MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 16

The Montana Administrative Register (MAR or Register), 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 The Notice Section contains state agencies' proposed new, amended, or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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 contains final rule notices which show any changes made since the proposal stage. All rule actions are effective the day after publication of the adoption notice unless otherwise specified in the final notice. The Interpretation Section contains the Attorney General's opinions and state declaratory rulings. Special notices and tables are found at the end 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 Secretary of State's Office, Administrative Rules Bureau, at (406) 444-2055.

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BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the proposed adoption of New Rules I through IV relating to the Montana pulse crop research and market development program	)))))	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On September 23, 2006, the Montana Department of Agriculture proposes to adopt the above-stated rules.

2. The Department of Agriculture will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Agriculture no later than 5:00 p.m. on September 7, 2006, to advise us of the nature of the accommodation that you need. Please contact Joel A. Clairmont at the Montana Department of Agriculture, 303 North Roberts, P.O. Box 200201, Helena, MT 59620-0201; Phone: (406) 444-3144; Fax: (406) 444-5409; or e-mail: agr@mt.gov.

3. The proposed new rules provide as follows:

NEW RULE I MONTANA PULSE CROP ADVISORY COMMITTEE (1) The committee shall be a six-member committee consisting of individuals actively involved in the pulse crop industry in the production, research, or marketing of pulse crops.

(2) A majority of the committee members must be pulse crop “producers” per 80-11-510(3), MCA. “Producer" is defined in 80-11-503(5), MCA.

(3) On initial appointment by the director of the Montana Department of Agriculture, one member shall be appointed for a one-year term, two members for a two-year term, and three members for a three-year term at the director’s discretion. After the initial term, all members may serve three-year terms with a maximum of three consecutive terms allowed.

AUTH: 80-11-504, MCA
IMP: 80-11-510, MCA

NEW RULE II DEFINITIONS When used in these rules, the following definitions apply:

(1) "Department" means the Montana Department of Agriculture.

(2) "Net receipts" are defined as net weight multiplied by the price paid to the producer.

(3) "Pulse crops" are defined as dry peas, lentils, chickpeas, and fava beans.

AUTH: 80-11-504, MCA
IMP: 80-11-503, 80-11-515, MCA

NEW RULE III ANNUAL PULSE CROP COMMODITY ASSESSMENT-COLLECTION (1) Section 80-11-516, MCA, charges the Montana Department of Agriculture with collecting the commodity assessment.

(2) The assessment shall be 1% of the net receipts of pulse crops produced in Montana.

(3) The assessment per 80-11-515, MCA, will occur at the time of first sale by a seller and must be collected by the first purchaser of the commodity from the seller. It shall occur at the time of each settlement for the commodity purchased or by invoice form provided by the Montana Department of Agriculture.

AUTH: 80-11-504, MCA
IMP: 80-11-515, MCA

NEW RULE IV APPLICATIONS FOR PULSE CROP RESEARCH AND MARKETING PROJECT FUNDS (1) Applications for project funding shall be filed with the department on or before December 1 of each year. Filing requirements will be satisfied by receipt of the original and ten copies of each application at the Montana Department of Agriculture.

(2) The advisory committee, at the first regular meeting of each calendar year, will review education, production, research, and marketing project applications and a recommendation made to the department as to which projects they would propose to fund and the amount of funding suggested. Recommended projects will be determined by amount of funds, type of project, need as determined by the industry, and whether the project is new or ongoing.

(3) Applicants shall be notified within 30 days after the committee's first calendar year meeting whether or not their application(s) have been granted and the amount to be funded for each approved project.

(4) The department shall evaluate all outstanding project agreements semiannually for adequate and satisfactory financial control, accounting, and performance by project participants.

(5) The department may modify or terminate the funding of any project if a determination is made that the grantee has not complied or cannot comply with a provision of the project agreement. The department shall notify the grantee in writing within 30 days of such determination of the reasons for the determination, and the effective date of the modification or termination.

AUTH: 80-11-504, MCA
IMP: 80-11-511, MCA

REASONS: The Montana pulse crop industry passed a positive referendum voting in favor of establishing a Montana Pulse Crop Research and Market Development Program. This program, created under 80-11-501 through 80-11-519, MCA, will be funded from a portion of the net receipts at the first point of sale of the

commodity. These rules define membership and terms of the advisory committee and develop the method by which the assessment fee will be collected and expended. It is estimated that this program will impact 200 pulse crop producers in Montana and will generate revenue of approximately $150,000 to $200,000 per year for research and market development of Montana pulse crops.

4. Concerned persons may submit their data, views, or arguments concerning the proposed action in writing to Joel A. Clairmont at the Montana Department of Agriculture, 303 North Roberts, P.O. Box 200201, Helena, MT 59620-0201; Fax: (406) 444-5409; or e-mail: agr@mt.gov. Any comments must be received no later than September 21, 2006.

5. If persons who are directly affected by the proposed action wish to express their data, views, or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments they have to Joel A. Clairmont at the Montana Department of Agriculture, 303 North Roberts, P.O. Box 200201, Helena, MT 59620-0201; Fax: (406) 444-5409; or e-mail: agr@mt.gov. A written request for hearing must be received no later than September 21, 2006.

6. If the department receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the appropriate administrative rule review committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 20 persons based on approximately 200 pulse crop producers in Montana.

7. The Department of Agriculture 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 and specifies for which program the person wishes to receive notices. Such written request may be mailed or delivered to Montana Department of Agriculture, 303 North Roberts, P.O. Box 200201, Helena, MT 59620-0201; Fax: (406) 444-5409; or e-mail: agr@mt.gov or may be made by completing a request form at any rules hearing held by the Department of Agriculture.

8. An electronic copy of this Notice of Proposed Adoption is available through the department's web site at www.agr.mt.gov, under the Administrative Rules section. The department strives to make the electronic copy of the Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the

department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

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

DEPARTMENT OF AGRICULTURE

/s/ Nancy K. Peterson	/s/ Timothy J. Meloy
Nancy K. Peterson, Director	Timothy J. Meloy, Attorney Rule Reviewer

Certified to the Secretary of State, August 14, 2006.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.30.630 pertaining to temporary water quality standards	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT (WATER QUALITY)

TO: All Concerned Persons

1. On September 19, 2006, at 3:00 p.m., the Board of Environmental Review will hold a public hearing at the Lincoln Ranger Station at 1569 Highway 200, Lincoln, Montana, to consider the proposed amendment of the above-stated rule. The hearing will be preceded by a public meeting at 2:00 p.m. at the same location. At the public meeting the Department of Environmental Quality will make a presentation and answer questions regarding the proposed amendment.

2. The board 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 board no later than 5:00 p.m., September 11, 2006, to advise us of the nature of the accommodation that you need. Please contact the board secretary at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386; or e-mail ber@mt.gov.

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

17.30.630 TEMPORARY WATER QUALITY STANDARDS (1) through (1)(e) remain the same.

~~(2) Following are the temporary water quality standards and related provisions for portions of Mike Horse Creek, Beartrap Creek and the upper Blackfoot River:~~

~~(a) The goal of the state of Montana is to have these waters support the uses designated for waters classified B-1 at ARM 17.30.623(1). The standards for the parameters listed in this rule temporarily modify the specific standards for those parameters provided in ARM 17.30.623 for each of the water bodies listed below, until the temporary standards expire or are terminated by the board. The standards for parameters not listed in this rule are the specific standards listed in ARM 17.30.623 except where those requirements conflict with the temporary standards listed below.~~

~~(b) The existing uses of these water bodies must be maintained during the period that these temporary standards are in effect.~~

~~(c)(i) Except as provided in (2)(c)(ii), these standards are effective until May 31, 2008.~~

~~(ii) On or before September 1, 2003, the department shall certify to the board the date upon which the United States granted authority to the petitioner, asarco,~~

~~inc., to conduct water restoration activities on the federal land that is subject to the implementation plan. If the date certified is later than May 31, 2001, the effective period established in (2)(c)(i) will be automatically extended by the number of days that elapsed between May 31, 2001, and the date certified. However, this extension may not exceed an additional two years beyond May 31, 2008.~~

~~(d)(i) Except as provided in (2)(d)(ii) below, the temporary water quality standards for Mike Horse Creek, from the clean water diversion structure (N47°1'19.3", W112°21'40.9") to its confluence with Beartrap Creek (N47°1'44.0", W112°21'13.0"), are as follows. For the reach described above, no increase from existing conditions for any of the parameters listed below (no decrease for pH) is allowed. The numeric temporary standards for the specific parameters listed below apply only at the monitoring site location BRSW-22 used to calculate those temporary standards. No more than 3% of the monitored samples may exceed the numeric metals standards or may be less than the pH standard below. Metals standards are in terms of micrograms per liter (µg/liter) total recoverable concentrations and the pH standard is in standard units (su).~~

~~Parameter~~	~~µg/liter~~
~~Cadmium~~	~~135.~~
~~Copper~~	~~3,000.~~
~~Iron~~	~~900.~~
~~Lead~~	~~230.~~
~~Manganese~~	~~6,000.~~
~~Zinc~~	~~22,000.~~
~~pH~~	~~must be maintained above 6.5 su.~~

~~(ii) The water quality standards for Mike Horse Creek, from the clean water diversion structure (N47°1'19.3", W112°21'40.9") to its confluence with Beartrap Creek (N47°1'44.0", W112°21'13.0"), during remediation-related construction activities are the quality that results from those activities, provided all necessary permits and authorizations are obtained and all reasonable steps are taken to minimize the duration, extent and magnitude of the short-term impacts.~~

~~(e)(i) Except as provided in (2)(e)(ii) below, the water quality standards for Beartrap Creek, from the foot of the Beartrap tailings impoundment dam (N47°1'42.1", W112°21'11.3") to its confluence with Anaconda Creek (N47°2'5.8", W112°21'31.1"), are as follows. For the reach described above, no increase from existing conditions for any of the parameters listed below (no decrease for pH) is allowed. The numeric temporary standards for the specific parameters listed below apply only at the monitoring site location BRSW-23 used to calculate those temporary standards. No more than 3% of the monitored samples may exceed the numeric metals standards or may be less than the pH standard below. Metals standards are in terms of micrograms per liter (µg/liter) total recoverable concentrations and the pH standard is in standard units (su).~~

~~Parameter~~	~~µg/liter~~
~~Cadmium~~	~~50.~~
~~Copper~~	~~700.~~

~~Iron~~	~~500.~~
~~Lead~~	~~80.~~
~~Manganese~~	~~3,700.~~
~~Zinc~~	~~7,500.~~
~~pH~~	~~must be maintained above 6.5 su.~~

~~(ii) The water quality standards for Beartrap Creek, from the foot of the Beartrap tailings impoundment dam (N47º1'42.1", W112º21'11.3") to its confluence with Anaconda Creek (N47º2'5.8", W112º21'31.1"), during remediation-related construction activities are the quality that results from those activities, provided all necessary permits and authorizations are obtained and all reasonable steps are taken to minimize the duration, extent and magnitude of the short-term impacts.~~

~~(f)(i) Except as provided in (2)(f)(ii) below, the water quality standards for the Blackfoot River, from Anaconda Creek (N47º2'5.8", W112º21'31.1") to the confluence of Stevens Gulch (N47º2'24.8", W112º22'15.8"), are as follows. For the reach described above, no increase from existing conditions for any of the parameters listed below (no decrease for pH) is allowed. The numeric temporary standards for the specific parameters listed below apply only at the monitoring site location BRSW-9 used to calculate those temporary standards. No more than 3% of the monitored samples may exceed the numeric metals standards or may be less than the pH standard below. Metals standards are in terms of micrograms per liter (µg/liter) total recoverable concentrations and the pH standard is in standard units (su).~~

~~Parameter~~	~~µg/liter~~
~~Cadmium~~	~~16.~~
~~Copper~~	~~220.~~
~~Lead~~	~~25.~~
~~Manganese~~	~~4,300.~~
~~Zinc~~	~~6,000.~~
~~pH~~	~~must be maintained above 6.5 su.~~

~~(ii) The water quality standards for the Blackfoot River, from Anaconda Creek (N47º2'5.8", W112º21'31.1") to its confluence with Stevens Gulch (N47º2'24.8", W112º22'15.8"), during remediation-related construction activities are the quality that results from those activities, provided all necessary permits and authorizations are obtained and all reasonable steps are taken to minimize the duration, extent and magnitude of the short-term impacts.~~

~~(g)(i) Except as provided in (2)(g)(ii) below, the water quality standards for the Blackfoot River, from the confluence of Stevens Gulch (N47º2'24.8", W112º22'15.8") to the confluence with Pass Creek (N47º2'30.5", W112º22'52.8"), are as follows. For the reach described above, no increase from existing conditions for any of the parameters listed below (no decrease for pH) is allowed. The numeric temporary standards for the specific parameters listed below apply only at the monitoring site location BRSW-12 used to calculate those temporary standards. No more than 3% of the monitored samples may exceed the numeric metals standards or may be less than the pH standards below. Metals standards are in terms of~~

~~micrograms per liter (µg/liter) total recoverable concentrations and the pH standard is in standard units (su).~~

~~Parameter~~	~~µg/liter~~
~~Cadmium~~	~~10.~~
~~Copper~~	~~70.~~
~~Iron~~	~~340.~~
~~Lead~~	~~23.~~
~~Manganese~~	~~900.~~
~~Zinc~~	~~2,700.~~
~~pH~~	~~must be maintained above 6.5 su.~~

~~(ii) The water quality standards for the Blackfoot River, from the confluence of Stevens Gulch (N47º2'24.8", W112º22'15.8") to the confluence with Pass Creek (N47º2'30.5", W112º22'52.8"), during remediation-related construction activities are the quality that results from those activities, provided all necessary permits and authorizations are obtained and all reasonable steps are taken to minimize the duration, extent and magnitude of the short-term impacts.~~

AUTH: 75-5-201, 75-5-312, MCA
IMP: 75-5-312, MCA

REASON: The board is proposing to amend ARM 17.30.630 to repeal the temporary water quality standards for cadmium, copper, iron, lead, manganese, zinc, and pH that were adopted in 2000 for portions of Mike Horse Creek, Beartrap Creek, and the upper Blackfoot River and were to remain in effect for eight years. If the temporary water quality standards for these streams are repealed as proposed, the specific water quality standards in ARM 17.30.623 for streams classified B-1 will once again apply to these waters.

Temporary water quality standards may be adopted for specific parameters that are causing a water body not to support one or more of its designated uses. The temporary water quality standards may be statistically based on ambient conditions and, as in this case, can be several orders of magnitude greater than the standards that otherwise would apply. The purpose of the temporary water quality standards is to allow the petitioner to develop and implement a cleanup plan and a schedule of activities with the intent to have the water body support its designated uses within the timeframe of the temporary standards.

