ISSUE NO. 3

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

TABLE OF CONTENTS

Page Number

NOTICE SECTION

BEFORE THE BOARD OF NURSING HOME ADMINISTRATORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to examinations, continuing education and fee schedule	)	NOTICE OF PROPOSED AMENDMENT OF ARM 8.34.414 EXAMINATIONS, 8.34.416 CONTINUING EDUCATION, AND 8.34.418 FEE SCHEDULE

NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On March 11, 2000, the Board of Nursing Home Administrators proposes to amend rules pertaining to examinations and fee schedule.

2. The Board of Nursing Home Administrators will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Nursing Home Administrators, no later than 5:00 p.m., on February 22, 1999, to advise us of the nature of the accommodation that you need. Please contact Becky Salminen, Board of Nursing Home Administrators, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-3561; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1667.

3. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.34.414 EXAMINATIONS ~~(1) Examinations will be administered on the second Thursday in April and October of each year.~~

(2) will remain the same but is renumbered (1).

~~(3)~~(2) In the event of failure, the individual may retake the examination ~~within the period of one year,~~ by paying ~~$210~~ exam fees referenced in ARM 8.34.418."

Auth: Sec. 37-1-131, 37-1-134, 37-9-201, 37-9-203, 37-9-304, MCA
IMP: Sec. 37-1-134, 37-9-201, 37-9-203, 37-9-301, 37-9-303, 37-9-304, MCA

REASON: The proposed amendment is necessary to meet the requirements of the National Association of Boards of Examiners of Long Term Care Administrators (NAB), the national examination agency. An applicant will be allowed to complete a computer based examination at a location near them rather than coming to Helena for the examination. This will allow a person one initial exam and up to three retakes in one year. The fee is set commensurate with costs incurred by the examination agency and respective to the program costs.

"8.34.416 CONTINUING EDUCATION (1) through (3) will remain the same.

(4) No more than 25 hours of college courses may be submitted for continuing education ~~in any three year period~~ without prior approval of the board. These courses shall be approved in advance by the continuing education committee and should contribute to the professional competence of the participant. ~~The remaining continuing education hours submitted during that three year period must pertain to nursing home administration.~~"

Auth: Sec. 37-1-131, 37-9-201, 37-9-203, MCA
IMP: Sec. 37-9-203, 37-9-305, MCA

REASON: The proposed amendment will allow nursing home administrators to utilize college courses that are germane to the profession for continuing education and no longer limits the number of hours that can be used to a three year period.

"8.34.418 FEE SCHEDULE (1) and (1)(a) will remain the same.

(b) ~~examination and license for the April examination~~ 210
NAB examination and re-examination 235
(c) jurisprudence re-examination 50

(c) through (k) will remain the same but are renumbered (d) through (l)."

Auth: Sec. 37-1-131, 37-1-134, 37-9-201, 37-9-203, 37-9-304, MCA
IMP: Sec. 37-1-134, 37-9-203, 37-9-304, MCA

REASON: The proposed amendment will provide a separate fee for re-taking the jurisprudence examination and the base fee charged by the national examination agency to take the exam. The fees are set commensurate with the costs of the other fees respective to the program costs. It is anticipated that approximately 15 licensees will be affected by the jurisprudence examination fee for a total of $750. The NAB examination and re-examination fee will not result in additional fees to the board as the fees are paid to the national examination agency.

4. Concerned persons may submit their data, views or arguments concerning the proposed action in writing to the Board of Nursing Home Administrators, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., March 9, 2000.

5. If the Board receives requests for a public hearing on the proposed action from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed action, from the appropriate administrative rule review committee of the legislature, from a governmental

agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 3 based on 30 applicants per year.

6. The Board of Nursing Home Administrators maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this Board. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding administrative rulemaking proceedings. Such written request may be mailed or delivered to the Board of Nursing Home Administrators, faxed to the office at (406)444-1667 or may be made by completing a request form at any rules hearing held by the Board of Nursing Home Administrators.

