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MONTANA ADMINISTRATIVE REGISTER

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

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

In the matter of proposed amendment of ARM 2.43.403, 2.43.409, 2.43.418, 2.43.425, 2.43.430, 2.43.432, 2.43.437, 2.43.451, and 2.43.452, pertaining to membership, service credit, and service purchases in retirement systems administered by the Board and repeal of 2.43.434, 2.43.435, 2.43.438, 2.43.711, 2.43.713, 2.43.714, 2.43.715, and 2.43.716 pertaining to service purchases and to social security coverage for the employees of the state and its political subdivisions.	NOTICE OF PROPOSED AMENDMENT AND REPEAL NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons.

1. On June 7, 1999, the Public Employees' Retirement Board proposes to amend ARM 2.43.403, 2.43.409, 2.43.418, 2.43.425, 2.43.430, 2.43.432, 2.43.437, 2.43.451, and 2.43.452, pertaining to membership, service credit, and service purchases for retirement systems administered by the Board and to repeal 2.43.434, 2.43.435, 2.43.438, 2.43.711, 2.43.713, 2.43.714, 2.43.715, and 2.43.716 pertaining to service purchases and to social security coverage for the employees of the state and its political subdivisions.

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

2.43.403 ~~EFFECT OF VOLUNTARY ELECTIONS~~ OPTIONAL MEMBERSHIP

(1) ~~All employees who may elect~~ Employees for which membership in a retirement system is optional ~~must do so~~ may become members by completing ~~a membership card,~~ an application provided by the board. ~~but once electing membership are subject to the same laws, rules and regulations as any member and may not discontinue~~ Once elected, members may not discontinue membership without termination of employment.

(2) ~~Exemption from (1) may be granted upon submission to the~~ The board may grant an exemption to (1) if the employee submits ~~of~~ proof that the employee was not given the opportunity to ~~freely~~ elect membership. The ~~filing of~~ employee must file this request for exemption ~~must be made~~ within ~~six months~~ 180 days of the ~~date that an individual enjoys the right to elect membership~~ employee's first day of employment.

(3) ~~In case of discontinuation of membership as certified above in (2),~~ If membership is discontinued, the board will refund ~~employee~~ contributions, plus interest ~~will be refunded~~ to the employee~~,~~. The board will not refund or issue a credit for employer contributions ~~will not be refunded~~.

AUTH: 19-2-403, 19-3-304 MCA
IMP: 19-2-403, 19-3-304, ~~19-3-403,~~ 19-3-412, ~~19-7-301~~, 19-13-301~~(3)~~ MCA

2.43.409 IMPROPER CREDIT (1) If the board finds that ~~any~~ membership service ~~has been~~ was ~~improperly~~ credited in error, it will ~~cause such credit to be canceled~~ cancel the service. ~~and the~~ The board will refund the ~~member's~~ accumulated contributions ~~attributable thereto refunded to~~ for the ~~member~~ service to the member.

(2) If the ~~cancellation involves the qualification and transfer of~~ service was transferred between ~~two or more Montana~~ retirement systems, the board will return the ~~state/~~employer contributions~~, with interest as determined by the board, will be returned~~ to the ~~retirement~~ original system ~~from which they were transferred~~.

AUTH: 19-2-403, 19-3-304, 19-5-201, 19-6-201, 19-7-201, 19-8-201, 19-9-201, 19-13-202 MCA
IMP: 19-2-903, 19-3-1403, 19-5-703, 19-6-704, 19-7-704, 19-8-804, 19-9-1003, 19-13-1002 MCA

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

(2) ~~(b) A legislator~~ Legislators may elect membership in PERS ~~at any time during the term of office~~ on or after the first day of their term of office. They must comply with 5-2-304 and 19-3-412, MCA. A legislative member ~~may purchase service by self-paying the~~ must pay monthly contributions for any or all months served by the member. A ~~legislator who is a~~ member ~~of the PSRS~~ must pay contributions through payroll deduction during a legislative session. Members may pay contributions directly to the board when the legislature is not in session. The ~~legislative~~ member will ~~be granted~~ earn proportional ~~membership service and~~ service credit for each month or partial month in which a member makes contributions ~~are paid~~. A legislator who contributes during a session will receive membership service for the biennium. ~~The amount the member must self-pay will be the~~ A member may purchase the entire term for service credit. The total contribution required for the ~~months being purchased~~ term will be based on the current statutory salary prescribed in 5-2-301, MCA, less any previous ~~payments of~~ contributions. ~~All self-payments must be remitted to the division~~ Legislative members must make all payments to the board no later than the last day of ~~the month preceding the end of the~~ their term.

(3) ~~(2)~~ A member appointed to fill an unexpired term ~~will be considered an elected official and~~ has the same rights and privileges as an elected official.

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

~~(5)~~(4) A member who elects to ~~qualify~~ purchase previous service as an elected official in the PERS ~~shall~~ must ~~qualify that service as prescribed in~~ comply with 19-3-505, MCA, except the cost will not include interest for any contributions due on service prior to July 1, 1993.
AUTH: 19-2-403, 19-3-304, 19-5-201, 19-7-201 MCA
IMP: 5-2-304, 19-2-701, 19-2-702, 19-3-315, 19-3-401, 19-3-412, ~~Title 19, Ch. 3, part 5, Ch. 5, part 3,~~ 19-5-301, ~~Ch. 7, part 3~~ 19-7-301 MCA

2.43.425 INCOMPLETE PAYMENTS ~~(1) No newly qualified or requalified service credits will accrue to a member's account until total payment has been made based upon the letter of intent on file with the board to purchase such service credits.~~

~~(2)~~(1) ~~If~~ The board will refund the additional contributions and interest to a non-vested member who ~~is not yet vested in his retirement benefits~~ terminates ~~covered~~ employment ~~for reasons other than death or disability, prior to~~ before completing ~~payments for purchasing~~ a service purchase, ~~described in (1), his additional contributions, plus accrued interest, shall be refunded to him and no~~ The member will not receive any additional service ~~credits~~ credit ~~or years of service will be added to the member's account~~.

~~(3)~~(2) If ~~any~~ a member ~~making payments to a retirement system in order to requalify previously refunded service or to qualify other types of service, as provided by statute, terminates covered employment due to death~~ dies or retires with a disability ~~prior to~~ before completing ~~payments~~ a service purchase, the member, or anyone acting on ~~his~~ the member's behalf, ~~must~~ may complete those payments ~~prior to payment of any benefits~~. The payments must be completed before the board will pay any benefits. The board will prorate the member's service based on payments already made, if no further payments will be made.

~~(4) If any member, or anyone acting on his behalf, fails to pay the balance of the agreed upon payments due, the additional contributions (plus interest) will be refunded to the member, his beneficiary, or his estate, the service being qualified will not accrue to his retirement account, and benefits will be paid based upon the previously credited service.~~
AUTH: 19-2-403, 19-3-304, 19-5-201, 19-6-201, 19-7-201, 19-8-201, 19-9-201, 19-13-202 MCA
IMP: 19-2-602, 19-2-704, Title 19, Ch. 3, part 5, 19-5-409, Chs. ~~5,~~ 6, 7, ~~8,~~ part 3, Ch. 8, part 9, Chs. 9 and 13, part 4 MCA

2.43.430 OUT-OF-STATE OR FEDERAL PUBLIC SERVICE (1) A ~~statutorily eligible~~ member of the PERS, game wardens' and peace officers' retirement system, or highway patrol officers' retirement system ~~member~~ may request to purchase out-of-state or federal public service by ~~must apply, in~~ writing, ~~to the retirement division,~~ a letter to the board. ~~supplying the~~ The letter must contain the following information certified by the

member's former employer:

(a) ~~certification by the member's former public retirement system of his~~ dates of employment, full- or part-time employment status, weekly or monthly hours of employment ~~(if part-time)~~, date and amount of refund, and current membership status~~,~~ ; or

(b) ~~certification by the member's former public employer that~~ if the member was employed ~~with the employer prior to~~ before the ~~employer's adoption of~~ employer adopted a public retirement system, the ~~dates of employment, full or part time employment status, weekly or monthly hours of employment (if part time),~~ information in (1)(a) and, if applicable, the name of the public retirement system and the date the employer adopted ~~a public retirement system, and name of the public retirement system adopted~~ it.

(2) The ~~division~~ board will calculate the actuarial cost of ~~qualifying such~~ granting the service based upon the member's preceding 12 month's salary. ~~during his sixth year of PERS service. If the member terminates covered employment prior to completing six years of PERS service, his sixth year salary will be projected based upon the member's actual salary paid for service beyond five years and the payroll rules then in effect.~~

~~(3) The actuarial cost rate will be the current total cost rate of the system plus simple interest from the date of initial eligibility for qualifying such service or the date on which he completed six years of PERS service, whichever is later.~~

~~(4) The member may purchase such service in one lump sum or equal monthly installments by payroll deduction, with monthly payments subject to additional interest. It will be the member's responsibility to initiate and terminate additional PERS contributions with his payroll officer. Any overpayments will be refunded to the member along with interest, upon the request of the member.~~

~~(5) No service will be credited to the member's account until full payment has been made.~~

AUTH: 19-2-403, 19-3-304 MCA
IMP: 19-3-512, 19-6-803, 19-8-903 MCA

2.43.432 "1-FOR-5" ADDITIONAL SERVICE (1) Subject to the ~~statutory limitations~~ requirements of each retirement system, a member ~~who has~~ with 5 or more years of membership service may purchase ~~1 full year of~~ additional service credit. Members may purchase 1 full year of additional service for each 5 full years of membership service credited in the retirement system. A member eligible to purchase ~~a full year of~~ additional service may ~~elect to~~ purchase full months of service totaling 11 months or less.

(2) The cost ~~of each year of additional service~~ will ~~be calculated by multiplying~~ equal the ~~appropriate~~ actuarial ~~cost~~ rate for the ~~member's~~ respective ~~retirement~~ system times the member's compensation ~~earned by the member during~~ for the immediately preceding 12 months ~~of membership service~~. ~~The cost of each~~ Each full month of additional service will ~~be~~ cost 1/12 the cost of ~~purchasing~~ a full year ~~of additional service~~.

~~(3) The cost of the purchase may be paid in one lump sum~~

~~payment or by a monthly installment plan. A member choosing the monthly installment plan will be charged the current interest rate set by the board and may purchase only 1 year of additional service. After completing an installment purchase, the member may purchase any remaining additional service for which the member is eligible.~~

~~(4)~~(3) ~~Service purchased under this rule must be included in the calculation which determines~~ The board will include a member's additional service when calculating the amount of a ~~member's~~ benefit, but ~~may~~ not ~~be counted toward~~ for initial retirement eligibility or ~~be included in~~ for ~~the calculation of an actuarial reduction for a member not eligible for service~~ early retirement, except ~~under the provisions of~~ in the following cases:

(a) PERS, which requires additional service to be included when calculating the early retirement reduction; and

(b) the sheriffs' retirement system, which requires additional service to be credited for the purpose of meeting retirement eligibility.

~~(5)~~(4) A retired member who returns to active PERS membership ~~is eligible to~~ may purchase additional service after ~~returning to active membership for~~ at least 12 months of active service. The amount of additional service which may be purchased will be based on the member's total membership service in ~~the system~~ PERS.

AUTH: 19-2-403, 19-3-304, 19-7-201 MCA
IMP: 19-3-513, 19-5-409, 19-6-804, 19-7-311, 19-7-804, 19-8-904, 19-9-411, 19-13-405 MCA

2.43.437 ~~PURCHASE OF PREVIOUS~~ MILITARY SERVICE ~~BY RETIREMENT SYSTEM MEMBERS~~ (1) ~~A member who is statutorily eligible to qualify previous active duty military service into the retirement system will become eligible to purchase each full year of service at the end of the member's year of membership service which makes him eligible to purchase that year of military service, as defined in statute. (For example, a member of the PERS who must first complete 10 years of service prior to becoming eligible to qualify any military service will become eligible to buy one year of that military service on the date he completes his 11th year of membership service in PERS.)~~ Members who meet the requirements of their retirement systems may purchase military service. The cost will equal the actuarial rate for the respective system times the member's compensation for the immediately preceding 12 months. Each full month of military service will cost 1/12 the cost of a full year.