As a condition of temporary standards adoption, the person who requests them must submit a cleanup plan that is designed to improve the water quality so that the water body supports its designated uses. The board is proposing this amendment to repeal the temporary water quality standards for portions of Mike Horse Creek, Beartrap Creek, and the upper Blackfoot River because of inadequate progress in meeting the goals in the implementation plan and failure to meet milestones that served as a basis for adopting the temporary standards. Due to this lack of progress, the board is proposing to terminate the temporary standards as expressly authorized under 75-5-312(11), MCA. Alternatively, the board could modify the implementation plan and schedule if there was "convincing evidence" that

the plan needs modification. 75-5-312(12), MCA. Since there is no evidence that a modified plan would assure continued progress in implementing the plan, the board is proposing to terminate the temporary standards and return the streams to the former standards for B-1 streams.

The lack of progress that has prompted the board's proposal to terminate the temporary standards is not limited to one failure, but consists of many. For example, there has been a chronic failure to submit the annual data summary report and annual work plan on time. In addition, numerous reclamation activities have not been completed according to the implementation plan's schedule. The activities that have not been completed in a timely fashion include: (1) the mine waste reclamation plan and removal for the Lower Mike Horse Creek (scheduled for completion in 2003); (2) the dispersed floodplain tailings reclamation plan and removal for the Beartrap Creek drainage (scheduled for completion in 2004); (3) the mine waste and possible adit discharge reclamation plan and removal on the Flosse and Louise patented claim (scheduled for completion in 2004); (4) the concentrated tailings reclamation plan and removal for the Upper Blackfoot River drainage near the confluence with Shave Creek (scheduled for completion in 2005); (5) the dispersed floodplain tailings reclamation plan and removal for the Upper Blackfoot River drainage (scheduled for completion in 2005); and (6) Stevens Gulch reclamation plan (scheduled for completion in 2006).

4. Concerned persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to the board secretary at Board of Environmental Review, 1520 E. Sixth Avenue, P.O. Box 200901, Helena, Montana, 59620-0901; faxed to (406) 444-4386; or e-mailed to ber@mt.gov, no later than 5:00 p.m., October 2, 2006. To be guaranteed consideration, mailed comments must be postmarked on or before that date.

5. Katherine Orr, attorney for the board, has been designated to preside over and conduct the hearing.

6. The board 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 that includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding: air quality; hazardous waste/waste oil; asbestos control; water/wastewater treatment plant operator certification; solid waste; junk vehicles; infectious waste; public water supplies; public sewage systems regulation; hard rock (metal) mine reclamation; major facility siting; opencut mine reclamation; strip mine reclamation; subdivisions; renewable energy grants/loans; wastewater treatment or safe drinking water revolving grants and loans; water quality; CECRA; underground/above ground storage tanks; MEPA; or general procedural rules other than MEPA. Such written request may be mailed or delivered to the Board of Environmental Review, 1520 E. Sixth Ave., P.O. Box 200901, Helena, Montana 59620-0901, faxed to the office at (406) 444-4386, e-mailed to the board secretary

at ber@mt.gov or may be made by completing a request form at any rules hearing held by the board.

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

BOARD OF ENVIRONMENTAL REVIEW

By: /s/ Joseph W. Russell
JOSEPH W. RUSSELL, M.P.H.,
Chairperson

Reviewed by:

/s/ John F. North
JOHN F. NORTH, Rule Reviewer

Certified to the Secretary of State, August 14, 2006.

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

In the matter of the adoption of New Rules I through V, and amendment of ARM 37.5.125 pertaining to Older Blind Program	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On September 13, 2006, at 11:00 a.m., a public hearing will be held in Room 207 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 September 5, 2006, 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; e-mail dphhslegal@mt.gov.

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

RULE I OLDER BLIND PROGRAM: DEFINITIONS Definitions for purposes of this subchapter:

(1) "Advisory council" means the Montana Vocational Rehabilitation Council.

(2) "Community awareness" means conducting activities to help improve public understanding and knowledge of the aspects of blindness and low vision and the problems facing older blind persons.

(3) "Consumer" means a person who the program has determined is eligible for and may receive older blind services.

(4) "Division" means the Disability Services Division of the department.

(5) "Functional areas" mean types of performance and assistance necessary for a person to successfully function independently in daily life and includes mobility, access to print information, self-care, independent living skills, access to technology, recreation, and social activities.

(6) "Impediment" means, for a person, an obstacle or inability to perform a task or achieve a goal that is caused by a disabling condition.

(7) "Independent living plan" means the plan prepared by the department in conjunction with the consumer. This plan specifies the independent living goals of the consumer, and the older blind services the department may provide to the consumer in order to assist the consumer to attain an improved quality of life.

(8) "Independent living skills training" means training in compensatory skills,

including use of adaptive equipment that allows an individual with visual impairments to cope with vision loss, perform daily living activities, and participate more independently in the community.

(9) "Individual advocacy training" means helping a consumer to identify their independent living needs, to develop a plan of action to meet those needs, to obtain and use resource information, and to develop problem-solving skills necessary for ensuring an independent and self-determined lifestyle.

(10) "Information and referral" means providing a consumer with basic information on equipment, financial assistance, recreation, housing, and attendant care, support groups, legal rights, and other disability and community topics and resources.

(11) "Legally blind" means a visual disability in which:

(a) a person's central visual acuity does not exceed 20/200 in the better eye with correcting lenses; or

(b) a person's visual field at the widest diameter subtends an angle no greater than 20 degrees.

(12) "Low vision" means a significant visual impairment that even with correction makes performance of daily tasks difficult.

(13) "Maintenance" means payments made to fund food, shelter, or clothing for a consumer.

(14) "Mobility training" means sequential instruction to a consumer in the use of remaining senses to determine position within the environment and techniques for safe movement from one place to another.

(15) "Older blind person" means a person age 55 or older whose blindness or low vision makes competitive employment extremely difficult to attain or who does not want to pursue employment but for whom independent living goals are feasible.

(16) "Orientation and mobility specialist" means a qualified professional in orientation and mobility either employed or contracted by the department who provides training to consumers so they can navigate safely in their home and community environments and access public transportation.

(17) "Peer counseling" means counseling and support provided to a consumer who is experiencing personal issues related to vision loss by another person or group who has had similar experiences. The peer helper functions as a role model, advocate, and resource person for the consumer.

(18) "Program" means the Blind and Low Vision Services Program administered by the division.

(19) "Qualified blind and low vision staff" or "qualified staff" means a rehabilitation teacher, vision rehabilitation therapist, orientation and mobility specialist, or the rehabilitation counselor employed by the program.

(20) "Rehabilitation counselor" means a vocational rehabilitation counselor who meets the standards of qualified professional as identified by the Montana Vocational Rehabilitation program and is employed by the program.

(21) "Rehabilitation teacher" or "vision rehabilitation therapist" means a qualified professional in rehabilitation teaching for blind and low vision persons either employed or contracted by the program who instructs consumers in functional areas of independent living.

(22) "Rehabilitation teaching services" or "vision rehabilitation therapy

services" mean the assessment of a consumer's need for and training in compensatory skills for functional areas to assist the consumer in coping with vision loss.

(23) "Significant visual impairment" means a vision loss of acuity or field that even with correction limits a person's activities or ability to function in a normal manner.

(24) "Supportive services" mean services provided by family members or other persons, organizations, or institutions to assist the consumer in functional areas.

AUTH: 53-2-201, 53-7-102, 53-7-302, 53-7-315, MCA
IMP: 53-7-301, 53-7-302, 53-7-303, 53-7-306, MCA

RULE II OLDER BLIND PROGRAM: ELIGIBILITY (1) A person may receive older blind services if the person:

(a) has appropriately applied for services;

(b) is 55 years or older in age;

(c) is legally blind, has low vision, or a significant visual impairment;

(d) requires services available through the program that will contribute to the person's maintenance or increased independence; and

(e) meets the other requirements of this subchapter applicable to consumers.

(2) The presence of a visual impairment or impediment may be determined by qualified staff based upon a functional assessment of the person's vision.

(3) A consumer's eligibility for services terminates when:

(a) a qualified staff member determines that the goals of the consumer's independent living plan have been achieved or cannot be achieved;

(b) due to fiscal or personnel resource exigencies the consumer's service delivery category is closed or the consumer is among the consumers whose service delivery is closed due to a reduction in the number of persons who can be served in the consumer's service delivery category;

(c) the consumer requests termination; or

(d) the consumer is no longer available for services.

(4) Prior to termination of a consumer's eligibility, the program will provide the consumer with notice of the termination and provide the consumer with the opportunity to seek an informal review of the proposed termination. If the person remains dissatisfied with the proposed termination, the person may request a fair hearing as provided for in [RULE V].

AUTH: 53-2-201, 53-7-102, 53-7-302, 53-7-315, MCA
IMP: 53-7-301, 53-7-302, 53-7-303, 53-7-306, MCA

RULE III OLDER BLIND PROGRAM: REDUCTION OF SERVICE POPULATION (1) The division, in accordance with state and federal law, administers the program to assure the fiscal integrity of the program. If the division determines that there are insufficient fiscal or personnel resources to appropriately serve consumers, the administrator of the division in consultation with the Montana Vocational Rehabilitation Council will limit service delivery based upon the criteria in

(2) through (5).

(2) For the purposes of limiting service delivery in order to meet fiscal and personnel resources exigencies, the following categories are applicable:

(a) Category 1, for consumers already accepted into the Older Blind Program.

(b) Category 2, for consumers who are legally blind and at risk of moving into a less independent environment due to vision loss.

(c) Category 3, for consumers with low vision (best acuity with correction of 20/80 or less in the better eye) or significant visual impairment that affects four or more areas of functioning, and consumers who are legally blind but not at risk of moving into a less independent environment.

(d) Category 4, for all other consumers with a significant visual impairment who meet the eligibility criteria for the Older Blind Program.

(3) For purposes of implementing service delivery limitations due to insufficient fiscal or personnel resources, the division will close, as appropriate to meet the fiscal and personnel resources exigencies, one or more categories of service delivery beginning with level 4. For each service delivery category closed, the division will initially close that category to further consumers. Consumers in that category already in receipt of services will continue to receive services unless it is necessary due to the exigencies to initiate closure of services to all persons in that category.

(4) If the division determines that there are fiscal or personnel resources available to serve some, but not all, of the consumers in a particular service delivery category, the division will continue to serve that number of consumers in that category for which it has adequate fiscal or personnel resources. Consumers to be served will be selected based upon the consumers' dates of application for the program beginning with the earliest date of application.

(5) If the division determines that there are fiscal or personnel resources available by which to begin to open a previously closed service delivery category but not serve all possibly eligible persons in that category, the division will serve that number of consumers for which it has adequate fiscal or personnel resources based upon the consumers' dates of application for the program beginning with the earliest date.

AUTH: 53-2-201, 53-7-102, 53-7-302, 53-7-315, MCA
IMP: 53-7-301, 53-7-302, 53-7-303, 53-7-306, MCA

RULE IV OLDER BLIND PROGRAM: SCOPE OF SERVICES (1) Older blind services are services determined necessary by qualified staff to assist a consumer with maintaining or increasing independence consistent with a consumer's priorities, concerns, abilities, interests, and choice.

(2) Older blind services include:

(a) outreach;

(b) low vision assessment, instruction, and assessment equipment;

(c) low vision aids and equipment;

(d) services and equipment fostering mobility and self-sufficiency;

(e) mobility training, Braille instruction, and other services and equipment to help an older individual who is blind adjust to blindness;

(f) independent living skills training;
(g) information and referral services;
(h) peer counseling;
(i) individual advocacy training;
(j) supportive services;
(k) rehabilitation teaching services;
(l) training necessary for living in the community and participating in community activities; and
(m) any other appropriate service designed to assist with daily living activities.
(3) Services may be made available in the discretion of the program to enhance independence, productivity, and quality of life, and independence of consumers as a group. Those services include, but are not limited to:
(a) community awareness programs to enhance understanding and integration into society; and
(b) activities to help improve public understanding of problems of consumers.
(4) Services provided to an individual consumer must be provided in accordance with the independent living plan.

AUTH: 53-2-201, 53-7-102, 53-7-302, 53-7-315, MCA
IMP: 53-7-301, 53-7-302, 53-7-303, 53-7-306, MCA

RULE V CONSUMER GRIEVANCES AND FAIR HEARINGS (1) A provider of older blind services must make available an informal procedure for resolution of any grievance that a consumer may have. Any matter of grievance not adequately resolved between a provider of services and a consumer may be brought before the department for review and resolution.
(2) An applicant for or consumer of older blind services provided through this subchapter who is the subject of an alleged adverse action of the program may pursue a fair hearing as permitted by and in accordance with this rule and ARM 37.30.1401.

AUTH: 53-2-201, 53-7-102, 53-7-302, 53-7-315, MCA
IMP: 53-7-301, 53-7-302, 53-7-303, 53-7-306, MCA

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

37.5.125 VOCATIONAL REHABILITATION AND BLIND AND LOW VISION SERVICES PROGRAMS: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the provision of Vocational Rehabilitation Services inclusive of the Blind and Low Vision Services Program are available to the extent granted and as provided in ARM 37.30.1401 and in [RULE V]. The provisions of ARM 37.5.307, 37.5.310, 37.5.311, 37.5.316, 37.5.328, and 37.5.331 do not apply to such hearings.

AUTH: 53-2-201, 53-6-113, 53-7-102, 53-7-206, 53-7-315, MCA
IMP: 53-7-102, 53-7-106, 53-7-206, 53-7-314, 53-7-315, 53-19-112, MCA

4. The proposed new rules along with the proposed amendment of the existing rule will serve to implement in rule the Montana Older Blind Program. The Older Blind Program is a federally authorized and in part funded program administered by the state that provides a variety of independent living services to eligible consumers. The program is an aspect of the federal program of Independent Living Services for Persons with Disabilities authorized by the Rehabilitation Act of 1973, as amended.

The purpose of the Older Blind Program is to facilitate independent living for older persons who are blind or who have significant vision limitations known as low vision. The services available through the program support persons with vision handicaps to maintain healthy engaged life styles and avoid unnecessary dependence and isolation.

The Independent Living Services Program is currently implemented in rule at ARM Title 37, chapter 31. The existing rules are not appropriate for the implementation of the services provided through the Older Blind Program which in purpose, definitions, eligibility, and services differs significantly from the substantive aspects of the general Independent Living Program. The proposed new rules along with the proposed amendment to the existing independent living services rule will assure comprehensive rule implementation of the program.

