ISSUE NO. 22

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

In the matter of the proposed amendment of ARM 6.6.3504 pertaining to contents of an annual audited financial report	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On December 16, 2003, at 10:00 a.m., a public hearing will be held in the 2nd floor conference room, State Auditor's Office, 840 Helena Avenue, Helena, Montana, to consider the proposed amendment of the above-stated rule.

2. The State Auditor's Office 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 require an accommodation, contact the office no later than 5:00 p.m., December 9, 2003, to advise us of the nature of the accommodation needed. Please contact Darla Sautter, State Auditor's Office, 840 Helena Avenue, Helena, Montana 59601; telephone (406) 444-2726; facsimile (406) 444-3497; or e-mail to dsautter@state.mt.us.

3. The rule proposed to be amended provides as follows, stricken matter interlined, new matter underlined:

6.6.3504 CONTENTS OF ANNUAL AUDITED FINANCIAL REPORT

(1) through (2) remain the same.

(a) ~~R~~report of independent certified public accountant~~.~~;

(b) ~~B~~balance sheet reporting admitted assets, liabilities, capital, and surplus~~.~~;

(c) ~~S~~statement of operations~~.~~;

(d) ~~S~~statement of cash flows~~.~~;

(e) ~~S~~statement of changes in capital and surplus~~.~~; and

(f) ~~N~~notes to financial statements. These notes ~~must be the same as~~ shall be those required by the appropriate 2004 NAIC annual statement instructions and the March 2004, NAIC Accounting Practices and Procedures Manual, which are adopted and incorporated by reference, and may be obtained by writing to the NAIC Executive Headquarters, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662. ~~any other notes required by generally accepted accounting principles and must also include:~~ The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to 33-2-701, 33-4-313, 33-7-118, 33-30-107, and 33-31-211, MCA, with a written description of the nature of these differences.

~~(i) A reconciliation of differences, if any, between the audited statutory financial statements and the annual~~

~~statement filed pursuant to 33-2-701, 33-4-313, 33-7-118, 33-30-107, and 33-31-211, MCA.~~

~~(ii) A summary of ownership and relationships of the insurer and all affiliated companies.~~

(g) remains the same, but is renumbered (3).

AUTH: 33-1-313, 33-2-1517 and 33-5-413, MCA
IMP: 33-2-1517 and 33-5-413, MCA

4. REASONABLE NECESSITY STATEMENT: It is necessary to amend ARM 6.6.3504 in order to adopt changes made in the NAIC model regulation.

5. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Darla Sautter, State Auditor's Office, 840 Helena Avenue, Helena, Montana 59601; or by facsimile (406) 444-3497; or by e-mail, addressed to dsautter@state.mt.us, and must be received no later than December 24, 2003.

6. Christina L. Goe has been designated to preside over and conduct the hearing.

7. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written requests may be mailed or delivered to the State Auditor's Office, 840 Helena Avenue, Helena, Montana 59601, or by facsimile to (406) 444-3497, or e-mailed to dsautter@state.mt.us, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

8. The bill sponsor notice requirements of 2-4-302, MCA, do not apply.

JOHN MORRISON, State Auditor
and Commissioner of Insurance

By: /s/ Alicia Pichette
Alicia Pichette
Deputy Insurance Commissioner

By: /s/ Christina L. Goe
Christina L. Goe
Rule Reviewer

Certified to the Secretary of State on November 17, 2003.

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

In the matter of the adoption of Rules I through XXI and the amendment of ARM 37.40.406, 37.85.406, 37.86.2801, 37.86.2901, 37.86.2905, 37.86.2910, 37.86.3002, 37.86.3005, 37.86.3009, 37.86.3022, 37.86.3025, 37.86.3411, 37.88.205, 37.88.305, 37.88.605 and 37.88.906 pertaining to medicaid reimbursement of hospitals	)))))))))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On December 17, 2003, at 2:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption and amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on December 8, 2003, 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; Email dphhslegal@state.mt.us.

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

RULE I ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15 last updated August 27, 2002 (Pub. 15), subject to the exceptions and limitations provided in the department's administrative rules. The department adopts and incorporates by reference Pub. 15, which is a manual published by the United States department of health and human services, centers for medicare and medicaid services (CMS), which provides guidelines and policies to implement medicare regulations which set forth principles for determining the reasonable cost of provider

services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) Hospitals located in the state of Montana providing inpatient and outpatient hospital services reimbursement under the retrospective cost based methodology for a hospital that is identified by the department as a distinct part rehabilitation unit are subject to the provisions regarding cost reimbursement and coverage limits and rate of increase ceilings specified in 42 CFR 413.30 through 413.40 (2002), except as otherwise provided in these rules. This provision applies to distinct part rehabilitation units only through January 31, 2003. The department adopts and incorporates by reference 42 CFR 413.30 through 413.40 (2002). A copy of 42 CFR 413.30 through 413.40 (2002) may be obtained through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) For cost report periods ending on or after July 1, 2003, for each hospital which is not a sole community hospital, critical access hospital or exempt hospital as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1), less 5.8% of such costs.

(c) For cost report periods ending on or after July 1, 2003, for each hospital which is a sole community hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1).

(d) For cost report periods ending on or after July 1, 2003, for each hospital which is a critical access or exempt hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services shall be limited to allowable costs, as determined in accordance with (1).

(2) All hospitals reimbursed under [Rules III through XI] or ARM 37.86.3005 must submit, as provided in (3), an annual medicare cost report in which costs have been allocated to the medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(3) All hospitals reimbursed under ARM 37.86.2905, [Rules III through XI] or ARM 37.86.3005 must file the cost report with the Montana medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(a) Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's

operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

(b) In the event a provider does not file a cost report within the time limit or files an incomplete cost report, the provider's total reimbursement will be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(4) For distinct part rehabilitation units identified in ARM 37.86.2901 and [Rule VII], the base year is the facility's cost report for the first cost reporting period ending after June 30, 1985 that both covers 12 months and includes Montana medicaid inpatient hospital costs. Exceptions will be granted only as permitted by the applicable provisions of 42 CFR 413.30 or 413.40 (2002).

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE II DESK REVIEWS, OVERPAYMENTS AND UNDERPAYMENTS

(1) Upon receipt of the cost report, the department will instruct the medicare intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

(2) Where the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.

(a) In the event of an overpayment, the department will, within 30 days after the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for hospital services or by repayments by the provider.

(b) If repayment is not made within 30 days after notification to the provider, the department will make deductions from rate payments with full recovery to be completed within 60 days from the date of the initial request for payment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment and requests a fair hearing.

(3) In the event an underpayment has occurred, the department will reimburse the provider within 30 days following the department's determination of the amount.

(a) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets.

(4) Providers aggrieved by adverse determinations by the department may request an administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

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

RULE III INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) Inpatient hospital service providers shall be subject to the billing requirements set forth in ARM 37.85.406. At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice: "Notice to physicians: medicaid payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws."

(2) The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital.

(3) Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(4) The provider may, at its discretion, add to the language of this statement the word "medicare" so that two separate forms will not be required by the provider to comply with both state and federal requirements.

(5) Except for hospital resident cases, a provider may not submit a claim until the recipient has been either:

(a) discharged from the hospital;

(b) transferred to another hospital; or

(c) designated by the department as a hospital resident as set forth in ARM 37.86.2901.

(6) The medicaid statewide average cost to charge ratio excluding capital expenses is 56%.

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

RULE IV INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, DIAGNOSIS RELATED GROUP (DRG) PAYMENT RATE DETERMINATION

(1) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:

(a) Prior to October 1st of each year, the department will assign a DRG to each medicaid discharge in accordance with the current medicare grouper program version, as developed by 3M health information systems. The assignment of each DRG is based on:

(i) the ICD-9-CM principal diagnoses;

(ii) the ICD-9-CM secondary diagnoses;

(iii) the ICD-9-CM medical procedures performed during the recipient's hospital stay;

(iv) the recipient's age;

(v) the recipient's sex; and

(vi) the recipient's discharge status.

(b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which reflects the cost of hospital resources used to treat cases in that DRG relative to the statewide average cost of all medicaid hospital cases. The relative weight for each DRG is available upon request from Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, effective for services provided on or after August 1, 2003.

(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective payment rate for that discharge except where there is no weight assigned to a DRG. Referred to as "exempt", the DRG will be paid at the statewide cost to charge ratio as defined in [Rule III].

(2) For those Montana hospitals designated by the department as of April 1, 1993 as having neonatal intensive care units, reimbursement for neonatal DRGs 385 through 389 shall be actual allowable cost determined on a retrospective basis, with allowable costs determined according to [Rule I].

(a) Such facilities shall be reimbursed on an interim basis during each facility's fiscal year. The interim rate shall be a percentage of usual and customary charges, and the percentage shall be the facility-specific cost to charge ratio, determined by the department in accordance with medicare reimbursement principles.

(b) Such hospitals shall not receive any cost outlier payment or other add-on payment with respect to such discharges or services.

(3) The Montana medicaid DRG relative weight values, average length of stay (ALOS), outlier thresholds and stop loss thresholds are contained in the DRG table of weights and thresholds (2002). The DRG table of weights and thresholds is published by the department. The department adopts and incorporates by reference the DRG table of weights and thresholds (2002). Copies may be obtained from the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

RULE V INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, 1992. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through October 1, 1992, which set forth medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Prior to settlement based on audited costs, the department will make interim payments for each facility's capital-related costs as follows:

(a) The department will identify the facility's total allowable medicaid inpatient capital-related costs from the facility's most recent audited or desk reviewed cost report. These costs will be used as a base amount for interim payments. The base amount may be revised if the provider can demonstrate an increase in capital-related costs as a result of an approved certificate of need that is not reflected in the base amount.

(b) All border hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case is $229. This rate shall be the final capital-related cost with respect to which the department waives retrospective cost settlement in accordance with these rules.

(c) The department will make interim capital payments with each inpatient hospital claim paid.

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

RULE VI INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, MEDICAL EDUCATION COSTS (1) The department shall reimburse inpatient hospital service providers for medical education related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(b), as amended through October 1, 1992.

(2) Prior to settlement based on audited costs, the department shall make interim payments for each facility's medical education related costs as follows:

(a) The department shall identify the facility's total allowable medicaid inpatient medical education related costs from the facility's most recent audited cost report. These costs will be used as a base amount for interim payments.

(b) The department will make interim medical education related cost reimbursement payments with each inpatient hospital claim paid.

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

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

RULE VII INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, COST OUTLIERS (1) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may receive payment as provided in this rule for cost outliers for DRGs other than neonatal DRGs 385 through 389 provided by neonatal intensive care units described in [Rule IV].

(2) To receive payment for a cost outlier, the combined cost of the medically necessary days and services of the inpatient hospital stay, as determined by the department, must exceed the cost outlier threshold established by the department for the DRG.

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

(a) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in [Rule III];

(b) subtracting the cost outlier threshold amount from the estimated costs to compute the cost outlier amount; and

(c) multiplying the cost outlier amount by 60% to establish the marginal cost outlier payment for the hospital stay.

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

RULE VIII INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, READMISSIONS AND TRANSFERS (1) All readmissions occurring within 30 days will be subject to review to determine whether additional payment as a new DRG or as an outlier is warranted. As a result of the readmission review, the following payment changes will be made:

(a) if it is determined that complications have arisen because of premature discharge and/or other treatment errors, then the DRG payment for the first admission shall be altered by combining the two admissions into one for payment purposes; or

(b) if it is determined that the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department will combine the two admissions into one for payment purposes.

(2) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for continuation of medical treatment between two hospitals, one of which is paid under the Montana medicaid prospective payment system.

(a) A transferring hospital reimbursed under the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for

each subsequent day of inpatient care determined by dividing the sum of the DRG payment for the case as computed in [Rule IV] and the appropriate outlier as computed in [Rule VII], if any, by the statewide average length of stay for the DRG; or

(ii) the sum of the DRG payment for the case as computed in [Rule IV] and the appropriate outlier as computed in [Rule VII], if any.

(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under [Rule IV] is paid the full DRG payment plus any appropriate outliers.

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

RULE IX INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, HOSPITAL RESIDENTS (1) Payment for hospital residents will be made as follows:

(a) upon obtaining hospital residency status, claims for that recipient may be billed on an interim basis;

(b) payment for the first 180 days of inpatient care will be the DRG payment for the case as computed in [Rule IV] and any appropriate outlier payment as computed in [Rule VII]; and

(c) payment for all patient care subsequent to 180 days will be reimbursed at a rate computed by multiplying the statewide average cost to charge ratio by the usual and customary billed charges.

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

RULE X INPATIENT HOSPITAL REIMBURSEMENT, DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS (1) Disproportionate share hospitals shall receive an additional payment amount equal to the product of the hospital's prospective base rate times the adjustment percentage of:

(a) 4% for rural hospitals; or

(b) 5% for urban hospitals.

(2) Subject to federal approval and the availability of sufficient state special revenue, all supplemental disproportionate share hospitals shall receive a supplemental disproportionate share hospital payment. In order to maintain access and quality in the most rural areas in Montana, critical access hospitals and exempt hospitals shall receive an increased portion of the available funding. The supplemental disproportionate share hospital payment shall be calculated using the formula: SDSH=(M/D)*P.

(a) For the purposes of the determining supplemental disproportionate share hospital payment amounts, the following definitions apply:

(i) "SDSH" represents the calculated supplemental disproportionate share hospital amount.

(ii) "M" represents the number of weighted medicaid paid

inpatient days provided by the hospital for which the payment amount is being calculated.

(A) For critical access hospitals and exempt hospitals, weighted medicaid inpatient days shall equal the number of medicaid inpatient days provided multiplied by 3.8.

(B) For all other hospitals, weighted medicaid inpatient days equals the number of medicaid paid inpatient days provided.

(iii) "D" equals the total number of weighted medicaid paid inpatient days provided by all supplemental disproportionate share hospitals in Montana.