~~(2) A member who has a period of less than one year of active duty military service to qualify (or remaining to be qualified on a multi-year military service) will become eligible to purchase any complete months of active duty military time after he has completed the appropriate years and months of membership service as described in statute. (For example, a member of the municipal police officers' retirement system who must first complete 15 years of service prior to becoming eligible to qualify his active duty military time, and who has~~

~~already become eligible and has purchased one full year of his total of one year and 3 months of active duty military service, becomes eligible to purchase the remaining 3 months of military service when he has completed 16 years and 3 months of service in the retirement system.)~~

~~(3) A member who has become eligible to purchase any year or partial year of previous active duty military service may make full payment for each year or partial year of military service on the date he completes his eligibility or he may elect to make monthly payments to the retirement system. Monthly payments will include interest at the rate currently set by the board and over the entire period of the monthly payments until the total amount is paid to qualify that period of military service.~~

~~(4) Any lump sum amounts required to qualify any eligible periods of military service will be increased by the appropriate interest rates in effect during the time between when a member could first have qualified the period of military service until such time as the service is actually qualified by the member into his retirement system. (For example, if a PERS member with 18 years of service elects to qualify 2 years of active duty military time into the PERS, the applicable interest will be added to the lump sum amount due on his first year of military service beginning on the date he completed his 11th year of PERS service and interest will be added to the lump sum amount due on his second year of military service beginning on the date he completed his 12th year of PERS service. Interest due on these sums will terminate on the date of the actual lump sum payment.)~~

~~(5) Members who make additional contributions to their retirement system in advance of their initial eligibility to qualify any periods of active duty military time shall have any interest earned on such deposits credited against any total amounts which would be due based on payment being made as of the dates of initial eligibility to purchase such service. (For example, if a member of the sheriffs' retirement system made $1,000 in additional contributions to the system in advance of his initial eligibility to purchase the first year of military service and had earned $50 in interest on those contributions as of the date of his initial eligibility to purchase the first year of military service, a total of $1,050 would be credited against the total amount due to actually qualify that first year of military service.)~~

~~(6) Any amounts contributed (or credited against amounts due) by the member to qualify eligible periods of active duty military time in excess of the total amounts due to qualify the service will be refunded to the member upon his request.~~

~~(7) Any eligible full or partial year periods of military service will be credited to the member's account only upon completion of payment(s) for that period of service.~~

(2) Highway patrol officers who did not elect GABA will pay a different cost for military service. The cost will equal the contributions for the year of service the member must complete to purchase the year of military. For example, a member purchasing the first year of military would pay an amount equal

to the contributions for the member's 16th year of service. To purchase the 2nd, 3rd, and 4th years, the member would pay an amount equal to the contributions for the 17th, 18th, and 19th years of service respectively. The member must also pay interest forward from the date the member is eligible to purchase the service to when payment is complete. The interest is the rate set by the board for member accounts.

(3) Members of PERS may purchase Korean or Vietnam military service at a different cost. The cost will equal the contributions for the year of service the member must complete to purchase the year of military. For example, a member purchasing the first year of military would pay an amount equal to the contributions for the member's 11th year of service. To purchase the 2nd, 3rd, and 4th years, the member would pay an amount equal to the contributions for the 12th, 13th, and 14th years of service respectively. The member must also pay interest forward from the date the member is eligible to purchase the service to when payment is complete. The eligibility date will be the later of July 1, 1999 or when the member completes the 10th year of service. The interest is the rate set by the board for member accounts.

AUTH: 19-2-403, 19-3-304, 19-6-201, 19-7-201, 19-8-201, 19-9-201, 19-13-202 MCA

IMP: 19-3-503, 19-6-304, 19-6-801, 19-7-310, 19-7-803, 19-8-304~~(3) and (4)~~, 19-8-901, 19-9-403, 19-13-403 MCA

2.43.451 PURCHASE OF ADDITIONAL SERVICE BY EMPLOYERS

(1) Additional service purchased ~~on behalf of~~ for members eligible for the retirement incentive program ~~or members eligible~~ under 19-2-706, MCA, is limited to three years or restrictions otherwise in place in 19-3-513, MCA~~, and ARM 2.43.432 for purchase of such service~~. The number of months of active duty military service or service from other public retirement systems purchased by a member after January 1, 1990 will reduce the amount of additional service for which the member is eligible to a combined total of no more than 60 months.

(2) ~~Potentially eligible members~~ Members must apply for additional service under the retirement incentive program on forms provided by the ~~retirement division~~ board prior to their voluntary termination from covered employment during the window period.

(3) ~~Potentially eligible members~~ Members ~~who have been~~ involuntarily terminated must apply for additional service under the retirement incentive program on forms provided by the ~~retirement division~~ board on or after May 14, 1993, but prior to January 1, 1994. ~~Potentially eligible members~~ Members ~~qualifying~~ applying under 19-2-706, MCA, must apply after January 1, 1995~~, but prior to July 1, 1997~~ on forms provided by the ~~retirement division~~ board.

(4) ~~Applications initially will be reviewed by the retirement division~~ The board will review the applications to determine the number of years of additional service an employer may purchase for ~~a~~ the member~~, is eligible to have purchased on~~

~~their behalf, the number of years of previously purchased additional service which may need to be refunded, or~~ The board will also determine the number of years of additional service which a member is eligible to purchase on their own behalf. The ~~retirement division~~ board may request any additional information it deems necessary from the employer or the member ~~in order~~ to complete this ~~initial~~ review.

(5) ~~Each application for additional service will then be forwarded by the retirement division~~ After review, the board will send the application to the ~~member's~~ employer ~~for certification of~~ to certify the following data: (a) termination date; ~~whether the member's~~ (b) reason for termination ~~was~~ (voluntary, ~~due to a~~ reduction in force, or ~~for another reason~~ other); (c) whether the member has taken advantage of other ~~termination~~ benefits provided ~~by state law~~ as an alternative ~~benefit~~ to this program; and (d) whether the ~~employee's~~ position ~~has been~~ was eliminated or reclassified.

(6) After receiving certification, ~~has been received from the member's employer that the potentially eligible member has terminated employment during the window period, the application for additional service~~ the board will ~~be~~ formally ~~reviewed~~ review and ~~approved~~ approve ~~by~~ the ~~board~~ request.

(7) The board will base the cost ~~of the additional service will be based~~ on the ~~eligible~~ member's final 12 months of ~~credited~~ service, ending with the last full month of service ~~as certified by the member's employer on a regular monthly payroll report~~. When calculating the cost for ~~purchasing service for~~ a member ~~who is currently~~ working ~~less than full time~~ part-time but whose final average salary will be based on full time service, the final 12-month salary will be proportionally adjusted ~~to reflect the purchase of full time additional service~~. The cost for purchasing the service will be billed to the member's former employer after ~~formal~~ approval of the application and the additional service will be utilized when computing the member's retirement benefit.

(8) A cost statement ~~of the cost of purchasing~~ to purchase the additional service will be ~~prepared and~~ sent to the ~~member's former~~ employer after the member ~~has been certified to have terminated~~ terminates. The employer may ~~elect to~~ pay the amount in full within one month of billing, or may select an installment ~~payment~~ plan. Under an installment plan, the maximum ~~for a~~ period ~~of up to~~ is 10 years, and employers may make annual or monthly payments. ~~which~~ Installment plans will include interest at an effective annual rate of 8%, compounded monthly. The ~~retirement division~~ board will provide early payoff or pay down figures, ~~including recalculation of remaining installment payments,~~ at the request of employers ~~utilizing a monthly or annual installment payment option~~. Prepayments will not relieve the employer of the obligation to make the next installment payment unless the amount owing is paid in full.

~~(9) A refund of the costs, including interest, of previously purchased additional service as provided in statute will be made to the eligible member after certification of the member's termination within the window period. A member is not~~

~~entitled to a refund for any portion of previously purchased military service or service from other public retirement systems, even though such purchases after January 1, 1990 may restrict eligibility for additional service under the provisions of 19-3-513(3), MCA.~~

AUTH: 19-2-403, 19-3-908 MCA
IMP: 19-2-706, 19-3-908 MCA

2.43.452 RETURN TO EMPLOYMENT WITHIN SAME JURISDICTION

(1) A member who ~~has received~~ receives additional service ~~purchased on the member's behalf by their former employer during the window incentive program or because of an involuntary termination as defined in~~ under 19-2-706 or 19-3-908, MCA, may be reemployed within the same jurisdiction. However, the member may only work for up to but not including 600 hours during any calendar year. A retired member must ~~have both terminated covered~~ terminate employment and ~~have received~~ receive at least one monthly retirement benefit ~~prior to return~~ before returning to active service. An inactive member ~~who chooses to delay retirement~~ may return to active service within the same jurisdiction after a 5 day break in service ~~of at least 5 days~~.

(2) A member who ~~has taken advantage of the retirement~~ receives the incentive, and ~~who~~ returns to ~~any type of~~ employment within the same jurisdiction, must notify the ~~retirement division~~ board within one week of employment. Service performed ~~by a member for the same jurisdiction pursuant to a~~ under an independent contract that fails the tests set out in ARM 2.43.302 is ~~considered~~ employment ~~and is~~ subject to the 600-hour limitation and reporting requirements.

(3) ~~The employer~~ Employers must report to the board the following information:

(a) ~~of~~ a member who ~~has taken~~ took advantage of ~~the retirement incentive or has received retirement benefits due to involuntary termination under~~ the provisions of 19-2-706, or 19-3-908, MCA, and who returned to work within the same jurisdiction;

(b) ~~must report all~~ current hours worked and amounts paid to the member ~~after return to employment within the same jurisdiction;~~ and

(c) ~~It is the employer's responsibility to accurately report~~ each member's active ~~duty~~ service or employment after retirement ~~to the retirement division. If a former employee is employed by an~~ with an independent contractor ~~(or as becomes~~ an independent contractor~~) engaged in business with the jurisdiction of the member's former employer, the employer will report this information to the retirement division as specified in ARM 2.43.453~~.

~~(4) As described in 19-3-908, MCA, all agencies of the state and all units of the university system are considered one and the same jurisdiction for purposes of the restrictions on return to covered employment for members taking advantage of the retirement incentive program. Each individual local government unit with a separate contract for coverage is considered a separate jurisdiction. (For example, a member terminating~~

~~employment with the department of agriculture may not return to employment for more than 600 hours during any calendar year with any state agency or unit of the university system, but may return to work with the city of Helena, without forfeiting the additional service credit purchased on their behalf by their former employer.)~~

~~(5)~~(4) When a member works for 600 or more hours for the same jurisdiction, the member forfeits the additional service, ~~under this rule, the retirement division~~ The board will ~~refund~~ give employers a credit for the amount ~~the employer~~ they paid for the service, minus the total retirement benefits paid to the member ~~to that point in time~~. If the employer ~~has not yet completed payments for the additional service~~ is paying on an installment contract, the ~~maximum~~ amount due will be the total benefits paid ~~until the point of~~ from retirement to forfeiture, ~~plus~~ The board will charge interest at an effective annual rate of 8%, compounded monthly, ~~from the member's original retirement date~~ for any outstanding balance.

AUTH: 19-2-403, 19-3-908 MCA
IMP: 19-2-706, 19-3-908 MCA

3. The amendments to ARM 2.43.403, 2.43.409, 2.43.418, 2.43.425, 2.43.430, 2.43.432, 2.43.437, 2.43.451, 2.43.452 are needed to make the rules comply with IRS regulations so the retirement systems will maintain their status as qualified retirement systems, to eliminate language that duplicates language contained in statute, and to make editorial changes so the rules are easier to understand. In 2.43.403, the incorrect cites were eliminated, and, 19-3-412, MCA, the correct cite was added. In 2.43.409, 2.43.418, 2.43.425, 2.43.430, 2.43.432, and 2.43.437, the added cites are new or renumbered statutes, or a specific statute was cited and the cite to the part or chapter was eliminated. The Board's general rule-making statute, 19-2-403 was added to those rules which did not cite it under authority.

4. The Board proposes to repeal the following rules:

2.43.434 on page 2-3144, Administrative Rules of Montana;
AUTH: 19-2-403, 19-3-304, 19-6-201, 19-7-201, 19-8-201, 19-9-201, 19-13-202 MCA
IMP: Title 19, Ch. 3, 6, 7, 8, 9, 13 MCA

2.43.435 on page 2-3145, Administrative Rules of Montana;
AUTH: 19-2-403, 19-3-304, 19-6-201, 19-7-201 MCA
IMP: Title 19, Ch. 3, 6, 7 MCA

2.43.438 on page 2-3147, Administrative Rules of Montana;
AUTH: 19-2-403, 19-6-201 MCA
IMP: 19-6-306 MCA

2.43.711 on page 2-3181, Administrative Rules of Montana;
AUTH: 19-1-201, 19-2-403 MCA
IMP: Title 19, Ch. 1 MCA

2.43.713 on page 2-3183, Administrative Rules of Montana;
AUTH: 19-1-201, 19-2-403 MCA
IMP: Title 19, Ch. 1, parts 3 and 5 MCA

2.43.714 on page 2-3183, Administrative Rules of Montana;
AUTH: 19-1-201, 19-2-403 MCA
IMP: Title 19, Ch. 1, parts 3 and 5 MCA

2.43.715 on page 2-3184, Administrative Rules of Montana;
AUTH: 19-1-201, 19-2-403 MCA
IMP: Title 19, Ch. 1, parts 7 and 8 MCA, and

2.43.716 on page 2-3184, Administrative Rules of Montana;
AUTH: 19-1-201, 19-2-403 MCA
IMP: Title 19, Ch. 1, MCA

5. The Board is repealing the following rules: ARM 2.43.434, and 2.43.435 pertaining to educational leave and purchase of retroactive service for fee basis officials because the statutes these rules implement were repealed or amended and the rules are not needed; ARM 2.43.438 pertaining to purchase of out-of-state service because it duplicates 2.43.430; ARM 2.43.711, 2.43.712, 2.43.713, 2.43.714, 2.43.715, and 2.43.716 pertaining to social security coverage because a long standing dispute with the Social Security Administration was resolved. Also, Chapter 58 Laws of 1999 transfers the Social Security program to the Department of Administration, so the rules are no longer needed.