The rule implementation of the Older Blind Program is necessary to assure that eligible persons are appropriately identified and engaged in service delivery. With the application of definitive criteria through the proposed rules, the fiscal and programmatic resources available for the delivery of services can be more effectively targeted to consumers who are blind or have vision impairments and more efficiently delivered given the particular needs of those consumers. Absent this rule adoption the appropriate development of the Older Blind Services Program would not be realized and some older blind consumers would lack appropriate services.

Rule I OLDER BLIND PROGRAM: DEFINITIONS

The definitions are necessary for the establishment and administration of the Older Blind Program. The definitions presented in the proposed rule encompass common nomenclature applied in the administration of the Older Blind Program. Acceptance for purpose of establishment and funding by the approving federal authorities of the Montana program is predicated upon the adoption of federally condoned eligibility criteria and of an appropriate array of services to meet the needs of the consumers that are to be delivered by an appropriate set of professionals. These definitions further effectuate those aspects of the program.

The terms "legally blind", "low vision", "significant visual impairment", "impediment", "functional areas", and "older blind person" provide the definitional parameters of eligibility for the services of the program. The definition of "older blind person" serves to establish an age parameter of 55 years of age or older and to provide that

there must be the presence of blindness or low vision that results in the need for service supports so that the person may realize independent living. These definitional parameters of eligibility are necessary to effectuate eligibility and to do so in the context of the governing federal authority at 29 USC 796j and 796k.

The types of services available through the program for individual consumers are encompassed in the definitions of "individual living advocacy", "information and referral", "maintenance", "mobility training", "peer counseling", "rehabilitation teaching services", and "supportive services". These program funded services are necessary to assure that an array of services may be drawn upon to adequately foster the independence of the program consumers. These services have been selected as the implemented set of services based upon their proven effectiveness in supporting the independent living of older blind persons. The "individual living advocacy" service and the "information and referral services" serve to inform and involve the consumer in the development of independent living services that are appropriate and necessary to meet the needs of the person. The other services available are those services that may be necessary to meet the functional and other needs of the person.

The professionals that may engage in the planning for and the delivery of services as identified in the rules are defined through the terms: "orientation and mobility specialist", "qualified blind and low vision staff", "rehabilitation counselor", and "rehabilitation teacher". These definitions, reflecting accepted professional categories for the delivery of services to blind and low vision persons, are important to assure that the service development and delivery of older blind services is executed appropriately and in the best interest of the consumers of those services.

Rule II OLDER BLIND PROGRAM: ELIGIBILITY

This proposed rule provides the eligibility criteria that govern the acceptance of persons by the department into the Older Blind Program. The criteria are in accordance with the predicate definition of "older individual who is blind" stated in 29 USC 796j of the authorizing federal statutory scheme. The proposed rule provides that the receipt of services by persons who are determined eligible is discretionary. Furthermore, the proposed rule provides that the department, as provided for in Rule III and as necessary, may determine eligibility and limit the provision of services for eligible persons based upon the availability of fiscal and programmatic resources.

No other options have been considered for the program since the eligibility criteria cannot vary from the essential requirements of the authorizing federal statutory scheme if the state is to maintain the commitment of federal monies dedicated to the program.

Departmental discretion is necessary with respect to the acceptance of eligible persons into the program and to removal from the program. This is necessary so as to maintain the fiscal and programmatic integrity of the program. The department determined that without this discretion the state would in effect have to accept all

potentially eligible persons resulting in this limited program operating as if it were an entitlement program with unlimited enrollment, over expenditures, and programmatic stresses.

Rule III OLDER BLIND PROGRAM: REDUCTION OF SERVICE POPULATION

This proposed rule provides a process and criteria by which to limit the number of consumers participating in the program as may be necessary to respond to fiscal and programmatic limitations. This process is necessary to assure the continued integrity of the program through a systematic rationing of the services that the state can make available based upon fiscal and program resources. Absence of this process and criteria is not a viable option since there would be no way to curtail over expenditures or address programmatic stresses. The approach of seeking the adoption of a process to incrementally eliminate eligibility for existing or potential consumers based upon need as determined by the extent of disabling condition was chosen, as opposed to program closure or service reductions across the entire service population, because it focuses the available resources on those persons identified as having the most significant service needs.

The four categories by which the rationing is to be accomplished reflect a gradation from those with the most significant disabilities in relation to sight and the most need for services to those with lesser disabilities and need. This choice as to criteria for the categories is the most appropriate rather than a system of first in last out that would forego considerations of need for services.

Rule IV OLDER BLIND PROGRAM: SCOPE OF SERVICES

This proposed rule delineates the type of services that may be provided to a consumer or group of consumers through the Older Blind Program, states that selection of necessary services is at the discretion of the department, and that services are to be delivered through an independent living plan (ILP).

This rule is necessary to implement the services of the program and provide the planning vehicle through which those services may be individually selected and monitored for a consumer. The slate of services that may be delivered is necessary so as to provide an appropriate spectrum of services that can address the various needs for enhancing the independent living of persons who are blind or have vision impairments. The implementation also assures that the services delivered are appropriate in accordance with the direction of the governing federal authority at 29 USC 796k specifying the principal independent living services. This spectrum assures flexibility in designing and implementing a program of individualized services. Options of providing smaller limited sets of services are not considered viable given the various individual needs exhibited by consumers.

A planning process, as proposed, is as well a necessary adjunct to the individualized delivery of services with appropriate departmental oversight to assure the selection and delivery of appropriate services with adequate cost controls. The option of

foregoing these features would be untenable since any number of inappropriate services could be conjured up and delivered without serving the consumer's best interests and the department would be without programmatic and fiscal controls over individual expenditures.

Rule V CONSUMER GRIEVANCES AND FAIR HEARINGS

This rule provides an informal recourse through which grievances may be resolved and a formal recourse of a fair hearing process conducted in accordance with the Montana Administrative Procedure Act (MAPA). The provision of an informal grievance process is necessary to allow for the opportunity for the consumer and the department to explore in a nonconfrontive and straightforward manner resolution of a consumer status or service issue. The provision of a fair hearing process is necessary to assure consumers that for issues that remain unresolved after the informal grievance process there is available recourse to a formal adjudication due process in an appropriate forum.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on September 21, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

/s/ Cary B. Lund
Rule Reviewer

/s/ Joan Miles
Director, Public Health and
Human Services

Certified to the Secretary of State August 14, 2006.

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

In the matter of the adoption of New Rules I through XXVIII pertaining to home and community-based services for adults with severe disabling mental illness	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Interested Persons

1. On September 13, 2006, at 11:00 a.m., a public hearing will be held in Room 207 of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption 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 September 5, 2006, 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; e-mail dphhslegal@mt.gov.

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

RULE I HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: FEDERAL AUTHORIZATION AND STATE ADMINISTRATION (1) The U.S. Department of Health and Human Services (HHS) has granted the department, under 42 CFS 441.300 through 441.310, the authority to establish a program of Medicaid funded home and community-based services for persons who have severe disabling mental illness, as defined in ARM 37.89.103, and who would otherwise have to reside in and receive Medicaid reimbursed care in a nursing facility or a hospital.

(2) The department, in accordance with the state and federal statutes and the rules generally governing the provision of Medicaid funded home and community-based services, any federal-state agreements specifically governing the provision of the Medicaid funded home and community-based services to be delivered under this program, and within the available funding appropriated for the program, may determine within its discretion:

(a) the types of services to be available through the program;

(b) the amount, scope, and duration of the services available through the program;

(c) the categories of persons to be served through the program;

(d) the total number of persons who may receive services through the

program;

(e) the total number of persons who may receive services through the program by category of eligibility, geographical area, or specific case management team; and

(f) eligibility of individual persons for the program.

(3) Enrollment in the program and the provision of services through the program are at the discretion of the department. There is no legal entitlement to enroll in the program or to receive any or all the services available through the program.

(4) The state has received federal approval to waive statewide coverage in the provision of program services. Program services may only be delivered to recipients in the following service areas for which federal approval of coverage has been received:

(a) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;

(b) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and

(c) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE II HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: THE PROVISION OF SERVICES

(1) The services available through the program are limited to those specified in this rule.

(2) The department may determine the particular services of the program to make available to a recipient based on, but not limited to, the following criteria:

(a) the recipient's need for a service generally and specifically;

(b) the availability of a specific service through the program and any ancillary service necessary to meet the recipient's needs;

(c) the availability otherwise of alternative public and private resources and services to meet the recipient's need for the service;

(d) the recipient's risk of significant harm or of death if not in receipt of the service;

(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; and

(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.

(4) Bases for denying a service to a person include, but are not limited to:

(a) the person requires more supervision than the service can provide;

(b) the person's needs, inclusive of health, cannot be effectively or appropriately met by the service;

(c) access to the service, even with reasonable accommodation, is precluded by the person's health or other circumstances;
(d) a necessary ancillary service is no longer available; or
(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.
(5) The following services, as defined in these rules, may be provided through the program:
(a) case management services;
(b) homemaking;
(c) personal assistance;
(d) adult day health;
(e) habilitation;
(f) respite care;
(g) personal emergency response systems;
(h) nutrition services;
(i) nonmedical transportation;
(j) outpatient occupational therapy;
(k) nursing;
(l) psycho-social consultation;
(m) dietetic services;
(n) adult residential care;
(o) specially trained attendant care;
(p) chemical dependency counseling;
(q) specialized medical equipment and supplies;
(r) supported living;
(s) illness management and recovery services; and
(t) Wellness Recovery Action Plan (WRAP) services.
(6) Monies available through the program may not be expended on the following:
(a) room and board; and
(b) special education and related services as defined at 20 USC 1401(16) and (17).
(7) A program service is not available to a recipient if that type of service is otherwise available to the recipient from another source.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE III HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS
(1) Services of the program may only be provided by or through a provider that:
(a) is enrolled with the department as a Medicaid provider or, if not an enrolled Medicaid provider, is under contract with a Medicaid provider that the department is contracting with for home and community-based case management services and that the department has authorized to reimburse non-Medicaid providers;

(b) meets all the requirements necessary for the receipt of Medicaid monies;
(c) has been determined by the department to be qualified to provide services to adults with severe disabling mental illness;
(d) is a legal entity;
(e) is appropriately insured as determined by the department; and
(f) meets all facility and other licensing requirements applicable to the services offered, the service settings provided, and the professionals employed.
(2) A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include a spouse or legal guardian.
(3) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE IV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ELIGIBILITY AND SELECTION

(1) The department may consider for eligibility in and may enroll in the program persons who the department determines qualify for enrollment in accordance with the criteria in [RULE IV].
(2) In order to be considered by the department for eligibility in the program, a person must be determined to qualify for enrollment in accordance with the criteria in this rule.
(3) A person is qualified to be considered for enrollment in the program if the person meets the following criteria:
(a) is 18 years of age or older or is certified as disabled by the Social Security Administration;
(b) is Medicaid eligible;
(c) requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206;
(d) does not currently reside in a hospital or a nursing facility;
(e) has needs that can be met through the program;
(f) meets the severe disabling mental illness definition at ARM 37.89.103; and
(g) resides in one of the following service areas for which federal approval of coverage has been received:
(i) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;
(ii) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and
(iii) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell.
(4) The department may consider for an available opening for program services a person who, as determined by the department:

(a) meets the criteria of [RULE IV];
(b) is actively seeking services;
(c) is in need of the services available;
(d) is likely to benefit from the available services; and
(e) has a projected total cost of plan of care that is within the limits specified in [RULE VII].
(5) The department offers an available opening for program services to the applicant, as determined by the department, who is:
(a) most in need of the available services;
(b) most likely to benefit from the available services; and
(c) whose projected total cost plan of care is within the applicable limits specified in [RULE VII].
(6) Factors to be considered in the determination of whether a person is:
(a) in need of the available program services;
(b) likely to benefit from those services; and
(c) which person is most likely to benefit from the available services include, but are not limited to, the following:
(i) medical condition;
(ii) degree of independent mobility;
(iii) ability to be alone for extended periods of time;
(iv) presence of problems with judgment;
(v) presence of a cognitive impairment;
(vi) prior enrollment in the program;
(vii) current institutionalization or risk of institutionalization;
(viii) risk of physical or mental deterioration or death;
(ix) willingness to live alone;
(x) adequacy of housing;
(xi) need for adaptive aids;
(xii) need for 24 hour supervision;
(xiii) need of person's caregiver for relief;
(xiv) appropriateness for the person, given the person's current needs and risks, of services available through the program;
(xv) status of current services being purchased otherwise for the person; and
(xvi) status of support from family, friends, and community.
(7) A recipient may be removed from the program by the department. Bases for removal from the program include, but are not limited to the following:
(a) a determination by the case management team that the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person's needs;
(b) the failure of the person to use the services as provided for in the plan of care;
(c) the behaviors of the person place the person, the person's caregivers, or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care;
(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;
(e) a determination by the case management team that the service providers

necessary for the delivery of services to the person, as provided for in the plan of care, are unavailable;

(f) a determination that the total cost of the person's plan of care is not within the limits specified at [RULE VII];

(g) the person no longer requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206; and

(h) the person no longer resides in one of the counties specified in [RULE IV].

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE V HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT (1) Services available through the program are reimbursed as provided in this rule.

(2) The following services are reimbursed as provided in (3):

(a) homemaking;
(b) adult day health;
(c) habilitation;
(d) personal emergency response systems;
(e) nutrition;
(f) psycho-social consultation;
(g) nursing;
(h) dietetic services;
(i) specially trained attendant care;
(j) chemical dependency counseling;
(k) supported living;
(l) adult residential care;
(m) respite care not provided by a nursing facility;
(n) nonmedical transportation;
(o) specialized medical equipment and supplies;
(p) illness management and recovery services; and
(q) Wellness Recovery Action Plan (WRAP).

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

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

(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general Medicaid Program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service of the general Medicaid Program.

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid Program:

(a) personal assistance as provided at ARM 37.40.1105; and
(b) outpatient occupational therapy as provided at ARM 37.86.610.
(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.
(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.
(8) Reimbursement will not be paid for a service that is otherwise available from another source.
(9) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with Medicaid monies.
(10) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PLANS OF CARE (1) A plan of care is a written plan of supports and interventions based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.
(2) The services that a recipient may receive through the program and the amount, scope, and duration of those services must be specifically authorized in writing through an individual plan of care for the person.
(3) The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least six months beginning with the date of the initial plan of care.
(4) Each plan of care is developed, reviewed, and revised by the case management team.
(5) The case management team, in developing the plan of care, consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals, and others who have knowledge of the recipient's needs.
(6) Each plan of care must include the following:
(a) diagnosis, symptoms, complaints, and complications indicating the need for services;
(b) a description of the recipient's functional level;
(c) objectives;
(d) any orders for:
(i) medication;
(ii) treatments;
(iii) restorative and rehabilitative services;

(iv) activities;
(v) therapies;
(vi) social services;
(vii) diet; and
(viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care;
(e) the specific program and other services to be provided, the frequency of the services, and the type of provider to provide them;
(f) the projected annualized costs of each program service; and
(g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.