(iv) "P" equals the unexpended, unencumbered disproportionate share hospital allotment for Montana, as determined by CMS according to section 1923 of the Social Security Act, remaining after routine disproportionate share hospital payments have been calculated according to (1), plus the state financial participation.

(v) The figures used in (2)(a)(ii) and (iii) must be from the department's paid claims data for the hospital's fiscal year that ended in the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

(3) Disproportionate share hospital payments will be limited to the cap established by the federal health care financing administration for the state of Montana. The adjustment percentages specified in this rule shall be ratably reduced as determined necessary by the department to avoid exceeding the cap.

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

RULE XI INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CERTIFIED REGISTERED NURSE ANESTHETISTS (1) If the secretary of health and human services has granted the facility authorization for continuation of cost pass-through under section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 608(c) of the Family Support Act of 1988 (Public Law 100-485), the department shall reimburse inpatient hospital service providers for certified registered nurse anesthetist costs on a reasonable cost basis as provided in ARM 37.86.2801(2).

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

RULE XII INPATIENT HOSPITAL REIMBURSEMENT, HOSPITAL REIMBURSEMENT ADJUSTOR (1) All hospitals meeting the eligibility requirements in [Rule XVI] shall receive a hospital reimbursement adjustor (HRA) payment. The payment consists of two separately calculated amounts. In order to maintain access and quality in the most rural areas of Montana, critical access hospitals and exempt hospitals shall receive both components of the HRA. All other hospitals shall receive only Part 1, as

defined below in (2)(a). For the purposes of determining HRA payment amounts, the following apply:

(2) Part 1 of the HRA payment will be based upon medicaid inpatient utilization, and will be computed as follows: HRA1=[M/D]*P.

(a) For the purposes of calculating Part 1 of the HRA, the following apply:

(i) "HRA1" represents the calculated Part 1 HRA payment.

(ii) "M" equals the number of medicaid inpatient days provided by the hospital for which the payment amount is being calculated.

(iii) "D" equals the total number of medicaid inpatient days provided by all hospitals eligible to receive an HRA payment.

(iv) "P" equals the total amount to be paid via Part 1 of the HRA. The state's share of "P" will be the total amount of revenue generated by Montana's hospital utilization fee, less all of the following:

(A) the amount expended as match for supplemental DSH payments as provided in ARM 37.56.2912;

(B) 4% of the total revenue generated by the hospital utilization fee, which will be expended as match for continuity of care adjustor payments, as provided in ARM 37.88.1106; and

(C) 5% of the total revenue generated by the hospital utilization fee, which will be expended as match for Part 2 of the HRA, as provided in (3).

(3) Part 2 of the IRA payment will be based upon total inpatient utilization, and will be computed as follows: HRA2=[I/D]*P.

(a) For the purposes of calculating Part 2 of the HRA, the following apply:

(i) "HRA2" represents the calculated Part 2 HRA payment.

(ii) "I" equals the number of inpatient days provided by the hospital for which the payment is being calculated.

(iii) "D" equals the total number of inpatient days provided by all hospitals eligible to receive Part 2 of the HRA payment.

(iv) "P" equals the total amount to be paid via Part 2 of the HRA. The state's share of "P" will be 5% of the total revenue generated by Montana's hospital utilization fee.

(b) The numbers used in (2) through (2)(a)(ii)(C) must be from the department's paid claims data from the hospital's fiscal year that ended in the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

(c) The numbers used in (3) through (3)(a)(iv) must be from the hospital utilization fee report filed with the department of revenue, in accordance with 15-66-201, MCA, and applicable rules administered by the department of revenue. The report must be from the previous calendar year.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE XIII MENTAL HEALTH OUTPATIENT PARTIAL HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY (1) Medicaid reimbursement is not available for outpatient partial hospitalization services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need, certifying that:

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

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

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

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

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

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

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

(b) made by a team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. No more than one member of the team of health care professionals may be professionally or financially associated with a partial hospitalization program. The team must include:

(i) a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry;

(ii) a licensed mental health professional; and

(iii) an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department.

(3) For recipients who are being transferred from a hospital's acute inpatient program to the same facility's partial hospitalization program, the certificate of need required under (1) may be completed by a facility based team of health care professionals:

(a) that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's psychiatric condition;

(b) that includes a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, and a licensed mental health professional; and

(c) the certificate of need must also be signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health

services as designated by the department.

(4) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need required under (1) is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed by the department or its designee at the request of the department, a provider, the individual or the individual's parent or guardian. Request for retrospective review must be:

(a) received within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from the partial hospitalization program; or

(b) received within 90 days after the eligibility determination for recipients determined eligible after discharge from the partial hospitalization program.

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

(6) Prior authorization is not a guarantee of payment as medicaid rules and regulations, client eligibility, or additional medical information on retrospective review may cause the department to refuse payment.

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

RULE XIV RESIDENTIAL PSYCHIATRIC CARE OUTSIDE MONTANA

(1) Payment for inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 37.85.207(3) and these rules. The Montana medicaid program will not make payment according to ARM 37.85.207(3)(b) or (c) for inpatient psychiatric services provided by residential treatment facilities located outside the state of Montana unless the department or its designee determines, as provided in this rule, that the services were unavailable in the state of Montana.

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

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

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

(3) The department or its designee will not commence a preadmission review for or certify an admission to an out-of-state residential treatment facility until receiving from the

prospective facility written verification that the recipient cannot be served within the state of Montana. Written verification must be provided in a form approved by the department or its designee, and must be completed and signed on behalf of in-state facilities indicating that the requirements of (2)(a) or (2)(b) are met. In-state facilities that do not complete, sign and return the form by fax to the prospective out-of-state provider within three days after receipt will be deemed to be unable to serve the recipient.

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

RULE XV ROUTINE DISPROPORTIONATE SHARE HOSPITAL (1) A hospital is eligible for routine disproportionate share hospital designation if:

(a) it has a medicaid inpatient utilization rate of at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in Montana or a low income utilization rate exceeding 20%; and

(b) it has a medicaid inpatient utilization rate of at least 1%.

(2) Urban hospitals must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to medicaid patients. Rural hospitals must have at least two physicians with staff privileges to perform non-emergent obstetric procedures who have agreed to provide obstetric services to medicaid recipients.

(3) This rule does not apply to hospitals which:

(a) serve inpatients who are predominantly individuals under 18 years of age; or

(b) do not offer non-emergent obstetric services as of December 21, 1987.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE XVI HOSPITAL REIMBURSEMENT ADJUSTOR (HRA), DATA SOURCES (1) A hospital reimbursement adjustor (HRA) payment will be made to an eligible Montana hospital licensed pursuant to Title 50, chapter 5, MCA, as either a hospital or a critical access hospital, that provides inpatient hospital services.

(2) Data sources for the department to determine which hospitals meet the criteria to receive an HRA payment, and the amount of the payment, may include, but are not limited to:

(a) the Montana hospital association (MHA) database;

(b) the medicaid paid claims database;

(c) filed or settled cost reports; and

(d) reports from the licensing bureau of the quality assurance division.

(3) Eligibility evaluations, payment amount calculations, and payments will be made annually.

(4) The Montana state hospital is not eligible for HRA.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE XVII HOSPITAL RESIDENCY STATUS (1) A recipient who is unable to be cared for in a setting other than the acute care hospital is eligible for hospital residency status.

(2) To obtain hospital residency status, the recipient must meet the following requirements:

(a) the recipient must utilize a ventilator for a continuous period of not less than eight hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period; and

(b) the recipient must have been an inpatient in an inpatient hospital for a minimum of six continuous months.

(3) The provider will have the responsibility of determining whether services could be provided in a skilled nursing care facility or by the home and community based waiver program to a medicaid recipient within the state of Montana.

(4) The provider shall maintain written records of inquiries and responses about the present and future availability of openings in nursing homes and the home and community based waiver program.

(5) A redetermination of nursing home or waiver availability must be made at least every six months.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE XVIII CALCULATING ROUTINE AND SUPPLEMENTAL DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (1) A Montana hospital may receive a low income utilization payment, whether a hospital is deemed a routine disproportionate share hospital. The percentage rate is computed as follows:

(a) LIUR=((A + B)/C) + (D/E) where:

(i) "LIUR" is the low income utilization rate;

(ii) "A" is the total revenue paid to the hospital to determine patient services under the medicaid state plan regardless of whether the services were furnished on a fee-for-service basis or through a managed care program in the hospital's fiscal year;

(iii) "B" is the cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year;

(iv) "C" is the total revenues of the hospital for patient services, including the amount of such cash subsidies in the hospital's fiscal year;

(v) "D" is the total hospital charges for inpatient hospital services attributable to charity care in the hospital's fiscal year, less any amount received for payment of these charges attributable to inpatient services. This amount shall not include contractual allowances and discounts (other than for

indigent patients not eligible for public assistance); and

(vi) "E" is the hospital's total charges for inpatient hospital services in the hospital's fiscal year.

(b) The above amounts used in the formula must be from the hospital's most recent fiscal year for which initial cost reports are available for all hospital providers.

AUTH: Sec. 2-4-201, 53-2-201 and 53-6-113, MCA
IMP: Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-149, MCA

RULE XIX MEDICAID UTILIZATION RATE (1) A hospital's medicaid utilization rate is the hospital's percentage rate computed by dividing the total number of medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period.

(2) The period used to determine whether a hospital is deemed a routine disproportionate share hospital will be the most recent calendar year for which final cost reports are available for all hospital providers.

(3) The period used to determine whether a hospital is deemed a supplemental disproportionate share hospital will be the same period used to calculate the amounts of the supplemental DSH payments, as provided in [Rule X].

(a) An inpatient day includes each day in which an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward or whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(b) The period used for determining the medicaid inpatient utilization rate will be the most recent calendar year for which final inpatient days and initial cost reports are available for all hospital providers.

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

RULE XX BORDER HOSPITAL REIMBURSEMENT (1) Inpatient hospital services provided in border hospitals will be reimbursed under the DRG prospective payment system described in [Rules IV through IX and XI].

(2) In addition to the prospective rate, border hospitals will be reimbursed for cost outliers as set forth in [Rule VII], and for capital costs as set forth in [Rule V], but shall not be reimbursed in addition to the DRG payment for medical education costs, neonatal intensive care stop-loss reimbursement or certified registered nurse anesthetist costs.

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

RULE XXI OUT-OF-STATE HOSPITAL REIMBURSEMENT

(1) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of

Montana will be reimbursed 50% of usual and customary billed charges for medically necessary services.

(2) Medicaid reimbursement for inpatient services shall not be made to hospitals located more than 100 miles outside the borders of Montana unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized within 48 hours.

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

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

37.40.406 SWING-BED HOSPITALS, REIMBURSEMENT (1) Montana medicaid will reimburse swing-bed hospitals as provided in this ~~section~~ rule for swing-bed hospital services provided in accordance with all applicable swing-bed hospital service requirements specified in ARM 37.40.401, 37.40.402, 37.40.405 and ~~37.40.406~~ this rule and subject to all other applicable laws and regulations.

(2) For swing-bed hospital services, the Montana medicaid program will pay a provider a per diem rate as specified in (2)(a) for each medicaid patient day, plus additional reimbursement for separately billable items as provided in (2)(b).

(a) The swing-bed hospital services per diem rate is the average medicaid per diem rate paid to nursing facilities under ARM 37.40.307 for routine services furnished during the calendar year immediately previous to the year in which the swing-bed hospital services are provided. Nursing facility routine services are those services included in the definition of "nursing facility services" specified at ARM 37.40.302~~(14)~~.

(b) and (c) remain the same.

(3) For purposes of reporting costs under ~~ARM 37.86.2801~~ [Rule I], inpatient hospital services providers which also provide swing-bed hospital services shall allocate hospital inpatient general routine service costs associated with swing-bed hospital services on the medicare "carve out" method as specified in 42 CFR 413.53(a)(2). The department ~~hereby~~ adopts and incorporates by reference 42 CFR 413.53(a)(2)(2004). A copy of 42 CFR 413.53(a)(2) may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(4) and (5) remain the same.

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

37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND

PAYMENT (1) Providers must submit clean claims to medicaid within the latest of:

(a) through (a)(iii) remain the same.

(b) ~~6~~ six months from the date on the medicare explanation of benefits approving the service, if the medicare claim was timely filed and the recipient was medicare eligible at the time the medicare claim was filed; or

(c) ~~6~~ six months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1)(a) and (b).

(2) For purposes of this rule:

(a) through (c) remain the same.

(d) The claim submission deadline specified in (1) through (1)(c) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to medicaid according to the requirements of ARM 37.85.407(6)(c) and subject to the claim submission deadline specified in (1) through (1)(c).

(3) through (7) remain the same.

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (5)(b) ~~above~~.

(a) remains the same.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this ~~subsection~~ rule, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) through (21)(z) remain the same.

(22) The net pay reimbursement for the provider types listed in (21) is 7% less than the amount provided in the following rules: ARM 37.83.811, 37.83.812, 37.83.825, 37.85.212, 37.86.105, 37.86.205, 37.86.506, 37.86.610, 37.86.705, 37.86.1004, 37.86.1005, 37.86.1406, 37.86.1806, 37.86.1807, 37.86.2005, 37.86.2207, 37.86.2209, 37.86.2211, 37.86.2405, 37.86.2505, 37.86.2605, 37.86.2801, 37.86.2905, 37.86.3005, 37.86.3007, 37.86.3009, 37.86.3011, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3205, ~~and~~ 37.86.4205, [Rules III, IV, V, VI, VII, VIII, IX, X, XI and XIII].

(a) remains the same.

(23) Notwithstanding any other provision, critical access hospital interim reimbursement is based on hospital specific medicaid cost to change ratio. Critical access hospitals will still be reimbursed their actual allowable costs determined on a retrospective basis as provided in ~~ARM 37.86.2801~~ [Rule I].