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

BOARD OF NURSING HOME ADMINISTRATORS
DONNA KAY JENNINGS, BOARD CHAIRPERSON

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF PLUMBERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to plumbing definitions, applications, examinations, master plumbers - registration of business names, renewals, fee schedule, qualifications - journeyman, temporary practice permits, out-of-state applicants, complaint procedure, medical gas endorsement required, application for endorsement, annual renewal of endorsement, endorsement verification	)	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF 8.44.402 DEFINITIONS, 8.44.403 APPLICATIONS, 8.44.404 EXAMINATIONS, 8.44.408 MASTER PLUMBERS - REGISTRATION OF BUSINESS NAME, 8.44.405 RENEWALS, 8.44.412 FEE SCHEDULE, 8.44.413 QUALIFICATIONS - JOURNEYMAN, 8.44.415 OUT-OF-STATE APPLICANTS, 8.44.416 TEMPORARY PRACTICE PERMITS, 8.44.418 COMPLAINT PROCEDURE, 8.44.501 MEDICAL GAS ENDORSEMENT REQUIRED, 8.44.502 APPLICATION FOR ENDORSEMENT, 8.44.503 ANNUAL RENEWAL OF ENDORSEMENT, 8.44.504, ENDORSEMENT VERIFICATION

TO: All Concerned Persons

1. On March 1, 2000, at 10:00 a.m., a public hearing will be held in the Large Conference Room on the Lower Level of the Arcade Building, 111 North Jackson, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Commerce 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 Department no later than 5:00 p.m., February 18, 2000, to advise us of the nature of the accommodation that you need. Please contact Patricia Osterhout, Board of Plumbers, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-4390; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1667.

3. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.44.402 DEFINITIONS (1) "Employ" ~~shall~~ means to provide with a job that pays wages or a salary, and includes the responsibility of hiring and firing. The employer shall pay payroll taxes on behalf of the employee.

~~(2) A quorum of the board shall be a majority of the members.~~

~~(3) ASME means the American society of mechanical engineers.~~

~~(4) Certification means an accreditation from an approved training program, acceptable to the board, which issues documentation such as diplomas, cards or certificates which provide proof the applicant has successfully completed training in the installation of medical gas systems, pursuant to the requirements imposed by NFPA 99C and section IX of the ASME Welding and Brazing Code.~~

~~(5) Endorsement means the approval issued by the board, signified by an endorsement card or other credential, which authorizes a person to install medical gas systems within the state of Montana.~~

~~(6)~~(2) "Farm or ranch" is defined in 39-3-402, MCA. ~~means buildings located on and used in conjunction with agricultural parcels of land that total 160 or more contiguous acres under one ownership or are otherwise classified as agricultural, pursuant to Title 15, chapter 7, part 2, MCA, and upon which agricultural products are produced and marketed.~~

(3) "Installation of plumbing and drainage systems" means, but is not limited to, the measuring, laying-out, cutting, fitting, soldering and gluing of pipe and/or the installation of fixtures and equipment for the purpose of connecting potable water or sewage.

(7) and (8) will remain the same but are renumbered (4) and (5).

~~(9)~~(6) ~~NFPA means the national fire protection association.~~ "Manufactured house" means a structure, transportable in one or more sections, which, in the traveling mode, is eight body feet or more in width or 40 body feet or more in length, or, when erected on site, is 320 or more square feet, and which is built on a permanent chassis and designed to be used as a dwelling with or without a permanent foundation when connected to the required utilities, and includes the plumbing, heating, air-conditioning, and electrical systems contained therein, except that such term shall include any structure which meets all the requirements of this section except the size requirements."

Auth: Sec. 37-69-202, 37-69-401, MCA
IMP: Sec. 37-69-102, 37-69-202, 37-69-401, MCA

REASON: The 1999 legislature implemented House Bill 98 which redefined "farm and ranch", 37-69-301, MCA and "manufactured home" 37-69-102, MCA. The proposed amendment is to update these definitions in accordance with said bill. The definition of "manufactured home" is being changed to comply with HUD regulations. Definitions pertaining to medical gas piping are being moved to sub-chapter 5 which pertains to medical gas endorsement. The definition of quorum is being deleted as it is provided for under 37-69-201, MCA.

"8.44.403 APPLICATIONS (1) through (4) will remain the same.

(5) Upon receipt and approval of an application for the journeyman or master plumber's examination, the department will send to the applicant an admittance ~~card~~ notice for the examination. The admittance ~~card~~ notice must be presented by the candidate at the examination.