(7) Inclusion of the need for and the identification of nonprogram services in the plan of care does not financially obligate the department to fund those services or to assure their delivery and quality.

(8) The case management team must provide a copy of the plan to the recipient.

(9) Plan of care approval is based on:
(a) completeness of plan;
(b) consistency of plan with the needs of the person; and
(c) feasibility of service provision, including cost-effectiveness of plan as provided for in [RULE VII]; and
(d) the conformance of the plan with [RULE I through IX].

(10) In accordance with ARM 37.85.414, the case management team must keep the plans of care on file and all records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: COST OF PLAN OF CARE (1) In order to maintain the program cost within the appropriate monies of the financial limitations imposed under federal authorities, the cost of plans of care for recipients may be limited by the department collectively and individually.

(2) The total annual cost of services for each recipient, except as provided in (3), may not exceed a maximum amount set by the department based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature.

(3) The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:
(a) the excess service need is short term and only a one time purchase is

necessary;

(b) the excess service need is intensive services of 90 days or less which are necessary to:

(i) resolve a crisis situation which threatens the health and safety of the recipient;

(ii) stabilize the recipient following hospitalization or acute medical episode; or

(iii) prevent institutionalization during the absence of the normal caregiver;

(c) the excess service need is adult residential services; or

(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.

(4) The cost of services to be provided under a plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

(5) The cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING

(1) The department provides written notice to an applicant for and recipient of services when a determination is made by the department concerning:

(a) financial eligibility;

(b) level of care;

(c) feasibility, including cost-effectiveness of services to the recipient; and

(d) termination of recipient's eligibility for the program.

(2) The department provides a recipient of services with notice ten working days before termination of services due to a determination of ineligibility.

(3) A person aggrieved by any adverse final determinations as listed in (1)(a) through (d) or any adverse determinations regarding services in the plan of care may request a fair hearing as provided in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

(4) Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE IX HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CASE MANAGEMENT, REQUIREMENTS (1) Case management is the planning for, arranging for, implementation of, and monitoring of the delivery of services available through the program to a recipient.

(2) Case management services include:

(a) developing a plan of care for a recipient;
(b) monitoring and managing a plan of care for a recipient;
(c) establishing relationships and contracting with service providers and community resources;
(d) maximizing a recipient's efficient use of services and community resources such as family members, church members, and friends;
(e) facilitating interaction among people working with a recipient;
(f) prior authorizing the provision of all services; and
(g) managing expenditures.
(3) A case management team must consist of:
(a) a registered nurse currently serving on a case management team serving persons who are recipients through the program of home and community services for the elderly and persons with physical disabilities; and
(b) a social worker currently employed by a licensed mental health center with two consecutive years experience providing case management services to adults with mental illness.
(4) The case management team must:
(a) be a legal entity contractually retained by the department to provide Medicaid funded home and community case management services to persons who are elderly or who have physical disabilities;
(b) function as directed by the department;
(c) assure that services provided to recipients are of appropriate quality and cost effective;
(d) provide case management services to no more than the number of persons specified by the department;
(e) manage expenditures within the allocated monies; and
(f) meet the department's reporting requirements.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE X HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT RESIDENTIAL CARE, REQUIREMENTS (1) Adult residential care is the provision of supportive services to a recipient residing in an adult foster home, a residential hospice, or a personal care facility.
(2) Adult residential care may include:
(a) personal care services as specified at ARM 37.40.1101(1) through (5);
(b) homemaking as specified at [RULE XVI];
(c) social activities;
(d) recreational activities;
(e) medication oversight; and
(f) assistance in arranging transportation for medical care.
(3) Adult residential care must provide for 24 hour on site response staff to meet scheduled or unpredictable needs of recipients and to provide supervision of recipients for safety and security.
(4) A recipient of adult residential care may not receive the following services

through the program:

(a) personal assistance as specified at [RULE XIII];

(b) homemaking services as specified at [RULE XVI];

(c) respite care as specified at [RULE XVII];

(d) medical alert personal emergency response system as specified at [RULE XXIV]; and

(e) nutrition as specified in [RULE XXII].

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SUPPORTED LIVING, REQUIREMENTS (1) Supported living is the provision of supportive services to a recipient residing in an individual residence or in a group living situation.

(2) Supported living services may include:

(a) independent living evaluation;

(b) service coordination;

(c) 24 hour supervision of the person;

(d) health and safety supervision;

(e) homemaking services as specified at [RULE XVI];

(f) habilitation aide as specified at [RULE XIV];

(g) supported employment as specified at [RULE XI];

(h) prevocational training as specified at [RULE XIV];

(i) nonmedical transportation as specified at [RULE XXVI]; and

(j) specially trained attendants as specified at [RULE XV].

(3) An entity providing supported living services must meet the following criteria:

(a) be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Quality in the areas of integrated living, congregate living, personal, social and community services, community employment services, and work services; and

(b) have two years experience in providing services to persons with mental disabilities.

(4) This service must be prior authorized by the department.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT DAY HEALTH, REQUIREMENTS (1) Adult day health is the provision of services to meet the health, social, and habilitation needs of a recipient in settings outside the recipient's place of residence. An entity providing adult day health services must be licensed as an adult day care center as provided at ARM 37.106.301, et seq.

AUTH: 53-2-201, 53-6-402, MCA

IMP: 53-2-401, 53-6-402, MCA

RULE XIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL ASSISTANCE, REQUIREMENTS (1) Personal assistance is the provision of an array of personal care and other services to a recipient for the purpose of meeting personal needs in the home and the community.

(2) Personal assistance services include the provision of the following services:

(a) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308;

(b) homemaking services as specified at [RULE XV];

(c) supervision for health and safety reasons; and

(d) nonmedical transportation as specified at [RULE XXVI].

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(4) The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308, and 37.40.1315 govern the provision of personal assistance services.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XIV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HABILITATION, REQUIREMENTS (1) Habilitation is the provision of intervention services designed for assisting a recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully at home and in the community.

(2) Habilitation services may include:

(a) residential habilitation;

(b) day habilitation;

(c) prevocational services;

(d) supported employment; and

(e) habilitation aide.

(3) Residential habilitation is habilitation provided in a community home for persons with mental disabilities.

(4) Day habilitation is habilitation provided in a day service setting.

(5) Prevocational services are habilitative activities that foster employability for a recipient who is not expected to join the general work force or participate in a transitional sheltered workshop within a year by preparing the recipient for paid or unpaid work. Prevocational services include teaching compliance, attendance, task completion, problem solving, and safety.

(6) Supported employment is intensive ongoing support to assist a recipient who is unlikely to obtain competitive employment in performing work activities in a variety of settings, particularly work sites where nondisabled persons are employed.

Supported employment service includes supervision, training, and other activities needed to sustain paid work by a recipient.

(7) Habilitation aide is the assistance of an aide directed at fostering the recipient's ability to achieve independence in instrumental activities of daily living such as homemaking, personal hygiene, money management, transportation, housing, and use of community resources. Habilitation aide services include conducting an assessment and the provision of training and teaching.

(8) An entity, inclusive of its staff, providing habilitation services must be qualified generally to provide the services and specifically to meet each recipient's defined habilitation needs.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS (1) Specially trained attendant care is the provision of supportive services to a recipient residing in their own residence.

(2) Specially trained attendant care services may include:

(a) personal assistance services as specified at [RULE XIII]; and

(b) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(3) A person providing specially trained attendant care must be an employee of a Medicaid enrolled personal assistance provider, trained in accordance with the department's training requirements by the provider and others to deliver the services that meet the specific needs of the recipient.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HOMEMAKING REQUIREMENTS

(1) Homemaking is the provision of general household activities or chore services to a recipient when the recipient is unable to manage the recipient's home or care for self or others in the home, or when another who is regularly responsible for these responsibilities is absent.

(2) Homemaking may include:

(a) household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing;

(b) social restorative services consisting of assistance which further a recipient's involvement with activities and other persons; and

(c) teaching services consisting of activities which improve a recipient's or family's skills in household management and social functioning.

(3) Homemaking services do not include the provision of personal care as specified at ARM 37.40.1101 and 37.40.1302.

(4) A person providing homemaking services must be:

(a) physically and mentally able to perform the duties required; and
(b) literate and able to follow written orders.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: RESPITE CARE, REQUIREMENTS (1) Respite care is the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility.

(2) Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods.

(3) Respite care services may be provided in a recipient's place of residence or through placement in another private residence or other related community setting, a hospital, a nursing facility, or a therapeutic camp.

(4) A person providing respite care services must be:
(a) physically and mentally qualified to provide this service to the recipient; and
(b) aware of emergency assistance systems.

(5) A person who provides respite care services to a recipient may be required by the case management team to have the following when the recipient's needs so warrant:
(a) knowledge of the physical and mental conditions of the recipient;
(b) knowledge of common medications and related conditions of the recipient; and
(c) capability to administer basic first aid.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS (1) Outpatient occupational therapy services may include:
(a) occupational therapy services as specified in ARM 37.86.601; and
(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient occupational therapy services provided at ARM 37.86.601, 37.86.605, 37.86.606, and 37.86.610 govern the provision of outpatient occupational therapy services.

(3) No visit limitation exists for maintenance therapy.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XIX HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PSYCHO-SOCIAL

CONSULTATION, REQUIREMENTS (1) Psycho-social consultation is consultation with providers and caregivers directly involved with a recipient and the development and monitoring of behavior programs.

(2) Psycho-social consultation services may include those services as specified at ARM 37.88.601 and 37.88.605.

(3) Requirements for the delivery of psychological services as specified at ARM 37.88.601 and 37.88.605 govern the provision of psycho-social consultation.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XX HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CHEMICAL DEPENDENCY COUNSELING, REQUIREMENTS (1) Chemical dependency counseling is the provision of counseling to a recipient with a substance abuse problem by a certified chemical dependency counselor.

(2) Chemical dependency counseling services may be provided on an individual or group basis.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: DIETETIC SERVICES, REQUIRMENTS (1) Dietetic services are the management of a person's nutritional needs.

(2) Dietetic services may include evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education, and dietetic research necessary for the management of a recipient's nutritional needs.

(3) Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NUTRITION, REQUIREMENTS

(1) Nutrition services are meals, congregate meals, and home delivered meals as specified at ARM 37.41.302 including the Meals on Wheels Program.

(2) The requirements for the delivery of nutrition services as specified at ARM 37.41.306 through 37.41.315 govern the provision of nutrition services.

(3) A full nutritional regimen of three meals a day may not be provided through this service.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NURSING, REQUIREMENTS

(1) Nursing is the provision of individual and continuous nursing care.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXIV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL EMERGENCY RESPONSE SYSTEMS, REQUIREMENTS (1) A personal emergency response system is an electronic device or mechanical system used to summon assistance in an emergency situation.

(2) A personal emergency response system must be connected to a local emergency response unit with the capacity to activate emergency medical personnel.

(3) The provision of a personal emergency response system as a service does not include the purchase, installation, or routine monthly charges of a telephone.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a recipient for the purpose of maintaining and improving the recipient's ability to reside at home and to function in the community.

(2) The provision of medical equipment and supplies services may include:

(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and

(b) the provision of supplies and care necessary to maintain a service animal.

(3) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) substantively meet the recipient's needs for accessibility, independence, health, or safety;

(c) be likely to improve the recipient's functional ability or the ability of a caregiver or service provider to maintain the recipient in the recipient's home; and

(d) be the most cost effective item that can meet the needs of the recipient.

(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.

(5) Specialized medical equipment and supplies services do not include:

(a) items used for leisure and recreational purposes only;

(b) items of clothing;

(c) basic household furniture; or

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit.

(6) A service animal is an animal trained to undertake particular tasks on behalf of a recipient that the recipient cannot perform and that are necessary to meet the recipient's needs for accessibility, independence, health, or safety.

(7) A service animal does not include any of the following:

(a) pets, companion animals, and social therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

(8) Supplies necessary for the performance of a service animal may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal to meet the specific needs of the recipient. Supplies do not include food to maintain the service animals.

(9) Care necessary to the health and maintenance of a service animal may include, but is not limited to, veterinarian care, transportation for veterinarian care, license, registration, and where the recipient or recipient's primary care giver is unable to perform it, grooming.

(10) Certain items of medical equipment or supplies for short term use, as specified by the department, may be leased or rented instead of purchased.

(11) The department may require a consultation prior to the purchase of certain equipment and supplies.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXVI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NONMEDICAL TRANSPORTATION, REQUIREMENTS (1) Nonmedical transportation is the provision to a recipient of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

(3) Nonmedical transportation providers must provide proof of:

(a) a valid Montana driver's license;

(b) adequate automobile insurance; and

(c) assurance of vehicle compliance with all applicable federal, state, and local laws and regulations.

(4) Nonmedical transportation services must be provided by the most cost effective mode.

(5) Nonmedical transportation services are available only for the transport of recipients to and from activities that are included in the individual plan of care.

AUTH: 53-2-201, 53-6-402, MCA

IMP: 53-2-401, 53-6-402, MCA

RULE XXVII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ILLNESS MANAGEMENT AND RECOVERY SERVICES, REQUIREMENTS (1) Illness management and recovery program consists of a series of weekly sessions where licensed mental health practitioners provide services consisting of personalized strategies for managing mental illness and achieving personal goals to individuals who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.

(2) The services may be provided in an individual or group format and generally last between three to six months.

(3) Mental health practitioners work collaboratively with individuals by offering a variety of information, strategies, and skills for use to further their own recovery.

(4) Illness management and recovery has been identified as an evidence-based practice by the Substance Abuse and Mental Health Services Administration.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXVIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: WELLNESS RECOVERY ACTION PLAN (WRAP) SERVICES, REQUIREMENTS (1) Wellness Recovery Action Plan (WRAP) is a self-management and recovery system.

(2) WRAP is designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist individuals in achieving their own life goals.

(3) A person who provides WRAP services to a waiver participant will be required by the case management team to be certified by the Copeland Center.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

3. The Department of Public Health and Human Services administers for the State of Montana the joint federal/state Medicaid Program of Health Care Services. The federal government allows the states to provide sets of Medicaid funded services to maintain persons in community integrated residential and service settings as opposed to institutional treatment settings such as nursing facilities. These sets of services are authorized through "home and community waivers", also referred to as "1915c waivers", authorized by the federal Centers for Medicare and Medicaid Services (CMS) through formal plan documents submitted by a state for approval.