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

37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL

(1) Reimbursement for inpatient hospital services is set forth in ARM 37.86.2905, and [Rules III through XII]. Reimbursement for outpatient hospital services is set forth in ARM 37.86.3005. The reimbursement period will be the provider's fiscal year. Cost of hospital services will be determined for inpatient and outpatient care separately. Administratively necessary days are not a benefit of the Montana medicaid program.

~~(a)~~ (2) The department may require providers of inpatient or outpatient hospital services to obtain authorization from the department or its designated review organization either prior to provision of services or prior to payment.

~~(i)~~ (3) Medicaid reimbursement shall not be made unless the provider has obtained authorization from the department or its designated review organization prior to providing any of the following services:

~~(A)~~ (a) inpatient psychiatric services provided in an acute care general hospital or a distinct part psychiatric unit of an acute care general hospital, as required by ARM 37.88.101~~.~~;

~~(B)~~ (b) inpatient rehabilitation services;

~~(C)~~ (c) except as provided in ~~(1)(a)(ii)~~ (4) all inpatient and outpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana;

~~(D)~~ (d) services related to organ transplantations covered under ARM 37.86.4701 and 37.86.4705; or

~~(E)~~ (e) outpatient partial hospitalization, as required by ARM 37.88.101.

~~(ii)~~ (4) Upon the request of an inpatient or outpatient hospital located more than 100 miles outside the borders of the state of Montana:

~~(A)~~ (a) the department may grant retrospective authorization if the person to whom services were provided was determined by the department to be retroactively eligible for Montana medicaid benefits including hospital benefits; or

~~(B)~~ (b) the department may grant retrospective authorization if the hospital is retroactively enrolled as a Montana medicaid provider, and the enrollment includes the dates of service for which authorization is requested; but

~~(C)~~ (c) the department may not grant retrospective authorization to a hospital under any other circumstances.

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

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

~~(ii) the recipient cannot be safely and appropriately~~

~~treated or contained in a less restrictive level of care;~~

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

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

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

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

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

~~(ii) made by a team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, a licensed mental health professional and an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department. No more than one member of the team of health care professionals may be professionally or financially associated with a partial hospitalization program.~~

~~(d) For recipients who are being transferred from a hospital's acute inpatient program to the same facility's partial hospitalization program, the certificate of need required under (1)(b) may be completed by a facility-based team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, and a licensed mental health professional. The certificate of need must also be signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department.~~

~~(e) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need required under (1)(b) is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed by the department or its designee at the request of the department, a provider, the individual or the individual's parent or guardian. Request for retrospective review must be:~~

~~(i) received within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from the partial hospitalization program; or~~

~~(ii) received within 90 days after the eligibility~~

~~determination for recipients determined eligible after discharge from the partial hospitalization program.~~

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

~~(g) Prior authorization is not a guarantee of payment as medicaid rules and regulations, client eligibility, or additional medical information on retrospective review may cause the department to refuse payment.~~

~~(2) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15 last updated August 27, 2002 (Pub. 15), subject to the exceptions and limitations provided in the department's administrative rules. The department adopts and incorporates by reference Pub. 15, which is a manual published by the United States department of health and human services, centers for medicare and medicaid services (CMS), which provides guidelines and policies to implement medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(a) Hospitals located in the state of Montana providing inpatient and outpatient hospital services reimbursement under the retrospective cost-based methodology for a hospital that is identified by the department as a distinct part rehabilitation unit are subject to the provisions regarding cost reimbursement and coverage limits and rate of increase ceilings specified in 42 CFR 413.30 through 413.40 (1992), except as otherwise provided in these rules. This provision applies to distinct part rehabilitation units only through January 31, 2003. The department hereby adopts and incorporates herein by reference 42 CFR 413.30 through 413.40 (1992). A copy of 42 CFR 413.30 through 413.40 (1992) may be obtained through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(b) For cost report periods ending on or after July 1, 2003, for each hospital which is not a sole community hospital, critical access hospital or exempt hospital as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (2), less 5.8% of such costs.~~

~~(c) For cost report periods ending on or after July 1, 2003, for each hospital which is a sole community hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related~~

~~costs of such services, shall be limited to allowable costs, as determined in accordance with (2).~~

~~(d) For cost report periods ending on or after July 1, 2003, for each hospital which is a critical access or exempt hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services shall be limited to allowable costs, as determined in accordance with (2).~~

~~(3) All hospitals reimbursed under ARM 37.86.2905 or 37.86.3005 must submit, as provided in ARM 37.86.2801(4), an annual medicare cost report in which costs have been allocated to the medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.~~

~~(4) All hospitals reimbursed under ARM 37.86.2905 or 37.86.3005 must file the cost report with the Montana medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. In the event a provider does not file a cost report within the time limit or files an incomplete cost report, the provider's total reimbursement will be withheld. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.~~

~~(5) For distinct part rehabilitation units identified in ARM 37.86.2901(7), the base year is the facility's cost report for the first cost reporting period ending after June 30, 1985 that both covers 12 months and includes Montana medicaid inpatient hospital costs. Exceptions will be granted only as permitted by the applicable provisions of 42 CFR 413.30 or 413.40 (1992).~~

~~(6) Upon receipt of the cost report, the department will instruct the medicare intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.~~

~~(7) Overpayments and underpayments will be dealt with as follows:~~

~~(a) Where the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.~~

~~(b) In the event of an overpayment, the department will, within 30 days after the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for hospital services or by repayments by the provider.~~

~~(c) If repayment is not made within 30 days after notification to the provider, the department will make deductions from rate payments with full recovery to be completed~~

~~within 60 days from the date of the initial request for payment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment and requests a fair hearing.~~

~~(d) In the event an underpayment has occurred, the department will reimburse the provider within 30 days following the department's determination of the amount.~~

~~(e) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefitted from either the payment or from a transfer of assets.~~

~~(8) Providers aggrieved by adverse determinations by the department may request an administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.~~

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

37.86.2901 INPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) "Administratively necessary days" or "inappropriate level of care services" ~~are~~ means those services for which alternative placement of a patient is planned and/or effected and for which there is no medical necessity for acute level inpatient hospital care.

(2) "Border hospital" means a hospital located outside Montana, but no more than 100 miles from the border.

(3) "Cost outlier" ~~is~~ means an unusually high cost case that exceeds the cost outlier thresholds as set forth in ~~ARM 37.86.2905(6)~~ [Rule VII].

(4) "Critical access hospital" means a limited-service rural hospital licensed by the Montana department of public health and human services.

(5) "Direct nursing care" means the care given directly to the patient which requires the skills and expertise of an RN or LPN.

~~(5)~~ (6) "Discharging hospital" ~~is~~ means a hospital, other than a transferring hospital, that formally discharges an inpatient. Release of a patient to another hospital, as described in ~~(17)~~ (20) or a leave of absence from the hospital will not be recognized as a discharge. A patient who dies in the hospital is considered a discharge.

~~(6)~~ (17) "~~Disproportionate~~ Routine disproportionate share hospital" means a hospital in Montana which meets the ~~following~~ criteria of [Rule XVI].~~:~~

~~(a) it has a medicaid inpatient utilization rate of at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state or a low income utilization rate exceeding 20%; and~~

~~(b) it has a medicaid inpatient utilization rate of at least 1%; and~~

~~(c) urban hospitals must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to medicaid patients. Rural hospitals must have at least two physicians with staff privileges to perform nonemergent obstetric procedures who have agreed to provide obstetric services to medicaid recipients.~~

~~(d) subsection (6)(c) does not apply to hospitals which:~~

~~(i) serve inpatients who are predominantly individuals under 18 years of age; or~~

~~(ii) do not offer non-emergent obstetric services as of December 21, 1987.~~

(7) "Distinct part rehabilitation unit" ~~is~~ means a unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 412.29 (1992).

(8) "Exempt hospital" means, for purposes of determining whether a hospital is exempt from the prospective payment system under ARM 37.86.2905~~(1)(a)~~, an acute care hospital that is located in a Montana county designated on or before July 1, 1991 as continuum code 8 or continuum code 9 by the United States department of agriculture under its rural-urban continuum codes for metro and nonmetro counties.

(9) "Hospital reimbursement adjustor" (HRA) means a payment to a Montana hospital as specified in [Rule XVI].

(10) "Hospital resident" means a recipient who is unable to be cared for in a setting other than the acute care hospital as provided in [Rule XVII].

~~(9)~~ (11) "Inpatient" means a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person generally is considered an inpatient if formally admitted as an inpatient with an expectation that the patient will remain more than 24 hours. The physician or other practitioner is responsible for deciding whether the patient should be admitted as an inpatient. Inpatient hospital admissions are subject to retrospective review by the medicaid peer review organization (PRO) to determine whether the inpatient admission was medically necessary for medicaid payment purposes.

~~(10)~~ (12) "Inpatient hospital services" means services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist or other practitioner as permitted by federal law, and that are furnished in an institution that:

(a) is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;

(b) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

(c) except as otherwise permitted by federal law, meets the requirements for participation in medicare as a hospital and has in effect a utilization review plan that meets the requirements of 42 CFR 482.30.

~~(11)~~ (13) "Large referral hospital" means an acute care hospital located in the state of Montana that serves as a

referral center and has been determined by the department as of April 1, 1993 to have a case mix with a statistically demonstrated level of intensity of care which is higher than the norm for Montana acute care hospitals. Such facilities are Benefis Health Care (Great Falls), Deaconess Medical Center (Billings), Community Medical Center (Missoula), St. James Hospital (Butte), St. Patrick's Hospital (Missoula) and St. Vincent's Hospital (Billings).

(14) "Low income utilization rate" means a payment to a Montana hospital as specified in [Rule XVIII].

(15) "Medicaid inpatient utilization rate" means a hospital's percentage rate as specified in [Rule XIX].

~~(12) "Low income utilization rate" for determining whether a hospital is deemed a disproportionate share hospital, is the percentage rate computed as follows:~~

~~(a) ((A + B)/C) + (D/E) where:~~

~~(i) "A" is the total revenue paid to the hospital for patient services under the medicaid state plan regardless of whether the services were furnished on a fee-for-service basis or through a managed care program in the hospital's fiscal year;~~

~~(ii) "B" is the cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year;~~

~~(iii) "C" is the total revenues of the hospital for patient services, including the amount of such cash subsidies in the hospital's fiscal year;~~

~~(iv) "D" is the total hospital charges for inpatient hospital services attributable to charity care in the hospital's fiscal year, less any amount received for payment of these charges attributable to inpatient services. This amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for public assistance); and~~

~~(v) "E" is the hospital's total charges for inpatient hospital services in the hospital's fiscal year.~~

~~(b) The above amounts used in the formula must be from the hospital's most recent fiscal year for which initial cost reports are available for all hospital providers.~~

~~(13) "Medicaid inpatient utilization rate" for determining whether a hospital is deemed a disproportionate share hospital means the hospital's percentage rate computed by dividing the total number of medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period. The period used will be the most recent calendar year for which final cost reports are available for all hospital providers.~~

~~(a) The term inpatient day in (13) includes each day in which an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward or whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

~~(b) The period used for determining the medicaid inpatient utilization rate will be the most recent calendar year for which final inpatient days and initial cost reports are available for all hospital providers.~~

~~(14)~~ (16) "Qualified rate adjustment payment" (QRA) means an additional payment as provided in ARM 37.86.2910 to a county owned, county operated or partially county funded rural hospital in Montana where the hospital's most recently reported costs are greater than the reimbursement received from Montana medicaid for inpatient care.

~~(15)~~ (18) "Rural hospital" means for purposes of determining disproportionate share hospital payments, an acute care hospital that is located within a "rural area" as defined in 42 CFR 412.62(f)(iii).

~~(16)~~ (19) "Sole community hospital" ~~is~~ means a DRG reimbursed hospital classified as such by the centers for medicare and medicaid services (CMS) in accordance with 42 CFR 412.92(a) through (d) ~~(1986)~~ and/or hospitals with less than 51 beds.

(20) "Supplemental disproportionate share hospital" means a hospital in Montana which meets the criteria in [Rule X].

~~(17)~~ (21) "Transferring hospital" ~~is~~ means a hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

~~(18)~~ (22) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area, as defined in 42 CFR 412.62(f)(2).

AUTH: Sec. 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141 and 53-6-149, MCA

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT ~~(1) For inpatient hospital services, the Montana medicaid program will reimburse providers as follows:~~

~~(a)~~ (1) For inpatient hospital services, including inpatient rehabilitation services and services provided in a setting that is identified by the department as a distinct part rehabilitation unit, provided within the state of Montana, providers will be reimbursed under the diagnosis related groups (DRG) prospective payment system described in [Rules IV through IX and XI]. ~~(2) except as otherwise specified in these rules. For medicare certified rehabilitation units (through January 31, 2003 only), exempt hospitals and critical access hospitals interim reimbursement is based on hospital specific medicaid inpatient cost to charge ratio, not to exceed 100%. Exempt hospitals and critical access hospitals will be reimbursed their actual allowable costs determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2801(2).~~

(2) Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system ~~will~~ may be reimbursed, in addition to the prospective DRG rate, for the following:

~~(i)~~ (a) capital-related costs as set forth in ~~(4)~~ [Rule V];

~~(ii)~~ (b) medical education costs as set forth in ~~(5)~~ [Rule VI];

~~(iii)~~ (c) cost outliers as set forth in ~~(6)~~ [Rule VII];

(d) readmissions and transfers, as set forth in [Rule VIII];

(e) hospital residents, as set forth in [Rule IX];

~~(iv) certified registered nurse anesthetist costs as provided in (15); and~~

~~(v)~~ (f) disproportionate share hospital payments as provided in ~~(13) and (14).~~ [Rule X];

(g) certified registered nurse anesthetist costs as provided in [Rule XI];

(h) qualified rate adjustor payments, as set forth in ARM 37.86.2910; and

(i) hospital reimbursement adjustor payments as provided in [Rule XII].