6. Interested persons may present their data, views, or arguments concerning the proposed amendments in writing no later than June 7, 1999 to:

Mike O'Connor, Executive Director
Public Employees' Retirement Board Staff
P.O. Box 200131
Helena, Montana 59620-0131

A Fax may be sent to (406) 444-5428.

An electronic message may be sent to the following Internet address: Kmccallum@State.mt.us

7. If a person who is directly affected by the proposed amendment wishes to express data, views and arguments orally or in writing at a public hearing, the person must make a written request for a hearing and submit this request along with any written comments to the above address. A written request for hearing must be received no later than June 7, 1999.

8. If the agency receives requests for a public hearing on the proposed actions from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative rule review committee of the

legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 3,098 persons based on February 1999 payroll reports of active members.

9. The Board maintains a list of interested persons and sends copies of rule notices to everyone on the list. Anyone may request their name be added to this list by calling the Board at (406) 444-3154.

Terry Teichrow, President
Public Employees' Retirement Board

Dal Smilie, Chief Legal Counsel and
Rule Reviewer

Kelly Jenkins, General Counsel and
Rule Reviewer

Certified to the Secretary of State on April 23, 1999.

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

In the matter of the amendment of rules 46.12.572 and 46.12.573 pertaining to ambulatory surgical centers	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 26, 1999, at 11:00 a.m., a public hearing will be held in 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 17, 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.

46.12.572 CLINIC SERVICES, COVERED PROCEDURES ~~(1) Clinic services, covered by the medicaid program, include the following ambulatory surgical center procedures which are covered by medicare and medicaid:~~

~~(a) Integumentary System:~~

~~(i) Gynecomastia excision, uni- and bilateral IV;~~

~~(ii) Breast biopsy (incision, excision, uni- or bilateral) III;~~

~~(iii) Mandible cyst excision, simple III;~~

~~(iv) Pilonidal cyst excision, simple, extensive III;~~

~~(v) Skin graft III;~~

~~(vi) Benign lesion, excision (Limpoma) I;~~

~~(vii) Fingernail, toenail removal I; and~~

~~(viii) Malignant lesion, excision (basal cell, Melanoma) I.~~

~~(b) Musculoskeletal System:~~

~~(i) Hammertoe repair IV;~~

~~(ii) Boutonniere repair IV;~~

~~(iii) Bunionectomy IV;~~

~~(iv) Ligament repair IV;~~

~~(v) Neurectomy - IV;~~
~~(vi) Osteotomy - IV;~~
~~(vii) Synovectomy - IV;~~
~~(viii) Arthroscopy - IV;~~
~~(ix) Fasciectomy/Fasciotomy - IV;~~
~~(x) Arthrodesis - IV;~~
~~(xi) Arthoplasty - IV;~~
~~(xii) Tendon repair with graft, implant or transfer - IV;~~
~~(xiii) Bursectomy - III;~~
~~(xiv) Capsulectomy/capsulotomy (metacarpophalangeal and interphalangeal) - III;~~
~~(xv) Ganglioncetomy (wrist) - III;~~
~~(xvi) Neuroma excision (Morton's and cutaneous and digital nerves) - III;~~
~~(xvii) Osteotomy metatarsal (metatarsal head excision) - III;~~
~~(xviii) Tendon repair without graft, implant or transfer - III;~~
~~(xix) Phalangectomy (amputation, fingers and toes) - II;~~
~~(xx) Sequestrectomy - II;~~
~~(xxi) Tendon Sheath Release (De Quervains) - II;~~
~~(xxii) Zygoma (Zygomatic arch), Reduction - II;~~
~~(xxiii) Closed Reduction of Nasal Fracture - I;~~
~~(xxiv) Tenotomy, hands, fingers, ankle, feet and toes - I;~~
~~(xxv) Trigger Finger Release (tendon sheath incision for) - I.~~
~~(c) Respiratory System:~~
~~(i) Septal Reconstruction - IV;~~
~~(ii) Submucous Resection (turbinate and nasal septum) - IV;~~
~~(iii) Ethmoidectomy - III;~~
~~(iv) Nasal Polypectomy - II;~~
~~(v) Antral Window (puncture) (Sinusotomy) - II;~~
~~(vi) Bronchoscopy - I;~~
~~(vii) Excision turbinate - I;~~
~~(viii) Laryngoscopy - I.~~
~~(d) Cardiovascular System:~~
~~(i) Varicose Vein Ligation - IV;~~
~~(ii) Temporal artery, ligation or biopsy - I.~~
~~(e) Hemic and Lymphatic System:~~
~~(i) Cervical Node (lymph node) biopsy - II.~~
~~(f) Digestive System:~~
~~(i) Pertioneoscopy (mini laparatomy) - IV;~~
~~(ii) Herniorrhaphy - IV;~~
~~(iii) Colostomy Revision (simple) - III;~~
~~(iv) Wedge Resection of Lip - III;~~
~~(v) Hemorrhoidectomy - III;~~
~~(vi) Bronchial Arch Appendage Excision - II;~~
~~(vii) Liver Biopsy, percutaneous - II;~~
~~(viii) Vermillionectomy (Lip peel) - II;~~
~~(ix) Fistulectomy - II;~~
~~(x) Esophagoscopy - I;~~

~~(xi) Gastroscopy I,~~
~~(xii) Rectal Dilation I,~~
~~(xiii) Tongue Biopsy I.~~
~~(g) Urinary System:~~
~~(i) Transurethral Resection of Bladder Tumor (Cystourethroscopy w/operative procedure) III,~~
~~(ii) Cystourethroscopy I,~~
~~(iii) Urethral Dilation I.~~
~~(h) Male Genital System:~~
~~(i) Varicocele repair IV,~~
~~(ii) Hydrocele excision III,~~
~~(iii) Spermatocele excision III,~~
~~(iv) Orchiectomy II,~~
~~(v) Prostate Biopsy I.~~
~~(i) Female Genital System:~~
~~(i) Laparoscopy IV,~~
~~(ii) Colpotomy, with exploration III,~~
~~(iii) Dilation and curettage, diagnostic and/or therapeutic (nonobstetric) III,~~
~~(iv) Hysterosalpingogram II,~~
~~(v) Perineoplasty II,~~
~~(vi) Vaginal tumor (cyst) excision II,~~
~~(vii) Vulva (labia) biopsy I,~~
~~(viii) Examination under Anesthesia (pelvic) I,~~
~~(ix) Vaginal Stenosis Release (dilation of vagina under anesthesia) I,~~
~~(x) Culdoscopy (Culdocentesis) I.~~
~~(j) Endocrine System:~~
~~(i) Thyroglossal Duct Cyst Removal III.~~
~~(k) Nervous System:~~
~~(i) Ulnar Nerve Repair IV,~~
~~(ii) Ulnar Nerve Transfer IV,~~
~~(iii) Neurolysis (including carpal tunnel decompression) III,~~
~~(l) Eye and Ocular Adnexa System:~~
~~(i) Cataract extraction IV,~~
~~(ii) Enucleation, with and without implant IV,~~
~~(iii) Iridectomy IV,~~
~~(iv) Eye Muscle Operation (extraocular muscles, strabismus procedure) IV,~~
~~(v) Ectropion/Entropion repair III,~~
~~(vi) Canthoplasty/Tarsorrhaphy II,~~
~~(vii) Chalazion excision I,~~
~~(viii) Discission lens (needling of lens) I,~~
~~(ix) Foreign Body Removal I,~~
~~(x) Pterygium (excision or transposition) I,~~
~~(xi) Lacrimal duct probing or reconstruction I.~~
~~(m) Auditory System:~~
~~(i) Mastoidectomy, simple (transmastoid antrotomy) IV,~~
~~(ii) Myringoplasty IV,~~
~~(iii) Stapedectomy IV,~~

~~(iv) Tympanoplasty (without mastoidectomy) IV;~~
~~(v) Myringotomy (including aspiration and/or eustachian tube inflation) I.~~
~~(2) Clinic services, covered by the medicaid program, include the following ambulatory surgical center procedures which are covered by medicaid but not by medicare:~~
~~(a) Integumentary System:~~
~~(i) Hyperhidrosis, bilateral, axillas, excision III;~~
~~(ii) Lacerations, repair of, over one hour IV;~~
~~(iii) Mammoplasty, reconstruction, unilateral IV;~~
~~(iv) Mammoplasty, reconstruction, bilateral IV;~~
~~(v) Rhytidectomy, regular IV;~~
~~(vi) Rhytidectomy, partial IV;~~
~~(vii) Rhytidectomy, with coronal lift IV;~~
~~(viii) Rhytidectomy, with brow lift IV;~~
~~(ix) Rhytidectomy, with chin revision IV;~~
~~(x) Rhytidectomy, eye revision IV;~~
~~(xi) Rhytidectomy, with blepharonplasty IV;~~
~~(xii) Abdominoplasty/lipectomy, revision or mini, 2 hours or less IV;~~
~~(xiii) Abdominoplasty/lipectomy IV;~~
~~(xiv) Chemical peel I;~~
~~(xv) Dermabrasion, perioral I;~~
~~(xvi) Dermabrasion, full face IV;~~
~~(xvii) Artistospan injection I;~~
~~(xviii) Z plasty (orthopedic) I.~~
~~(b) Musculoskeletal System:~~
~~(i) Baker's cyst excision III;~~
~~(ii) Biopsy, muscle I;~~
~~(iii) Torticollis repair IV;~~
~~(iv) Bone reconstruction III;~~
~~(v) Closed reduction fracture, with x ray III;~~
~~(vi) Closed reduction fracture, without x ray I;~~
~~(vii) Debridement (orthopedic) II;~~
~~(viii) Exostosis, excision I~~
~~(ix) Foreign body excision, without x ray (orthopedic) I~~
~~(x) Foreign body excision, with x ray (orthopedic) III;~~
~~(xi) Fusion II;~~
~~(xii) Hardware, removal I;~~
~~(xiii) Manipulation of joints with x ray II;~~
~~(xiv) Manipulation of joints, without x ray I;~~
~~(xv) Mass excision with scar revision (of bone) III;~~
~~(xvi) Metatarsal head, excision, unilateral II;~~
~~(xvii) Metatarsal head, excision, bilateral III;~~
~~(xviii) Open reduction fracture, without x ray II;~~
~~(xix) Tenosynovectomy III;~~
~~(xx) Brachioplasty IV~~
~~(xxi) Implant removal, unilateral II;~~
~~(xxii) Implant removal, bilateral III;~~
~~(xxiii) Inferior capsulotomy, unilateral III;~~