(6) will remain the same."

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-69-303, MCA

REASON: The Board no longer issues an admittance card. The proposed amendment will allow the board flexibility in determining the type of notice, i.e. card or letter, to send to applicants.

"8.44.404 EXAMINATIONS (1) through (4) will remain the same.

(5) Examination papers may be reviewed in the board office for a period of 60 days immediately following the examination date only. Note taking will be allowed during the time of review, but the notes must be left in the board office. Questions on the review must be submitted in writing for response by the board.

(6) will remain the same.

(7) When an applicant fails to take the first examination for which he was scheduled, he may have his examination fee apply towards the next examination ~~for which he is scheduled~~. However, if the applicant fails to take the ~~second~~ next examination, his fee shall be forfeited and application for any subsequent examination will require another examination fee."

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-69-304, 37-69-305, 37-69-306, 37-69-307, MCA

REASON: The proposed amendment clarifies that notes taken during an exam review must be left in the board office to ensure the security of the exam and better explains when an examination fee is required.

"8.44.405 RENEWALS (1) will remain the same.

(2) All master and journeyman licenses shall expire on the date set in ARM 8.2.208. It is unlawful for a person who refuses or fails to pay the renewal fee to practice plumbing work in this state. A lapsed license may be reinstated within one year of the default without examination on payment of the arrears, and compliance with board requirements. A lapsed license not renewed within one year following its expiration date terminates automatically. The terminated license may not be reinstated, and a new original license must be obtained by submitting a new application, meeting the current requirements, passing the examination, and paying the appropriate fee."

Auth: Sec. 37-1-101, 37-69-202, MCA
IMP: Sec. 37-69-307, MCA

REASON: The board is proposing the change to clarify the process when a license is terminated after one year.

"8.44.408 MASTER PLUMBERS - REGISTRATION OF BUSINESS NAME (1) through (3) will remain the same.

(4) A master license shall be affiliated with only one plumbing business as master plumber of record, to be listed on the annual renewal form, and may not affiliate with a second plumbing business as master plumber of record, without terminating the first through written notice to the board office.

(5) and (6) will remain the same.

(7) Prior to any individual or entity bidding and contracting for work in the field of plumbing, the individual must first obtain a master plumber's license in the state of Montana.

(8) A master plumber license authorizes the individual's firm to obtain plumbing permits for doing plumbing work under the individual's license. A journeyman plumber's license does not authorize the individual to obtain a plumbing permit or to engage in or advertise as a plumbing business."

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-69-305, 37-69-306, 37-69-323, 37-69-101(6), MCA

REASON: The proposed amendment in (4) provides that the master plumber must submit a statement in writing if he is no longer the master plumber of record for a plumbing business.

The amendment to add the proposed wording under (7) and (8) will clarify the board's position that only master plumbers licensed in the state of Montana can bid and contract for plumbing work and to clarify that only a master plumber can obtain plumbing permits and advertise as a plumbing business. This clarification will ensure that only persons that have met the licensure requirements enacted to protect the public health, safety, and welfare of the citizens of Montana can offer to perform plumbing work.

"8.44.412 FEE SCHEDULE (1) through (12) will remain the same.

(13) Copies of documents 20"

Auth: Sec. 37-1-134, 37-69-202, 37-69-401, MCA
IMP: Sec. 37-1-134, 37-1-304, 37-1-305, 37-69-202, 37-69-307, 37-69-401, MCA

REASON: The proposed change will require that persons requesting copies of documents, including lists of licensees for continuing education purposes, will be required to pay an administrative fee. This fee is commensurate with the costs

of providing lists of licensees and other documents. It is anticipated that the board will receive approximately 10 requests for copies of documents per year for a total of $200.

"8.44.413 QUALIFICATIONS - JOURNEYMAN (1) and (1)(a) will remain the same.

(b) Copy of an apprenticeship completion certificate or certified statement issued by the United States department of labor, bureau of apprenticeship and training, or a recognized state apprenticeship agency/council. Experience granted for a registered apprenticeship is contingent upon successfully completing the requirement of the apprenticeship program;

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

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-69-304, 37-69-302, 37-69-323, MCA

REASON: The proposed amendment further clarifies the necessary documentation of experience for journeyman plumbers. Experience obtained in an apprenticeship program will be considered as valid experience only if the person completes the program and receives a completion certificate. Otherwise, the experience will not be considered as valid experience.