~~(b) Inpatient hospital services provided in hospitals located outside the state of Montana, but no more than 100 miles from the border, referred to in these rules as "border hospitals", will be reimbursed under the DRG prospective payment system described in (2). In addition to the prospective rate, border hospitals will be reimbursed for cost outliers as set forth in (6), and for capital costs as set forth in (4), but shall not be reimbursed in addition to the DRG payment for medical education costs, neonatal intensive care stop-loss reimbursement or certified registered nurse anesthetist costs or catastrophic cases.~~

~~(c) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana will be reimbursed 50% of usual and customary billed charges for medically necessary services.~~

~~(i) Medicaid reimbursement for inpatient services shall not be made to hospitals located more than 100 miles outside the borders of Montana unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized within 48 hours.~~

~~(2) The department's DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to DRGs. The procedure for determining the DRG prospective payment rate is as follows:~~

~~(a) Prior to October 1st of each year, the department will assign a DRG to each medicaid discharge in accordance with the current medicare grouper program version, as developed by 3M health information systems. The assignment of each DRG is based on:~~

~~(i) the ICD-9-CM principal diagnosis;~~

~~(ii) the ICD-9-CM secondary diagnoses;~~

~~(iii) the ICD-9-CM medical procedures performed during the recipient's hospital stay;~~

~~(iv) the recipient's age;~~

~~(v) the recipient's sex;~~

~~(vi) the recipient's discharge status.~~

~~(b) For each DRG, the department determines a relative weight, depending upon whether or not the hospital is a large referral hospital, which reflects the cost of hospital resources~~

~~used to treat cases in that DRG relative to the statewide average cost of all medicaid hospital cases. The relative weight for each DRG is available upon request from Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, effective for services provided on or after August 1, 2003.~~

~~(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective payment rate for that discharge except where there is no weight assigned to a DRG, referred to as "exempt", the DRG will be paid at the statewide cost to charge ratio as defined in (12).~~

~~(3) For those Montana hospitals designated by the department as of April 1, 1993 as having neonatal intensive care units, reimbursement for neonatal DRG's 385 through 389 shall be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2801(2). Such facilities shall be reimbursed on an interim basis during each facility's fiscal year. The interim rate shall be a percentage of usual and customary charges, and the percentage shall be the facility-specific cost to charge ratio, determined by the department in accordance with medicare reimbursement principles. Such hospitals shall not receive any cost outlier payment or other add-on payment with respect to such discharges or services.~~

~~(4) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, 1992. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through October 1, 1992, which set forth medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(a) Prior to settlement based on audited costs, the department will make interim payments for each facility's capital-related costs as follows:~~

~~(i) The department will identify the facility's total allowable medicaid inpatient capital-related costs from the facility's most recent audited or desk reviewed cost report. These costs will be used as a base amount for interim payments. The base amount may be revised if the provider can demonstrate an increase in capital-related costs as a result of an approved certificate of need that is not reflected in the base amount.~~

~~(ii) All border hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case is $229.~~

~~Such rate shall be the final capital-related cost with respect to which the department waives retrospective cost settlement in accordance with these rules.~~

~~(iii) The department will make interim capital payments with each inpatient hospital claim paid.~~

~~(5) The department shall reimburse inpatient hospital service providers for medical education related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(b), as amended through October 1, 1992.~~

~~(a) Prior to settlement based on audited costs, the department shall make interim payments for each facility's medical education related costs as follows:~~

~~(i) The department shall identify the facility's total allowable medicaid inpatient medical education related costs from the facility's most recent audited cost report. These costs will be used as a base amount for interim payments.~~

~~(ii) The department will make interim medical education related cost reimbursement payments with each inpatient hospital claim paid.~~

~~(6) In addition to the DRG payment, providers reimbursed under the DRG prospective payment system may receive payment as provided in this section for cost outliers for DRGs other than neonatal DRGs 385 through 389 provided by neonatal intensive care units described in (3).~~

~~(a) To receive payment for a cost outlier, the combined cost of the medically necessary days and services of the inpatient hospital stay, as determined by the department, must exceed the cost outlier threshold established by the department for the DRG.~~

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

~~(i) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide medicaid cost to charge ratio set forth in (11);~~

~~(ii) subtracting the cost outlier threshold amount from the estimated costs to compute the cost outlier amount; and~~

~~(iii) multiplying the cost outlier amount by 60% to establish the marginal cost outlier payment for the hospital stay.~~

~~(7) All readmissions occurring within 30 days will be subject to review to determine whether additional payment as a new DRG or as an outlier is warranted. As a result of the readmission review, the following payment changes will be made:~~

~~(a) if it is determined that complications have arisen because of premature discharge and/or other treatment errors, then the DRG payment for the first admission shall be altered by combining the two admissions into one for payment purposes; or~~

~~(b) if it is determined that the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the department will combine the two admissions into one for payment purposes.~~

~~(8) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for~~

~~continuation of medical treatment between two hospitals, one of which is paid under the Montana medicaid prospective payment system.~~

~~(a) A transferring hospital reimbursed under the DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:~~

~~(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for each subsequent day of inpatient care determined by dividing the sum of the DRG payment for the case as computed in (2) and the appropriate outlier as computed in (6), if any, by the statewide average length of stay for the DRG; or~~

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

~~(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under (2) is paid the full DRG payment plus any appropriate outliers.~~

~~(9) Inpatient hospital service providers shall be subject to the billing requirements set forth in ARM 37.85.406. At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice: "Notice to physicians: medicaid payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws." The acknowledgment must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The provider may, at its discretion, add to the language of this statement the word "medicare" so that two separate forms will not be required by the provider to comply with both state and federal requirements. In addition, except for hospital resident cases, a provider may not submit a claim until the recipient has been either:~~

~~(a) discharged from the hospital;~~

~~(b) transferred to another hospital; or~~

~~(c) designated by the department as a hospital resident as set forth in (10).~~

~~(10) "Hospital resident" means a recipient who is unable to be cared for in a setting other than the acute care hospital.~~

~~(a) To obtain hospital residency status, the recipient must meet the following requirements:~~

~~(i) the recipient must utilize a ventilator for a continuous period of not less than eight hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period. "Direct nursing care" means the care given directly to the patient which requires the skills and expertise~~

~~of an RN or LPN;~~

~~(ii) recipients must have been an inpatient in an inpatient hospital for a minimum of six continuous months; and~~

~~(iii) providers will have the responsibility of determining whether services could be provided in a skilled nursing care facility or by the home and community based waiver program to a medicaid recipient within the state of Montana. The provider will also be required to maintain written documentation consisting of written inquiries and responses to nursing homes and the home and community based waiver program case management team inquiring as to the present and future availability of openings in the nursing homes or programs and indicating if an opening is not available. In addition to an initial determination, a redetermination of nursing home or waiver availability must be made at least every six months.~~

~~(b) Payment for hospital residents will be made as follows:~~

~~(i) upon obtaining hospital residency status, claims for that recipient may be billed on an interim basis;~~

~~(ii) payment for the first 180 days of inpatient care will be the DRG payment for the case as computed in (2) and any appropriate outlier payment as computed in (6); and~~

~~(iii) payment for all patient care subsequent to 180 days will be reimbursed at a rate computed by multiplying the statewide average cost to charge ratio by the usual and customary billed charges.~~

~~(11) The medicaid statewide average cost to charge ratio excluding prospective capital expenses is 56%.~~

~~(12) The Montana medicaid DRG relative weight values, average length of stay (ALOS), outlier thresholds and stop loss thresholds are contained in the DRG table of weights and thresholds (April 2002 edition). The DRG table of weights and thresholds is published by the department of public health and human services. The department hereby adopts and incorporates by reference the DRG table of weights and thresholds (April 2002 edition). Copies 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.~~

~~(13) Disproportionate share hospitals shall receive an additional payment amount equal to the product of the hospital's prospective base rate times the adjustment percentage of:~~

~~(a) 4% for rural hospitals;~~

~~(b) 5% for urban hospitals having less than 100 beds; or~~

~~(c) for urban hospitals having 100 or more beds, the adjustment shall be computed as (P - 15) (.5) + 2.5, where "P" is the greater of the hospital's medicaid inpatient or low income utilization rate.~~

~~(14) Disproportionate share hospital payments will be limited to the cap established by the federal health care financing administration for the state of Montana. The adjustment percentages specified in (13)(a), (b) and (c) shall be ratably reduced as determined necessary by the department to avoid exceeding the cap.~~

~~(15) If the secretary of health and human services has~~

~~granted the facility authorization for continuation of cost pass-through under section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 608(c) of the Family Support Act of 1988 (public law 100-485), the department shall reimburse inpatient hospital service providers for certified registered nurse anesthetist costs on a reasonable cost basis as provided in ARM 37.86.2801(2).~~

~~(16) Subject to the availability of state, county and federal funding, restrictions imposed by federal law and approval of the state plan by the United States department of health and human services, CMS, a county owned, county operated or partially county funded rural hospital is eligible for the qualified rate adjustment payment once each fiscal year as provided in ARM 37.86.2910.~~

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

37.86.2910 INPATIENT HOSPITAL ~~SERVICES~~ REIMBURSEMENT, QUALIFIED RATE ADJUSTMENT PAYMENT (1) Subject to the availability of sufficient county and federal funding, restrictions imposed by federal law, and the approval of the state plan by the centers for medicare and medicaid services (CMS), the department will pay, in addition to the ~~established~~ medicaid ~~rates~~ payments provided for in ARM 37.86.2905 and [Rules III through XII], a qualified rate adjustment payment to an eligible county owned, operated, or partially county funded rural hospital in Montana as provided in ARM 37.86.2810.

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

37.86.3002 OUTPATIENT HOSPITAL SERVICES, SCOPE AND REQUIREMENTS (1) The requirements of ARM 37.86.2801, [Rule I], 37.86.3001, 37.86.3005 and this rule are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) Outpatient hospital services do not include:

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

(iii) independent exercise programs, such as pool therapy, swim programs~~,~~ or health club memberships;

(iv) through (b)(iii) remain the same.

(c) chemical dependency treatment services; ~~and~~

(d) and (d)(i) remain the same.

(ii) therapeutic services that are incident to physician services and provided under the direct personal supervision of a physician. Outpatient physical therapy, occupational therapy and speech therapy are not subject to the direct physician supervision requirement. Therapy services are limited as in ARM 37.86.606; and

(e) and (4) remain the same.

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

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

37.86.3005 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT AND QUALIFIED RATE ADJUSTMENT PAYMENT (1) remains the same.

(2) Outpatient hospital services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901~~(4) and (8)~~ will be reimbursed under ARM 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020 and 37.86.3025 for medically necessary services.

(3) For critical access hospitals and exempt hospitals, interim reimbursement for outpatient hospital services is based on hospital specific medicaid outpatient cost to charge ratio, not to exceed 100%. Critical access hospitals and exempt hospitals will be reimbursed their actual allowable costs determined according to ~~ARM 37.86.2801(2)~~ [Rule I]. If a provider fails or refuses to submit the financial information, including the medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges (billed charges).

(4) remains the same.

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

37.86.3009 OUTPATIENT HOSPITAL SERVICES, PAYMENT METHODOLOGY, EMERGENCY VISIT SERVICES (1) remains the same.

~~(2) Emergency visit services provided by hospitals will be reimbursed as follows:~~

~~(a)~~ (2) ~~for~~ For emergency visits that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901~~(4) and (8)~~ and meet ~~ARM 37.86.3009~~(1), reimbursement will be based on the APC methodology in ARM 37.86.3020.~~; and~~

~~(i)~~ (3) ~~for~~ For emergency visits not meeting ~~ARM 37.86.3009~~(1), reimbursement will be a prospective fee for evaluation and stabilization as specified in the department's outpatient fee schedule plus ancillary reimbursement for laboratory, imaging and other diagnostic services not included in the APR reimbursement. The evaluation and stabilization fee is considered payment in full.~~; or~~

~~(b)~~ (4) ~~an~~ An evaluation and stabilization fee is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment and other outpatient hospital services.~~; and~~

~~(i)~~ (5) ~~physician~~ Physician services are separately billable according to the applicable rules governing billing for physician services.~~; or~~

~~(c)~~ (6) ~~for~~ For emergency visits which the medical professional rendering the screening and evaluation determine are emergent but not on the department's emergency list, a hospital may send the claim and emergency room documentation for review to the department for payment of a fee other than the

evaluation and stabilization fee.

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

37.86.3022 OUTPATIENT HOSPITAL SERVICES, ~~PROSPECTIVE PAYMENT METHODOLOGY,~~ PARTIAL HOSPITALIZATION SERVICES (1) and (2) remain the same.

~~(3) All partial hospitalization services for full-day programs and half-day programs, as defined in ARM 37.86.3001, require prior authorization as required in ARM 37.86.2801.~~

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

37.86.3025 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT FOR SERVICES NOT PAID UNDER THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM (1) through (5) remain the same.

(6) For services provided on or after August 1, 2003, hospitals receiving a provider-based status from CMS must send a copy of the CMS letter granting provider-based status to the department's hospital program officer at Department of Public Health and Human Services, Child and Adult Health Resources, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 and must receive department approval prior to billing as a provider-based clinic.

(a) Physicians, mid-levels and other professionals billing for services on a professional billing form for services provided in a provider-based clinic must show hospital outpatient as the place of service on the claim and will receive payment as in ARM 37.86.105(2).

(b) and (c) remain the same.

(7) Interim payment for certified registered nurse anesthetists (CRNAs) will be reimbursed at hospital specific outpatient cost to charge ratio and settled as a pass through in the cost settlement, as provided in ~~ARM 37.86.2905~~ [Rule XI].

(8) The department ~~hereby~~ adopts and incorporates by reference the outpatient hospital fee schedule dated August 1, 2003. A copy may be obtained through the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

37.86.3411 CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, FINANCIAL RECORDS AND REPORTING (1) through (3) remain the same.

