards for Licensing of Laboratories Conducting Analyses of Public Water Supplies, p. 3080, 291

11.4.101 and other rules - Transfer from the Department of Family Services - Aging Services, p. 2279

11.5.901 and other rules - Transfer from the Department of Family Services - Home Attendant Services, p. 3218

11.14.101 and other rules - Transfer from the Department of Family Services - Licensure of Child Care Facilities - Transfer from the Department of Health and Environmental Sciences - Requirements for Health Care Centers, p. 2594, 2881

16.28.101 and other rules - Control of Sexually Transmitted Diseases, p. 1690, 2493

16.29.101 and other rules - Public Health Control Measures for Dead Human Bodies, p. 2428, 345

16.30.801 and other rules - Control of Transmission of Infectious Diseases to Emergency Medical Service Providers, p. 488

16.30.801 and other rules - Control of Transmission of Infectious Diseases to Emergency Medical Service Providers, p. 2438

16.32.320 Hospital Swing Beds, p. 1890, 146

16.38.307 State Laboratory Fees for Analyses, p. 628

42.21.113 and other rules - Personal Property Trended Depreciation Schedules and Valuations for the 1999 Tax Year, p. 2451, 3316, 154
42.22.1311 and other rule - Industrial Property Trend Factors, p. 2949, 3318
42.38.101 and other rules - Unclaimed Property, p. 1399, 2511

SECRETARY OF STATE, Title 44

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
44.14.101 and other rule - Retention of Records Stored on Digital Media, p. 341

(Commissioner of Political Practices)
44.10.321 and other rules - Reporting of Contributions and Expenditures, p. 635

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 March 1999, appear. Vacancies scheduled to appear from May 1, 1999, through July 31, 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 April 7, 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 MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Appellate Defender Commission (Administration)			
Mr. Michael Sherwood Missoula Qualifications (if required): attorney	Governor	Parker	3/18/1999 1/1/2000
Board of Architects (Commerce)			
Mr. Eugene Vogl Billings Qualifications (if required): registered architect	Governor	reappointed	3/27/1999 3/27/2002
Board of Dentistry (Commerce)			
Dr. Michael McCarthy Billings Qualifications (if required): dentist	Governor	Youngbauer	3/29/1999 3/29/2004
Ms. Deana Standley Great Falls Qualifications (if required): dental hygienist	Governor	Anderson	3/29/1999 3/29/2004
Board of Environmental Review (Environmental Quality)			
Ms. Susan Kirby Brooke Bozeman Qualifications (if required): public member	Governor	Younkin	3/8/1999 12/31/2001
Mr. Joseph Russell Kalispell Qualifications (if required): county health officer	Governor	Dennehy	3/8/1999 12/31/2001
Board of Livestock (Livestock)			
Mr. Jerry E. Leep Amsterdam Qualifications (if required): dairy producer	Governor	reappointed	3/4/1999 3/1/2005

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Livestock (Livestock) cont.			
Mr. Bob Lee Judith Gap Qualifications (if required): cattle producer	Governor	Grove	3/4/1999 3/1/2005
Mr. Jeremy Kinross-Wright Big Timber Qualifications (if required): swine producer	Governor	Braaten	3/4/1999 3/1/2005
Board of Medical Examiners (Commerce)			
Dr. Katherine Markette Missoula Qualifications (if required): doctor of medicine	Governor	Calderwood	3/18/1999 9/1/2000
Board of Nursing (Commerce)			
Ms. Vickie Badgley Stevensville Qualifications (if required): licensed practical nurse	Governor	Walker	3/10/1999 7/1/2000
Board of Social Work Examiners and Professional Counselors (Commerce)			
Dr. Leta Livoti Helena Qualifications (if required): licensed professional counselor	Governor	reappointed	3/9/1999 1/1/2003
Ms. Antoinette Rosell Billings Qualifications (if required): licensed professional counselor	Governor	reappointed	3/9/1999 1/1/2003
Judge Richard A. Simonton Glendive Qualifications (if required): public member	Governor	reappointed	3/9/1999 1/1/2003