In 1980, Montana initiated the first program in the country of home and community services funded with Medicaid monies. That program provided developmental disabilities treatment services in community settings as opposed to an institutional Intermediate Care Facility for the Mentally Retarded (ICF/MF). Montana early on also developed a home and community program to serve persons who are elderly or

who have physical disabilities. That program allows persons to avoid institutionalization in nursing facilities or hospitals. In more recent years that program has expanded to encompass services for persons with brain injuries.

The Montana Legislature in 2005 passed substantive legislation, 2005 Laws of Montana, Chapter 353, and appropriated monies authorizing the department to seek federal approval for a home and community program that would serve adults who have severe disabling mental illness.

The state has determined that among the population of persons with mental illness there are those for whom the severity of their mental illness is so disabling that they are unable to adequately care for themselves and are in need of a nursing facility to maintain their well being, particularly their health. The state will be submitting an application to CMS requesting approval to implement as an alternative to Medicaid funded institutional services a program of less restrictive home and community services to provide for the various health care needs of persons with severe disabling mental illness.

Under the federal authority governing the implementation of home and community services funded with Medicaid monies, each authorized program is to have a service population defined by particular disabilities and certain service needs and is to be limited in number. In addition, a state may limit the services on a geographical basis. These parameters are proposed by a state and approved by CMS. The services in this proposed program that the state is submitting for federal approval are generally not available as Medicaid funded services otherwise. The state is requesting approval of this home and community services program to serve at any given time up to 105 adults with severe disabling mental illness and to do so in three geographical areas based on an urban core. Those areas are: 1) Yellowstone County area, inclusive of Big Horn, Carbon, Stillwater, and Sweet Grass counties; 2) Butte-Silver Bow County area, inclusive of Beaverhead, Deer Lodge, Granite, and Powell counties; and 3) Cascade County area, inclusive of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole counties.

The state expects that this program of services will significantly advance the state's efforts to more effectively and efficiently meet the needs of persons with severe disabling mental illness. The state hopes that this program will model positive changes and significantly advance systems change in the delivery of mental health services by the state.

The implementation of this set of proposed rules, with the resulting establishment of a service program focused on providing services to meet the needs of adults with severe disabling mental illness, is necessary to generally assure the well being of those persons who participate in the program. Adults with severe disabling mental illness are vulnerable to institutionalization. Their mental illness precludes self care in many respects and results in deteriorating physical health and further exacerbation of their mental illness. The provision of services to assist them in maintaining day to day health and personal care, living independently, and coping

with their mental illness can foster and maintain their ability to live in a community setting.

The department has considered maintaining the status quo as an alternative to this initiative. The status quo does not include, and due to funding sources, cannot include those services that can sustain a person by meeting daily living needs. Other alternatives could not be identified.

The state must submit a formal application for federal approval for the initiation of this proposed program. The department has been receiving technical assistance and guidance from the regional and national federal CMS officials. It is the intent of the state to initiate services in October of 2006. Currently, in accordance with Presidential Executive Order 13175, November 6, 2000, a review period has been afforded the tribal governments in Montana. The state expects to submit the plan to the reviewing federal officials after September 4, 2006. The proposed rule set will be formally filed for adoption with the Secretary of State upon approval of the home and community services plan by the federal reviewing authorities.

PROPOSED RULE I: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: FEDERAL AUTHORITIZATION AND STATE ADMINISTRATION

Proposed Rule I states the federal authority governing federal approval for the implementation of the state's new program of Home and Community Services for Adults with Severe Disabling Mental Illness that is to be funded with Medicaid monies. The provision by a state of health care and health care related services funded with federally derived Medicaid monies necessitates conformance by the state with federal statutes, regulations, and policies that govern expenditures of those monies. This proposed rule is necessary to denote that authority. The option of not specifying the federal authority governing the program was not considered appropriate.

In addition, the proposed rule establishes the discretion of the department to manage the various aspects of the program in conformance with federal authority, the appropriated budget authority, and as otherwise determined appropriate by the department. This application of discretion to the program is necessary to assure continuing conformance with the governing federal authority so as to avoid withdrawal of federal approval for the program and to avoid federal recoupment for expenditures of federal monies inappropriately expended. Discretion is also necessary to assure that the program is managed within the programmatic and fiscal parameters and limitations that the Legislature may impose upon the department in the appropriation process. The necessity to conform with governing authority and fiscal dictates precludes consideration of other options.

The proposed rule denotes the geographical regions within which the program will make services available. The state is seeking to obtain a waiver of statewide coverage in its federal program approval. The program is proposed to be

implemented with a small total enrollment and in three geographical regions rather than on a statewide basis due to the lack of sufficient resources for statewide implementation. Consequently, the alternative of initiating the program on a broader or statewide basis was not considered.

PROPOSED RULE II: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SERVICES

The proposed rule would specify the array of services that is to be available through the state's new program of Home and Community Services for Adults with Severe Disabling Mental Illness. These are the services that the department may provide to persons who meet the criteria for the program as outlined in proposed RULE IV. Proposed RULE II outlines the criteria for the department to determine the particular services, inclusive of program and nonprogram services, necessary to meet the recipient's needs. Proposed RULE II also states the criteria for denying a service to a person.

The proposed rule, specifying the array of services available through the program, is necessary for the purposes of conforming administration of the program with the governing federal authority, in particular the plan for the program as approved by CMS. The specification of the array of services is necessary for recipients, advocates, and providers to be informed of the list of available program services.

The provisions providing that a recipient may have a service denied or terminated and specifying the criteria for denial or termination of a particular service are necessary to apprise recipients that receipt of particular services are subject to conditions and to provide notice of those qualifying conditions. Specification of the criteria is also necessary to provide conformance with the governing federal authority, in particular the plan for the program as approved by CMS.

The option of not outlining the services and the criteria for denying or terminating a program service was rejected, as it would leave the public without any guidance as to the array of services included in the program as well as the basis for denying a program service, and the department would lack express rule authority by which to appropriately regulate the use of particular services by recipients in accordance with governing authorities and the identified needs of the recipients.

The services selected to be offered as program services are those services that the department determined would be of positive consequence in meeting the health and health related needs of the service population, adults with severe disabling mental illness, and that are appropriate services to be delivered under the service criteria of the governing federal authorities. Most of these services were selected by reference to the existing program of home and community services for persons who are elderly or have a physical disability. That program of services is designed to meet many of the same needs for its service population that this proposed program is to make available to persons with severe disabling mental illness. Those services are well established, having been in place for many years, and therefore are well

established, having been in place for many years, and therefore are well known to the provider community and have established definitions and standards of reimbursement. This existing set of services provides the desirable array of services by which to meet the outstanding needs of the intended service population. Consequently, viable alternative sets of services were not identified as to be considered in the alternative.

In addition, two services designed to particularly need the daily support of persons with severe disabling mental illness are included among the proposed services. Those services are illness management and recovery services and the Wellness Recovery Action Plan. These services are model services that have been identified by the efficacious components in a service array for persons with severe disabling mental illness. Other alternatives for the purpose of these services were not identified.

PROPOSED RULE III: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS

The proposed rule would establish the general provider requirements for the program of Home and Community Services for Adults with Severe Disabling Mental Illness. The proposed requirements include enrollment as a Medicaid provider, compliance with Medicaid fiscal and quality assurance standards, existence as legal entity, appropriate insurance coverage, and conformance with facility and professional licensing standards. The proposed rule also precludes immediate family members from serving as a provider and allows for services to other family members if approved by the case management team. The proposed rule is necessary to establish that the services available through the program may only be provided by or through a provider that is enrolled as a Medicaid provider with the department, that meets all licensing and other nonprogrammatic requirements, that complies with the requirements related to the receipt of Medicaid monies, that meets the programmatic requirements governing the delivery of services, and that is not compensated for familial responsibilities. These provider requirements are necessary to provide conformance with the governing federal authority.

The option of not providing for provider selection by the program and compliance by the provider with governing authorities was rejected, as it would leave the public vulnerable to unqualified providers and the state vulnerable to the misappropriation of program funding.

PROPOSED RULE IV: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ELIGIBILITY AND SELECTION

The proposed rule states the eligibility criteria for acceptance into the program, the criteria for a person accepted into the program to be considered for a particular service opportunity that becomes available, the criteria by which among those

persons being considered for a service opportunity the person most suitable for the service opportunity is selected, and bases upon which a person may be removed from a service opportunity or the program. These features are necessary to assure that services are provided to persons who are appropriate for and in need of the services of the program and that the eligibility parameters of the plan entered into with CMS for the program are properly implemented and complied with. Of further importance is the necessity for the rules in order to fairly and appropriately assign the service opportunities of the program as among the persons determined to be eligible.

Service opportunities under federal law for Medicaid funded home and community services are not available on an unlimited basis. By agreement with the federal officials, a ceiling must be placed upon the service population for the program. The proposed rules are further necessary to assure that the number of service opportunities are rationed within the limits of the federal approval and state appropriations.

The program is to be available in three geographical regions of the state and there is funding for a total of 105 slots per year.

The option of not outlining the enrollment and disenrollment criteria was rejected, as the public, consumers, families, advocates, and program providers would be uninformed. In accordance with the federal authority for the program, it is necessary for the department to outline the enrollment and disenrollment criteria.

The department initiated the program for the purpose of addressing a significant need for health and health related services to maintain adults with severe disabling mental illness in community settings as opposed to more restrictive less integrated institutional settings. Consequently, consideration was not given to varying the principal definitional parameters for the eligibility criteria. That criteria referenced from an existing set of criteria established in departmental rule is based on national criteria for establishing the presence of severe mental illness. The definition of a service population is essential to federal approval of the program as a Medicaid funded home and community program. The federal authorities limit the potential service populations to persons who can meet standard Medicaid eligibility and who are within a well defined service population predicated upon one or more types of disability. The state may not vary from criteria once accepted by the approving federal authorities. Some of the proposed eligibility criteria, in particular that related to potential institutionalization, are necessarily drawn from the governing federal authority that commands such criteria.

The proposed criteria to govern termination of services were generally drawn from the established home and community services program for persons who are elderly or who have physical disabilities. The selection of that existing set of criteria was considered most appropriate in that there will be significant similarities in the delivery of this program's services to delivery of services to that program's service population. The criteria of that program for purposes of termination has been drawn

from over 20 years of experience in eligibility matters and service delivery.

PROPOSED RULE V: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT

The proposed rule would establish how the services available in the program will be reimbursed. That proposed rule groups lists of services by each type of reimbursement methodology and describes the reimbursement methodologies. The proposed rule also states that reimbursement is not available for services that may be reimbursed through another program, that there is no copayment cost sharing requirement for program services, and that there is no reimbursement for the provision of program services to other members of a recipient's household or family unless specifically provided for in these rules.

The option of not stating the reimbursement practices of the department was rejected, as clarity of reimbursement is essential for the fiscal management of the program.

The methodologies for reimbursement of services provided through the Home and Community Services Program for Adults with Severe Disabling Mental Illness are those currently applied to the state's program of home and community services for persons who are elderly or who have physical disabilities. This set of methodologies is being selected over other possible methodologies because it is a well established set of methodologies that is being applied to an existing program that has close parallels to this program. Furthermore, the providers of services for this waiver program may be the same providers for the elderly and physically disabled. Implementation of this set of methodologies for the department and the providers will be facilitated by the use of the same set.

As a further measure to facilitate implementation and to provide conformity, those program services that are the same as any of the services currently available as so-called "state plan" Medicaid services, inclusive of personal assistance, outpatient occupational therapy, and the various mental health services, are to be reimbursed in the same manner as the state plan services.

Other approaches to reimbursement for these services were not considered since there are significant advantages, administratively and in provider relations, to replicating the reimbursement methodologies for the long established state plan services and for the services of the elderly and disabled home and community program.

PROPOSED RULE VI: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PLANS OF CARE

The proposed rule would require the development of plans of care for recipients of Home and Community Services for Adults with Severe Disabling Mental Illness. The particular types of services that may be provided to a recipient, along with the

specifics of hours of delivery, choices of providers, and unique aspects of delivery for a recipient, are set forth in the plan of care. The proposed rule also establishes the process for development of a plan of care, provides that the case management team is responsible for the plan of care, and denotes the intervals for which plans of care are initially developed and subsequently reviewed.

The proposed rule is necessary to assure the appropriate planning for an implementation of service provision to persons eligible for the program. The delivery of services to a person will be ineffective unless the planning, development, and delivery of services is done in a manner that matches those services to the person's needs and assures that they are effectively delivered and monitored. The plan of care serves that purpose.

The plan of care requirements assure that there is consistent implementation within the state of services for recipients. Federal guidelines for the state include the requirement for individual plans of care for program enrollees to address needs and outline services appropriate to meet those needs. The department must comply with and cannot vary from the federal guidelines in order to receive approval and funding for the program.

The option of not implementing the plan of care and not defining the components of a plan of care, the responsible parties for a plan of care, and the file retention practices was rejected. In the absence of the plan of care, the program would not effectively deliver services. The department did not find any alternative structures and processes to that of the plan of care.

PROPOSED RULE VII: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: COST OF PLANS OF CARE

The proposed rule would govern the total costs of each plan of care for services provided to each recipient of Home and Community Services for Adults with Severe Disabling Mental Illness. The proposed rule provides that the annual cost of services for each enrollee is limited, unless expressly waived by the department, to a maximum amount calculated based upon the number of permissible enrollees and the amount of monies available to the program as authorized in appropriations by the legislature. The amount is also limited in that the cost of program services for all eligible persons in the aggregate cannot exceed what it would cost to provide services in a nursing facility for those persons. The proposed rule lists certain types of circumstances, temporary or extended, for which a plan of care for a program enrollee may exceed the maximum amount set by the department. These fiscal limitations are necessary to assure that the state may fiscally manage the program within the legislative appropriation available for the program and within the restrictions imposed by the governing federal authorities and in turn to apprise recipients, providers, and others of those fiscal limitations.

The option of not proposing the rule was not considered since financial restrictions

upon the expenditures for the program are state and federal law legal obligations. In addition, the public, consumers, families, and program providers would not be aware of the financial limitation imposed upon the department in the administration of the program. Other forms of restrictive financial limitation were not considered since the provision of services is desirable and the proposed restrictions were appropriate to meet fiscal and legal requirements.

PROPOSED RULE VIII: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING

The proposed rule would establish the due process that would be available to recipients who wish to contest an adverse programmatic decision through reference to existing rules for fair hearings and adverse actions that would be appropriately applicable to this program. This proposed rule is necessary to assure conformity with due process requirements established in laws applicable to the program.

The department did not consider foregoing the adoption of this rule because of the necessity under federal law of providing due process fair hearings for persons who may be aggrieved by departmental actions concerning their eligibility and benefits. Under federal authority, the due process to be accorded must be in the form of a fair hearing. Consequently, the department did not consider any alternative due process forums or procedures.