(4) Financial records must be maintained for a period of ~~6~~ six years, ~~3~~ three months after a cost report is filed with respect to the period covered by the records or until the cost report is finally settled, whichever is later.

(5) The records described in (1) must be available at the facility at all reasonable times and shall be subject to

inspection, review and audit by the department or its agents, the United States department of health and human services, the general accounting office, the Montana legislative auditor~~,~~ and other appropriate governmental agencies.

(6) through (7)(b) remain the same.

(8) Overpayments and underpayments are collected or paid as provided in ~~ARM 37.86.2801~~ [Rule I] and references in that rule to a "hospital" shall be deemed to be references to a case management provider.

(9) remains the same.

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

37.88.205 LICENSED CLINICAL SOCIAL WORK SERVICES, REQUIREMENTS (1) remains the same.

(2) For purposes of medicaid coverage and reimbursement, licensed social work services are limited to the services designated in the department's Covered Social Work CPT Codes List (~~April 1999~~ 2004). The department ~~hereby~~ adopts and incorporates ~~herein~~ by reference the Covered Social Work CPT Codes List (~~April 1999~~ 2004). A copy of the Covered Social Work CPT Codes List (~~April 1999~~ 2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, ~~1400 Broadway~~ 555 Fuller, P.O. Box ~~202951~~ 202905, Helena, MT 59620-~~2951~~ 2905.

(3) through (7) remain the same.

(8) Inpatient social work services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ~~ARM 37.86.2905~~ [Rule IV] are not reimbursable as licensed clinical social worker services. These noncovered services include:

(a) through (c) remain the same.

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

37.88.305 LICENSED PROFESSIONAL COUNSELOR SERVICES, REQUIREMENTS (1) remains the same.

(2) For purposes of medicaid coverage and reimbursement, licensed professional counselor services are limited to the services designated in the department's Covered Licensed Professional Counselor CPT Codes List (~~April 1999~~ 2004). The department ~~hereby~~ adopts and incorporates ~~herein~~ by reference the Covered Licensed Professional Counselor CPT Codes List (~~April 1999~~ 2004). A copy of the Covered Licensed Professional Counselor CPT Codes List (~~April 1999~~ 2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, ~~1400 Broadway~~ 555 Fuller, P.O. Box ~~202951~~ 202905, Helena, MT 59620-~~2951~~ 2905.

(3) through (7) remain the same.

(8) Inpatient professional counselor services provided in a hospital on an inpatient basis that are covered by medicaid as

part of the diagnosis related group (DRG) payment under ~~ARM 37.86.2905~~ [Rule IV] are not reimbursable as licensed professional counselor services. These noncovered services include:

(a) through (c) remain the same.

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

37.88.605 LICENSED PSYCHOLOGIST SERVICES, REQUIREMENTS

(1) remains the same.

(2) For purposes of medicaid coverage and reimbursement, licensed psychologist services are limited to the services designated in the department's Covered Psychologist CPT Codes List (~~April 1999~~ 2004). The department ~~hereby~~ adopts and incorporates ~~herein~~ by reference the Covered Psychologist CPT Codes List (~~April 1999~~ 2004). A copy of the Covered Psychologist CPT Codes List (~~April 1999~~ 2004) may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, ~~1400 Broadway~~ 555 Fuller, P.O. Box ~~202951~~ 202905, Helena, MT 59620-~~2951~~ 2905.

(3) through (5) remain the same.

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

(7) Licensed psychologist services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ~~ARM 37.86.2905~~ [Rule IV] are not reimbursable as psychological services. These noncovered services include:

(a) through (c) remain the same.

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

37.88.906 MENTAL HEALTH CENTER SERVICES, COVERED SERVICES

(1) Mental health center services, covered by the medicaid program, include the following:

(a) and (b) remain the same.

(c) community-based psychiatric rehabilitation and support;

(d) through (5)(b) remain the same.

(6) Practitioner services provided in a hospital on an inpatient basis that are covered by medicaid as part of the diagnosis related group (DRG) payment under ~~ARM 37.86.2905~~ [Rule IV] are not reimbursable as mental health center services. These noncovered services include:

(a) through (c) remain the same.

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

4. The Department is proposing these new rules and rule

amendments to implement enhanced Medicaid reimbursement rates for medical hospitals. Enhanced Medicaid rates are mandated under a hospital utilization fee bill enacted by the 2003 Montana Legislature. The Department is taking this opportunity to renumber and clarify the rules governing Medicaid inpatient hospital reimbursement and to correct clerical mistakes in several rules, all of them related to Medicaid hospital reimbursement.

Over the past several years, the costs hospitals incur for providing care have continually risen, as has the number of Medicaid patients they serve. At the same time, Medicaid reimbursement for inpatient hospital services has not kept pace with costs. In some cases, it has actually been reduced. These proposed amendments would increase Medicaid reimbursement to Montana hospitals in two ways: (1) increased Disproportionate Share Hospital (DSH) payments would allow the Department to spend the full federal allotment of Medicaid funds; and (2) implementation of a new payment to hospitals would partially compensate for the unreimbursed cost of serving Medicaid patients. The source of the new payment is revenue from the hospital utilization fee established in 15-66-102, MCA, which must be used to provide funding for increases in medicaid payments to hospitals.

The proposed changes are necessary to maintain the quality of care Medicaid recipients receive, to assure that they have reasonable access to care, and to mitigate the shifting of costs from Medicaid patients to privately insured and privately paying individuals. Quality of care is maintained because the payments established under the proposed rules will allow facilities to hire an adequate number of direct care staff members and to invest in vital diagnostic and treatment technologies. Many of Montana's hospitals are rural, with no other properly equipped medical facility within many miles. The additional Medicaid payments established under the proposed rule changes will maintain access by helping to keep these facilities open to serve all who need care.

The Department considered and rejected the alternative of increasing Medicaid diagnosis related group (DRG) or per-diem reimbursement rates. This option is not practical because the source of the state match for the new Medicaid payments is a newly enacted hospital utilization fee. The hospital utilization fee is temporary; a "sunset" provision terminates it at the end of 2004. If the hospital reimbursement fee is not re-enacted by the 2005 Montana legislature, it will be more efficient to simply remove the new rules and cease making the payments than to adjust the DRG and per-diem reimbursement systems again.

Proposed new Rules XII, XVI and XVIII contain new material necessary to implement the hospital utilization fee for inpatient bed days and to provide the public notice and an

opportunity to comment on the proposed rates. Proposed new Rules I through XI, XIII through XV, XVII and XIV through XXI contain no new substantive material. They are the result of removing unrelated provisions from existing rules and non-definitional material from definitions. Each proposed new rule and amended rule would contain only one subject. This is necessary to conform them to 2-4-302, MCA and would make them easier to read and find. This proposed renumbering was requested by the Secretary of State's Office.

RULE I

In order to make the rules easier to read, the Department proposes to move ARM 37.86.2801(2) through (8), cost reports and settlement, into a new rule. No substantive change is intended.

RULES II through XI

These proposed new rules would renumber the rules governing Medicaid inpatient hospital reimbursement. The renumbering is intended to make the rules easier to read and find. No substantive change is intended.

RULE XII

This proposed rule defines the methodology for the new payment, the hospital reimbursement adjustor, or HRA. The HRA would be made to all Montana hospitals providing inpatient services. The HRA payment is intended to provide Critical Access Hospitals and Exempt Hospitals with an elevated portion of the available amount. To accomplish this, the HRA would consist of two parts. Part 1 would be based on Medicaid inpatient utilization and is made to all eligible hospitals. Part 2 would partially reimburse hospitals for unreimbursed Medicaid costs associated with providing outpatient services, and is based on total inpatient utilization. Total inpatient utilization is an accurate approximation of outpatient Medicaid services provided by a hospital. It is much easier for a small hospital to report quickly and accurately and for the Department to verify. Part 2 payments would be made only to critical access hospitals and exempt hospitals.

RULE XIII

The Department is proposing this new rule to renumber the provisions on outpatient hospital services prospective payment methodology. The text of this rule is currently part of ARM 37.86.3022. No substantive change is intended.

RULE XIV

The Department is proposing this new rule to renumber the rules governing Medicaid reimbursement for residential psychiatric care provided outside the borders of Montana. The text of this

rule is currently part of ARM 37.88.1106. No substantive change is intended.

RULE XV

The Department is proposing this new rule to renumber and amend the provisions related to disproportionate share hospitals. To be consistent with the new reimbursement structure, the term "routine" would be added to "disproportionate share hospital" to distinguish the payment from the new "supplemental disproportionate state hospital" payment. The other text of the proposed rule is from ARM 37.86.2901.

RULE XVI

The Department proposes a new "hospital reimbursement adjustor" (HRA) payment as previously described. This rule would define eligibility and data sources used to determine eligibility. The new payment would be made to all licensed hospitals that provide inpatient services. The methodology for calculating the HRA is set forth in proposed new Rule XII.

RULE XVII

The Department proposes renumbering the provisions governing hospital residency status. The text of this rule is currently in ARM 37.86.2905. No substantive change is intended.

RULE XVIII

The Department proposes consolidating all provisions for calculating disproportionate share hospital payments and supplemental disproportionate share hospital payments in this rule. This proposed rule would clarify ARM 37.86.2905(1) that provides DRG hospitals may receive supplemental and routine DSH, HRA payments and all the reimbursement currently in the rule. Critical Access Hospitals and Exempt hospitals are allowed to receive supplemental and routine DSH, HRA payments and retrospective cost-based reimbursement, subject to the facility-specific cap set in Section 1923(g) of the SSA, 42 U.S. Code 1396r-4. That section limits disproportionate share hospital payments to hospitals reimbursed at cost based on the value of charity care provided. The Department is taking this opportunity to correct a clerical mistake by striking the word "planned" from the provision on prior authorization of services by hospitals more than 100 miles outside the state because it conflicts with the concept of an "emergent situation".

The Department proposes to use the current methodology for calculating DSH payments for routine DSH payments. Thus, the word "routine" would be inserted in ARM 37.86.2905(13)(a). ARM 37.86.2905(13)(c) would be deleted as unnecessary. The methodology is no longer used.

All hospitals meeting the new definition of supplemental disproportionate share hospital will receive a supplemental DSH payment; with the total amount of supplemental DSH payments depending upon funding available after routine DSH payments are calculated. The calculation is based on Medicaid utilization as represented by days of service provided. This calculation includes an adjustment to make sure that Critical Access and Exempt hospitals receive an elevated proportion of the total amount available.

RULE XIX

The Department proposes renumbering the provisions governing Medicaid utilization rate and consolidating them in this rule. The text of this rule is currently in ARM 37.86.2901. No substantive change is intended.

RULE XX

The Department is proposing to renumber the provisions governing reimbursement of "border hospitals" defined as hospitals within 100 miles outside the borders of Montana. The text of the proposed rule is currently found in ARM 37.86.2905. No substantive change is intended.

RULE XXI

The Department is proposing to renumber the provisions governing swing-bed hospital reimbursement. The text of the proposed rule is currently found in ARM 37.40.406. No substantive change is intended.

ARM 37.86.2901

The definition of DSH would be changed to add "routine" disproportionate share hospital. This would distinguish it from the new "supplemental" disproportionate share hospital designation. All eligibility and payment amount calculations for routine disproportionate share hospitals would be the same as they currently are for all disproportionate share hospitals. The Department is proposing a clarification of the fact that only hospitals in Montana can be deemed routine disproportionate share hospitals.

A definition of supplemental disproportionate share hospital would be added. This would allow the Department to provide qualifying hospitals with additional reimbursement as intended by the 2003 Montana legislature. The proposed criteria are the minimum federally allowed requirements. Specifically, hospitals would have a minimum of 1% Medicaid inpatient utilization and would not have discontinued providing non-emergent obstetric care since December 21, 1987. More hospitals will be eligible for the new supplemental disproportionate share hospital payments under the proposed amendment than have been eligible

for current DSH payments.

The definition of "Hospital Resident" would be moved into ARM 37.86.2901 to conform to current rule practice.

A reference to the definition of the proposed new Hospital Reimbursement Adjustor (HRA) payment is proposed. The methodology for calculating the proposed payment is set forth in the proposed amendment to ARM 37.86.2915.

The term "disproportionate share hospital" would be changed to "routine disproportionate share hospital".

The definition of "Medicaid Inpatient Utilization rate" would be amended so it applies to both routine and supplemental disproportionate share hospitals.

Throughout the rule, the Department would renumber as necessary and would change references to be consistent with the proposed changes and current rule practice. Non-definitional material was removed from this rule and moved to separate rules.

ARM 37.86.2905

The Department proposes that the language pertaining to billing requirements previously contained in ARM 37.86.2905(9), (11) and (12) be separated into its own rule for the sake of clarity. The Department does not intend this to change the substantive provisions.

The Department proposes that this rule be renumbered for reasons explained above. The changes are not intended to change substantive policy.

The Department proposes deleting ARM 37.86.2905(16) because the qualified rate adjustment provisions would be consolidated in ARM 37.86.2910.

The Department also proposes deletion of ARM 37.86.2905(17) regarding the qualified rate adjustor payments. This provision would unnecessarily repeat language in proposed ARM 37.86.2914, which is devoted entirely to the qualified rate adjustment (QRA) payments.

ARM 37.86.2910

The Qualified Rate Adjustment (QRA) language in ARM 37.86.2910 would be amended to include some of the language in ARM 37.86.2905. The language in those two rules is redundant, so the section in ARM 37.86.2905 would be deleted, and ARM 37.86.2910 would include the intent and methodology regarding the QRA payments.

ARM 37.86.3022

In order to make the rules easier to read, the Department proposes to move ARM 37.86.2801(1)(b) through (1)(g), partial hospitalization, to ARM 37.86.3022, which also governs partial hospitalization. If adopted, these amendments would consolidate all the provisions related to partial hospitalization in this rule.