~~(xxiv) Inferior capsulotomy, bilateral III.~~
~~(c) Respiratory System:~~
~~(i) Caldwell LUC III;~~
~~(ii) Bronchoscopy, with operative procedure III;~~
~~(iii) Rhinoplasty IV;~~
~~(iv) Rhinoplasty, with chin implant IV.~~
~~(d) Digestive System:~~
~~(i) Adnoidectomy I;~~
~~(ii) Arch bar removal I;~~
~~(iii) Tonsillar tag excision II;~~
~~(iv) Tonsillectomy, with or without adnoidectomy II;~~
~~(v) Epigastric herniorrhaphy III;~~
~~(vi) Esophagoscopy with operative procedure II;~~
~~(vii) Inguinal herniorrhaphy, infant, unilateral III;~~
~~(viii) Inguinal herniorrhaphy, infant, bilateral IV;~~
~~(ix) Inguinal herniorrhaphy, adult, unilateral IV;~~
~~(x) Inguinal herniorrhaphy, adult, bilateral IV;~~
~~(xi) Rectal polypectomy I;~~
~~(xii) Umbilical herniorrhaphy III;~~
~~(xiii) Umbilical herniorrhaphy, with bilateral inguinal herniorrhaphy IV;~~
~~(xiv) Umbilical sinus, excision II.~~
~~(e) Male Genital System:~~
~~(i) Orchiopexy IV;~~
~~(ii) Orchiopexy & hernia IV;~~
~~(iii) Circumcision, pediatric I;~~
~~(iv) Circumcision, adult III;~~
~~(v) Testicular biopsy I.~~
~~(f) Female Genital System:~~
~~(i) Cervical amputation (Sturmorf) IV;~~
~~(ii) Cervical cone II;~~
~~(iii) Cryotherapy, with biopsy and/or D & C II;~~
~~(iv) Episiotomy II;~~
~~(v) MacDonald's procedure II;~~
~~(vi) Pelvic endoscopy (Shirodkar) III;~~
~~(vii) Hysteroscopy III;~~
~~(viii) Perineorrhapy III;~~
~~(ix) Transvaginal ligation of tubes III;~~
~~(x) Tubal insufflation I;~~
~~(xi) Vaginal web, excision I;~~
~~(xii) Vaginoplasty IV.~~
~~(g) Nervous System:~~
~~(i) Caudal anesthesia, diagnostic procedure I;~~
~~(ii) Coeliac (splanchnic), diagnostic procedure I;~~
~~(iii) Lumbar sympathetic anesthesia, diagnostic procedure I;~~
~~(iv) Neurolysis;~~
~~(A) Carpal tunnel decompression III;~~
~~(B) Finger II;~~
~~(C) Other III.~~
~~(v) Carpal tunnel ligament release III;~~
~~(vi) Nerve repair, finger II;~~

~~(vii) Nerve repair, other III.~~
~~(h) Eye and Ocular Adenexa:~~
~~(i) Conjunctiva, repair of I;~~
~~(ii) Eye, unilateral IV;~~
~~(iii) Eye, bilateral IV;~~
~~(iv) Wedge resection, eyelid III;~~
~~(v) Blepharoplasty, combined IV;~~
~~(vi) Blepharoplasty, combined with brow repair IV;~~
~~(vii) Blepharoplasty IV;~~
~~(viii) Capsulotomy, closed, unilateral or bilateral III;~~
~~(ix) Capsulotomy, open, with exchange of implants, unilateral III;~~
~~(x) Capsulotomy, open, with exchange of implants, bilateral IV.~~
~~(i) Auditory System:~~
~~(i) Polytubes, removal I;~~
~~(ii) Otoplasty, unilateral I;~~
~~(iii) Otoplasty, bilateral I.~~
~~(j) Dentistry - Oral Surgery:~~
~~(i) Impacted wisdom teeth, removal of two or less I;~~
~~(ii) Impacted wisdom teeth, removal of more than two II;~~
~~(iii) Multiple teeth extractions, adult I;~~
~~(iv) Multiple teeth extractions, children I.~~

(1) Ambulatory surgical center (ASC) services:

(a) are services that will be covered by medicaid if provided in an outpatient ASC setting incident to provision of physician or dental services to the patient where the services and supplies are furnished in the ASC on a physician's or dentist's order by ASC personnel under the supervision of ASC medical staff;

(b) are limited as provided by ARM 46.12.571(1) through 46.12.571(5) with the term clinic taken to mean ASC;

(c) are limited to those procedures attributable to an ASC day procedure group as allowed at ARM 46.12.573(1) and are listed in the department's fee schedule for ASCs.

~~(3)~~ (2) Clinic services, covered by the medicaid program, include the following services provided by a diagnostic clinic:

(a) speech therapy;
(b) audiology;
(c) hearing aids;
(d) physical therapy;
(e) occupational therapy; and
(f) medical and dental evaluation, diagnosis and treatment services.

~~(5)~~ (3) Clinic services, covered by the medicaid program, include physician services covered in ARM 46.12.2001 through 46.12.2003.

~~(6)~~ (4) Clinic services, covered by the medicaid program, include mid-level practitioner services covered in ARM 46.12.2010 through 46.12.2013.

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

46.12.573 CLINIC SERVICES, REIMBURSEMENT ~~(1) Rates for ambulatory surgical center services shall be the lower of the provider's actual (submitted) charge for the service or the fee specified in the following fee schedule:~~

~~(a) group I procedures $237.00;~~

~~(b) group II procedures $281.00;~~

~~(c) group III procedures $303.00; and~~

~~(d) group IV procedures $345.00.~~

(1) Ambulatory surgical center services as defined in ARM 46.12.570(2) provided by an ASC will be reimbursed on a fee basis. A separate fee will be paid within each day procedure group (DPG) as specified in the DPG ambulatory surgery classification system developed by the Canadian institute for health information (CIHI). Payment for ambulatory surgical center services is a fee for each visit determined as follows:

(a) The department assigns a DPG to each medicaid procedure or service. The DPG system is an ambulatory surgery classification system that assigns patients to one of 66 groups according to the CPT-4 procedure codes.

(b) The department determines a fee for each DPG which reflects the estimated cost of ASC resources used to treat cases in that group relative to the statewide average cost of all medicaid cases. Fees for DPGs for ASC are specified in the department's ASC fee schedule. The department hereby adopts and incorporates by reference the ASC fee schedule (July, 1999). A copy of the 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.

(c) Except as provided in (1)(d), the payment specified in (1)(b) is an all inclusive bundled payment per procedure or service which shall be deemed to cover all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment and other ASC services. For purposes of ASC surgery services, a visit shall be deemed to include all ASC services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event.

(d) Physician services are separately billable according to the applicable medicaid rules governing billing for physician services.

(e) For ASCs, any DPGs determined by the department to be unstable shall be reimbursed as a stop-loss payment. If the provider's net usual and customary charges are more than 400% or less than 75% of the fee specified in (1)(b), the DPG shall be deemed unstable and the net charges shall be paid at the statewide cost to charge ratio specified in (1)(h). For purposes of the stop-loss provision, the provider's net

ambulatory surgery charges are defined as the total usual and customary claim charges less charges for any noncovered services.

(f) If the department's ambulatory surgical center fee schedule described in (1)(b) does not assign a fee for a particular DPG, the DPG shall be reimbursed at the statewide average ambulatory surgical center cost to charge ratio specified in (1)(h).

(g) Ambulatory surgery services for which the CPT-4 procedure code is not included in the day procedure grouper described in (1)(a) shall be reimbursed at the statewide average ambulatory surgical center cost to charge ratio specified in (1)(h).

(h) The medicaid ambulatory surgical center statewide average cost to charge ratio equals .67.

(i) When multiple procedures are performed at the same time on the same patient, the first procedure listed shall be paid as provided at (1)(b), (1)(e), (1)(f) or (1)(g) as appropriate. Subsequent procedure codes shall be paid at 50% of the rate listed at (1)(b), (1)(e), (1)(f) or (1)(g) as appropriate.

(2) and (3) remain the same.

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

3. An increasing number of Ambulatory Surgical Centers (ASC) are operating both nationwide and in Montana. ASCs perform outpatient surgical procedures at a much lower cost than hospitals can. However, ASCs do not have to accept Medicaid patients. This rule change is necessary to entice ASCs to accept Medicaid recipients for surgeries (at a rate much less expensive than hospitals) and thereby conserve Medicaid funds. The Department also expects active participation of ASCs to allow Medicaid recipients greater access to medical care.

ASC rates have not increased in the last 10 years. In 1998 the Department contracted with Abt Associates to study ASCs. The study indicated that with a rate increase of 60% to ASCs, Medicaid will pay 60% of billed charges and 80% of the Medicare rate. These are the same percentages currently paid to outpatient hospitals. However, because of lower overhead costs at ASCs, Medicaid will pay ASCs 50% of what they pay outpatient hospitals per procedure.

Currently the Medicaid fee schedule has four payment levels for ASCs. The Department proposes that the ASC fee schedule be expanded to the same 66 levels as outpatient hospitals. This would allow the Department to match ASC Medicaid payment amounts to the multitude of surgical procedures which ASCs perform.

The Department considered four options before proposing adoption

of the DPG system for ASCs. First, the Department could have kept the existing reimbursement system in place, without adjusting the fees to reflect increased ASC costs. This option was rejected because the fee schedule was inadequate to cover ASC costs and because the four category grouper was outdated and inadequate for the variety of procedures performed by ASCs.

Second, the Department could have adopted the current Medicare reimbursement system for ASC services. The Department rejected this option because the Medicare system is undergoing revision to address certain operating flaws.

Third, the Department could have adopted the proposed Medicare reimbursement system. The Department rejected this option because the proposed system is still being developed, and was not expected to be implemented for an indefinite period of time. The Department found the anticipated delay associated with this option to be unacceptable.

Fourth, the Department considered and proposes adoption of the DPG system as the best option. DPG uses a modern grouper which accurately reflects the services currently provided by ASCs. The Montana Medicaid program has already successfully used the DPG grouper in its outpatient hospital rule. Implementation of this option would be relatively easy and would simplify the Department's multiple reimbursement methodologies.

ARM 46.12.572

The Department proposes elimination of the list of Ambulatory Surgical Center procedures from subsections (1) and (2). In its place, the Department proposes that the DPG ambulatory surgery classification system developed by the Canadian Institute for Health information (CIHI) and the 66 groups of the CPT-4 procedure code on form HCFA-1500 be incorporated by reference. Copies of the DPG ambulatory surgery classification system and form HCFA-1500 are available from the Department's Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. Under the proposed rule, Medicaid reimbursement of ASC procedures would be limited as provided in ARM 46.12.571(1) through 46.12.571(5).

The elimination of the list of ASC procedures would allow coverage to be defined in one subsection, requiring subsections (3) through (6) to be renumbered. Due to a clerical mistake, existing ARM 46.12.572 does not contain a subsection (4). The following subsections are renumbered accordingly.

ARM 46.12.573

The Department proposes expansion of the four reimbursement rate categories in subsection (1) to 66 categories by incorporating

by reference the groups of the CPT-4 procedure code on form HCFA-1500. The Department has prepared a proposed fee schedule assigning a fee for each of the 66 categories. A copy of the proposed fee schedule may be obtained from the Department's Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The fees listed in the proposed schedule are approximately 60% greater than under the existing rule.

Proposed subsection (1) also provides procedures for setting fees for ASC procedures which are unstable and for ASC procedures which are not included in the CPT-4 day procedure grouper or for which no fee has been set in the Department's fee schedule. Unstable fee categories would be reimbursed at the statewide average cost to charge ratio of .67 for the provider's total usual and customary rate less charges for non-covered services. ASC procedures which have not been included in the CPT-4 grouper or for which no fee has been set in the Department's fee schedule would also be reimbursed at the statewide average cost to charge ratio of .67.

When multiple ASC procedures are provided at the same time on the same patient, the proposed fee for the second and subsequent procedure would be 50% of the rate for the first procedure.

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.

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 June 3, 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 23, 1999.

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

In the matter of the amendment of ARM 46.12.601, 46.12.602, 46.12.605 and 46.12.606 pertaining to medicaid dental services	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 26, 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 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 17, 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.

46.12.601 DENTAL SERVICES, DEFINITIONS (1) Dental service is ~~the~~ medically necessary treatment of the teeth and associated structures of the oral cavity. ~~and treatment of disease, injury or impairment which may affect the oral and general health of the individual. The services must be provided by a licensed dentist, a licensed dental hygienist under the direct supervision of a licensed dentist, or a denturist, when the full or partial denture services are prescribed by a dentist. The services must be within the scope of their professions, as defined by law.~~ Dental service includes the provision of orthodontia and prostheses.

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

46.12.602 DENTAL SERVICES, REQUIREMENTS (1) These requirements are in addition to those ~~contained in ARM 46.12.301 through 46.12.308~~ rule provisions generally applicable to medicaid providers and the provision of services under medicaid coverage.

(2) Medicaid reimbursement for dental care is limited to those services ~~as provided~~ specified in ARM 46.12.606.

~~(3) Emergency dental care may only be provided where there is trauma, infection, or severe pain. Prior authorization is not necessary for emergency dental care. For reimbursement to be made, emergency dental care that has been received must be:~~

~~(a) reviewed and approved by the designated review organization; and~~

~~(b) a covered service as provided in ARM 46.12.606.~~

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

46.12.605 DENTAL SERVICES, REIMBURSEMENT (1) The department ~~will~~ pays the lowest of the following for dental~~, denturist and orthodontic~~ services covered by the medicaid program:

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

(b) the amount allowable for the same service under medicare as stated by a medicare explanation of benefits; or

(c) the amount specified in the department's fee schedules~~, contained in sections G and H of the department's dental services provider manual (October 1995) and in section F of the department's denturist services provider manual (July 1993) published by the department.~~

(2) For the purpose of specifying fees for reimbursement of covered dental ~~and orthodontic~~ services, the department incorporates by reference ~~sections G and H of the department's dental service provider manual (October 1995) published by the department:~~ the fee schedule, effective July 1999. Copies of the fee schedule are 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 59620-2951.