PROPOSED RULE IX: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CASE MANAGEMENT, REQUIREMENTS

This proposed rule sets forth the purpose of, tasks of, composition of, and certain provider requirements peculiar to case management teams. The proposed rule is necessary in that the establishment of case management teams is vital to the delivery of the services of a program of home and community services. The teams are to effectuate the plans of care.

Recipients will benefit in that their service needs in conjunction with the recipients are professionally determined and service delivery is managed to assure effective competent delivery and service adjustments as needed.

The department selected the proposed case management tasks because they are the tasks that are currently applicable to the case management teams serving the recipients in the home and community services program for the elderly and persons with disabilities. These tasks, due to their universality in assuring the delivery of services, also typically appear in other case management services of the department.

The proposed professionals to be designated members of the case management team, the registered nurse experienced in the delivery of services for the program for

the elderly and persons with physical disabilities, and the social worker with experience in mental health services, were chosen because there is the need to utilize in case management services those professionals who are experienced either in the service modality of home and community services or in the management of treatment for persons with mental illness. Other types of professionals and other professional configurations were considered but did not offer the advantages of the chosen types and configuration and would not be as capable of immediate delivery of services in the initial phase of startup.

PROPOSED RULES X THROUGH XXVIII

Proposed Rules X through XXVIII specify the requirements for the various specific services that may be obtained and paid for through the adult with severe disabling mental illness program. Those services as specified in proposed Rule II include adult residential care services, supported living services, adult day health services, personal assistance services, habilitation services, specially trained attendant care services, homemaking services, respite care services, outpatient occupational therapy services, psycho-social consultation services, chemical dependency counseling services, dietetic services, nutrition services, nursing services, personal emergency response systems services, specialized medical equipments and supplies services, illness management and recovery services, Wellness Recovery Action Plan services, and nonmedical transportation services. These services have been selected as described in the discussion of proposed Rule II.

The various requirements pertaining to the proposed services have been drawn directly from the requirements applicable to those services currently as provided in the context of the program of home and community services for persons who are elderly or who have physical disabilities. As noted in the discussion of proposed Rule II, this set of services is well established in the context of that other program. Consequently, uniformity of requirements among the two programs is appropriate for purposes of administrative convenience and provider performance and compliance. Other sets of requirements were not considered appropriate given the desirability of uniformity.

4. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on September 21, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

/s/ Cary Lund
Rule Reviewer

/s/ Russell Cater for
Director, Public Health and Human Services

Certified to the Secretary of State August 14, 2006.

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

In the matter of the amendment of ARM 37.86.2803, 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.3007, 37.86.3020, and 37.86.3105 pertaining to Medicaid reimbursement for inpatient and outpatient hospital services	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On September 13, 2006, at 3:00 p.m., a public hearing will be held in Room 207 of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who 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 September 5, 2006, 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; e-mail dphhslegal@mt.gov.

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

<u>37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING</u>

(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 ~~April 2005~~ <u>February 2006</u> (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, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) remains the same.

(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) through (4) remain the same.

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

37.86.2904 INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) through (5) remain the same.

(6) The Medicaid statewide average cost to charge ratio excluding capital expenses is ~~56%~~ 50%.

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

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, 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) and (b) remain the same.

(c) The department computes a Montana average base price per case. This average base price per case is $1980 excluding capital expenses, medical education, and disproportionate share hospital payments effective for services provided from August 1, 2003 through December 31, 2005. For services provided January 1, 2006 through June 30, 2006, the average base price per case is $2037 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided between July 1, 2006 and September 30, 2006, the average base price is $2118 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided on or after ~~July 1, 2006~~ October 1, 2006, the average base price is ~~$2118~~ $2025 excluding capital expenses, medical education, and disproportionate share hospital payments.

(d) remains the same.

(2) For those Montana hospitals designated by the department after July 15, 2005 as having met the requirements for a specialty (level II) and subspecialty (level III) neonatal intensive care facility as provided in the Guidelines for Perinatal Care, Fifth Edition (2002), published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, reimbursement for neonatal DRGs 385 through 389 will be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2803. The guidelines are adopted and incorporated by reference and are available through the Department of Public Health and Human Services, Health Resources Division, 1400

Broadway, P.O. Box 202951, Helena, MT 59620-2951. In addition, such facilities:

(a) and (b) remain the same.

(c) will 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), and outlier thresholds are contained in the DRG Table of Weights and Thresholds (effective ~~July 1, 2006~~ October 1, 2006) published by the department. The department adopts and incorporates by reference the DRG Table of Weights and Thresholds (effective ~~July 1, 2006~~ October 1, 2006). Copies may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

37.86.2912 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, 2004~~ October 1, 2005. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through ~~October 1, 2004~~ October 1, 2005, which set forth Medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) remains the same.

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

37.86.2914 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~~ 2005.

(2) remains the same.

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

37.86.2916 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 ARM 37.86.2907~~.

(2) and (3) remain the same.

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

37.86.2918 INPATIENT HOSPITAL, READMISSIONS, AND TRANSFERS

(1) and (2) remain the same.

(3) 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 ARM 37.86.2907 and the appropriate outlier, capital, medical education, and DSH add-ons as computed in ARM 37.86.2912, 37.86.2914, 37.86.2916, and 37.86.2925, 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 ARM 37.86.2907 and the appropriate outlier, capital, medical education, and DSH add-ons as computed in ARM 37.86.2912, 37.86.2914, 37.86.2916, and 37.86.2925, if any.

(b) A discharging hospital (i.e., the hospital to which the recipient is transferred) reimbursed under ARM 37.86.2907 is paid the full DRG payment plus any appropriate outliers, capital, medical education, and DSH add-ons, if any.

(4) and (5) remain the same.

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

37.86.3007 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, CLINICAL DIAGNOSTIC LABORATORY SERVICES

(1) Clinical diagnostic laboratory services, including automated multichannel test panels (commonly referred to as "ATPs") and lab panels, will be reimbursed on a fee basis as follows with the exception of hospitals reimbursed under ARM 37.86.3005 and specific lab codes which are paid under ARM 37.86.3020:

(a) and (b) remain the same.

(c) For purposes of this rule, clinical diagnostic laboratory services include the laboratory tests listed in codes defined in the HCPCS and listed in the Clinical Diagnostic Fee Schedule (CLAB) published December 14, 2005. ~~Certain tests are exempt from the fee schedule. These tests are listed in the CMS Publication 45 (Pub. 45) last modified August 28, 2002, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology specified in ARM 37.86.3005(2).~~

(d) remains the same.

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

37.86.3020 OUTPATIENT HOSPITAL SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION (1) 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 on a rate-per-service basis using the Outpatient Prospective Payment System (OPPS) schedules. Under this system, Medicaid payment for hospital outpatient services included in the OPPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of APCs published annually in the Code of Federal Regulations (CFR). The rates for OPPS are determined as follows:

(a) The department uses a conversion factor for each APC group ~~based on Montana's highest Medicare urban rate, as published annually in the CFR~~ as defined at ARM 37.86.3001(2). The APC based fee equals the Medicare specific relative weight for the APC times the conversion factor that is the same for all APCs with the exceptions of services in ARM 37.86.3025. APCs are based on classification assignment of HCPCS codes.

(b) through (h) remain the same.

(2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) in ~~69~~ 70 Federal Register ~~211~~ 217, November ~~2, 2004~~ 10, 2005, effective January 1, ~~2005~~ 2006. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

37.86.3105 OUTPATIENT HOSPITAL SERVICES, PULMONARY REHABILITATION SERVICES (1) and (2) remain the same.

~~(3) The patient must have a referral to individual case management (ICM) before receiving pulmonary rehabilitation services.~~

(4) remains the same but is renumbered (3).

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

3. The Department of Public Health and Human Services (the department) is proposing the amendment of ARM 37.86.2803, 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.3007, 37.86.3020, and 37.86.3105 pertaining to Medicaid reimbursement for inpatient hospital services. The purpose of the proposed rule amendments is to adjust the cost to charge ratio for inpatient hospital services paid under the Prospective Payment System (PPS), to expand and restructure certain DRG rules to make them more comprehensive and easier to understand, to update obsolete references to federal publications and regulations, to

correct errors, and to remove obsolete and redundant rule provisions.

ARM 37.86.2803

The department proposes an update of this rule pertaining to cost reporting. United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issued a revised Publication 15, the Medicare Provider Reimbursement Manual dated February 2006. If this reference was not updated, providers of Medicaid hospital services that also provide Medicare hospital services would be required to use the April 2005 version of Publication 15 for Medicaid cost reporting and the February 2006 version for Medicare cost reporting. The department's proposed amendment would simplify cost reporting duties for those providers. The department does not intend the proposed amendment to have any effect on rates.

The department is taking this opportunity to delete an obsolete provision in ARM 37.86.2803(1)(b). In July 2003, when the department amended its rules to eliminate a 5.8% reduction to cost reports, this rule subsection was overlooked. The proposed amendment would correct the oversight and delete the obsolete provision. If the proposed amendment was not adopted, there would be confusion about the applicability of the former cost reporting methodology.

ARM 37.86.2904

The department is proposing to amend the statewide cost to charge ratio to 50% to match a trend reflected in hospital cost reports from 1999 through 2004. The current statewide cost to charge ratio was established at 56%, using 1999 cost reports, and has not been amended since that time.

The actual statewide cost to charge ratios for hospitals reimbursed under PPS were:

1999	55.2%
2000	53.9%
2001	52.6%
2002	51.7%
2003	50.7%
2004	49.4%

The proposed statewide cost to charge ratio includes only hospitals reimbursed under PPS and would no longer include Critical Access Hospitals. Critical Access Hospitals are reimbursed 101% of costs and their cost to charge ratios are typically 20% higher than PPS hospitals. In 1999, there were only 12 Critical Access Hospitals with total charges of $820,313.00. In 2004, those numbers jumped to 42 Critical Access Hospitals with total charges of $7,825,589. The department finds that including the Critical Access Hospitals in the cost to charge ratio for PPS hospitals would significantly taint the calculations. While the proposed method of computing cost to charge ratios will more accurately reflect costs, the change would

reduce the overall payment of outliers and exempt DRGs to PPS hospitals.

ARM 37.86.2907

Montana's method of payment for inpatient hospital services is prospective payment using the Diagnosis Related Groups (DRG). On June 12, 2006, the department adopted a payment method in which the payment for a Medicaid inpatient hospital service equals the relative weight of the DRG for that service times the base price plus all applicable add-ons, such as medical education, capital and disproportionate share hospital payments. The payment method is also designed to give hospitals an added measure of financial support to help cover the costs of exceptionally expensive cases by also paying an "outlier" amount. The charges for medically necessary services are multiplied by the cost to charge ratio and then compared to the cost outlier threshold for the appropriate DRG. Costs exceeding the threshold are multiplied by a marginal cost ratio (60%) to determine the outlier reimbursement amount.

Montana Medicaid has chosen to develop its own set of relative weights because Montana's population differs significantly from Medicare's population. Also, because of Montana's sparse population, it is awkward to adopt relative weights that reflect much more urban styles of practice. The relative weights are based on data from inpatient stays in Montana hospitals in SFY 2002 to 2005 paid utilizing the DRG system. As of the date of this notice, SFY 2005 claims are still incomplete. The data set includes claims as of June 30, 2005. The geometric mean (geomean) of the charge amounts for each individual DRG was calculated. These calculated charge amounts were used as the measure to calculate the relative weights. The new relative weights were set so they average to 1.0 for the claims that would be paid on a DRG basis. For example, if a given DRG had geomean charges of $6,000, and the geomean charge for all DRGs was $3,000, then that DRG would be assigned a relative weight of 2.0000. Some DRGs had very low volumes. If there were fewer than five cases within the time frame for a particular DRG, then that DRG was made exempt from prospective payment. These DRGs are paid on a cost-to-charge ratio because they are so rare that stable weights cannot be calculated with confidence. A total of 530 valid DRGs were evaluated because 22 DRGs are no longer valid. Of these, 121 DRGs have a “0” relative weight because there were fewer than five cases per DRG.

When claims paid on a DRG basis are unusually expensive, they may become eligible for cost outlier payments. Cost outlier thresholds are set separately for each DRG so that outlier payments will not exceed an average of 10% of the payments for that DRG. The Medicare program aims for a range between 5% and 8%. The cost outlier thresholds are multiples of the DRG rate. The Montana Medicaid program has used this approach since at least 1993. The Medicare program uses a different approach under which the threshold is higher than the DRG rate by a fixed dollar amount that is the same for every DRG. As a rule of thumb, thresholds tend to be between two and four times as high as the DRG payment. The department calculated the proposed cost outlier thresholds by multiplying the gross DRG by four,

on a DRG-by-DRG basis. Because cost outlier thresholds are set individually for each DRG and depend on the charges for that group, the thresholds for low-volume DRGs (those DRGs with less than five claims) cannot be calculated with confidence. These DRGs have no relative weights and will be paid on a cost-to-charge ratio and therefore, will have no cost outlier thresholds.

The mental health DRGs (DRG 425 through 433) are split by age of the patient (under 18 and 18 or older) when calculating the proposed relative weights and the proposed cost outlier thresholds. The relative weight and the cost outlier threshold for DRG 462 (Rehabilitation) was negotiated with the rehabilitation facilities in 2004 and will not be changed at this time.

ARM 37.86.2912 and 37.86.2914

The department is proposing amendments to update references to Medicare cost reimbursement principles in these rules. Capital-related costs and medical education costs are allowable as provided in federal regulation 42 CFR 412.113. If the references to that regulation were not updated, providers of Medicaid hospital services that also provide Medicare hospital services would be required to use the October 1, 2004 version for Medicaid cost reporting and the October 1, 2005 version for Medicare cost reporting. The department's proposed amendment would conform the Medicaid cost reimbursement principles to those currently used by Medicare and would simplify cost reporting duties for hospitals that provide Medicare and Medicaid services. The department does not intend the proposed amendments to have any effect on rates.

ARM 37.86.2916

The department is taking this opportunity to correct an oversight in this rule. Currently, it provides for the exemption of neonatal DRGs 385 through 389 from the cost outlier payment system. Neonatal DRGs 385 through 389, critical access hospitals and exempt hospitals, are reimbursed actual allowable costs. There is no need for an outlier payment methodology to cover high cost cases requiring those services. If this proposed amendment is not adopted, providers and the public might incorrectly conclude that the neonatal DRGs are the only hospital services exempt from the cost outlier payment methodology. Such a conclusion might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on the current reimbursement rates.