The name change from Health Policy and Services Division to Child and Adult Health Resources Division is being shown in the affected rules. Internal references to new or amended rules have also been updated to reflect the changes made in this notice.

Fiscal impact and persons affected

The proposed rules and amendments will not adversely affect hospital patients or increase the rates they pay. 15-16-102, Montana Code Annotated specifically forbids taxed facilities from recouping the cost of the utilization fee by adding an amount to patients' bills. In 2001, there were about 100,000 hospital admissions and about 430,000 inpatient days statewide. Of those, 14,000 of the admissions and about 97,000 of the days were Medicaid covered. In June of 2003, about 82,400 people were eligible for medicaid inpatient services, and none of them will be adversely affected by the proposed rules. The rule will potentially increase reimbursement to every licensed hospital in Montana. As of June 23, 2003, there were 59 individually licensed hospitals in Montana. It is possible that one or more of these facilities will not meet all the utilization criteria in order to be eligible for a continuity of care adjustor, supplemental DSH payment or a Hospital Reimbursement Adjustor Payment, but it is anticipated that most of the hospitals in Montana will be eligible for one or more of the payments. The total net amount of the increase in reimbursement to hospitals statewide will be $19,418,341 in SFY 2004 and $22,941,125 in SFY 2005.

5. The Department proposes that these new rules and amendments will be applied retroactively to January 1, 2004.

6. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on December 24, 2003. Data, views or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. 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.

7. 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

/s/ Gail Gray
Director, Public Health and Human Services

Certified to the Secretary of State November 17, 2003.

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

In the matter of the adoption of new rules I through XIV, amendment of ARM 12.11.501, 12.11.3435, 12.11.3455, 12.11.3460, and the repeal of ARM 12.11.345, pertaining to recreational water use	)	NOTICE OF ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On July 31, 2003, the Fish, Wildlife and Parks Commission (commission) published MAR Notice No. 12-288 regarding the proposed adoption of new rules I through XIV, amendment of ARM 12.11.501, 12.11.3435, 12.11.3455, 12.11.3460, and the repeal of ARM 12.11.345, pertaining to recreational water use at page 1583 of the 2003 Montana Administrative Register, Issue Number 14.

2. The commission has adopted the following rules exactly as proposed:

Rule I (ARM 12.11.1402)
Rule II (ARM 12.11.1404)
Rule III (ARM 12.11.2705)
Rule IV (ARM 12.11.3204)
Rule V (ARM 12.11.2307)
Rule VI (ARM 12.11.3214)
Rule VII (ARM 12.11.3506)
Rule VIII (ARM 12.11.3963)
Rule IX (ARM 12.11.1406)
Rule X (ARM 12.11.5405)
Rule XI (ARM 12.11.1415)
Rule XII (ARM 12.11.1420)
Rule XIII (ARM 12.11.5205)
Rule XIV (ARM 12.11.5420)

3. The commission has amended ARM 12.11.501, 12.11.3435, 12.11.3455, and 12.11.3460 as proposed.

4. The commission has repealed ARM 12.11.345 as proposed.

5. The following comment was received and appears with the commission's response:

COMMENT: One individual was concerned that the department was not enforcing ARM 12.11.2308 regarding Hebgen Lake. This individual encouraged the department to enforce that rule and put signs and buoys up immediately so that the public would be more aware of and abide by the rule.

RESPONSE: Under 2-4-305, MCA, the commission is required to respond to comments concerning the proposed rules. This comment addresses another rule which the commission adopted on October 3, 2002. However, for informational purposes, the commission states that buoys are in place, and signs are now posted pertaining to ARM 12.11.2308 on Hebgen Lake.

By: /s/ Dan Walker
Dan Walker, Chairman
Fish, Wildlife and Parks Commission

By: /s/ Rebecca Dockter
Rebecca Dockter
Rule Reviewer

Certified to the Secretary of State November 17, 2003

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.74.401, 17.74.402, 17.74.403 and 17.74.404 pertaining to fees for asbestos project permits, accreditation and renewal of accreditation in an asbestos-related occupation, approval of training courses offered for accreditation and audits of training courses and refresher courses, and the repeal of ARM 17.74.405 pertaining to penalties	NOTICE OF AMENDMENT AND REPEAL (ASBESTOS)

TO: All Concerned Persons

1. On July 31, 2002, the Department of Environmental Quality published MAR Notice No. 17-196 regarding a notice of public hearing on the proposed amendment and repeal of the above-stated rules at page 1595, 2003 Montana Administrative Register, issue number 14.

2. The Department has amended ARM 17.74.401, 17.74.402 and 17.74.403 and repealed ARM 17.74.405 exactly as proposed. The Department has amended ARM 17.74.404 as proposed, but with the following changes, deleted matter interlined, new matter underlined:

17.74.404 COURSE AUDIT FEES (1) through (1)(e) remain as proposed.

(f) asbestos inspector course and ~~project~~ asbestos management planner course presented in conjunction $1,560

(g) through (2) remain as proposed.

3. The following comments were received and appear with the Department's responses:

COMMENT NO. 1: A commentor opposed the permit fee rule amendments because the proposed tiered fee scale could be abused and revised permit fees would not be paid.

RESPONSE: The Department audits abatement contractors' records, which would include contract and fee audits, to insure compliance with fee requirements.

COMMENT NO. 2: The Department received comments opposing the proposed audit fee schedule for training course audit fees. The commentor was concerned that the proposed audit fee schedule was not justified, because it does not appear to be commensurate with course duration and does not seem to reflect Department costs associated with conducting a training course audit.

RESPONSE: The Department believes the proposed audit fees are justified based upon the differences in courses and based upon Program costs of conducting audits. The Department tracks, periodically reevaluates, and, if necessary, adjusts fees to insure that they are commensurate with Program costs.

COMMENT NO. 3: The Department received a comment opposing the repeal of ARM 17.74.405.

RESPONSE: The Department proposed to repeal ARM 17.74.405 because it has been superceded by 75-2-515, MCA.

COMMENT NO. 4: The Department received comments expressing concerns about the general use of Program funding.

RESPONSE: Program costs have increased; however, revenues generated by fees and EPA funding have not increased. The Program is funded by fees listed in ARM Title 17, chapter 74, subchapter 4, and a grant from the EPA. For the past few years, EPA grant money has remained constant. In order to maintain resources at the budget level established by the legislature, the Department is compelled to increase fees.

COMMENT NO. 5: The Department received comments opposing the proposed permit fees because the commentor believes the fee schedule was insufficient to cover Program costs, especially in light of the recent annual permit fee reduction.

RESPONSE: The Department believes the proposed fee amendments are sufficient to cover costs of the Program. The annual permit fee was reduced to make annual permit fees commensurate with Program costs.

COMMENT NO. 6: The Department received comments concerning the need to increase the number of Program employees in an effort to enforce compliance.

RESPONSE: The legislature establishes appropriations and staffing levels. Allocation of Program employees is outside the scope of this proposed rule change.

COMMENT NO. 7: The Department received comments concerning the need to update its current substantive regulations.

RESPONSE: The Department is currently reviewing the asbestos rules to determine the need, if any, for regulatory changes. Updating ARM Title 17, chapter 74, subchapter 3 is not within the scope of this rulemaking.

COMMENT NO. 8: The Department received a comment opposing the proposed permit fee based on concerns that annual permits will be applied for instead of project permits when project costs reach $20,000 or more.

RESPONSE: Annual, or facility, permits only apply to facilities where the facility has an asbestos health and safety plan and employs accredited abatement personnel. The facility permit is intended for facilities that do asbestos abatement continuously throughout the year. Such facilities include refineries, universities, paper plants, power plants, lumber

mills, and other large facilities. The Department will issue annual permits only to those facilities that qualify and will audit permit holders to assess compliance with applicable requirements.

COMMENT NO. 9: A commentor indicated that permit fees in the higher contract cost categories are disproportionately more expensive relative to the lower categories. In addition, the commentor questioned why building owners, who pay the permit fees, pay the bills for those who are not compliant.

RESPONSE: The Department believes it will be easier for applicants to calculate permit fees if there is only one fee number representing each tier. In response to the question concerning building owners paying the bill for non-compliant parties, the Department takes non-compliance very seriously. Since the Program has fewer staff as compared to larger programs, it must rely on complaints to aid in enforcing the Program. In addition, it must also rely on compliant parties and accredited persons to provide compliance assistance whenever it sees potential non-compliance. The fees are established to be commensurate with the costs of the Program, and the Department will continue to enforce against those who violate the rules.

COMMENT NO. 10: A commentor was concerned with the increased accreditation fees and commented that the fees are excessive for small businesses.

RESPONSE: The Department has not raised accreditation fees since 1993. Program costs have increased since that time, and the current fees are not sufficient to adequately fund the program. The Department tracks and reevaluates fees periodically to insure they are commensurate with program costs.

COMMENT NO. 11: A commentor indicated concern regarding the course approval fee increase.

RESPONSE: Course approval fees are being increased by the same percentage as other fees. The Department tracks and reevaluates fees periodically to insure they are commensurate with costs.

COMMENT NO. 12: A commentor indicated that other states do not require course audits and that biannual audits are excessive.

RESPONSE: The requirement for course audits is outside the scope of this proposed rulemaking.

COMMENT NO. 13: A commentor expressed concern over higher training costs which will be borne by abatement contractors.

RESPONSE: The Department tracks and evaluates fees and uses this information to establish fees that are commensurate with Program costs.

COMMENT NO. 14: A commentor expressed concern that higher fees will result in higher non-compliance.

RESPONSE: The Department currently investigates complaints and conducts inspections to determine compliance. The Department will continue to enforce the asbestos regulations by offering both compliance assistance and taking enforcement actions against those who violate the regulations.

COMMENT NO. 15: A commentor questioned why initial course approval fees are equivalent to refresher course approval fees and why audit fees for half-day refresher courses and full-day refresher courses are the same.

RESPONSE: Department activities associated with initial course approval and audits do not vary significantly between initial and refresher courses and full and half-day courses.

DEPARTMENT OF ENVIRONMENTAL QUALITY

By: *Jan P. Sensibaugh*
JAN P. SENSIBAUGH, Director

Reviewed by:

David Rusoff
DAVID RUSOFF, Rule Reviewer

Certified to the Secretary of State, November 17, 2003.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 23.6.101, 23.6.103, 23.6.105, 23.6.106, 23.6.108, 23.6.109, 23.6.110, and 23.6.113 concerning definitions, classification of tow truck equipment, establishment of the tow truck complaint resolution committee, establishment of the procedures governing the committee, and clarification of the rules governing the state rotation system	)	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On September 25, 2003, the Department of Justice published MAR Notice No. 23-6-142 regarding a public hearing on the proposed amendment of the above-stated rules at page 2019 of the 2003 Montana Administrative Register, issue no. 18.

2. The Department of Justice has amended ARM 23.6.103, 23.6.105, 23.6.106, 23.6.108, 23.6.109, 23.6.110, and 23.6.113 as proposed.

3. The Department has amended ARM 23.6.101 with the following changes, stricken matter interlined, new matter underlined:

23.6.101 DEFINITIONS In addition to the definitions contained in 61-8-903, MCA, and unless the context requires otherwise, the following definitions apply to this subchapter:

(1) "Cargo or other property" means the contents and non-motor vehicle (as defined in the policy), items in, on or attached ~~inside or on a towed or hauled vehicle or any unit attached~~ to ~~a~~ the towed or stored vehicle.

(2) through (7) remain as proposed.

(8) "Garage keeper's legal liability or on-hook insurance" means insurance coverage for loss or damage to motor vehicles (as defined in the policy), which are in the care of the insured for towing, storage or repair and for~~, an entity that keeps customers' motor vehicles for storage or repair,~~ which loss or damage is caused by the insured's failure to exercise the degree of care required by law.

AUTH: 61-8-911, MCA
IMP: 61-8-903, MCA

4. The following comment was received and appears with the Department of Justice's response:

COMMENT 1: At the public hearing, Jim Dusenberry, President of the Montana Tow Truck Association, testified in favor of the amendments with the suggestion that the definitions of "cargo" and "garage keeper's legal liability or on-hook insurance" be amended for clarification. Mr. Dusenberry had consulted with the insurance industry and testified that confusion around these definitions had been a problem in the past and that his proposed amendments would clarify the terms.

RESPONSE: Mr. Dusenberry's suggestions were incorporated into the rules and the definitions of "cargo" and "garage keeper's legal liability or on-hook insurance" reflect his proposed amendments.

By: /s/ Mike McGrath
MIKE MCGRATH
Attorney General
Department of Justice

/s/ Ali Bovingdon
ALI BOVINGDON, Rule Reviewer

Certified to the Secretary of State November 17, 2003.

BEFORE THE BOARD OF BARBERS AND COSMETOLOGISTS
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of NEW RULE I (24.121.101) regarding rules applicable to barbers, cosmetologists, electrologists, manicurists and estheticians	)))))	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On August 14, 2003, the Board of Barbers and the Board of Cosmetologists published MAR Notice No. 24-121-1 regarding a public hearing on the proposed adoption of the above-stated rule at page 1776 of the 2003 Montana Administrative Register, issue no. 15.

2. A public hearing on the proposed adoption was held on September 5, 2003. Public comments were received concerning the proposed rule changes. The Board has thoroughly considered the comments and the Board's responses are as follows:

Comment 1: One commenter stated that both barbers and cosmetologists should be allowed to travel to client homes to render barbering or cosmetology services.

Response 1: The proposed new interim rule clarifies that, until the new Board of Barbers and Cosmetologists adopts new Board rules, all licensees shall abide by the existing rules of the former Board of Barbers or the Board of Cosmetologists. The new Board will have a public hearing and encourages the submission of comments when they begin the process of adopting new rules.

Comment 2: One commenter opposes the merger of the Board of Barbers and the Board of Cosmetologists into the Board of Barbers and Cosmetologists.