~~(a) dental and orthodontic services that are designated in the manual as being reimbursed through the report method, "BE", or are listed in the manual under the fee column are reimbursed by the medicaid program at 65.2% of the billed charge for services provided to adults and 80% of the billed charge for services provided to children. For purposes of this rule, services provided to children are services provided while the recipient is under age 18. Coverage requirements for children will remain the same, only the reimbursement is changed.~~

~~(3) Subject to ARM 46.12.516, children's dental and orthodontic services not listed in sections G and H of the dental services provider manual, that are determined to be medically necessary by the department's designated review organization after an UPSTATE screen will be and that are delivered in accordance with ARM 46.12.514, et seq are reimbursed through the "by report" method at 80% of the billed charges.~~

~~(4) For the purpose of specifying fees for reimbursement of covered denturist services, the department incorporates by reference section F of the department's denturist service provider manual (July 1993).~~

(3) Reimbursement for services delivered to adults is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 65.2% of the provider's usual and customary charge for the service. Services delivered to adults are services provided while the recipient is age 21 and over.

(4) Reimbursement for services delivered to a child is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 80% of the provider's usual and customary charge for the service. Services delivered to children are services provided while the recipient is up to and including age 17.

(5) Reimbursement for services delivered to individuals age 18 through 20 is the fee specified in the fee schedule for adults, or if reimbursement is based on the "by report" method 80% of the provider's usual and customary charge for the service.

~~(5)~~ (6) No extra fee for pulp capping or bases is reimbursable.

~~(6)~~ (7) Payment for denture adjustments during the first year after delivery of the dentures ~~will be made~~ is available only to a dentist or denturist who did not make the dentures.

~~(7)~~ (8) Medical procedures, ~~which are~~ within the scope of practice for licensed dentists, ~~but which~~ that are not listed in ~~sections G and H of~~ the dental services provider manual ~~will be~~ are reimbursed in accordance with the methodologies provided in ARM 46.12.502A and 46.12.2003.

~~(8)~~ (9) A dentist examining more than one medicaid recipient in a long-term care facility on the same day ~~shall be~~ is allowed payment for one nursing home call in addition to the examination fees. Examination is considered a recorded evaluation.

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

46.12.606 DENTAL SERVICES, COVERED PROCEDURES (1) For purposes of specifying coverage of dental ~~and orthodontic~~ services ~~covered by~~ through the medicaid program ~~and the limitations on the coverage of those services~~, the department incorporates by reference ~~sections G and H of~~ the dental services provider manual (1999 edition) ~~(October 1995) published by the department~~ effective July 1999 and the denturist services provider manual (1999 edition) effective July 1999. The dental and denturist services provider manuals, provided to providers of those services, inform the providers of the requirements applicable to the delivery of services. Copies of the manuals are 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 59620-2951.

~~(2) For purposes of specifying denturist services, covered by the medicaid program and the limitations on the coverage of those services, the department incorporates by reference section F of the denturist services provider manual (July 1993) published by the department.~~

~~(a) all services provided by a denturist must be prescribed by a licensed dentist.~~

~~(3)~~ (2) ~~Licensed dentists~~ Dentists may bill medical "CPT" procedure codes as provided in ARM 46.12.502A and 46.12.2001 for any medicaid-covered medical procedure which they are allowed to provide under the Dental Practice Act that is not otherwise listed in the dental services provider manual. ~~These procedures must be billed in accordance with the administrative rules governing physician services at ARM 46.12.2001 et seq.~~

~~(4)~~ (3) All services which require prior authorization from the designated review organization are ~~designated by a "yes" in the column titled "AUTH. REQ."~~ identified in ~~sections C and H of~~ the ~~dental services~~ provider manuals. Reimbursement ~~will~~ is not ~~be~~ provided for such services unless prior authorization has been given by the designated review organization.

~~(5)~~ (4) Coverage of denture services are subject to the following requirements and limitations:

~~(a) all denture services must be provided by a dentist or prescribed by a dentist and provided by a licensed denturist;~~

(a) a denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed by a dentist; and

(b) requests for full prosthesis must show the approximate date of the most recent extractions, and/or the age and type of the present prosthesis~~;~~.

~~(c)~~ (5) ~~replacement~~ Replacement of lost dentures is a covered service subject to the following requirements and limitations:

~~(i)~~ (a) the dentist or denturist must indicate "lost dentures" on the request for prior authorization for replacement;

~~(ii)~~ (b) full dentures which are over 10 years old may be replaced when the treating dentist documents the need for replacement;

~~(iii)~~ (c) partial dentures which are over 5 years old may be replaced with full dentures;

~~(iv)~~ (d) dentures which are between 5 and 10 years old may be replaced when the treating dentist documents the need for replacement, but reimbursement ~~will be~~ is at the rate for duplicating (or jumping) the dentures;

~~(v)~~ (e) the limits on coverage of denture replacement may be exceeded when the designated review organization determines that the existing dentures are causing the recipient serious physical health problems; and

~~(vi)~~ (f) replacement of a lost dentures is limited to one replacement per recipient per lifetime.

(6) and (7) remain the same.

~~(8) The denturist service provider manual and the dental services provider manual are available from the Department of Public Health and Human Services, Medicaid Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.~~

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

3. The rules proposed for amendment in this notice govern the provision of dental services funded with medicaid monies. Those services are for the identification and treatment of medically necessary conditions involving both natural and prosthetic tooth structures of both adults and children. The rules define and specify the nature and scope of dental services that may be funded with medicaid monies. In addition, the rules govern reimbursement for those services.

The proposed rule amendments are generally necessary to conform the rules with changes in the law governing the practice of denturity in the state and to provide in the aggregate higher rates of reimbursement as authorized by the 1999 General Appropriations Act - House Bill No. 2.

ARM 46.12.601 DENTAL SERVICES, DEFINITIONS

The proposed rule amendments to ARM 46.12.601, DENTAL SERVICES, DEFINITIONS, modify the definition of dental service by adding language that the treatment must be medically necessary, by removing language concerning treatment affecting the oral and general health, by removing the requirements as to the appropriate professionals for provision of treatment, and by adding an explicit statement that dental service includes the provision of orthodontia and prostheses. These changes are necessary to clarify the rules for better comprehension. The Department has selected the option of amending the definition to conform the rule with changes in Montana law relating to the practice of dentistry.

The proposed changes to the definition of dental services include the removal of the limitation upon reimbursement of denturists. The option of leaving in the definition the current express requirement that a dentist must prescribe the provision of full or partial denture services to be provided by a denturist, is unacceptable in that these provider requirements should not appear in a definition.

The proposed amendments would also remove ambiguous language concerning the treatment of disease, injury or impairment affecting the oral and general health and replace it with more

precise language providing that dental service includes the provision of orthodontia and prostheses. While reimbursable dental services currently include orthodontia and prostheses, the definition of dental services in the rule does not clearly encompass those distinct types of services which relate to the oral cavity instead of tooth structure. The proposed definitional change, expressly including the two types of services is necessary to assure that there is legal authority for coverage of the services and that persons eligible for medicaid funded dental services and the providers of services are, when relying upon the rules on dental services coverage and reimbursement, made aware of the coverage for these types of dental services. The option of revising the definition to remove the ambiguous language and expressly including these two important areas of service is the appropriate option since the option of not providing for express inclusion of the services in the definition would continue to lead to confusion concerning the scope of covered services.

The proposed amendment to the definition of dental services includes the removal of the outdated limitation upon reimbursement of denturists with regard to the provision of full or partial denture services prescribed by a dentist. Under the current medicaid dental rules, denturists are required to obtain a dentist's prescription for any and all services provided to a recipient. The current statutes at Title 37, chapter 29, MCA governing the practice of denturists, however, allow denturists to provide certain services without a prescription from a dentist. The option of leaving the definition unchanged is unacceptable in that it would leave in rule an outdated requirement that is not appropriate under state law governing the practice of denturists.

The proposed change, adding the term "medically necessary", would predicate dental services on this express requirement drawn from the federal authorities governing the provision of services funded with medicaid monies. The inclusion of the term is necessary to counter the misperception of some persons that dental services funded through medicaid monies are not subject to the medical necessity criteria that is a general requirement for medical services funded with medicaid monies. The option of including the term in the definition is the appropriate option in that, unlike the option of not including this fundamental requirement, this option will avoid inappropriate payment of claims, and possible confusion on the part of recipients and providers.

ARM 46.12.602 DENTAL SERVICES, REQUIREMENTS

ARM 46.12.602, DENTAL SERVICES, REQUIREMENTS, provides the overall program requirements for providers of dental services.

The proposed amendments to ARM 46.12.602 would remove the

citation to certain other rules governing coverage of medical services with medicaid funding and replace it with a general statement of reference and would remove certain criteria governing the provision of emergency dental care.

The proposed change, removing the citations to general provider and services requirements at ARM 46.12.301 through 46.12.308, is necessary in that those rules in the citations are not necessarily comprehensive for the purposes of the citation and in that additional rules providing further general limitations of coverage and general requirements for providers of services are adopted on occasion. The option of providing a general reference, unlike the option of leaving the matter as currently expressed with specific references, is the best option in that it does not mislead providers in to assuming that the cited rules are the only applicable rules.

The proposed deletion of the provision relating to dental care in an emergency situation, will eliminate the Department's previous policy requiring prior authorizations for all emergency services. Prior authorization has not proven to be cost effective in this area. Thus it is necessary to amend the rule to change this requirement.

ARM 46.12.605 DENTAL SERVICES, REIMBURSEMENT

ARM 46.12.605, DENTAL SERVICES, REIMBURSEMENT specifies the reimbursement methodologies that are applicable to the services provided through the dental program.

The proposed amendments to the reimbursement rule would bring the reimbursement methodology in this rule into conformity with the department's typical reimbursement methodology for medicaid services. The rule would be restructured with deletion of unnecessary verbiage and dated material and reworded to provide for improved comprehension of the rule.

The rule currently incorporates by reference the department's dental services and denturist services provider manuals. The proposed amendments would include incorporation of the department's fee schedule with information on how to obtain that fee schedule. This option is more appropriate than the option of leaving the references to the incorporated material in an outdated form and thereby leading to confusion when referred to for guidance.

Traditional or standard dental procedures are reimbursed through a historically established set of rates subject to modification based on suggested changes from the Medicaid Dental Advisory Council and changes in available funding through legislative appropriation.

Some dental procedures, however, are reimbursed on other than established rates for the service. Some services are reimbursed on the "by report" method. That method provides that the provider may bill the department at the provider's "usual and customary" fee, which the department then reimburses at a percentage rate of the submitted fee. The other method of reimbursement, resource based relative value scale (RBRVS), is the medicaid rate methodology for medical type procedures typically performed by physicians. This rule amendment is necessary in order to account for increased legislative appropriation.

The proposed amendment to the rule, providing a cross reference to rule ARM 46.12.502A, in addition to ARM 46.12.2003, for purposes of reimbursing medical procedures that are within scope of practice of dentists, is necessary for ease of using a consistent method of setting fees. That methodology of reimbursement, utilizing the Current Physician's Terminology (CPT-4) Procedure Codes, is the RBRVS reimbursement system.

The proposed amendments, rewriting the provisions for the current rates of reimbursement for by report codes in the dental program, are proposed only for clarification purposes. No substantive changes are proposed. This option is the best option as it will specify for the providers the applicable methods for purposes of reimbursement.

ARM 46.12.606 DENTAL SERVICES, COVERED PROCEDURES

ARM 46.12.606, DENTAL SERVICES, COVERED PROCEDURES, specifies those dental services that are available through the dental program and provides the criteria for the provision of those services.

Because of changes in the issuance of the provider manuals, the proposed amendment would provide references to the new versions of the Medicaid Dental and Medicaid Denturist Provider Manuals. This is the appropriate option as the manuals are currently what the dental program is using to provide guidance to the program. Reference to the old manuals will only provide misinformation and confusion to providers.

The proposed amendment, adding a new statement predicating the provision by a denturist of an initial immediate full prosthesis and initial partial prosthesis on the prescription of a dentist, is necessary to conform with the coverage at part 1 of Title 37, chapter 29, MCA. Limitations that are not in conformance with lawful practice are to be deleted. This option is the appropriate option in that the only other option is to leave in place rules which are contrary with the statutes governing the practice of denturitry, thereby giving rise to confusion over coverage.