ARM 37.86.2918

The department is taking this opportunity to correct an oversight in this rule providing formulae for calculating reimbursement for inpatient hospital readmissions and transfers. Readmissions and transfer reimbursement rates currently include add-ons for capital expenses, medical education, and disproportionate share hospital

costs in the calculation. Currently, however, the rule does not mention add-ons. If these proposed amendments are not adopted, providers and the public might incorrectly conclude that add-ons are not considered in computing Medicaid reimbursement rates for readmissions and transfers. Such a conclusion might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendments to have any effect on the current reimbursement rates.

ARM 37.86.3007

The department has been using the Medicare Clinical Diagnostic Fee Schedule (CLAB) since August 2003 to reimburse Medicaid outpatient hospital clinical diagnostic laboratory services so that Medicaid reimbursement will parallel Medicare. The department is taking this opportunity to propose amendments to conform this rule to current practice. If this proposal was not adopted, hospital laboratories that also provide services to Medicare patients would have to maintain two different coding systems, unnecessarily increasing costs and billing mistakes. Use of the CLAB fee schedule will not have an adverse financial effect on hospitals. The department does not intend the proposed amendments to have any effect on diagnostic laboratory reimbursement rates.

ARM 37.86.3020

The department has used the conversion factor as defined at ARM 37.86.3001 since August 2003 to convert the nationwide Medicare specific relative weight for each APC group into a Medicaid reimbursement rate adjusted for actual Montana costs. The sentence regarding the conversion factor in this rule unnecessarily repeated language from the definition of "conversion factor" in ARM 37.86.3001. This duplication could have resulted in differing interpretations of the rule. The department is proposing an amendment that would delete the duplicated language and would substitute a cross reference to the definition. If the current text was maintained, it might lead to unnecessarily increased costs to providers and the department for administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on the current reimbursement rates.

The department is also proposing an amendment to this rule that would update the current outpatient prospective payment system (OPPS) to incorporate the Medicare Outpatient Prospective Payment System (OPPS) schedules effective January 1, 2006. This proposal would allow the Medicare reimbursement methodology to parallel the Medicare methodology. If Medicaid reimbursement did not parallel Medicare, hospitals would have to maintain different coding systems for Medicare and Medicaid.

ARM 37.86.3105

The department is taking this opportunity to propose an amendment deleting redundant language in this rule requiring a referral to individual case management as a condition precedent to receiving outpatient pulmonary rehabilitation services. If this proposed amendment is not adopted, the unnecessary case management provisions in this rule might result in differing interpretations of the requirements for pulmonary rehabilitation. The current text might lead to unnecessarily increased costs to recipients and the department for duplicate referrals or administrative reviews and hearings necessary to resolve differences in interpretation of the rule. The department does not intend the proposed amendment to have any effect on recipients or hospitals.

Fiscal effects

The department expects the proposed adjustment of relative DRG relative weights and threshold in ARM 37.86.2907 to be budget neutral for State Fiscal Year 2007. Some DRGs will increase and others will decrease, but overall, the proposed amendments will not affect the Medicaid budget. An individual hospital may be affected if it specializes or otherwise provides services in proportions that differ from the average Montana DRG hospital.

None of the other proposed amendments are expected to have a fiscal effect.

Persons and entities affected

In Montana there are 42 critical access hospitals, two exempt hospitals and 24 ambulatory surgical centers eligible to receive Medicaid reimbursement. They would be affected by the proposed reimbursement increases.

Currently, three hospitals meet the standard for Level III neonatal care and provide neonatal services to 71 babies per year. Three hospitals meet the standard for Level II care and provide services to approximately 251 babies per year. All six hospitals would be affected by the proposed amendments to ARM 37.86.2907.

There are 15 DRG hospitals within the state of Montana and 37 DRG hospitals in border states that would be affected by changes in the table of weights and thresholds.

4. The department intends the proposed amendments to be effective October 1, 2006. Although the Medicare OPPS schedules were effective for Medicare purposes January 1, 2006, Montana is proposing to apply them effective October 1, 2006.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on September 21, 2006. Data, views, or arguments may also be submitted by

facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

/s/ John Koch
Rule Reviewer

/s/ Russell Cater for
Director, Public Health and Human Services

Certified to the Secretary of State August 14, 2006.

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

In the matter of the transfer and amendment of ARM 8.32.301 through 8.32.308, 8.32.401 through 8.32.405, 8.32.408, 8.32.411 through 8.32.413, 8.32.415, 8.32.417, 8.32.426 through 8.32.430, 8.32.501, 8.32.502, 8.32.507, 8.32.601, 8.32.604 through 8.32.606, 8.32.801, 8.32.802, 8.32.806 through 8.32.808, 8.32.1102, 8.32.1104 through 8.32.1111, 8.32.1113, 8.32.1116, 8.32.1118, 8.32.1119, 8.32.1402 through 8.32.1412, 8.32.1414, 8.32.1501 through 8.32.1505, 8.32.1508, 8.32.1509, 8.32.1601 through 8.32.1604, 8.32.1606, 8.32.1607, 8.32.1609 through 8.32.1611, 8.32.1721, 8.32.1722, 8.32.1725, and 8.32.1732, adoption of NEW RULE I, repeal of 8.32.504 through 8.32.506, 8.32.1101, and 8.32.1401, and transfer of 8.32.101, 8.32.201, 8.32.202, 8.32.409, 8.32.410, 8.32.416, 8.32.425, 8.32.603, 8.32.608, 8.32.610, 8.32.804, 8.32.1103, 8.32.1112, 8.32.1114, 8.32.1413, 8.32.1506, 8.32.1510, 8.32.1605, 8.32.1608, 8.32.1612, 8.32.1723, 8.32.1724, 8.32.1726 through 8.32.1731, and 8.32.1733 pertaining to nursing	)	NOTICE OF TRANSFER AND AMENDMENT, ADOPTION, REPEAL, AND TRANSFER

TO: All Concerned Persons

1. On April 20, 2006, the Board of Nursing (board) published MAR Notice No. 8-32-69 regarding the proposed transfer and amendment, adoption, repeal, and transfer of the above-stated rules, at page 956 of the 2006 Montana Administrative Register, issue no. 8.

2. On May 12, 2006, a public hearing was held on the proposed transfer and amendment, adoption, repeal, and transfer of the above-stated rules in Helena. No comments or testimony were received.

3. The board has transferred and amended the following rules exactly as proposed:

8.32.415	(24.159.301)	8.32.428	(24.159.402)	8.32.601	(24.159.406)
8.32.604	(24.159.407)	8.32.605	(24.159.409)	8.32.606	(24.159.410)
8.32.1102	(24.159.601)	8.32.1109	(24.159.605)	8.32.1116	(24.159.606)
8.32.1108	(24.159.609)	8.32.806	(24.159.612)	8.32.1118	(24.159.615)

8.32.801	(24.159.625)	8.32.802	(24.159.630)	8.32.807	(24.159.635)
8.32.808	(24.159.640)	8.32.1110	(24.159.650)	8.32.1111	(24.159.655)
8.32.1113	(24.159.662)	8.32.1119	(24.159.666)	8.32.1104	(24.159.670)
8.32.1105	(24.159.674)	8.32.1106	(24.159.677)	8.32.1107	(24.159.680)
8.32.427	(24.159.905)	8.32.1414	(24.159.915)	8.32.1405	(24.159.1003)
8.32.1406	(24.159.1004)	8.32.1407	(24.159.1005)	8.32.1409A	(24.159.1006)
8.32.1408	(24.159.1010)	8.32.1409	(24.159.1011)	8.32.408	(24.159.1021)
8.32.401	(24.159.1022)	8.32.501	(24.159.1023)	8.32.404	(24.159.1025)
8.32.405	(24.159.1028)	8.32.430	(24.159.1029)	8.32.412	(24.159.1038)
8.32.417	(24.159.1046)	8.32.502	(24.159.1052)	8.32.507	(24.159.1053)
8.32.1402	(24.159.1203)	8.32.1403	(24.159.1204)	8.32.1404	(24.159.1205)
8.32.1409A	(24.159.1206)	8.32.408	(24.159.1221)	8.32.401	(24.159.1222)
8.32.501	(24.159.1223)	8.32.403	(24.159.1225)	8.32.405	(24.159.1228)
8.32.429	(24.159.1229)	8.32.412	(24.159.1238)	8.32.417	(24.159.1246)
8.32.502	(24.159.1252)	8.32.507	(24.159.1253)	8.32.1502	(24.159.1401)
8.32.1410	(24.159.1403)	8.32.1411	(24.159.1404)	8.32.1412	(24.159.1405)
8.32.308	(24.159.1411)	8.32.304	(24.159.1413)	8.32.305	(24.159.1414)
8.32.401	(24.159.1415)	8.32.501	(24.159.1416)	8.32.405	(24.159.1418)
8.32.412	(24.159.1428)	8.32.417	(24.159.1436)	8.32.502	(24.159.1442)
8.32.507	(24.159.1443)	8.32.1503	(24.159.1462)	8.32.1504	(24.159.1463)
8.32.1505	(24.159.1464)	8.32.1508	(24.159.1466)	8.32.301	(24.159.1470)
8.32.302	(24.159.1475)	8.32.303	(24.159.1480)	8.32.307	(24.159.1485)
8.32.307A	(24.159.1490)	8.32.1721	(24.159.1601)	8.32.1722	(24.159.1602)
8.32.1725	(24.159.1605)	8.32.1732	(24.159.1631)	8.32.1601	(24.159.2001)
8.32.1610	(24.159.2002)	8.32.1611	(24.159.2003)	8.32.1602	(24.159.2010)
8.32.1603	(24.159.2011)	8.32.1604	(24.159.2012)	8.32.1606	(24.159.2020)
8.32.1607	(24.159.2021)	8.32.1609	(24.159.2023)	8.32.413	(24.159.2301)

4. The board has adopted NEW RULE I (24.159.901) exactly as proposed.

5. The board has repealed ARM 8.32.504, 8.32.505, 8.32.506, 8.32.1101, and 8.32.1401 exactly as proposed.

6. The board has transferred the following rules exactly as proposed:

8.32.409	(24.159.1036), (24.159.1236), (24.159.1426)
8.32.416	(24.159.1041), (24.159.1241), (24.159.1431)

8.32.101	(24.159.101)	8.32.201	(24.159.201)	8.32.202	(24.159.202)
8.32.603	(24.159.408)	8.32.608	(24.159.411)	8.32.610	(24.159.416)
8.32.804	(24.159.656)	8.32.1103	(24.159.604)	8.32.1112	(24.159.659)
8.32.1114	(24.159.665)	8.32.1413	(24.159.903)	8.32.1506	(24.159.1465)
8.32.1605	(24.159.2013)	8.32.1608	(24.159.2022)	8.32.1612	(24.159.2004)
8.32.1723	(24.159.1610)	8.32.1724	(24.159.1611)	8.32.1726	(24.159.1612)
8.32.1727	(24.159.1616)	8.32.1728	(24.159.1625)	8.32.1729	(24.159.1630)
8.32.1730	(24.159.1636)	8.32.1731	(24.159.1640)	8.32.1733	(24.159.1604)

7. On February 23, 2006, the Department of Labor and Industry (department) and Board of Nursing (board) published MAR Notice No. 24-101-202 regarding the rules implementing HB 182 at page 383 of the 2006 Montana Administrative Register, issue no. 4. Board of Nursing rules specifically were proposed on page 433. On June 22, 2006, the department and board published final rulemaking action on MAR Notice No. 24-101-202 at page 1583 of the 2006 Montana Administrative Register, issue no. 12. Board of Nursing rules specifically were amended as proposed on page 1597.

ARM 8.32.306, 8.32.402, 8.32.410, 8.32.411, 8.32.425, 8.32.426, 8.32.1501, 8.32.1509, and 8.32.1510 are included in both MAR Notice No. 8-32-69 and 24-101-202. In order to aid the user and clearly identify how these notices impact each other, additional information is included as applicable.

8. ARM 8.32.306 (24.159.1412) will not be amended as proposed in issue no. 8. The same amendment was proposed in issue no. 4 and amended in issue no. 12; therefore, it is unnecessary to amend the rule as proposed. ARM 8.32.306 (24.159.1412) is transferred as proposed.

9. ARM 8.32.425 (24.159.401) and 8.32.410 (24.159.1040), (24.159.1240), (24.159.1430) are transferred as proposed. ARM 8.32.1510 (24.159.1468) is transferred as proposed with catchphrase changes as indicated in issue no. 8.

10. The board has amended ARM 8.32.402 (24.159.1024), (24.159.1224), (24.159.1417), 8.32.411 (24.159.1037), (24.159.1237), (24.159.1427), 8.32.426 (24.159.910), 8.32.1501 (24.159.1461), and 8.32.1509 (24.159.1467), with the following changes, stricken matter interlined, new matter underlined:

8.32.402 (24.159.1024) LICENSURE BY EXAMINATION REQUIREMENTS
(1) remains as proposed.
(2) remains as amended in MAR issue no. 12.
(3) through (13) remain as proposed.

AUTH: 37-8-202, MCA
IMP: 37-1-131, 37-8-406, 37-8-416, MCA

8.32.402 (24.159.1224) LICENSURE BY EXAMINATION REQUIREMENTS
(1) remains as proposed.
(2) remains as amended in MAR issue no. 12.
(3) through (13) remain as proposed.

AUTH: 37-8-202, MCA
IMP: 37-1-131, 37-8-406, 37-8-416, MCA

8.32.402 (24.159.1417) LICENSURE BY EXAMINATION REQUIREMENTS
(1) remains as proposed.
(2) remains as amended in MAR issue no. 12.

(3) through (13) remain as proposed.

AUTH: 37-8-202, MCA
IMP: 37-1-131, 37-8-406, 37-8-416, MCA

8.32.411 (24.159.1037) RENEWALS (1) and (2) not amended as proposed in MAR issue no. 8, but text remains as amended in MAR issue no. 12.
(3) and (4) deleted as proposed in MAR issue no. 8.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-134, 37-8-202, MCA

8.32.411 (24.159.1237) RENEWALS (1) and (2) not amended as proposed in MAR issue no. 8, but text remains as amended in MAR issue no. 12.
(3) and (4) deleted as proposed in MAR issue no. 8.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-134, 37-8-202, MCA

8.32.411 (24.159.1427) RENEWALS (1) and (2) not amended as proposed in MAR issue no. 8, but text remains as amended in MAR issue no. 12.
(3) Renewal notices will be sent to all currently licensed advanced practice registered nurses (APRNs) as specified in ARM 24.101.414. The licensee shall complete the application and return it, the proof of continuing education required by ~~ARM 8.32.411~~ (3)(a)(iii) and (4), and the renewal fee to the board before the date set by ARM 24.101.413. Upon receiving the completed renewal application and fee, the board shall issue a certificate of renewal for the two-year period following the date set by ARM 24.101.413. If the renewal application is postmarked after the renewal deadline, it is subject to the late penalty fee specified in ARM 24.101.403. The provisions of ARM 24.101.408 apply.
(a) through (4) not amended as proposed in MAR issue no. 8, but text remains as amended in MAR issue no. 12.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-134, 37-8-202, MCA

8.32.426 (24.159.910) GENERAL REQUIREMENTS FOR LICENSURE AS MEDICATION AIDE (1) through (1)(b) remain as proposed.
(2) through (5) remain as amended in MAR issue no. 12.
(6) deleted as proposed in MAR issue no. 12.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-101, 37-8-202, MCA

8.32.1501 (24.159.1461) PRESCRIPTIVE AUTHORITY FOR ELIGIBLE APRNS (1) and (2) remain as proposed.