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Governor's Council on Families (Public Health and Human Services)			
Ms. Emily Matt Salois Missoula Qualifications (if required): public member	Governor	Acevedo	3/25/1999 8/18/2000
Governor's HIV/AIDS Advisory Council (Public Health and Human Services)			
Dr. Paul Kathrein Great Falls Qualifications (if required): public member	Governor	Marks	3/1/1999 11/23/2000
Ms. Sheryl Dernbach Billings Qualifications (if required): public member	Governor	Carter	3/1/1999 11/23/2000
Mr. Fred Zaino Conrad Qualifications (if required): public member	Governor	Carter	3/1/1999 11/23/2000
Montana Workforce Investment Board (Labor and Industry)			
Mr. Peter Blouke Helena Qualifications (if required): representing lead state agencies	Governor	not listed	3/19/1999 0/0/0
Ms. Laurie Ekanger Helena Qualifications (if required): representing lead state agencies	Governor	not listed	3/19/1999 0/0/0
Mr. Don Judge Helena Qualifications (if required): representing labor organizations	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Superintendent Nancy Keenan Helena Qualifications (if required): representing lead state agencies	Governor	not listed	3/19/1999 0/0/0
Mr. Dennis Lerum Missoula Qualifications (if required): representing community colleges and community based organizations	Governor	not listed	3/19/1999 0/0/0
Ms. Pat Haffey Helena Qualifications (if required): representing lead state agencies	Governor	not listed	3/19/1999 0/0/0
Mr. Jon Oldenburg Lewistown Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Sen. Vicki Cocchiarella Missoula Qualifications (if required): representing Montana Senate	Governor	not listed	3/19/1999 0/0/0
Sen. Fred Thomas Stevensville Qualifications (if required): representing Montana Senate	Governor	not listed	3/19/1999 0/0/0
Ms. Diane R. Ruff Billings Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Felicity McFerrin Helena Qualifications (if required): representing labor organizations	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Mr. Jim Hollenback Superior Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Gordon Morris Helena Qualifications (if required): representing chief elected officials	Governor	not listed	3/19/1999 0/0/0
Mr. Alan Nicholson Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Richard A. Crofts Helena Qualifications (if required): representing lead state agencies	Governor	not listed	3/19/1999 0/0/0
Mr. Wyman McDonald Helena Qualifications (if required): representing tribal	Governor	not listed	3/19/1999 0/0/0
Ms. Ellin Nesset Bozeman Qualifications (if required): representing youth activities	Governor	not listed	3/19/1999 0/0/0
Ms. Sally Newhall Great Falls Qualifications (if required): representing youth activities	Governor	not listed	3/19/1999 0/0/0
Rep. Verdell Jackson Kalispell Qualifications (if required): representing Montana House of Representatives	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Rep. Jeff Mangan Great Falls Qualifications (if required): representing Montana House of Representatives	Governor	not listed	3/19/1999 0/0/0
Mr. Jim Smitham Butte Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Paul Linell Scobey Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Darrell Morehouse Glasgow Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Linda Twichel Wolf Point Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Dave Keck Butte Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Jo Alice Mospan Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Jim Swan Havre Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Mr. Erik Burke Helena Qualifications (if required): representing Governor	Governor	not listed	3/19/1999 0/0/0
Ms. Sharon Hagemo Missoula Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Dewey Skelton Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Rick Hays Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Susan Knedler Lewistown Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Jim Davison Anaconda Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Lew Grill Billings Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Diane Harkins Billings Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Mr. Lyle Phillips Columbia Falls Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Randy Pugh Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Ms. Jan Van Fossen Missoula Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Gary Willis Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Bill Barr Sidney Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Mr. Webb Brown Helena Qualifications (if required): representing business	Governor	not listed	3/19/1999 0/0/0
Commissioner Carol Brooker Thompson Falls Qualifications (if required): representing chief elected officials	Governor	not listed	3/19/1999 0/0/0
Mr. Jerry Rukavina Great Falls Qualifications (if required): representing labor organizations	Governor	not listed	3/19/1999 0/0/0

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Workforce Investment Board (Labor and Industry) cont.			
Ms. Susan Christoffersen Kalispell Qualifications (if required): representing youth activities	Governor	not listed	3/19/1999 0/0/0
Ms. Sharon Liederman Helena Qualifications (if required): representing community colleges and community based organizations	Governor	not listed	3/19/1999 0/0/0
Mr. Bob Bennett Miles City Qualifications (if required): representing community colleges and community based organizations	Governor	not listed	3/19/1999 0/0/0
Mr. Pat Wise Helena Qualifications (if required): representing labor organizations	Governor	not listed	3/19/1999 0/0/0
State Tax Appeal Board (Administration)			
Ms. JereAnn Nelson Helena Qualifications (if required): public member	Governor	McKelvey	3/4/1999 1/1/2005
Trauma Care Committee (Public Health and Human Services)			
Dr. Joseph Leal Glendive Qualifications (if required): representing the Eastern Regional Trauma Advisory Committee	Governor	reappointed	3/10/1999 11/2/2003