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 June 3, 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 Flungen
Director, Public Health and Human Services

Certified to the Secretary of State April 23, 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 XXV, and the repeal of ARM 46.10.303 and 46.10.307 pertaining to AFDC foster care	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND REPEAL

TO: All Interested Persons

1. On May 26, 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 repeal 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 17, 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 IV-E FOSTER CARE ELIGIBILITY: DEFINITIONS For purposes of this subchapter, the following definitions apply:

(1) "Business asset development account (BADA)" means an account in a bank or other similar financial institution containing funds to be used for business development such as the purchase of assets or operation or maintenance of a business. The account must be in the joint names of a member of the filing unit and capital opportunities or other lending institution. All funds from the account must be disbursed directly to vendors of the business.

(2) "Child" means a person who is under age 18 or who is age 18 or older if the person is a full-time student in a secondary school who is reasonably expected to obtain a secondary school diploma or its equivalent in or before the month of the person's 19th birthday.

(3) "Child-caring institution" means a public or a private nonprofit institution licensed or approved by the state to provide care for no more than 25 children who have been removed from the home of the children's parents or guardians by a voluntary agreement or by court order. The term does not

include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children determined to be delinquent.

(4) "Child support rights" means a child's legal entitlement to cash assistance from a parent with whom the child does not live.

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

(6) "Dependent child" means a child as defined in this rule who is deprived of parental support or care due to any of the causes set forth in [Rule VII], lives with a specified relative as provided in [Rule VI] and lacks income and resources sufficient for the child's needs according to the assistance standards and resource limits set forth in [Rules XV and XIX].

(7) "Earned income" means all income earned by an individual from work or an activity in which the individual is engaged, including but not limited to wages, salary, commissions, and tips. Earned income means gross earned income prior to any deductions or withholding for income or social security taxes, garnishments, attachments, income deductions, insurance premiums, or any other purpose.

(8) "Earned income from self-employment" means the total profit from the business enterprise determined by subtracting business expenses as allowed in [Rule XIII] from gross revenue. Returns from capital investments are earned income when produced as a result of the individual's own efforts.

(9) "FAIM cash assistance" means assistance in the form of monthly cash payments provided in the families achieving independence in Montana program.

(10) "Filing unit" means the child for whom IV-E eligibility is being sought and the persons with whom the child lives whose income and resources are considered in determining the child's eligibility.

(11) "Foster home" means a home licensed or approved by the state to provide care for a child or children who have been removed from the home of the child or children's parents or guardians by voluntary agreement or by court order.

(12) "IV-E foster care maintenance payments" means monthly cash payments made for the support and maintenance of a child living in a foster home, child caring institution, or kinship placement pursuant to the federal Social Security Act, subchapter IV, part E, 42 USC 670 through 672.

(13) "Gross monthly income" means all earned and unearned income received in the month being considered, except for income excluded under [Rules XVI and XVIII]. In stepparent household cases as described in [Rule VIII], gross monthly income includes any income of the stepparent deemed available to the spouse as unearned income as provided in [Rule XIV].

(14) "Kinship placement" means an out of home placement in the home of an appropriate relative who is not required to be licensed as a foster care home.

(15) "Married" means that a legally recognized marital

relationship exists between two persons, regardless of whether the marriage was created ceremonially or by common law.

(16) "Medical support rights" means a child's legal entitlement to health insurance coverage and/or assistance in paying medical expenses from a parent with whom the child does not live.

(17) "Minor parent" means a person under the age of 18 who is the biological or adoptive parent of a dependent child who is in the care of the minor parent.

(18) "Month of eligibility" means the month in which either:

(a) the child's parent or legal guardian entered into a voluntary placement agreement in regard to the child; or

(b) the petition was filed which resulted in a judicial determination to the effect that it would be contrary to the welfare of the child to remain in the home and that reasonable efforts have been made to prevent or eliminate the need to remove the child from the home.

(19) "Net monthly income" means gross monthly income less any earned or unearned income excluded pursuant to [Rules XVI and XVIII] and less any earned income disregarded in [Rule XVII].

(20) "Out of home care" means full-time care of a child in an out of home setting for the purpose of providing food, shelter, security, safety, guidance, and, if necessary, treatment to children who are without the care and guidance of their parents or guardians. Out of home care includes, but is not limited to, care provided in child care institutions, foster homes, and kinship placements.

(21) "Placing worker" means an individual who has the authority and responsibility to make decisions regarding the placement of a child who has been removed from the child's home by a voluntary agreement entered into by the child's parent or legal guardian or as a result of a judicial determination that removal from the home will serve the child's welfare. A placing worker may be an employee or agent of a governmental unit, private organization, or other entity, including but not limited to the department's child and family services division, an Indian tribe, department of corrections and Lutheran social services.

(22) "Primary wage earner (PWE)" means, in a household where both of a child's natural and/or adoptive parents are residing with the child, the parent who earned the most total gross income in the 24 month period immediately preceding the month of eligibility. If both parents earned the same amount, the PWE is whichever parent is designated by the eligibility worker.

(23) "Unearned income" means all income that is not earned income as defined in this rule and includes but is not limited to social security benefits, veteran's benefits or payments, worker's compensation payments, unemployment compensation payments, child support payments, and dividends paid on capital

investments.

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

RULE II IV-E FOSTER CARE ELIGIBILITY: GENERAL REQUIREMENTS (1) IV-E eligibility for a child who has been placed in out of home care shall be determined based on circumstances in the month of eligibility as defined in [Rule I].

(2) A child shall be determined IV-E eligible if:

(a) the child was placed in out of home care:

(i) pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian; or

(ii) by a court of competent jurisdiction pursuant to the provisions of Title 41, chapter 3, MCA;

(b) the state or tribe has legal responsibility for the child's care and placement;

(c) the child:

(i) meets the requirements for IV-E eligibility as specified in [Rule I through Rule XX] in the month of eligibility; or

(ii) was living in the home of a specified relative as provided in [Rule VI] during any month in the 6 months immediately prior to the month of eligibility and would have met the requirements for IV-E eligibility as specified in [Rule I through Rule XX] during said month; and

(d) meets all other eligibility requirements of [Rule I through Rule XX].

(3) If a child is determined to be IV-E eligible in the month of eligibility, eligibility continues as long as the child remains in state or tribal custody or jurisdiction, regardless of subsequent changes in the filing unit's income or resources. However, eligibility no longer exists when:

(a) deprivation of parental support as defined in [Rule VII] no longer exists; or

(b) the child is age 18 unless the child is a full-time student in a secondary school who is reasonably expected to obtain a secondary school diploma or its equivalent on or before the month of the child's 19th birthday.

(4) A child who is IV-E eligible and who meets the requirements of (5) may receive benefits consisting of:

(a) IV-E foster care medicaid coverage; and

(b) IV-E foster care maintenance payments.

(5) After a child has been determined to be IV-E eligible, eligibility for IV-E foster care medicaid coverage and maintenance payments shall be determined based on the income and resources of the child in subsequent months. If the child's countable income and/or resources exceed the maximum allowable income and resources provided in [Rule XV] and [Rule XIX], the child shall not be entitled to benefits although the child may still be IV-E eligible.

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

RULE III IV-E FOSTER CARE ELIGIBILITY: RESIDENCY (1) In order for a child to be IV-E eligible, the parent or parents of the child must be residents of the state of Montana in the month of eligibility. There is no durational residency requirement for the child's parent or parents.

(2) After a child is determined to be IV-E eligible, eligibility shall not be lost due to a change in residence of the child and/or the child's parents, and the state of Montana shall pay the IV-E foster care maintenance payments for the child as long as the child is eligible for benefits. However, if the child is living or physically located in a state other than Montana after the month of eligibility, the state which shall be responsible for providing medicaid coverage for the child shall be determined in accordance with the residency provisions of 42 CFR 435.403, as amended through October 1, 1997, which are hereby adopted and incorporated by reference. A copy of this regulation may be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

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

RULE IV IV-E FOSTER CARE ELIGIBILITY: CITIZENSHIP (1) As a condition of IV-E eligibility and to receive IV-E maintenance payments and/or medicaid, a child must be either a citizen of the United States, a person born in Samoa who is not a U.S. citizen, or a qualified alien as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, section 431(b)(1) through (6).

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

RULE V IV-E FOSTER CARE ELIGIBILITY: AGE (1) As a condition of IV-E eligibility, a child must be either:

(a) under the age of 18; or

(b) age 18 or older if the child is a full-time student in a secondary school who is reasonably expected to obtain a secondary school diploma or its equivalent in or before the month of the child's 19th birthday.

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

RULE VI IV-E FOSTER CARE ELIGIBILITY: LIVING WITH A SPECIFIED RELATIVE (1) As a condition of IV-E eligibility, at any time within 6 months immediately prior to the month of eligibility the child must have been living with any relation by blood including those of half blood, marriage, or adoption who

is within the fifth degree of kinship to the child in a place of residence maintained as their home.

(a) The relative with whom the child resided must be the child's parent, grandparent, great grandparent, great-great grandparent, great-great-great grandparent, sibling, uncle, aunt, great uncle, great aunt, great-great uncle, great-great aunt, first cousin, first cousin once removed, nephew, niece, or step relatives of the same degree of kinship; for example, stepparent, stepgrandparent, or stepsibling.

(b) A spouse of any of the relatives named above is considered to be within the required degree of kinship, even after the marriage is terminated by death or divorce.

(2) IV-E eligibility may exist even though either the child or the relative is temporarily absent from the home, if the relative continues to exercise responsibility for the care and control of the child and plans to resume exercising responsibility for the care and control of the child at a later date, and the temporary absence does not exceed 90 days.

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

RULE VII IV-E ELIGIBILITY: DEPRIVATION OF PARENTAL SUPPORT

(1) As a condition of IV-E eligibility, a child must be deprived of parental support in the month of eligibility due to:

(a) death of a parent or parents;

(b) continued absence of a parent or parents;

(c) physical or mental incapacity of a parent or parents; or

(d) unemployment of parent.

(2) A child is considered to be deprived of parental support due to the continued absence of a parent if the nature and duration of the absence is such as to either interrupt or terminate the parent's functioning as a provider of maintenance, physical care, or guidance for the child.

(a) A parent who is absent solely due to the performance of active duty in the armed services of the United States as defined in 37 USC 101(3) is not considered to be absent.

(3) A child is considered to be deprived of parent support due to physical or mental incapacity if:

(a) the parent has a physical or mental defect, illness, or impairment which has been established through competent medical evidence;

(b) the incapacity is of such a debilitating nature as to reduce substantially or eliminate the parent's ability to support or care for the child; and

(c) the incapacity is expected to last at least 30 days.

(4) A child is considered to be deprived of parental support due to unemployment of the primary wage earner if the family's income does not exceed the income standards provided in [Rule XV] for a family of that size.

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

RULE VIII IV-E FOSTER CARE ELIGIBILITY: STEPPARENT HOUSEHOLDS (1) A stepparent household is one in which a parent who lives with the child or children for whom a IV-E eligibility determination is being made or sought is married to and living with a person who is not the natural or adoptive parent of at least one of the children for whom IV-E eligibility is being determined.

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

RULE IX IV-E FOSTER CARE ELIGIBILITY: INCLUSION IN THE FILING UNIT (1) The child's IV-E eligibility is based on the total countable income and resources of all members of the filing unit in the month of eligibility.

(2) Except as provided in (3) below, the following individuals must be included in the child's filing unit:

(a) the child for whom IV-E eligibility is being determined;

(b) any natural or adoptive parent of the child with whom the child was living in that month; and

(c) any blood-related or adoptive brother or sister of the child with whom the child was living in that month, including half brothers or sisters.

(3) The following individuals are not included in the child's filing unit:

(a) individuals who are receiving supplemental security income (SSI) benefits;

(b) stepsiblings; and

(c) siblings over 19 years of age.

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

RULE X CHILD AND MEDICAL SUPPORT REQUIREMENTS (1) Except as provided in (2), in every case where a child is receiving IV-E foster care maintenance payments and/or medicaid benefits based on the absence of a parent from the home, the child's specified caretaker relative must:

(a) assign child and/or medical support rights to the department; and

(b) cooperate in establishing paternity and obtaining child and/or medical support.

(2) A specified caretaker relative is not required to cooperate in establishing paternity and obtaining child and/or medical support if good cause for refusing to do so is determined to exist in accordance with the provisions of 45 CFR 232.40 through 232.49, as amended through October 1, 1995. The department hereby adopts and incorporates by reference 45 CFR

232.40 through 232.49, as amended through October 1, 1995, pertaining to good cause for refusal to cooperate. Copies of 45 CFR 232.40 through 232.49, as amended through October 1, 1995, may be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(3) In addition to requiring assignment of rights and cooperation as provided in (1), the department may seek an order requiring the payment of child and/or medical support for the child receiving IV-E foster care benefits by either or both of the child's parents.