"8.44.415 OUT-OF-STATE APPLICANTS - RECIPROCITY (1) and (2) will remain the same.

(3) The board may enter into a written reciprocal agreement for a journeyman license with the license authority of another state or jurisdiction if the following conditions are met and are reviewed annually to ensure ongoing equivalent standards:

(a) The state requires five years of actual and documented experience in the field of plumbing;

(b) The state's examination is based on the uniform plumbing code;

(c) The state requires both a written and practical portion on their examination;

(d) The state requires a minimum passing score of 70% on their examination;

(e) A current copy of that state's requirements must be kept on file at the board office; and

(f) The reciprocal agreement must be approved by the board in open session and executed by signature of the presiding chairperson."

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-1-304, MCA

REASON: The 1997 legislature implemented legislation at Section 1, Chapter 210 which granted the Board authority to enter into reciprocity agreements. The proposed amendment implements the requirements for reciprocity as allowed in 37-1-304, MCA.

"8.44.416 TEMPORARY PRACTICE PERMITS (1) will remain the same.

(2) A temporary permit shall expire on the last day of the month ~~date~~ of the next scheduled examination or upon receipt of the results, whichever occurs first. If the applicant fails or does not write the next scheduled examination, a ~~second~~ temporary permit ~~will not~~ may be ~~issued~~ renewed at the discretion of the board, on a case by case basis upon receipt of a letter requesting renewal of a temporary practice permit and stating their intention to take the next scheduled examination. The letter must be accompanied by the examination fee. If the applicant does not take the next scheduled examination, the temporary practice permit will expire and the examination fee will be forfeited.

(3) will remain the same."

Auth: Sec. 37-1-319, 37-69-306, MCA
IMP: Sec. 37-1-305, 37-69-306, MCA

REASON: The 1999 legislature implemented House Bill 390 which granted the Board the authority to renew temporary practice permits. The proposed amendment sets forth the criteria for the board to renew a temporary practice permit as required by 37-1-305 and 37-69-306, MCA.

"8.44.418 COMPLAINT PROCEDURE (1) and (2) will remain the same.

(3) Upon receipt of the written complaint form alleging a violation of board statute or rules against a licensee, the board office shall log in the complaint and assign it a complaint number. The complaint shall then be sent to the licensee complained about for a written response. Upon receipt of the licensee's written response, both complaint and response shall be considered by the screening panel of the board for appropriate action, including dismissal, investigation or a finding of reasonable cause of violation of a statute or rule. The board office shall notify both complainant and licensee of the determination made by the screening panel.

(4) and (5) will remain the same.

(6) Upon receipt of the written complaint form alleging unlicensed practice, the board office shall log in the complaint and assign it a complaint number. The board counsel, under direction from the board chairman, will assign the complaint for immediate investigation. Upon receipt of the investigative report, both complaint and report shall be considered by the board for appropriate action, including dismissal, letter of warning, cease and desist order or injunctive action. The board office shall notify all parties involved of the determination made by the board.

(7) If, during the course of inspecting for license compliance, the compliance specialist of the department asks for a license from a person at a job site where the person is performing plumbing work and that person is unable to show

proof of licensure, a citation will be issued as outlined in 37-69-310, MCA.

Auth: Sec. 37-69-202, MCA
IMP: Sec. 37-1-308, 37-1-309, MCA

REASON: The proposed amendment will set forth the procedures for the department and board to handle unlicensed practice complaints in order to facilitate the prompt handling of the cases.

"8.44.501 MEDICAL GAS ENDORSEMENT REQUIRED - DEFINITIONS (1) and (2) will remain the same.

(3) The following definitions apply to this sub-chapter:

(a) "ASSE" means the American society of sanitary engineering.

(b) "Certification" means an accreditation from an approved training program, acceptable to the board, which issues documentation such as diplomas, cards or certificates which provide proof the applicant has successfully completed training in the installation of medical gas systems, pursuant to the requirements imposed by NFPA 99C and section IX of the ASME Welding and Brazing Code.