BOARD AND COUNCIL APPOINTEES FROM MARCH, 1999

Appointee	Appointed by	Succeeds	Appointment/End Date
Trauma Care Committee (Public Health and Human Services) cont.			
Dr. Michael B. Orcutt Great Falls Qualifications (if required): representing the Central Regional Trauma Advisory Committee	Governor	reappointed	3/10/1999 11/2/2003
Dr. Kendall Flint Browning Qualifications (if required): representing Indian Health Service	Governor	reappointed	3/10/1999 11/2/2003
Dr. Gregory J. Moore Missoula Qualifications (if required): representing the Western Regional Trauma Advisory Committee	Governor	Vaught	3/10/1999 11/2/2003
Ms. Colleen Overcast Chinook Qualifications (if required): representing Montana Emergency Medical Services Association	Governor	Chapman	3/10/1999 11/2/2003
Mr. John M. Mootry Dillon Qualifications (if required): representing the Montana Hospital Association	Governor	O'Hara	3/10/1999 11/2/2000
Vocational Rehabilitation Advisory Council (Public Health and Human Services)			
Mr. Chris Clasby Missoula Qualifications (if required): represent people with disabilities and advocates	Director	Jarvie	3/15/1999 3/15/2001
Water Pollution Control Advisory Council (Environmental Quality)			
Mr. Lewis Keim Whitefish Qualifications (if required): representative of a fishing organization	Governor	Farling	3/10/1999 0/0/0