(4) A child who is otherwise IV-E eligible will not be denied eligibility because of the failure or refusal of the placing worker, child's parent, or specified caretaker relative to comply with the requirements of (1)(a) or (1)(b) of this rule.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-2-613, and 53-6-131, MCA

RULE XI IV-E ELIGIBILITY: A CONDITION OF NEED MUST EXIST (1) A child is not IV-E eligible unless the filing unit has income and resources equal to or less than the applicable income and resource standards established in [Rules XV and XIX] in the month of eligibility.

(2) After the initial determination of IV-E eligibility, the child is not eligible for IV-E benefits as specified in [Rule II (4)(a) and (b)] unless the child has income and resources equal to or less than the applicable income and resource standards established in [Rules XV and XIX].

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-2-613 and 53-6-131, MCA

RULE XII IV-E FOSTER CARE ELIGIBILITY: INCOME (1) Income standards as set forth in [Rule XV] are used to determine whether a child or children is IV-E eligible based on income. Two sets of income standards are used. They are as follows:

(a) the gross monthly income (GMI) standards, which specify the maximum level of gross monthly income a filing unit with a particular number of members may have to be IV-E eligible; and

(b) the net monthly income (NMI) standards, which specify the maximum level of net monthly income a filing unit with a particular number of members may have to be IV-E eligible.

(2) To determine the IV-E eligibility of a child or children, the filing unit's gross monthly income as defined in [Rule I] is compared to the applicable GMI standard, and, after specified exclusions and disregards specified in [Rules XVI, XVII, and XVIII] are applied, it is compared to the applicable NMI standard. If the filing unit's gross monthly income exceeds the GMI standard or the filing unit's net monthly income exceeds

the NMI standard, the child or children are not IV-E eligible.

(3) The GMI and NMI standards which are used for each comparison are chosen based on the number of the persons in the filing unit and whether the filing unit has a shelter obligation.

(a) A filing unit is considered to have a shelter obligation if a member of the filing unit is obligated to meet a portion of the shelter expenses of the filing unit's place of residence, such as rent, a payment under a contract to purchase a house or other place of residence, a mortgage payment, real property taxes, home owner's insurance, mobile home lot rent, or utilities such as heating fuel, water, or lights. A filing unit receiving a government rent or housing subsidy is considered to have a shelter obligation even if the filing unit's share of the rent or housing payment is $0.

(4) Income received or reasonably expected to be received in the month of eligibility is compared to the applicable GMI and NMI standards.

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

RULE XIII IV-E FOSTER CARE ELIGIBILITY: TREATMENT OF INCOME (1) All available income of any required member of the filing unit is counted in determining IV-E eligibility, unless a specific provision elsewhere in this chapter provides that the income will be excluded, disregarded, or otherwise not counted.

(a) Income is considered available both when actually available and when a member of the filing unit has a legal interest in it and the legal ability to make the income available for support and maintenance.

(2) In determining the amount of income earned from self-employment, the total profit from the business enterprise is calculated by subtracting allowable business expenses from gross receipts or revenue. This total profit, unless it is excluded under a provision of [Rule XVI], is the gross income to which the earned income disregards specified in [Rule XVII] are applied to arrive at countable earned income.

(a) Business expenses are costs directly related to the production of goods or the furnishing of services and without which the goods could not be produced or the services furnished. Allowable business expenses include materials, labor, tools, rental equipment, supplies, and utilities.

(b) Allowable business expenses do not include depreciation or personal work related expenses such as clothing or transportation to the site of employment.

(3) Income averaging may be used to determine monthly income if:

(a) income is paid during 1 month but is intended to cover a period of time which is greater than 1 month. In such cases, the monthly income is calculated by dividing the total amount of the payment or payments by the number of months the payment or

payments are intended to cover. An example would be an employee who receives a paycheck during only 9 months of the year but whose salary is considered to be for a 12 month period; or

(b) income fluctuates significantly from month to month. An example would be an employee paid an hourly wage whose hours worked vary from month to month.

(4) Income tax refunds are not considered as either earned or unearned income but are considered a resource to the filing unit.

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

RULE XIV IV-E ELIGIBILITY: DEEMING OF INCOME (1) The income of certain individuals who live with the filing unit but are not members of the filing unit is considered in determining IV-E eligibility. The income of such individuals is considered by means of a procedure known as "deeming" which is described in (3) below.

(2) The income of the following individuals is deemed to be available to the filing unit:

(a) a stepparent, i.e., a person who is not the natural or adoptive parent of any child in the filing unit but is married to the parent of a child in the filing unit;

(b) a sponsor of an alien for the 3 years immediately following the alien's entry into the United States;

(c) a parent of a minor parent if the minor parent is the child placed in out of home care; and

(d) the spouse of a caretaker relative when the caretaker relative is included in the assistance unit and the spouse of a pregnant woman when the pregnant woman has no other eligible child in the home.

(3) The following amounts are subtracted from the income of individuals whose income is required to be deemed, and the net amount obtained is counted as unearned income available to the filing unit, regardless of whether that amount is actually made available to the filing unit for its support and maintenance:

(a) a standard work expense of $90 is subtracted from the individual's earned income, if any;

(b) an amount of earned income, unearned income, or a combination of both which is equal to the net monthly income standard for a family consisting of the individual whose income is deemed and all persons who live with the individual and qualify as the individual's dependents for federal income tax purposes but are not included in the filing unit;

(c) actual verified amounts paid by the individual to persons who do not live with the individual but who qualify as dependents of the individual for federal income tax purposes; and

(d) actual verified amounts of alimony or child support paid by the individual to persons not living with the

individual.

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

RULE XV IV-E FOSTER CARE ELIGIBILITY: TABLES OF INCOME STANDARDS (1) The following income standards will be used as provided in [Rule XII] to determine IV-E eligibility:

(a)

GROSS MONTHLY INCOME STANDARDS

Number of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ 616	$ 224
2	823	361
3	1,032	496
4	1,241	629
5	1,449	751
6	1,658	868
7	1,867	984
8	2,074	1,093
9	2,176	1,195
10	2,276	1,295
11	2,364	1,382
12	2,451	1,469
13	2,529	1,547
14	2,601	1,621
15	2,673	1,693
16	2,736	1,756

(b)

NET MONTHLY INCOME STANDARDS

Number of Persons in Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ 333	$ 121
2	445	195
3	558	268
4	671	340
5	783	406
6	896	469
7	1,009	532
8	1,121	591
9	1,176	646
10	1,230	700
11	1,278	747
12	1,325	794
13	1,367	836
14	1,406	876
15	1,445	915
16	1,479	949

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

RULE XVI IV-E FOSTER CARE ELIGIBILITY: EXCLUDED EARNED INCOME (1) The following earned income is not counted when comparing the filing unit's gross monthly income to the applicable GMI standard:

(a) for any 6 months of the calendar year, the earned income of a dependent child who is a full-time student;

(b) income received by a dependent child under section 503 of the Job Training Partnership Act (JTPA) of 1982, P.L. 97-300, for the first 6 months of participation in JTPA training; and

(c) earned income tax credit (EITC) advance payments and refunds.

(2) The following earned income is not counted when comparing the filing unit's net monthly income to the applicable NMI standard:

(a) for any 6 months of the calendar year, the earned income of a dependent child who is a full-time student;

(b) during the seventh and following months of the calendar year in which the child has received IV-E benefits, the earned income of a dependent child who is a full-time student if the child's total income including the child's earned income does not exceed the GMI standard for a household of that size;

(c) income received by a dependent child under section 503

of the JTPA, for the first 6 months of participation in JTPA training; and

(d) EITC advance payments and refunds.

(2) Income tax refunds are not considered as either earned or unearned income but are considered a resource to the filing unit.

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

RULE XVII IV-E FOSTER CARE ELIGIBILITY: EARNED INCOME DISREGARDS (1) To determine the net monthly income which will be compared to the applicable NMI standard, the disregards set forth in (2)(a) and (b) below are subtracted from the total gross earned income of each member of the filing unit after the exclusions provided in [Rule XVI] have been applied.

(2) The following disregards will be applied in the order listed:

(a) a standard work expense disregard of $90 for each member of the filing unit who has earned income; and

(b) a dependent care disregard for payments made by a member of the filing unit for the care of a dependent child or incapacitated adult living in the same home as the filing unit, provided that:

(i) the amount disregarded may not exceed $175 per month per person for persons 2 years of age or older or $200 per month per child for children younger than 2 years of age;

(ii) the disregard applies only to payments for care during the time when the employed member of the filing unit is at the place of employment or en route between the place of employment and the site of the dependent care; and

(iii) only amounts paid or due for the month for which eligibility is being determined may be disregarded.

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

RULE XVIII IV-E FOSTER CARE ELIGIBILITY: EXCLUDED UNEARNED INCOME (1) The following unearned income is not counted when comparing the filing unit's gross monthly income and net monthly income to the applicable GMI and NMI standards:

(a) complementary assistance from other agencies and organizations which consists of:

(i) goods and services not intended to be covered by the FAIM cash assistance grant; or

(ii) a supplement to FAIM cash assistance payments for a different purpose.

(b) agent orange settlement payments;

(c) undergraduate student loans and grants for educational purposes such as Pell grants, supplemental educational opportunity grants, state student incentive grants, college work study, BIA assistance, veterans financial

assistance, university year for action (UYA);

(d) low income energy assistance payments (LIEAP);

(e) the value of the food stamp coupon allotment;

(f) the value of U.S. department of agriculture donated foods;

(g) any benefits received under Title VII of the nutrition program for the elderly of the Older Americans Act of 1965 as amended;

(h) the value of supplemental food assistance received under the Child Nutrition Act of 1966 and the special food services program for children under the National School Lunch Act, P.L. 92-433 and P.L. 93-150;

(i) all monies awarded to Indian tribes by the Indian claims commission or court of claims as authorized by P.L. 92-254, 93-134, 94-114, and 94-540;

(j) payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(k) any contribution made by relatives or others on behalf of the filing unit which is not directly available to the filing unit;

(l) the tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act, P.L. 92-203;

(m) all payments under Title I of the Elementary and Secondary Education Act;

(n) incentive payments or reimbursement of training related expenses made to participants in the work readiness component (WoRC) of the FAIM program;

(o) payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the service corps of the retired executives and active corps of executives and any other program under Titles II and III of P.L. 93-113;

(p) payments to individual volunteers in service to America (VISTA) volunteers under Title I of P.L. 93-113, pursuant to section 404(g) of that law; and

(q) small nonrecurring gifts such as those for Christmas, birthdays, and graduation, up to $30 per member of the filing unit in any period of 3 consecutive calendar months.

(2) Income tax refunds are not considered as either earned or unearned income but are considered a resource to the filing unit.

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

RULE XIX IV-E FOSTER CARE ELIGIBILITY: RESOURCE LIMITATION (1) A child is not IV-E eligible if the equity value of combined countable resources of all members of the filing unit exceeds $1,000 in the month of eligibility.

(2) After the initial determination of eligibility, the

child is not eligible for IV-E benefits as specified in [Rule II(4)(a) and (b)] if the equity value of the child's countable resources exceeds $1,000.

(3) All real and personal property is counted in determining eligibility if any member of the filing unit has the legal right or actual ability to liquidate the property or the member's interest in the property for cash, unless it is a resource specifically excluded in [Rule XX].