Response 2: The 2003 Montana Legislature enacted Chapter 243, Laws of 2003 (House Bill 196), an act combining the existing Board of Barbers and Board of Cosmetologists into one professional licensing board, the new Board of Barbers and Cosmetologists. The bill was signed by the Governor on April 8, 2003, with an effective date of October 1, 2003. The new Board of Barbers and Cosmetologists is required under the law to prescribe administrative rules regarding the licensing, regulation and disciplining of all professions under the Board's jurisdiction. The proposed new rule simply clarifies that the existing rules of the former Board of Barbers and Board of Cosmetologists will remain in effect until the new Board is able to adopt their rules.

3. The Board has adopted NEW RULE I (ARM 24.121.101), exactly as proposed.

BOARD OF BARBERS AND
COSMETOLOGISTS
WENDELL PETERSEN, CHAIR

/s/ WENDY J. KEATING
Wendy J. Keating, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

/s/ MARK CADWALLADER
Mark Cadwallader
Alternate Rule Reviewer

Certified to the Secretary of State November 17, 2003.

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 1.2.419 regarding the scheduled dates for the Montana Administrative Register	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On October 16, 2003, the Secretary of State published MAR Notice No. 44-2-122 regarding the public hearing on the proposed amendment of the above-stated rule at page 2267 of the Montana Administrative Register, Issue No. 19.

2. The Secretary of State has amended ARM 1.2.419 exactly as proposed.

3. No comments or testimony were received.

/s/ Bob Brown
BOB BROWN
Secretary of State

/s/ Janice Doggett
JANICE DOGGETT
Rule Reviewer

Dated this 17th day of November 2003.

NOTICE OF FUNCTION 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.

Economic Affairs Interim Committee:

- Department of Agriculture;
- Department of Commerce;
- Department of Labor and Industry;
- Department of Livestock;
- Office of the State Auditor and Insurance Commissioner; and
- Office of Economic Development.

Education and Local Government 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 and Justice Interim Committee:

- Department of Corrections; and
- Department of Justice.

Energy and Telecommunications Interim Committee:

- Department of Public Service Regulation.

Revenue and Transportation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

State Administration, 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	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 that have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through September 30, 2003. This table includes those rules adopted during the period October 1, 2003 through December 31, 2003 and any proposed rule action that was pending during the past six-month period. (A notice of adoption must be published within six months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through September 30, 2003, 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 2002 and 2003 Montana Administrative Registers.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number.

GENERAL PROVISIONS, Title 1

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BOARD APPOINTEES AND VACANCIES

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

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

In this issue, appointments effective in October 2003, appear. Vacancies scheduled to appear from December 1, 2003, through February 29, 2004, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a board should refer to the bill that created the board for details about the number of members to be appointed and necessary qualifications.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of November 10, 2003.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Barbers and Cosmetologists (Labor and Industry)			
Ms. Darlene Battaiola Butte Qualifications (if required): cosmetologist	Governor	not listed	10/1/2003 10/1/2007
Ms. Karan Charles Miles City Qualifications (if required): barber	Governor	not listed	10/1/2003 10/1/2006
Ms. Maxine Collins Helena Qualifications (if required): manicurist	Governor	not listed	10/1/2003 10/1/2008
Ms. Verna Dupuis Bozeman Qualifications (if required): cosmetologist	Governor	not listed	10/1/2003 10/1/2006
Mr. Edward Dutton Kalispell Qualifications (if required): barber	Governor	not listed	10/1/2003 10/1/2008
Ms. Kordelia French Plentywood Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2008
Ms. Delores Lund Plentywood Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Wendell Petersen Missoula Qualifications (if required): cosmetologist	Governor	not listed	10/1/2003 10/1/2008

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Barbers and Cosmetologists (Labor and Industry) cont.			
Ms. Sharon Richie	Governor	not listed	10/1/2003
Hamilton			10/1/2007
Qualifications (if required): barber			
Board of Outfitters (Labor and Industry)			
Mr. Craig Madsen	Governor	Pasquale	10/28/2003
Great Falls			10/1/2006
Qualifications (if required): fishing outfitter			
Mr. Russ Smith	Governor	Rugg	10/28/2003
Philipsburg			10/1/2006
Qualifications (if required): hunting and fishing outfitter			
Board of Private Security Patrol Officers and Investigators (Labor and Industry)			
Mr. Gary Gray	Governor	Skillicorn	10/10/2003
Great Falls			8/1/2004
Qualifications (if required): representative of a contract security company			
Mr. Ronald Rowton	Governor	reappointed	10/10/2003
Lewistown			8/1/2006
Qualifications (if required): representative of a county sheriff's department			
Ms. Linda Sanem	Governor	Patterson	10/10/2003
Bozeman			8/1/2006
Qualifications (if required): private investigator			
Ms. Mori Woods	Governor	Dent	10/10/2003
Columbus			8/1/2006
Qualifications (if required): representative of a city police department			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Psychologists (Labor and Industry)			
Dr. Edward Trontel	Governor	Martin	10/13/2003
Kalispell			9/1/2008
Qualifications (if required): psychologist			
Lewis and Clark Bicentennial Commission (Historical Society)			
Ms. Marcy Hamburg	Governor	Doeden	10/28/2003
Savage			10/1/2006
Qualifications (if required): public member			
Mr. John G. Lepley	Governor	reappointed	10/1/2003
Fort Benton			10/1/2006
Qualifications (if required): representative of the public			
Mr. Darrell Martin	Governor	reappointed	10/1/2003
Hays			10/1/2006
Qualifications (if required): representative of the Indian tribes			
Montana Fetal Alcohol Syndrome Advisory Council (Public Health and Human Services)			
Ms. Mary Behrendt	Governor	not listed	10/1/2003
Columbia Falls			10/1/2005
Qualifications (if required): public member			
Ms. Mary Chaboya	Governor	not listed	10/1/2003
Libby			10/1/2005
Qualifications (if required): public member			
Mr. Richard Chiotti	Governor	not listed	10/1/2003
Helena			10/1/2005
Qualifications (if required): public member			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Fetal Alcohol Syndrome Advisory Council (Public Health and Human Services) cont.			
Ms. Leita Cook Helena Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Billford Curley, Sr. Lame Deer Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Dr. Suzanne Dixon Great Falls Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Allison Failing Poplar Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Mike Hermanson Billings Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Patti Jacques Helena Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Diane Jeanotte Billings Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Dr. John Johnson Helena Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Fetal Alcohol Syndrome Advisory Council (Public Health and Human Services) cont.			
Ms. Crystal LaPlant Browning Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Dr. Ted Laine Missoula Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Irene Lake St. Ignatius Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Mike Lande Billings Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Carole Lankford Pablo Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Vickie Leigland Great Falls Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Terry McAnally Poplar Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Myrna Medicine Horse Crow Agency Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Fetal Alcohol Syndrome Advisory Council (Public Health and Human Services) cont.			
Mr. Roland Mena Helena Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Cheryl Jill Plumage Harlem Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Thomas Price Eureka Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Dr. Michael Spence Helena Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Linda Tarinelli Bozeman Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Mr. Richard Williams Bozeman Qualifications (if required): public member	Governor	not listed	10/1/2003 10/1/2005
Ms. Margaret Ann Yellow Kidney Browning Qualifications (if required): public member		Governor	not listed10/1/2003 10/1/2005
Montana Homeland Security Task Force (Military Affairs)			
Mr. Jim Greene Helena Qualifications (if required): DES administrator and chairman	Governor	reappointed	10/1/2003 10/1/2004

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Statewide Independent Living Council (Public Health and Human Services)			
Rep. Carol Lambert	Director	Lockwood	10/27/2003
Hammond			10/27/2005
Qualifications (if required): none specified			
Sen. Gerald Pease	Director	not listed	10/27/2003
Lodge Grass			10/27/2005
Qualifications (if required): state senator			
Montana Vocational Rehabilitation Council (Public Health and Human Services)			
Ms. Denise Corrao	Director	Tremper	10/1/2003
Miles City			10/1/2005
Qualifications (if required): vocational rehabilitation advocate position			
Ms. Barbara Varnum	Director	Null	10/1/2003
Kalispell			10/1/2005
Qualifications (if required): vocational rehabilitation counselor			
Public Safety Communications Council (Administration)			
Mr. Geoff Feiss	Governor	Rice	10/6/2003
Helena			6/18/2004
Qualifications (if required): representative of utilities			
Mr. Ken Leighton-Boster	Governor	Dawson	10/6/2003
Helena			6/18/2004
Qualifications (if required): representative of emergency medical services and a state agency			
State Emergency Response Commission (Military Affairs)			
Sen. Thomas Beck	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Office of the Governor			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Mr. Clifford Brophy	Governor	not listed	10/6/2003
Columbus			10/1/2007
Qualifications (if required): representing a law enforcement association			
Mr. Stephen Brueske	Governor	not listed	10/6/2003
Great Falls			10/1/2007
Qualifications (if required): representing National Weather Service			
Ms. Sally Buckles	Governor	not listed	10/6/2003
Boulder			10/1/2007
Qualifications (if required): representing emergency management association			
Mr. Tim Burton	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing League of Cities and Towns			
Mr. Daniel Dennehy	Governor	not listed	10/6/2003
Butte			10/1/2007
Qualifications (if required): representing local emergency planning committee			
Mr. Tom Ellerhoff	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Department of Environmental Quality			
Mr. Jim Hyatt	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Department of Transportation			
Ms. Jolene Jacobson	Governor	not listed	10/6/2003
Polson			10/1/2007
Qualifications (if required): representing tribal emergency response committee			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Mr. Jim Johnson	Governor	not listed	10/6/2003
Missoula			10/1/2007
Qualifications (if required): representing a railroad company			
Ms. Sally Johnson	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Department of Public Health and Human Services			
Mr. Steve Larson	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing fire service association			
Mr. Joe Marcotte	Governor	not listed	10/6/2003
Billings			10/1/2007
Qualifications (if required): representing hospitals			
Mr. Tim Murphy	Governor	not listed	10/6/2003
Missoula			10/1/2007
Qualifications (if required): representing Department of Natural Resources and Conservation			
Mr. Bill Rhoads	Governor	not listed	10/6/2003
Butte			10/1/2007
Qualifications (if required): representing a utility company			
Mr. Joseph Roth	Governor	not listed	10/6/2003
Billings			10/1/2007
Qualifications (if required): representing public health association			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Mr. Royce A. Shipley	Governor	not listed	10/6/2003
Great Falls			10/1/2007
Qualifications (if required): representing Malmstrom Air Force Base			
Mr. Donald Skaar	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Department of Fish, Wildlife, and Parks			
Sen. Barry "Spook" Stang	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing trucking association			
Mr. Ed Tinsley	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Montana Association of Counties			
Mr. Frank Tobel	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Montana National Guard			
Mr. Mike Tooley	Governor	not listed	10/6/2003
Helena			10/1/2007
Qualifications (if required): representing Montana Department of Justice			
Mr. Mike Vogel	Governor	not listed	10/6/2003
Bozeman			10/1/2007
Qualifications (if required): representing the University System			
Mr. Seldon Weedon	Governor	not listed	10/6/2003
Great Falls			10/1/2007
Qualifications (if required): representing Fire Training School			

BOARD AND COUNCIL APPOINTEES FROM OCTOBER 2003

Appointee	Appointed by	Succeeds	Appointment/End Date
State Emergency Response Commission (Military Affairs) cont.			
Ms. Linda Williams	Governor	not listed	10/6/2003
Fort Benton			10/1/2007
Qualifications (if required): representing DES Association			
State Tax Appeal Board (Administration)			
Mr. Joe Roberts	Governor	Mulroney	10/27/2003
Helena			1/1/2007
Qualifications (if required): public member			