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 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
Board of Banking (Commerce)		
Mr. Loren Tucker, Virginia City Qualifications (if required): public member	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Board of Banking (Commerce) cont.		
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 Service (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
Ms. Lee Micken, Bozeman Qualifications (if required): hearing aid dispenser	Governor	7/1/1999
Board of Nursing (Commerce)		
Ms. Nancy Heyer, Missoula Qualifications (if required): registered professional nurse	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Board of Nursing (Commerce) cont.		
Ms. Terry Buhre, Lewistown Qualifications (if required): LPN	Governor	7/1/1999
Board of Nursing Home Administrators (Commerce)		
Ms. Arline Rabenberg, Wolf Point Qualifications (if required): public member of age 55	Governor	5/28/1999
Board of Pharmacy (Commerce)		
Ms. Shirley Baumgartner, Glasgow Qualifications (if required): licensed pharmacist	Governor	7/1/1999
Board of Physical Therapy Examiners (Commerce)		
Mr. Jeff Pallister, Great Falls Qualifications (if required): physical therapist	Governor	7/1/1999
Board of Plumbers (Commerce)		
Mr. Robert Nault, Havre Qualifications (if required): master plumber	Governor	5/4/1999
Mr. Donald Kent, Bozeman Qualifications (if required): journeyman plumber	Governor	5/4/1999
Mr. Elmer Lazure, Helena Qualifications (if required): public member	Governor	5/4/1999
Mr. Terry Campbell, Helena Qualifications (if required): representing the Department of Environmental Quality	Governor	5/4/1999
Ms. Jo Hawkins, Helena Qualifications (if required): public member	Governor	5/4/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Board of Plumbers (Commerce) cont.		
Mr. Richard Knatterud, Helena Qualifications (if required): sanitary engineer	Governor	5/4/1999
Mr. Greg Butts, Helena Qualifications (if required): sanitary engineer	Governor	5/4/1999
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 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 -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Board of Radiologic Technologists (Commerce) cont.		
Ms. Cynthia L. Smith, Billings Qualifications (if required): radiologist technologist	Governor	7/1/1999
Mr. Alan Sevier, Glendive Qualifications (if required): public member	Governor	7/1/1999
Board of Real Estate Appraisers (Commerce)		
Mr. Roger Jacobson, Kalispell Qualifications (if required): real estate appraiser	Governor	5/1/1999
Board of Realty Regulation (Commerce)		
Mr. John Beagle, Sidney Qualifications (if required): realtor and an independent	Governor	5/9/1999
Ms. Shelly Noe, Absarokee Qualifications (if required): public member and a republican	Governor	5/9/1999
Board of Regents of Higher Education (Education)		
Ms. Kimberly Cunningham, Billings Qualifications (if required): student representative	Governor	6/1/1999
Board of Sanitarians (Commerce)		
Mr. John Shea, Anaconda Qualifications (if required): public member	Governor	7/1/1999
Board of Science and Technology Development (Commerce)		
Mr. Dolph Harris, Sidney Qualifications (if required): representing the private sector	Governor	6/30/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Board of Science and Technology Development (Commerce) cont.		
Mr. Loren Smith, Great Falls	Governor	6/30/1999
Qualifications (if required): representing the private sector and expertise in applied technology		
Mr. Will Brooke, Bozeman	Governor	6/30/1999
Qualifications (if required): representing the private sector and an attorney		
Ms. Susan Riplett, Billings	Governor	6/30/1999
Qualifications (if required): representing private business and finance		
Mr. Doug Lair, Big Timber	Governor	6/30/1999
Qualifications (if required): representing the private sector		
Mr. Haven Holsapple, Hamilton	Governor	6/30/1999
Qualifications (if required): representing early stage financing of private businesses		
Mr. Monte Giese, Great Falls	Governor	6/30/1999
Qualifications (if required): representing early stage financing of private businesses		
Board of Veterans' Affairs (Military Affairs)		
Mr. Johnny Buck, Glendive	Governor	5/18/1999
Qualifications (if required): veteran		
Board of Veterinary Medicine (Commerce)		
Dr. Don Smith, Livingston	Governor	7/31/1999
Qualifications (if required): licensed veterinarian		
Building Codes Advisory Council (Commerce)		
Mr. Richard Grover, Missoula	Director	6/1/1999
Qualifications (if required): board of plumbers		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Building Codes Advisory Council (Commerce) cont.		