(c) "Endorsement" means the approval issued by the board, signified by an endorsement card or other credential, which authorizes a person to install medical gas systems within the state of Montana.

(d) "NFPA" means the national fire protection association."

Auth: Sec. 37-69-202, 37-69-401, MCA
IMP: Sec. 37-69-402, MCA

REASON: The definitions proposed were previously contained in ARM 8.44.402 and are being moved to sub-chapter 4 as they only apply to medical gas endorsements.

"8.44.502 APPLICATION FOR ENDORSEMENT (1) through (2)(a) remain the same.

(b) documentation that provides proof the applicant has successfully completed an approved training program which meets the criteria of ASSE series 6000 professional qualification standards and a third party testing source acceptable to the board, and has obtained certification in the installation of medical gas systems, based on NFPA 99C and Section IX of the ASME Welding and Brazing Codes;

(c) through (4) remain the same."

Auth: Sec. 37-69-202, 37-69-401, MCA
IMP: Sec. 37-69-401, MCA

REASON: The Board has proposed this amendment to change the type of training programs that are acceptable to the board for medical gas endorsements in order to comply with the current ASSE requirements.

"8.44.503 ANNUAL RENEWAL OF ENDORSEMENT (1) All medical gas endorsements shall expire annually. Each endorsement holder must submit a renewal form, proof of a current certification, and the required renewal fee. Failure to submit the annual renewal fee and to renew the endorsement within 30 days following the expiration date shall require the applicant to reapply for endorsement as required by board rule.

Auth: Sec. 37-69-202, 37-69-401, MCA
IMP: Sec. 37-69-401, MCA

REASON: The proposed amendment requires current certification for renewal of a medical gas endorsement to insure that the applicant is complying with current ASSE series standards.

4. Concerned persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Plumbers, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile, number (406) 444-1667, and must be received no later than 5:00 p.m., March 9, 2000.

5. Lon Mitchell, attorney, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 has been designated to preside over and conduct this hearing.

6. The Board of Plumbers maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all Board of Plumbers administrative rulemaking proceedings or other administrative proceedings. Such written request may be mailed or delivered to the Board of Plumbers, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 444-1667, or may be made by completing a request form at any rules hearing held by the Board of Plumbers.

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

BOARD OF PLUMBERS
DUANE STEINMETZ, CHAIRMAN

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF RADIOLOGIC TECHNOLOGISTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees	)))	NOTICE OF PROPOSED AMENDMENT OF 8.56.409 FEE SCHEDULE and 8.56.607 PERMIT FEES

NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On March 11, 2000, the Board of Radiologic Technologists proposes to amend the above-stated rules.

2. The Board of Radiologic Technologists will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Radiologic Technologists no later than 5:00 p.m. on March 1, 2000, to advise us of the nature of the accommodation that you need. Please contact Helena Lee, Board of Radiologic Technologists, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-3091; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1667.

3. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.56.409 FEE SCHEDULE (1) and (1)(a) will remain the same.

(b) Application fee - radiologic technologist	~~30~~ 60
(c) Original certificate fee	~~15~~ 30
(d) Renewal license fee - radiologic technologist	~~25~~ 50
(e) Late renewal fee (in addition to renewal fee)	~~40~~ 50

(f) and (g) will remain the same."

Auth: Sec. 37-14-202, MCA
IMP: Sec. 37-14-303, 37-14-305, 37-14-309, 37-14-310, MCA

"8.56.607 PERMIT FEES

(1) Application fee	$~~30~~ 45
(2) and (2)(a) will remain the same.	
(b) Each section	~~5~~ 15
(3) Original certificate fee	~~35~~ 40
(4) Renewal fee	~~25~~ 40
(5) Late renewal fee (in addition to renewal fee)	~~40~~ 50

(6) and (7) will remain the same."

Auth: Sec. 37-14-202, MCA

IMP: Sec. 37-14-303, 37-14-305, 37-14-309, 37-14-310, MCA

REASON: The proposed changes in the fees are commensurate with the program costs for the Board of Radiologic Technologists. Under the current fee schedule, the Board's projected revenue is $31,495 and the Board's appropriation for fiscal year 2000 is $64,623. If the fees are increased as proposed, the projected revenue would be $57,360 or an increase of $25,865. The fee increase will affect 11,000 current licensees and 100 new licensees. The board's revenue collected in the last biennium was below its expenditures in order to draw down its cash balance in accordance with state law. The Board last amended its fee schedule in 1997 at which time some of the fees were reduced in response to excessive cash balance.