(3) The Board of Pharmacy will be notified in a timely manner by the board when the status of an APRN's prescriptive authority changes~~,~~.

AUTH: 37-8-202, MCA
IMP: 37-8-202, MCA

8.32.1509 (24.159.1467) SUSPENSION OR REVOCATION OF PRESCRIPTIVE AUTHORITY (1) remains as proposed.

(2) An advanced practice registered nurse whose prescriptive authority has ended is not authorized to prescribe until written notice is received from the board that ~~the~~ the nurse's prescriptive authority has been reinstated.

AUTH: 37-8-202, MCA
IMP: 37-8-202, MCA

BOARD OF NURSING
KAREN POLLINGTON, R.N., CHAIRPERSON

/s/ MARK CADWALLADER
Mark Cadwallader
Alternate Rule Reviewer

/s/ Keith Kelly
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 14, 2006

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.29.2831, related to penalties assessed against uninsured employers	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On July 6, 2006, the Department of Labor and Industry published MAR Notice No. 24-29-208 regarding the public hearing on the proposed amendment of the above-stated rule at page 1703 of the 2006 Montana Administrative Register, issue no. 13.

2. On July 28, 2006, the department held a public hearing in Helena regarding the above-stated rule. No comments were received from the public. No written comments were received prior to the closing date of August 4, 2006.

3. The department has amended ARM 24.29.2831 exactly as proposed.

/s/ MARK CADWALLADER	/s/ DORE SCHWINDEN
Mark Cadwallader	Dore Schwinden, Deputy Commissioner
Alternate Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 14, 2006.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.30.1302 and 24.30.1311, relating to occupational health and safety in mines	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On July 6, 2006, the Department of Labor and Industry published MAR Notice No. 24-30-207 regarding the public hearing on the proposed amendment of the above-stated rules at page 1706 of the 2006 Montana Administrative Register, issue no. 13.

2. On July 28, 2006, the department held a public hearing in Helena regarding the above-stated rules. No comments were received from the public. No written comments were received prior to the closing date of August 4, 2006.

3. The department has amended ARM 24.30.1302 and 24.30.1311 exactly as proposed.

/s/ MARK CADWALLADER	/s/ DORE SCHWINDEN
Mark Cadwallader	Dore Schwinden, Deputy Commissioner
Alternate Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 14, 2006.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of	)	NOTICE OF ADOPTION
NEW RULE I pertaining to	)	
incorporation by reference of	)	(Crane and Hoist Operator Engineer
ANSI B30.5	)	Licensing Program)

TO: All Concerned Persons

1. On June 22, 2006, the Department of Labor and Industry (department) published MAR Notice No. 24-135-2 regarding the proposed adoption of the above-stated rule, at page 1509 of the 2006 Montana Administrative Register, issue no. 12.

2. On July 19, 2006, a public hearing was held on the proposed adoption of the above-stated rule in Helena. No comments or testimony were received.

3. The department has adopted NEW RULE I (24.135.411) exactly as proposed.

DEPARTMENT OF LABOR AND INDUSTRY

/s/ MARK CADWALLADER
Mark Cadwallader
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 14, 2006

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

In the matter of the amendment of ARM 37.12.401 pertaining to laboratory testing fees	)))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On May 18, 2006, the Department of Public Health and Human Services published MAR Notice No. 37-382 at page 1227 of the Montana Administrative Register, issue number 10, regarding the proposed amendment of the above-stated rule.

2. The department has amended ARM 37.12.401 as proposed.

3. No comments or testimony were received.

/s/ Dawn Sliva
Rule Reviewer

/s/ Russell Cater for
Director, Public Health and
Human Services

Certified to the Secretary of State August 14, 2006.

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 or Register) 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

2. Go to cross reference table at end of each Number and title which lists MCA section numbers and Department 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 March 31, 2006. This table includes those rules adopted during the period April 1 through June 30, 2006 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 or Register).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 2006, 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 2006 Montana Administrative Register.

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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 July 2006 appear. Vacancies scheduled to appear from September 1, 2006, through November 30, 2006, 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 August 1, 2006.

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 JULY 2006

Appointee	Appointed by	Succeeds	Appointment/End Date
Aging Advisory Council (Public Health and Human Services)			
Ms. Gladys Considine	Governor	Branstetter	7/18/2006
Missoula			7/18/2009
Qualifications (if required): public representative			
Ms. Mary Lou Miller	Governor	Erickson	7/18/2006
Wolf Point			7/18/2009
Qualifications (if required): public representative			
Ms. Mary Mumby	Governor	England	7/18/2006
Kalispell			7/18/2009
Qualifications (if required): public representative			
Board of Nursing (Labor and Industry)			
Ms. Deborah Hanson	Governor	Rice	7/1/2006
Miles City			7/1/2010
Qualifications (if required): public representative			
Ms. Karen Pollington	Governor	reappointed	7/1/2006
Havre			7/1/2010
Qualifications (if required): registered nurse			
Ms. Brenda Schye	Governor	Erickson	7/1/2006
Fort Peck			7/1/2010
Qualifications (if required): public representative			

BOARD AND COUNCIL APPOINTEES FROM JULY 2006

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Nursing (Labor and Industry) cont.			
Ms. Kathleen Sprattler	Governor	Thomas	7/1/2006
Billings			7/1/2010
Qualifications (if required): licensed practical nurse			
Community Service Commission (Labor and Industry)			
Mr. George Dennison	Governor	not listed	7/1/2006
Missoula			7/1/2009
Qualifications (if required): representative of higher education			
Mr. John Ilgenfritz	Governor	not listed	7/1/2006
Helena			7/1/2009
Qualifications (if required): representative of disaster and emergency services			
Mr. Chris Kolstad	Governor	Kettner	7/1/2006
Ledger			7/1/2009
Qualifications (if required): public representative			
Ms. Sue Tinsley	Governor	Coopersmith	7/1/2006
Helena			7/1/2009
Qualifications (if required): representative of K-12 education			
Department of Corrections Director (Corrections)			
Director Michael Ferriter	Governor	Slaughter	7/1/2006
Helena			0/0/0
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM JULY 2006

Appointee	Appointed by	Succeeds	Appointment/End Date
Electrical Board (Labor and Industry)			
Ms. Dawn Achten Billings	Governor	Martel	7/1/2006 7/1/2011
Qualifications (if required): public representative			
Human Rights Commission (Labor and Industry)			
Ms. Julie Cajune Ronan	Governor	Pease	7/1/2006 1/1/2009
Qualifications (if required): public representative			
Montana Historical Society Board of Trustees (Historical Society)			
Mr. George Horse Capture Great Falls	Governor	Cole	7/1/2006 7/1/2011
Qualifications (if required): public representative			
Mr. Thomas Nygard Bozeman	Governor	Morgan	7/1/2006 7/1/2011
Qualifications (if required): public representative			
Ms. Crystal Wong Shors Helena	Governor	Siebel	7/1/2006 7/1/2011
Qualifications (if required): public representative			
Public Defender Commission (Administration)			
Mr. Doug Kaercher Havre	Governor	reappointed	7/1/2006 7/1/2009
Qualifications (if required): public representative nominated by the Senate President			

BOARD AND COUNCIL APPOINTEES FROM JULY 2006

Appointee	Appointed by	Succeeds	Appointment/End Date
Public Defender Commission (Administration) cont.			
Mr. Stephen Nardi	Governor	reappointed	7/1/2006
Kalispell			7/1/2009
Qualifications (if required): attorney nominated by State Bar			
Mr. Ivan Small	Governor	Newbreast	7/1/2006
Poplar			7/1/2009
Qualifications (if required): member of organization advocating on behalf of racial minorities			
State Tax Appeals Board (Administration)			
Ms. Karen Powell	Governor	Thornquist	7/15/2006
Helena			1/1/2009
Qualifications (if required): public representative			

VACANCIES ON BOARDS AND COUNCILS -- SEPTEMBER 1, 2006 through NOVEMBER 30, 2006

Board/current position holder	Appointed by	Term end
9-1-1 Advisory Council (Administration)		
Mr. Mark Lerum, Helena	Director	11/3/2006
Qualifications (if required): Helena Police Department		
Mr. Geoff Feiss, Helena	Director	11/3/2006
Qualifications (if required): Montana Telecommunications Association		
Mr. Jeff Brandt, Helena	Director	11/3/2006
Qualifications (if required): Department of Administration		
Mr. Steve Larson, Helena	Director	11/3/2006
Qualifications (if required): Montana State Fire Chiefs Association		
Mr. Chuck Winn, Bozeman	Director	11/3/2006
Qualifications (if required): Montana State Fire Chiefs Association		
Mr. Joe Calnan, Montana City	Director	11/3/2006
Qualifications (if required): Montana State Volunteer Fire Fighters Association		
Mr. Larry Sheldon, Helena	Director	11/3/2006
Qualifications (if required): Qwest Communications		
Mr. Don Hollister, Kalispell	Director	11/3/2006
Qualifications (if required): Century Tel		
Ms. Jenny Hansen, Helena	Director	11/3/2006
Qualifications (if required): Department of Administration		

VACANCIES ON BOARDS AND COUNCILS -- SEPTEMBER 1, 2006 through NOVEMBER 30, 2006

Board/current position holder	Appointed by	Term end
9-1-1 Advisory Council (Administration) cont.		
Mr. Brian Wolf, Helena Qualifications (if required): Department of Administration	Director	11/3/2006
Ms. Lisa Kelly, Kalispell Qualifications (if required): Century Tel	Director	11/3/2006
Ms. Margaret Morgan, Helena Qualifications (if required): Western Wireless	Director	11/3/2006
Mr. Craig Bender, Great Falls Qualifications (if required): 3 Rivers Wireless	Director	11/3/2006
Mr. Mike Doto (city not listed) Qualifications (if required): Montana State Volunteer Fire Fighters Association	Director	11/3/2006
Mr. Phil Maxwell (city not listed) Qualifications (if required): Montana Telecommunications Association	Director	11/3/2006
Ms. Anne Kindness (city not listed) Qualifications (if required): Helena Police Department	Director	11/3/2006
Mr. Dennis Luttrell (city not listed) Qualifications (if required): Qwest Communications	Director	11/3/2006
Ms. Aimee Grmoljez, Helena Qualifications (if required): Verizon Wireless	Director	11/3/2006

VACANCIES ON BOARDS AND COUNCILS -- SEPTEMBER 1, 2006 through NOVEMBER 30, 2006

Board/current position holder	Appointed by	Term end
9-1-1 Advisory Council (Administration) cont.		
Mr. Stanley Kaleczyc (city not listed) Qualifications (if required): Verizon Wireless	Director	11/3/2006
Mr. Terry Ferestad, Billings Qualifications (if required): Western Wireless	Director	11/3/2006
Mr. Ernie Peterson (city not listed) Qualifications (if required): 3 Rivers Wireless	Director	11/3/2006
Ms. Becky Berger, Helena Qualifications (if required): Department of Administration	Director	11/3/2006
Ms. Anita Moon, Helena Qualifications (if required): Department of Administration	Director	11/3/2006
Board of Alternative Health Care (Labor and Industry)		
Ms. Kathleen Dunham, Arlee Qualifications (if required): direct midwife	Governor	9/1/2006
Ms. Eloise Hargrove, Belgrade Qualifications (if required): public member	Governor	9/1/2006
Board of Barbers and Cosmetologists (Labor and Industry)		
Ms. Verna Dupuis, Bozeman Qualifications (if required): cosmetologist	Governor	10/1/2006

VACANCIES ON BOARDS AND COUNCILS -- SEPTEMBER 1, 2006 through NOVEMBER 30, 2006

Board/current position holder	Appointed by	Term end
Board of Barbers and Cosmetologists (Labor and Industry) cont.		
Ms. Karan Charles, Miles City	Governor	10/1/2006
Qualifications (if required): barber		
Board of Medical Examiners (Labor and Industry)		
Dr. Michael D. LaPan, Sidney	Governor	9/1/2006
Qualifications (if required): licensed podiatrist		
Dr. Arthur K. Fink, Glendive	Governor	9/1/2006
Qualifications (if required): doctor of osteopathy		
Dr. Anna Earl, Chester	Governor	9/1/2006
Qualifications (if required): doctor of medicine		
Board of Outfitters (Labor and Industry)		
Mr. Craig Madsen, Great Falls	Governor	10/1/2006
Qualifications (if required): fishing outfitter		
Mr. Russ Smith, Philipsburg	Governor	10/1/2006
Qualifications (if required): hunting and fishing outfitter		
Board of Psychologists (Labor and Industry)		
Dr. Jay Palmatier, Missoula	Governor	9/1/2006
Qualifications (if required): psychologist licensed in public health		
Historical Records Advisory Board (Historical Society)		
Mr. Kim Allen Scott, Bozeman	Governor	9/7/2006
Qualifications (if required): Public Representative		

VACANCIES ON BOARDS AND COUNCILS -- SEPTEMBER 1, 2006 through NOVEMBER 30, 2006

Board/current position holder	Appointed by	Term end
Historical Records Advisory Board (Historical Society) cont.		
Ms. Jodie Foley, Helena	Governor	9/7/2006
Qualifications (if required): State Archivist		
Lewis and Clark Bicentennial Commission (Historical Society)		
Mr. John G. Lepley, Fort Benton	Governor	10/1/2006
Qualifications (if required): representative of the public		
Ms. Marcy Hamburg, Savage	Governor	10/1/2006
Qualifications (if required): public member		
Montana Noxious Weed Trust Fund Advisory Council (Agriculture)		
Sen. Mack Cole, Forsyth	Director	10/20/2006
Qualifications (if required): at large representative		
Mr. Bob Bushnell,	Director	10/20/2006
Qualifications (if required): sportsman/wildlife group representative		
State Historic Preservation Review Board (Historical Society)		
Mr. Douglas Johnson, Hamilton	Governor	10/1/2006
Qualifications (if required): having historic property administration expertise		
Mr. Conrad Fisher, Lame Deer	Governor	10/1/2006
Qualifications (if required): having traditional cultural property expertise		