Mr. Robert Ross, Kalispell Qualifications (if required): home builder	Director	6/1/1999
Ms. Linda Cockhill, Helena Qualifications (if required): public member	Director	6/1/1999
Mr. Bruce Suenram, Helena Qualifications (if required): state fire marshal	Director	6/1/1999
Mr. Robert C. McKenna, Helena Qualifications (if required): engineer	Director	6/1/1999
Mr. Robert J. Karhu, Helena Qualifications (if required): architect	Director	6/1/1999
Mr. Evan Peacock, Helena Qualifications (if required): building contractor	Director	6/1/1999
Mr. Mike Skinner, Helena Qualifications (if required): mobile homes	Director	6/1/1999
Ms. Kim Palmieri, Billings Qualifications (if required): municipal building officials	Director	6/1/1999
Mr. Joe F. Wolfe, Helena Qualifications (if required): state electrical board	Director	6/1/1999
Committee on Telecommunications Services for the Handicapped (Public Health and Human Services)		
Mr. Edward Van Tighem, Great Falls Qualifications (if required): deaf	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Committee on Telecommunications Services for the Handicapped (Public Health and Human Services) cont.		
Ms. Cathy Brightwell, Helena Qualifications (if required): member from an interLATA interexchange carrier	Governor	7/1/1999
Ms. Flo Ellen Hippe, Great Falls Qualifications (if required): handicapped	Governor	7/1/1999
Community Services Advisory Council (Governor)		
Mr. Charles McCarthy, Helena Qualifications (if required): representative of the Department of Public Health and Human Services	Governor	7/1/1999
Ms. Sherry Stevens Wulf, Kalispell Qualifications (if required): representing a non-profit agency	Governor	7/1/1999
Ms. Norma Bixby, Lame Deer Qualifications (if required): representative of tribal government	Governor	7/1/1999
Electrical Board (Commerce)		
Mr. Ron VanDiest, Helena Qualifications (if required): licensed electrician	Governor	7/1/1999
Family Education Savings Program Oversight Committee (Education)		
Mr. Patrick P. Davison, Billings Qualifications (if required): presiding officer of the Board of Regents	Governor	7/1/1999
Ms. Sarah Kelly, Helena Qualifications (if required): public member	Governor	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Flathead Basin Commission (Governor)		
Ms. Marilyn Wood, Kalispell Qualifications (if required): public member	Governor	6/30/1999
Mr. Paul Smiley, Columbia Falls Qualifications (if required): public member	Governor	6/30/1999
Mr. Gary Wicks, Polson Qualifications (if required): public member	Governor	6/30/1999
Gambling Study Commission (Legislative Services)		
Ms. Phoebe Williams, Deer Lodge Qualifications (if required): business owner with no economic interest in the gambling industry	Governor	6/30/1999
Ms. Barbara Nemecek, Billings Qualifications (if required): doctorate in social science pertinent to socioeconomic analysis	Governor	6/30/1999
Professor Rodney Brod, Missoula Qualifications (if required): representative of Sociology Department of the University of Montana	Governor	6/30/1999
Professor Shannon Taylor, Bozeman Qualifications (if required): representative of the school of business at Montana State University	Governor	6/30/1999
Dr. Robert Caldwell, Helena Qualifications (if required): mental health professional	Governor	6/30/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
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		
Health Care Advisory Council (Public Health and Human Services)		
Ms. Laurie Ekanger, Helena	Governor	6/30/1999
Qualifications (if required): representing the Executive Branch		
Ms. Kathleen Richardson, Havre	Governor	6/30/1999
Qualifications (if required): representing Region 2		
Mr. Max Agather, Kalispell	Governor	6/30/1999
Qualifications (if required): representing Region 5		
Dr. Lawrence R. Palazzo, Glasgow	Governor	6/30/1999
Qualifications (if required): representing Region 1		
Ms. Joan Taylor, Helena	Governor	6/30/1999
Qualifications (if required): representing Region 4		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Health Care Advisory Council (Public Health and Human Services) cont.		
Ms. Kristianne Wilson, Billings Qualifications (if required): representing Region 3	Governor	6/30/1999
Information Technology Managers Council (Administration)		
Mr. Tony Herbert, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Steve Colberg, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Mike Billings, Helena Qualifications (if required): none specified	Director	7/1/1999
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