4. Concerned persons may submit their data, views or arguments concerning the proposed action in writing to the Board of Radiologic Technologists, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., March 9, 2000.

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 the request along with any comments they have to the Board of Radiologic Technologists, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., March 9, 2000.

6. If the Board receives requests for a public hearing on the proposed action from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed action, from the appropriate administrative rule review committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 120 based on the renewal and new licensees in Montana.

7. The Board of Radiologic Technologists maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this Board. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding the Board of Radiologic Technologists. Such written request may be mailed or delivered to the Board of Radiologic Technologists at 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at(406)444-1667 or may be made by completing a request form at any rules hearing held by the Board of

Radiologic Technologists.

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

BOARD OF RADIOLOGIC
TECHNOLOGISTS
JANE CHRISTMAN, CHAIRMAN

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF PUBLIC EDUCATION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 10.56.101 relating to student assessment	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF ARM 10.56.101 RELATING TO STUDENT ASSESSMENT

TO: All Concerned Persons

1. The Board of Public Education will hold public hearings to consider the amendment of ARM 10.56.101, relating to student assessment, from 4:30 to 6:30 p.m. on the dates indicated at the following locations:

Missoula	March 3, 2000 - Big Sky High School Library, 3100 South Avenue West
Helena	March 6, 2000 - Lewis & Clark Library, 120 South Last Chance Gulch, Large Conference Room
Billings	March 7, 2000 - Parmly Billings Library, 510 North Broadway, Broadway Room

2. The Board of Public Education will make reasonable accommodations for persons with disabilities who wish to participate in any of these public hearings or need an alternative accessible format of this notice. If you require an accommodation, contact the Office of Public Instruction no later than 5:00 p.m. on February 18, 2000 to advise us of the nature of the accommodation that you need. Please contact Lindy Miller, P.O. Box 202501, Helena, MT 59620-2501, telephone: (406) 444-6774, FAX: (406) 444-2893. TDD will be available upon request.

3. Statement of Reasonable Necessity. The Board of Public Education is proposing to amend the administrative rule concerning student assessment. This rule change is necessary because the 55th Legislature directed the Office of Public Instruction to disclose student assessment data for a test required by the Board of Public Education. The 56th Legislature directed the Office of Public Instruction to continue the process of developing content and performance standards and selecting a statewide assessment aligned to the state standards and to assist districts with the implementation, purchase, and scoring of that aligned assessment instrument. By revising this rule, the Board of Public Education and the Superintendent of Public Instruction are coordinating these provisions and carrying out their statutory duties under 20-2-121(12), MCA, to adopt rules for

student assessment in public schools. The revisions are also necessary for school districts and the State to comply with requirements to continue receiving federal funding.

A focus group of American Indian education leaders was convened to discuss student assessment issues and the impact on American Indian students. This group and the Montana Indian tribes will continue to be involved in discussions related to the amendment of this rule, and are receiving notices of all proceedings in this matter.

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

10.56.101 STUDENT ASSESSMENT (1) By the authority of ~~section~~ 20-2-121(12), MCA, the board of public education adopts rules for ~~student~~ state-level assessment in the public schools and those private schools seeking accreditation.

(2) The board recognizes that the primary purpose of ~~student assessment is to improve the quality of education and that there are a variety of assessment tools~~ assessment is to serve learning. Classroom assessment is the primary means through which assessment impacts instruction and learning for individuals. State-level and large-scale assessment affect learning through assisting policy decisions and assuring program quality for all students. ~~At the local level, because norm-referenced tests are not designed to measure local programs, districts should begin to develop appropriate school and classroom assessment tools to measure the attainment of educational goals and objectives and the level of individual student achievement. Assessment results will be used in instructional planning and in evaluating the effectiveness of educational programs. At the state level, since it is useful to know how Montana students generally compare to students from other states,~~ To meet both classroom and state-level needs, assessment will provide information about the proficiency level of student achievement relative to established standards, as well as the status of Montana's schools in relation to other groups of students, states, and nations.