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

RULE XX IV-E FOSTER CARE ELIGIBILITY: EXCLUDED RESOURCES

(1) The following resources are not counted when determining IV-E eligibility:

(a) the home which is the usual residence of the filing unit;

(b) one motor vehicle which has an equity value of $1,500 or less. Any equity value in excess of $1,500 for the first vehicle and the entire equity value of any additional vehicle or vehicles is counted in determining eligibility;

(c) household furniture and goods, clothing and other personal effects, equipment or other items necessary to produce food, home produce for family use and consumption only, and other items of limited value essential for day-to-day use;

(d) tools and equipment essential for the self-employment of a member of the filing unit;

(e) one burial plot for each member of the filing unit;

(f) funds designated for the funeral, burial, and/or cremation expenses of members of the filing unit as follows:

(i) for each member of the filing unit, a sum of $1,500 or less designated for such expenses under an irrevocable agreement; or

(ii) for each member of the filing unit, an unlimited sum designated for such expenses under an irrevocable agreement;

(g) real property other than the usual residence of the filing unit, for a maximum of 6 months, if the family is making a good faith effort to sell the property;

(h) agent orange settlement payments;

(i) radiation exposure compensation payments;

(j) Maine Indian Claims Settlement Act of 1980 payments;

(k) restitution paid pursuant to the Civil Liberties Act of 1988 to individuals of Japanese ancestry who were interned and Aleuts who were relocated during world war II;

(l) major disaster and emergency assistance payments received pursuant to the Disaster Relief and Emergency Assistance Amendments of 1988;

(m) all funds in a business asset development account (BADA), provided that if the business fails and any funds from the account are disbursed to a member of the filing unit, those funds shall be counted as a resource in the month they are disbursed and in each subsequent month until the funds are spent

down;

(n) cash benefits paid under a fire or casualty insurance policy for 90 days after the date of receipt;

(o) the face value of any life insurance owned by any member of the filing unit, but not the cash value of such insurance;

(p) any funds in an escrow account established for a member of the filing unit who is participating in the housing and urban development (HUD) family self-sufficiency (FSS) program;

(q) settlement proceeds paid to a member of the filing unit in the factor VIII or IX concentrate blood products class action lawsuit, MDL 986, No. 93-C-7452, northern district of Illinois;

(r) funds in a family health account (FHA);

(s) any unspent portion of an earned income tax credit (EITC) advance payment or refund, in the first month after the month in which it is received; pursuant to [Rule XVI], EITC pavements and refunds are excluded as earned income in the month of receipt;

(t) student financial assistance made for attendance costs under Title IV of the Higher Education Act or bureau of Indian affairs student assistance programs under the Higher Education Technical Amendments Act of 1987; and

(u) a loan which a member of the filing unit receives and has a legal obligation to repay pursuant to a written agreement signed by the member.

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

RULE XXI IV-E FOSTER CARE ELIGIBILITY: PLACE OF APPLICATION (1) Application for IV-E eligibility must be submitted to the office of public assistance in the county of residence of the specified caretaker relative with whom the child lived immediately prior to being placed in foster care.

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

RULE XXII IV-E FOSTER CARE ELIGIBILITY: PERIODIC REDETERMINATIONS OF ELIGIBILITY (1) After the initial determination of IV-E eligibility, the child's IV-E eligibility and eligibility for benefits as specified in [Rule II(4)(a) and (b)] shall be investigated and redetermined every 6 months.

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

RULE XXIII IV-E FOSTER CARE ELIGIBILITY: SAFEGUARDING AND SHARING INFORMATION (1) Use and disclosure of information concerning applicants for or recipients of IV-E eligibility are

restricted to purposes directly connected with the administration of the IV-E program, except as provided in 42 USC 671(a)(8) and (9), as amended through July 16, 1996, which governs use and disclosure of information in the IV-E foster care program. The department hereby adopts and incorporates by reference 42 USC 671(a)(8) and (9) as amended through July 16, 1996. A copy of 42 USC 671(a)(8) and (9) as amended through July 16, 1996, may be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, 111 North Sanders Street, P.O. Box 4210, Helena MT 59604-4210.

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

RULE XXIV IV-E FOSTER CARE ELIGIBILITY: GROUNDS FOR TERMINATION OF BENEFITS; NOTICE OF TERMINATION (1) If a child is determined to be IV-E eligible in the month of eligibility, eligibility continues as long as the child remains in state or tribal custody or jurisdiction regardless of subsequent changes in the filing unit's income or resources. However, eligibility no longer exists when:

(a) deprivation of parental support as defined in [Rule VII] no longer exists; or

(b) the child is age 18 unless the child is a full-time student in a secondary school who is reasonably expected to obtain a secondary school diploma or its equivalent on or before the month of their 19th birthday.

(2) When a child becomes ineligible for IV-E benefits, a written notice must be sent to the placing worker at least 10 days prior to the date on which the benefits will terminate, except as provided in (3)(a) through (c)(ii). The notice must state that the benefits are being terminated, the reason for the termination, and the date on which the benefits will terminate. The notice must also contain information about the right to a fair hearing and to contact the department prior to the effective date of termination to discuss any disagreement or misunderstanding regarding eligibility.

(3) The department is not required to send notice 10 days prior to the date of termination but must send notice not later than the date of termination if:

(a) the department has information from a reliable source that the child has died;

(b) the child's whereabouts are unknown; or

(c) the placing worker has signed a written statement which:

(i) requests the termination of benefits for the child; or

(ii) contains information which indicates that the child is no longer eligible for benefits and also contains an acknowledgment that benefits for the child must be terminated as a result of that information.

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

RULE XXV IV-E FOSTER CARE ELIGIBILITY: OPPORTUNITY FOR HEARING (1) The placing worker who does not agree with an adverse action of the department related to IV-E eligibility shall have the right to a hearing as provided in ARM 46.2.201 through 46.2.214.

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

3. The rules 46.10.303 and 46.10.307 as proposed to be repealed are on pages 46-765 and 46-767 of the Administrative Rules of Montana.

AUTH: Sec. 53-4-112 and 53-4-231, MCA
IMP: Sec. 53-4-112, 53-4-201, 53-4-211 and 53-4-231, MCA

4. The federal Social Security Act in Title 42, subchapter IV, part E, of the USC, 42 USC 670 through 672, provides for cash and medical assistance to be furnished to children who have been removed from their homes and placed in foster care homes or in child care institutions. This program, known as the IV-E Foster Care Program, is a joint federal-state program which is operated by the states in accordance with federal law and receives federal funding.

The IV-E foster care program was created specifically to provide assistance to children who were receiving or were eligible for assistance under the federally funded Aid to Families with Dependent Children (AFDC) program at the time they were removed from their homes. Until 1996, the AFDC program provided cash and medical assistance to low income children deprived of parental support due to the death, absence, incapacity or unemployment of one or both of the child's parents.

However, on August 22, 1996, Congress passed the Personal Responsibility and Work Opportunity Act (PRWORA), PL 104-193, which eliminated the AFDC program and created in its stead Temporary Assistance to Needy Families (TANF) block grant funding for state programs serving low income families with children. Section 108 of PRWORA also amended the provisions of the Social Security Act relating to IV-E foster care. As amended the statute provided that children who would have been eligible for AFDC under the AFDC requirements in effect on June 1, 1995 would be eligible for IV-E foster care assistance. Thus, eligibility for IV-E foster care is now based on the AFDC requirements in effect prior to the passage of PRWORA. Section 5513(b) of the Balanced Budget Act of 1997, PL 105-33, amended the Social Security Act to provide that IV-E foster care eligibility was based on the AFDC requirements as of July 16,

1996, rather than as of June 1, 1996. The July 16, 1996 date was chosen to provide consistency with certain provisions of the Medicaid statute applying the July 1996 date.

Since the AFDC program no longer exists after PRWORA, the Department of Public Health and Human Services (the Department) has repealed the administrative rules which governed the AFDC program in ARM Title 46, chapter 10. The Department has adopted in their place new rules pertaining to the Families Achieving Independence in Montana (FAIM) program, which is the Montana's TANF funded program serving low income families with children. However, because eligibility for IV-E foster care is based on the AFDC requirements specified in the AFDC rules which were repealed, it is necessary to adopt new IV-E foster care rules which set forth the eligibility requirements previously specified in the AFDC rules.

At the time the Department repealed the AFDC rules, it did not repeal ARM 46.10.307 pertaining to IV-E foster care because the new foster care rules had not been adopted. ARM 46.10.307 is now being repealed because the policies previously specified in that rule are now addressed in the new foster care rules which the Department proposes to adopt. The Department also inadvertently failed to repeal one AFDC rule, ARM 46.10.303, at the time the other AFDC rules were repealed. That rule is now being repealed because it pertains to a program which no longer exists.

The proposed rules, with the exception of Rule VII, contain the same policies previously set forth in the AFDC rules, due to the fact that eligibility for IV-E foster care is required by federal law to be based on AFDC policy in effect on July 16, 1996. The only area in which the states have any leeway is in regard to the provision of IV-E foster care to children who are potentially eligible for assistance as a result of the unemployment of the parent who is the primary wage earner (PWE). Under the AFDC rule in effect in July 1996, a child who was living with both of the child's parents was considered deprived of parental support and hence could qualify for AFDC if the parent who was the PWE was unemployed. The federal AFDC regulations in effect in 1996 provided that the PWE was generally not considered unemployed unless the PWE was employed less than 100 hours per month.

However, as of August 7, 1998, the federal AFDC regulation governing eligibility based on unemployment of the PWE, 45 CFR 233.100, was amended. As amended the regulation eliminates the 100 hour test for determining unemployment of the PWE and allows the states to define unemployment using any reasonable standard, such as hours of work or dollar amounts, as long as the definition of unemployment is not more restrictive than the AFDC regulation in effect in 1996.

The Department has chosen to determine whether the PWE is unemployed based on the filing unit's total income. Proposed Rule VII provides that a child is deprived of parental support due to unemployment of the PWE if the filing unit's total countable income does not exceed the income standards in Rule XV for a family of that size. By defining unemployment in terms of family income and using the same income standards applicable to other households containing only one parent, the Department has chosen to treat single parent and two parent families the same, rather than having stricter eligibility requirements for two parent families where the basis of eligibility was unemployment. For example, under the old definition of unemployment, a child who was living with both parents prior to placement in out of home care would be ineligible for IV-E foster care if the parent who was the PWE worked more than 100 hours in that month, even if the family was eligible for AFDC based on the family's total countable income. By contrast, a child who lives with only one of the child's natural or adoptive parents is eligible if the family's total countable income does not exceed the income standards, without regard to the number of hours the child's parent worked during the month. The Department believes it is more equitable to apply the same eligibility test to both two parent and single parent families.

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 June 3, 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 23, 1999.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the proposed adoption of new rules permitting the referral of Department of Justice debts to the Department of Administration or other agency designated by law.	)))))))	NOTICE OF ADOPTION

TO: All Interested Persons

1. On March 11, 1999, the Department of Justice published a notice of proposed adoption of new rules I to IV pertaining to the referral of Department of Justice debts to the Department of Administration or other agency designated by law. The notice was published at pages 399 to 403 of the 1999 Montana Administrative Register, Issue Number 5.

2. The department has adopted Rules I (ARM 23.2.401), II (ARM 23.2.402), III (ARM 23.2.403), and IV (ARM 23.2.404) exactly as proposed.

3. One comment was received from the Department of Revenue:

COMMENT: The debt collection function of the Department of Administration was transferred to the Department of Revenue by passage of House Bill 168 (1999). The phrase "department of administration, or other agency designated by law" should be replaced with "department of revenue."

RESPONSE: The Department of Justice was aware of House Bill 168 (1999) when it proposed these rules. House Bill 168's effective date is July 1, 1999. As these rules become effective May 7, 1999, the phrase "department of administration, or other agency designated by law" will remain in the adopted rule as it covers the current situation, as well as the situation after July 1, 1999.

By: Melanie Symons
MELANIE SYMONS
Rule Reviewer

By: Joseph P. Mazurek
JOSEPH P. MAZUREK
Attorney General
Department of Justice

NOTICE OF FUNCTIONS OF ADMINISTRATIVE RULE REVIEW COMMITTEE

Interim Committees and the Environmental Quality Council

Administrative rule review is a function of interim committees and the Environmental Quality Council (EQC). These interim committees and the EQC have administrative rule review, program evaluation, and monitoring functions for the following executive branch agencies and the entities attached to agencies for administrative purposes.

Business and Labor Interim Committee:

- Department of Agriculture;
- Department of Commerce;
- Department of Labor and Industry;
- Department of Livestock;
- Department of Public Service Regulation; and
- Office of the State Auditor and Insurance Commissioner.

Education Interim Committee:

- State Board of Education;
- Board of Public Education;
- Board of Regents of Higher Education; and
- Office of Public Instruction.

Children, Families, Health, and Human Services Interim Committee:

- Department of Public Health and Human Services.

Law, Justice, and Indian Affairs Interim Committee:

- Department of Corrections; and
- Department of Justice.

Revenue and Taxation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

State Administration, Public Retirement Systems, and Veterans' Affairs Interim Committee:

- Department of Administration;
- Department of Military Affairs; and
- Office of the Secretary of State.

Environmental Quality Council:

- Department of Environmental Quality;
- Department of Fish, Wildlife, and Parks; and
- Department of Natural Resources and Conservation.

These interim committees and the EQC have the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. They also may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt, amend, or repeal a rule.

The interim committees and the EQC welcome comments and invite members of the public to appear before them or to send written statements in order to bring to their attention any difficulties with the existing or proposed rules. The mailing address is PO Box 201706, Helena, MT 59620-1706.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1. Consult ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.
Statute Number and Department	2. Go to cross reference table at end of each title which lists MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1999. This table includes those rules adopted during the period April 1, 1999 through June 30, 1999 and any proposed rule action that was pending during the past 6-month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 1999, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1998 and 1999 Montana Administrative Registers.

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