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
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
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

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
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
Mr. Bob Morris, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Joel Oelfke, Helena Qualifications (if required): none specified	Director	7/1/1999
Ms. Judy Jones, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Gregg Wheeler, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Eivind Nilsen, Helena Qualifications (if required): none specified	Director	7/1/1999
Mr. Michael Randall, Helena Qualifications (if required): none specified	Director	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Information Technology Managers Council (Administration) cont.		
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		
Microbusiness Advisory Council (Commerce)		
Mr. Richard C. King, Havre	Governor	6/30/1999
Qualifications (if required): experience in revolving loan fund		
Mr. Duane Kurokawa, Wolf Point	Governor	6/30/1999
Qualifications (if required): banker		
Mr. Stephen Mehring, Great Falls	Governor	6/30/1999
Qualifications (if required): revolving loan fund		
Mr. Jim Hollenback, Superior	Governor	6/30/1999
Qualifications (if required): microbusiness owner		
Mr. Mark Dahl, Butte	Governor	6/30/1999
Qualifications (if required): banker		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Microbusiness Advisory Council (Commerce) cont.		
Ms. Billie Lee, Ronan	Governor	6/30/1999
Qualifications (if required): representing small cities		
Ms. Candace Eide, Glendive	Governor	6/30/1999
Qualifications (if required): representing low income groups		
Montana Consensus Council (Governor)		
Sen. Greg Jergeson, Chinook	Governor	6/30/1999
Qualifications (if required): public member		
Governor Marc Racicot, Helena	Governor	6/30/1999
Qualifications (if required): none specified		
Mr. Mike Zimmerman, Butte	Governor	6/30/1999
Qualifications (if required): none specified		
Ms. Janet Ellis, Helena	Governor	6/30/1999
Qualifications (if required): none specified		
Mr. Donald Snow, Missoula	Governor	6/30/1999
Qualifications (if required): none specified		
Ms. Monica Switzer, Richey	Governor	6/30/1999
Qualifications (if required): none specified		
Rep. Karl Ohs, Harrison	Governor	6/30/1999
Qualifications (if required): public member		
Ms. Elaine Forest, Helena	Governor	6/30/1999
Qualifications (if required): Native American		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Montana Consensus Council (Governor) cont.		
Mr. Bruce Vincent, Libby Qualifications (if required): public member	Governor	6/30/1999
Mr. Robbie Garrett, Dillon Qualifications (if required): public member	Governor	6/30/1999
Ms. Anne Hedges, Helena Qualifications (if required): public member	Governor	6/30/1999
Montana Historical Society Board of Trustees (Historical Society)		
Ms. Susan McDaniel, Miles City Qualifications (if required): public member	Governor	7/1/1999
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 Library Services Advisory Council (State Library)		
Mr. Bill Cochran, Billings Qualifications (if required): representing the Montana Library Association	Governor	6/20/1999
Rep. Linda McCulloch, Missoula Qualifications (if required): representing the Montana Legislature	Governor	6/20/1999
Mr. Wes Plann, Terry Qualifications (if required): representing library users from Eastern Montana	Governor	6/20/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Montana Library Services Advisory Council (State Library) cont.		
Ms. Gloria Wahl, Lewistown	Governor	6/20/1999
Qualifications (if required): representing library users from Central Montana		
Ms. Lois Fitzpatrick, Helena	Governor	6/20/1999
Qualifications (if required): representing academic libraries		
Ms. Peggy Bloom, Missoula	Governor	6/20/1999
Qualifications (if required): representing library users from Western Montana		
Ms. Delores Drennen, Miles City	Governor	6/20/1999
Qualifications (if required): representing public libraries		
Ms. Lynn Donvan, Sidney	Governor	6/20/1999
Qualifications (if required): representing school libraries		
Mr. Duran DuBoise, Butte	Governor	6/20/1999
Qualifications (if required): representing persons unable to use traditional library services		
Montana Mint Committee (Agriculture)		
Mr. John Ficken, Kalispell	Governor	7/1/1999
Qualifications (if required): mint grower		
Montana Research and Development Task Force (Commerce)		
Mr. Edwin H. Jasmin, Bigfork	Governor	6/30/1999
Qualifications (if required): public member		
Mr. Ken Thuerbach, Victor	Governor	6/30/1999
Qualifications (if required): public member		
Rep. Ernest Bergsagel, Malta	Governor	6/30/1999
Qualifications (if required): public member		