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Alternative Livestock Advisory Council (Fish, Wildlife, and Parks)		
Dr. Duane Douglas, Sidney	Governor	1/1/2004
Qualifications (if required): veterinarian		
Ms. Becky Mesaros, Cascade	Governor	1/1/2004
Qualifications (if required): representative of the alternative livestock industry		
Mr. Stanley Rauch, Victor	Governor	1/1/2004
Qualifications (if required): representative of sportspersons		
Appellate Defender Commission (Administration)		
Ms. Beverly Kolar, Geyser	Governor	1/1/2004
Qualifications (if required): public member		
Board of Chiropractors (Commerce)		
Dr. Gregory Hoell, Bozeman	Governor	1/1/2004
Qualifications (if required): chiropractor		
Board of Horse Racing (Commerce)		
Ms. Susan Austin, Kalispell	Governor	1/20/2004
Qualifications (if required): representative of District 5		
Mr. Jay C. Clark, Sweetgrass	Governor	1/20/2004
Qualifications (if required): representative of the horse racing industry		
Mr. Charles Carruthers, Butte	Governor	1/20/2004
Qualifications (if required): representative of the horse racing industry		
Ms. Brenda Koch, Lewistown	Governor	1/20/2004
Qualifications (if required): representative of District 2		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Board of Occupational Therapy Practice (Commerce)		
Ms. Debra J. Ammondson, Great Falls	Governor	12/31/2003
Qualifications (if required): occupational therapist		
Board of Personnel Appeals (Labor and Industry)		
Mr. Jack Holstrom, Clancy	Governor	1/1/2004
Qualifications (if required): attorney with labor-management experience		
Board of Public Education (Board of Public Education)		
Ms. Joyce A. Silverthorne, Dixon	Governor	2/1/2004
Qualifications (if required): Democrat representing District 1		
Board of Regents of Higher Education (Education)		
Mr. Ed Jasmin, Bigfork	Governor	2/1/2004
Qualifications (if required): Republican from District 1		
Board of Research and Commercialization Technology (Commerce)		
Mr. Tom Kaiserski, Columbus	House Speaker	2/11/2004
Qualifications (if required): none specified		
Board of Respiratory Care Practitioners (Commerce)		
Dr. Robert Pueringer, Billings	Governor	1/1/2004
Qualifications (if required): physician		
Mr. Robert Kirtley, Bozeman	Governor	1/1/2004
Qualifications (if required): respiratory care practitioner		
Capital Finance Advisory Council (Administration)		
Mr. Dick Anderson, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Board of Investments		
Sen. Bea McCarthy, Anaconda	Governor	2/14/2004
Qualifications (if required): legislator		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Capital Finance Advisory Council (Administration) cont.		
Sen. Chuck Swysgood, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Budget Office		
Sen. Royal C. Johnson, Billings	Governor	2/14/2004
Qualifications (if required): legislator		
Mr. Jim Currie, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Transportation		
Mr. Bob Thomas, Stevensville	Governor	2/14/2004
Qualifications (if required): representative of the Board of Housing		
Mr. Mark A. Simonich, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Commerce		
Mr. W. Ralph Peck, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Agriculture		
Mr. Bud Clinch, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Natural Resources and Conservation		
Mr. Mark Semmens, Great Falls	Governor	2/14/2004
Qualifications (if required): representative of the Board of Regents		
Ms. Jan Sensibaugh, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Environmental Quality		
Ms. Michelle Barstad, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Montana Facility Finance Authority		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Capital Finance Advisory Council (Administration) cont.		
Mr. Scott Darkenwald, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Administration		
Capitol Restoration Commission (Administration)		
Mr. Loren Smith, Great Falls	Lt. Governor	12/3/2003
Qualifications (if required): public member appointed by the Lieutenant Governor		
Ms. Jeanne Michael, Billings	Lt. Governor	12/3/2003
Qualifications (if required): public member appointed by the Lieutenant Governor		
Ms. Gayle Shanahan, Helena	Governor	12/3/2003
Qualifications (if required): public member appointed by the Governor		
Rep. Linda L. Holden, Valier	Governor	12/3/2003
Qualifications (if required): public member		
Developmental Disabilities Planning and Advisory Council (Public Health and Human Services)		
Ms. Sylvia Danforth, Miles City	Governor	1/1/2004
Qualifications (if required): services provider		
Sen. Bea McCarthy, Anaconda	Governor	1/1/2004
Qualifications (if required): legislator		
Mr. Dan McCarthy, Helena	Governor	1/1/2004
Qualifications (if required): representative of the Office of Public Instruction		
Dr. R. Timm Vogelsberg, Missoula	Governor	1/1/2004
Qualifications (if required): university program representative		
Rep. Bob Lawson, Whitefish	Governor	1/1/2004
Qualifications (if required): legislator		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Developmental Disabilities Planning and Advisory Council (Public Health and Human Services) cont.		
Ms. Bernadette Franks-Ongoy, Helena	Governor	1/1/2004
Qualifications (if required): representative of the Montana Advocacy Program		
Ms. Marlene Disburg, Helena	Governor	1/1/2004
Qualifications (if required): representative of vocational rehabilitation		
Ms. Jannis Conselyea, Helena	Governor	1/1/2004
Qualifications (if required): representative of Department of Public Health and Human Services		
Ms. Kim Evermann, Helena	Governor	1/1/2004
Qualifications (if required): representative of the Older Americans Act		
Ms. JoAnn Dotson, Helena	Governor	1/1/2004
Qualifications (if required): Title IV representative		
Grass Conservation Commission (Natural Resources and Conservation)		
Mr. Dewayne Ozark, Glasgow	Governor	1/1/2004
Qualifications (if required): grazing district preference rights holder		
Independent Living Council (Public Health and Human Services)		
Mr. John Pipe, Poplar	Director	12/1/2003
Qualifications (if required): representing consumers		
Judicial Nomination Commission (Justice)		
Mr. Tony Harbaugh, Miles City	Governor	1/1/2004
Qualifications (if required): public member		
Ms. Elizabeth Brennan, Missoula	Supreme Court	12/31/2003
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Montana Alfalfa Seed Committee (Agriculture)		
Mr. John Wold, Laurel	Governor	12/21/2003
Qualifications (if required): representative of the alfalfa seed growers		
Mr. Kim Martinson, Townsend	Governor	12/21/2003
Qualifications (if required): representative of alfalfa seed sellers		
Montana Children's Trust Fund Board (Public Health and Human Services)		
Ms. Judy Birch, Helena	Governor	1/1/2004
Qualifications (if required): representative of the Office of Public Instruction		
Rep. Betty Lou Kasten, Brockway	Governor	1/1/2004
Qualifications (if required): public member		
Ms. Betty Hidalgo, Great Falls	Governor	1/1/2004
Qualifications (if required): public member		
Ms. Shirley Brown, Helena	Governor	1/1/2004
Qualifications (if required): representative of the Department of Public Health and Human Services		
Mr. Mark A. Bryan, Bozeman	Governor	1/1/2004
Qualifications (if required): public member		
Montana Correctional Enterprises Ranch Advisory Council (Corrections)		
Mr. Don Davis, Deer Lodge	Governor	1/29/2004
Qualifications (if required): public member		
Sen. Francis Koehnke, Townsend	Governor	1/29/2004
Qualifications (if required): public member		
Mr. Ray Lybeck, Kalispell	Governor	1/29/2004
Qualifications (if required): public member		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Montana Correctional Enterprises Ranch Advisory Council (Corrections) cont.		
Rep. Robert Thoft, Stevensville Qualifications (if required): public member	Governor	1/29/2004
Sen. Thomas Beck, Helena Qualifications (if required): public member	Governor	1/29/2004
Rep. Edward (Ed) J. Grady, Canyon Creek Qualifications (if required): public member	Governor	1/29/2004
Mr. Bill Slaughter, Helena Qualifications (if required): public member	Governor	1/29/2004
Mr. Ross Swanson, Deer Lodge Qualifications (if required): public member	Governor	1/29/2004
Sen. Bill Tash, Dillon Qualifications (if required): public member	Governor	1/29/2004
Sen. Gerald Pease, Lodge Grass Qualifications (if required): public member	Governor	1/29/2004
Rep. Allen Rome, Garrison Qualifications (if required): public member	Governor	1/29/2004
Ms. Gayle Lambert, Deer Lodge Qualifications (if required): public member	Governor	1/29/2004
Mr. Bill Dabney, Deer Lodge Qualifications (if required): public member	Governor	1/29/2004
Mr. Steve Hartman, Deer Lodge Qualifications (if required): public member	Governor	1/29/2004

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Montana Correctional Enterprises Ranch Advisory Council (Corrections) cont.		
Sen. Sherm Anderson, Deer Lodge	Governor	1/29/2004
Qualifications (if required): public member		
Montana Economic Advisory Council (Governor)		
Mr. Tom Scott, Billings	Governor	2/14/2004
Qualifications (if required): member of EDAG		
Rep. Dave Kasten, Brockway	Governor	2/14/2004
Qualifications (if required): public member		
Mr. Jerry Driscoll, Helena	Governor	2/14/2004
Qualifications (if required): public member		
Mr. Scott Mendenhall, Cardwell	Governor	2/14/2004
Qualifications (if required): public member		
Mr. Turner Askew, Whitefish	Governor	2/14/2004
Qualifications (if required): member of EDAG		
Ms. Sharron Quisenberry, Bozeman	Governor	2/14/2004
Qualifications (if required): public member		
Mr. Will Weaver, Great Falls	Governor	2/14/2004
Qualifications (if required): public member		
Montana Health Coalition (Public Health and Human Services)		
Dr. Paul S. Donaldson, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Mr. Paul Peterson, Missoula	Director	2/1/2004
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Montana Health Coalition (Public Health and Human Services) cont.		
Sen. Duane Grimes, Clancy	Director	2/1/2004
Qualifications (if required): none specified		
Mr. Larry Robinson, Ronan	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Kris Kleinschmidt, Great Falls	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Kristianne Wilson, Billings	Director	2/1/2004
Qualifications (if required): none specified		
Rep. Edith J. Clark, Sweet Grass	Director	2/1/2004
Qualifications (if required): none specified		
Mr. Garfield Little Light, Billings	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Mary Caferro, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Laurie Francis, Livingston	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Marianne Krpan, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Claudia Clifford, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Mr. James Holcomb, Great Falls	Director	2/1/2004
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Montana Health Coalition (Public Health and Human Services) cont.		
Ms. Connie Welsh, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Mr. Dave Young, Bozeman	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Joan Bowsher, Helena	Director	2/1/2004
Qualifications (if required): none specified		
Ms. Kathy Jensen, Plentywood	Director	2/1/2004
Qualifications (if required): none specified		
Montana Higher Education Student Assistance Corporation (Education)		
Mr. Rick Bartos, Helena	Board of Regents	12/31/2003
Qualifications (if required): at large member		
Montana Statewide Independent Living Council (Public Health and Human Services)		
Ms. Kris Kleinschmidt, Great Falls	Director	1/2/2004
Qualifications (if required): none specified		
Multistate Tax Compact Advisory Council (Revenue)		
Mr. Alec Hansen, Helena	Director	2/27/2004
Qualifications (if required): representing the political subdivisions of Montana		
Mr. Gordon Morris, Helena	Director	2/27/2004
Qualifications (if required): representing the political subdivisions of Montana		
Mr. Kurt Alme, Helena	Director	2/27/2004
Qualifications (if required): Director of the Department of Revenue		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Noxious Weed Seed Free Forage Advisory Council (Agriculture)		
Mr. W. Ralph Peck, Helena	Director	12/11/2003
Qualifications (if required): Director		
Mr. LaMonte Schnur, Townsend	Director	12/11/2003
Qualifications (if required): forage producer		
Mr. Dennis Cash, Bozeman	Director	12/11/2003
Qualifications (if required): ex officio		
Mr. Ray Ditterline, Bozeman	Director	12/11/2003
Qualifications (if required): ex officio		
Mr. Kelly Flynn, Townsend	Director	12/11/2003
Qualifications (if required): outfitters and guides		
Mr. Clay Williams, Livingston	Director	12/11/2003
Qualifications (if required): weed districts		
Mr. Tim Schaff, Fishtail	Director	12/11/2003
Qualifications (if required): forage producer		
Mr. Wayne Maughn, Fort Benton	Director	12/11/2003
Qualifications (if required): livestock/agriculture		
Ms. Marcy Mack, Pablo	Director	12/11/2003
Qualifications (if required): weed districts		
Mr. David Leininger, Lewistown	Director	12/11/2003
Qualifications (if required): forage producer		
Mr. Ross Wagner, Kalispell	Director	12/11/2003
Qualifications (if required): forage producer		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Noxious Weed Seed Free Forage Advisory Council (Agriculture) cont.		
Mr. Jim Pfau, Stevensville	Director	12/11/2003
Qualifications (if required): feed pellets/cubes products		
Peace Officers Standards and Training Advisory Council (Justice)		
Mr. Mike Batista, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Montana Law Enforcement Academy		
Mr. Shawn T. Driscoll, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Montana Highway Patrol		
Mr. Jim Smith, Helena	Governor	2/14/2004
Qualifications (if required): representative of the League of Cities and Towns		
Ms. Elaine Allestad, Big Timber	Governor	2/14/2004
Qualifications (if required): representative of the Board of Crime Control		
Mr. Christopher Miller, Deer Lodge	Governor	2/14/2004
Qualifications (if required): representative of the Montana Attorneys Association		
Mr. Dennis McCave, Billings	Governor	2/14/2004
Qualifications (if required): representative of the Montana Detention Officers Association		
Mr. John Strandell, Great Falls	Governor	2/14/2004
Qualifications (if required): representative of the Sheriffs and Peace Officers Association		
Dr. Ray Murray, Missoula	Governor	2/14/2004
Qualifications (if required): representative of the public		
Mr. Gary Fjelstad, Forsyth	Governor	2/14/2004
Qualifications (if required): representative of the Montana Association of Counties		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Peace Officers Standards and Training Advisory Council (Justice) cont.		
Mr. John Ramsey, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Fish, Wildlife, and Parks		
Mr. Bill Dove, Bozeman	Governor	2/14/2004
Qualifications (if required): representative of the Police Protective Association		
Dr. James W. Burfeind, Missoula	Governor	2/14/2004
Qualifications (if required): representative of criminal justice educators		
Ms. Winnie Ore, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Corrections		
Ms. Shanna Bulik-Chism, Great Falls	Governor	2/14/2004
Qualifications (if required): representative of juvenile detention administrators		
Ms. Anne Kindness, Billings	Governor	2/14/2004
Qualifications (if required): representative of 911 services		
Mr. Mark Tymrak, Bozeman	Governor	2/14/2004
Qualifications (if required): representative of the Police Chiefs Association		
Mr. Greg Hintz, Missoula	Governor	2/14/2004
Qualifications (if required): representative of the Deputy Sheriff's Association		
Mr. Jack Wiseman, Helena	Governor	2/14/2004
Qualifications (if required): representative of the Department of Livestock		
Resource Conservation Advisory Council (Natural Resources and Conservation)		
Mr. Tom Stelling, Fort Shaw	Director	1/30/2004
Qualifications (if required): representative of conservation districts		

VACANCIES ON BOARDS AND COUNCILS -- DECEMBER 1, 2003 through FEBRUARY 29, 2004

Board/current position holder	Appointed by	Term end
Resource Conservation Advisory Council (Natural Resources and Conservation) cont.		
Ms. Marieanne Hanser, Billings	Director	1/30/2004
Qualifications (if required): representative of South Central Montana		
Mr. Robert Fossum, Richland	Director	1/30/2004
Qualifications (if required): representative of Eastern Montana		
Ms. Vicki McGuire, Eureka	Director	1/30/2004
Qualifications (if required): representative of Western Montana		
Mr. Dave Schwarz, Terry	Director	1/30/2004
Qualifications (if required): representative of conservation districts		
Mr. Bob Breipohl, Saco	Director	1/30/2004
Qualifications (if required): representative of North Central Montana		
Mr. Robert Anderson, Poplar	Director	1/30/2004
Qualifications (if required): representative of general public		