Board/current position holder	Appointed by	Term end
Montana Research and Development Task Force (Commerce) cont.		
Sen. Mignon Waterman, Helena Qualifications (if required): public member	Governor	6/30/1999
Mr. Richard A. Crofts, Helena Qualifications (if required): public member	Governor	6/30/1999
Mr. Ralph Hutcheson, Bozeman Qualifications (if required): public member	Governor	6/30/1999
Dr. Tom McCoy, Bozeman Qualifications (if required): public member	Governor	6/30/1999
Mr. Chuck Merja, Sun River Qualifications (if required): public member	Governor	6/30/1999
Dr. Lloyd Chestnut, Missoula Qualifications (if required): public member	Governor	6/30/1999
Mr. Rob Ryan, Hamilton Qualifications (if required): public member	Governor	6/30/1999
Mr. Chris Busch, Ronan Qualifications (if required): public member	Governor	6/30/1999
Montana Special Education Advisory Panel (Office of Public Instruction)		
Mr. Wallace Melcher, Helena Qualifications (if required): business concerned with transition	Superintendent	7/1/1999
Rep. Royal C. Johnson, Billings Qualifications (if required): legislator	Superintendent	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Montana Special Education Advisory Panel (Office of Public Instruction) cont.		
Ms. Judith Oberst, Helena Qualifications (if required): parent of a child with disabilities	Superintendent	7/1/1999
Ms. Mary Ann Akers, Helena Qualifications (if required): state agency	Superintendent	7/1/1999
Ms. Mary Susan Fishbaugh, Billings Qualifications (if required): higher education	Superintendent	7/1/1999
Ms. Kim Miller, Lewistown Qualifications (if required): regular classroom teacher	Superintendent	7/1/1999
Ms. Crystal Dreese, Billings Qualifications (if required): individual with a disability	Superintendent	7/1/1999
Mr. Ed Heiser, Eureka Qualifications (if required): general educator	Superintendent	7/1/1999
Superintendent Maria Harrison, Shelby Qualifications (if required): county superintendent	Superintendent	7/1/1999
Ms. Sondra Strong, Kalispell Qualifications (if required): special education program administrator	Superintendent	7/1/1999
Ms. Laurie Pipinich, Great Falls Qualifications (if required): teacher of children with disabilities	Superintendent	7/1/1999
Ms. Vicki LaFond-Smith, Helena Qualifications (if required): parent of a child with disabilities	Superintendent	7/1/1999
Ms. Julie Traver, Bozeman Qualifications (if required): parent of a child with disabilities	Superintendent	7/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Montana Special Education Advisory Panel (Office of Public Instruction) cont.		
Ms. Judy Jonart, Butte	Superintendent	7/1/1999
Qualifications (if required): regular classroom teacher		
Ms. Linda Adelson, Bozeman	Superintendent	7/1/1999
Qualifications (if required): private school representative		
Ms. Carol Damm, Miles City	Superintendent	7/1/1999
Qualifications (if required): representative from juvenile and adult corrections		
Montana State Veterans Cemetery Advisory Council (Military Affairs)		
Mr. James W. Duffy, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Mr. Mickey Nelson, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Ms. Alma Dickey, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Ms. Irma Paul, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Ms. Rose Marie Storey, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Mr. Herb Ballou, Helena	Director	5/1/1999
Qualifications (if required): none specified		
Mr. George Paul, Helena	Director	5/1/1999
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Montana State Veterans Cemetery Advisory Council (Military Affairs) cont.		
Mr. Jim Heffernan, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. Ruddy Reilly, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. Ray Read, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. M. Herbert Goodwin, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. Robert C. McKenna, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. James F. Jacobsen, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. Edward Mosier, Missoula Qualifications (if required): none specified	Director	5/1/1999
Mr. Al Kirkeby, Helena Qualifications (if required): none specified	Director	5/1/1999
Mr. Hugh "Tony" Cummings, Helena Qualifications (if required): none specified	Director	5/1/1999
Major Steve Martinka, Helena Qualifications (if required): none specified	Director	5/1/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 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 Advisory Council (Agriculture)		
Rep. Bob Gilbert, Sidney	Director	6/30/1999
Qualifications (if required): Montana Weed Control Association		
Rep. Robert Thoft, Stevensville	Director	6/30/1999
Qualifications (if required): biological research and control		
Mr. Jim Squires, Glendive	Director	6/30/1999
Qualifications (if required): agriculture crop production		
Ms. Linda Ellison, Bozeman	Director	6/30/1999
Qualifications (if required): sportsman/wildlife group		
Mr. Charles M. Jarecki, Polson	Director	6/30/1999
Qualifications (if required): at-large member		
Mr. W. Ralph Peck, Helena	Director	6/30/1999
Qualifications (if required): director of the Department of Agriculture		
Mr. Bob Ullom, Billings	Director	6/30/1999
Qualifications (if required): herbicide dealer and applicator		
Ms. Nancy Thuesen, Reserve	Director	6/30/1999
Qualifications (if required): consumer group		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Noxious Weed Advisory Council (Agriculture) cont.		
Mr. Steve Roth, Big Sandy	Director	6/30/1999
Qualifications (if required): Livestock Production		
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		
Mr. Bob McNeill, Dillon	Director	7/24/1999
Qualifications (if required): outfitters/guides		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Noxious Weed Seed Free Forage Advisory Council (Agriculture) cont.		
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		
Petroleum Tank Release Compensation Board (Environmental Quality)		
Mr. Terry Phillips, Helena	Governor	6/30/1999
Qualifications (if required): representative of the state fire prevention and investigation program		
Postsecondary Education Policy and Budget Committee (Legislative Fiscal Analyst)		
Ms. Kris Copenhaver-Landon, Billings	Governor	6/30/1999
Qualifications (if required): student representative		
Mr. Erik Hanson, Helena	Governor	6/30/1999
Qualifications (if required): representative of the executive branch		
Private Land-Public Wildlife Advisory Council (Fish, Wildlife and Parks)		
Mr. Verle Rademacher, White Sulphur Springs	Governor	6/30/1999
Qualifications (if required): media representative		
Mr. Lonnie McCurdie, Conrad	Governor	6/30/1999
Qualifications (if required): sportsman		
Rep. Emily Swanson, Bozeman	Governor	6/30/1999
Qualifications (if required): legislator		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Private Land-Public Wildlife Advisory Council (Fish, Wildlife and Parks) cont.		
Ms. Darlyne Dascher, Fort Peck Qualifications (if required): landowner	Governor	6/30/1999
Ms. Jean Kelly, Kalispell Qualifications (if required): sportsperson	Governor	6/30/1999
Mr. Tony Carroccia, Big Timber Qualifications (if required): landowner	Governor	6/30/1999
Mr. Steve Roth, Big Sandy Qualifications (if required): landowner	Governor	6/30/1999
Mr. Dave Cole, Helena Qualifications (if required): hunter	Governor	6/30/1999
Sen. John Hertel, Moore Qualifications (if required): legislator	Governor	6/30/1999
Mr. Tom Hougen, Melstone Qualifications (if required): landowner	Governor	6/30/1999
Mr. Cecil Noble, Kalispell Qualifications (if required): outfitter	Governor	6/30/1999
Mr. Lee Gustafson, Billings Qualifications (if required): hunter	Governor	6/30/1999
Mr. Ray Marxer, Dillon Qualifications (if required): ranch manager	Governor	6/30/1999
Mr. John Wilkinson, Miles City Qualifications (if required): outfitter	Governor	6/30/1999

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Reserved Water Rights Compact Commission (Natural Resources and Conservation)		
Mr. Gene Etchart, Glasgow	Governor	6/1/1999
Qualifications (if required): public member		
Mr. Jack Salmond, Choteau	Governor	6/1/1999
Qualifications (if required): public member		
Rep. Robert Thoft, Stevensville	Governor	6/1/1999
Qualifications (if required): public member		
Mr. Chris D. Tweeten, Helena	Attorney General	5/1/1999
Qualifications (if required): none specified		
Ms. Tara DePuy, Livingston	Governor	6/1/1999
Qualifications (if required): public member		
State Library Commission (State Library)		
Mr. Harold G. Stearns, Helena	Governor	5/22/1999
Qualifications (if required): public member		
Ms. Dorothy Laird, Whitefish	Governor	5/22/1999
Qualifications (if required): public member		
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		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
SummitNet Executive Council (Administration) cont.		
Mr. Scott Buswell, Helena	Governor	7/1/1999
Qualifications (if required): representative of the Office of Public Instruction		
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		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Tourism Advisory Council (Commerce) cont.		
Mr. Kelly Flynn, Townsend	Governor	7/1/1999
Qualifications (if required): public member representing Gold West Country and outfitters		
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		
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		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Yellowstone River Task Force (Fish, Wildlife and Parks) cont.		
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 Corp 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		
Youth Justice Advisory Council (Justice)		
Ms. Valarie Weber-Rasch, Billings	Governor	6/10/1999
Qualifications (if required): representative of a public agency concerned with detention services		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Youth Justice Advisory Council (Justice)		
Ms. Donna Maddux, Whitefish	Governor	6/10/1999
Qualifications (if required): representative of the education community		
Miss Rachaelle Williams, Billings	Governor	6/10/1999
Qualifications (if required): youth representative		
Mr. Craig Anderson, Glendive	Governor	6/10/1999
Qualifications (if required): representing probation services		
Ms. Gail Gray, Helena	Governor	6/10/1999
Qualifications (if required): representing educational services		
Mr. Rick Day, Helena	Governor	6/10/1999
Qualifications (if required): representing correctional services		
Rep. Ernest Bergsagel, Malta	Governor	6/10/1999
Qualifications (if required): representing the Montana legislature		
Ms. Sally K. Stansberry, Missoula	Governor	6/10/1999
Qualifications (if required): represents private non-profit organization concerned with delinquency		
Judge Gary Acevedo, Pablo	Governor	6/10/1999
Qualifications (if required): representing the judiciary and Native American concerns		
Mr. Allen Horsfall, Jr., Hamilton	Governor	6/10/1999
Qualifications (if required): representing a public agency concerned with detention services		
Ms. Jani McCall, Billings	Governor	6/10/1999
Qualifications (if required): representing non-profit organizations concerned with mental health		

VACANCIES ON BOARDS AND COUNCILS -- MAY 1, 1999 through JULY 31, 1999

Board/current position holder	Appointed by	Term end
Youth Justice Advisory Council (Justice) cont.		
Judge Marc George Buyske, Shelby	Governor	6/10/1999
Qualifications (if required): representing the judiciary		
Captain Kevin Clader, Missoula	Governor	6/10/1999
Qualifications (if required): representing law enforcement		
Mr. Steven Nelsen, Bozeman	Governor	6/10/1999
Qualifications (if required): represents private non-profit organizations concerned with delinquency		
Ms. Ellin Nesset, Bozeman	Governor	6/10/1999
Qualifications (if required): representing non-profit organizations concerned with youth development		
Ms. Peggy Beltrone, Great Falls	Governor	6/10/1999
Qualifications (if required): representative of local government		
Mr. Chuck Hunter, Helena	Governor	6/10/1999
Qualifications (if required): representing a public agency concerned with delinquency prevention		
Ms. Tara Young, Laurel	Governor	6/10/1999
Qualifications (if required): youth representative		
Mr. Joseph Fekete, Essex	Governor	6/10/1999
Qualifications (if required): youth representative		