(3) A~~a~~ll accredited schools will annually administer ~~norm-referenced tests selected from a list of such tests~~ assessment instruments approved by the board ~~and provided by the office of public instruction, except that schools that on the effective date of this rule are either:~~

~~(a) not using norm referenced tests from the board approved list;~~

~~(b) not using norm referenced tests to test in grade levels four, eight and eleven; or~~

~~(c) using only parts of the approved norm referenced tests; have until July 1991 to comply with this subsection~~.

(a) The tests will be administered to all students in grades four, eight and eleven in reading, ~~language~~ communication arts, mathematics, science, and social studies.

~~A spring~~ For planning purposes, the tests will be given ~~and the test date will be within the empirical norm date time frame for the select test. If the spring test date falls outside the empirical norm date time frame, appropriate interpolated norms must be used~~ during a week in the spring of the year, identified by the office of public instruction a year prior to the testing date.

(b) All ~~scores~~ test results will be ~~sent~~ provided to the office of public instruction and school districts ~~with the annual fall report~~ in a format specified by the office of public instruction and approved by the board of public education.

~~(3)~~(4) Test ~~scores~~ results are a part of each student's permanent records ~~which will be governed by the office of public instruction's guidelines for student records~~ as described in ARM 10.55.2002.

~~(4)~~(5) The office of public instruction will ~~collect and~~ provide ~~a statewide summary of~~ a report of the results to the board, ~~and~~ the legislature, and the public. ~~No comparison of one Montana school or district to another will be made by the board of public education or the office of public instruction but~~ sSchools are encouraged to compare their ~~scores~~ results with the state ~~norms~~ results and share testing information ~~and results~~ with parents and local community~~y~~ies.

~~(5)~~(6) The superintendent of public instruction is authorized to make available the reported student assessment data in compliance with confidentiality requirements of federal and state law.

~~(6) All norm-referenced test~~ Assessment results released to the public ~~by schools~~ will be accompanied by a clear statement of the purposes of the test, subject areas ~~that have been~~ tested, level of measurement of the content standards, ~~how they were tested,~~ and the percent of students who ~~did not~~ participated in the ~~norm-referenced~~ testing, ~~limitations of norm-referenced tests, what is meant by the results and how the results will be used~~. The release will include additional information to provide a fair and useful context for assessment reporting (e.g., dropout rates, mobility rates, poverty levels, district size) that will assist districts to examine their educational programs to assure effectiveness.

(7) All students will participate in the state-level assessment. Students with disabilities or limited English proficiency (LEP) shall participate ~~in the regular assessment~~ using the approved assessment instruments, unless it is determined that the student's ~~attainment of educational goals~~ progress toward the content standards cannot be adequately measured with the ~~regular district~~ approved assessment instruments even when provided accommodations.

(a) For students with disabilities, the individualized education program (IEP) teams have the authority to specify accommodations to be provided, as defined in (8), for participation by the student in the ~~regular district~~ state-level assessment.

(i) When an IEP team determines that an accommodation

for a student's disability would still not allow for adequate measurement of the student's ~~attainment of educational goals goals~~ progress toward the content standards, the IEP team may waive ~~participation in~~ using the ~~district norm-referenced test~~ approved assessment instruments by providing an ~~alternative~~ alternate form of ~~testing~~ assessment that is appropriate to determine the student's ~~attainment of educational goals and objectives~~ progress toward the content standards.

(b) For students ~~with LEP~~ who have been identified by a team of educators as ~~limited English proficient~~ LEP, those teams have the authority to specify accommodations to be provided, as defined in (8), for participation by the student in the ~~regular district~~ state-level assessment.

(i) When the team of educators determines that an accommodation for an LEP student who has had fewer than three years of instruction in English would still not allow for adequate measurement of the student's ~~attainment of educational goals~~ progress toward the content standards, the team of educators may waive ~~participation in~~ using the ~~district test~~ approved assessment instruments by providing an ~~alternative~~ alternate form of ~~testing~~ assessment that is appropriate to determine the student's ~~attainment of educational goals and objectives~~ progress toward the content standards.

(c) The office of public instruction will provide guidance to schools concerning alternate testing.

(8) Accommodations allow ~~the~~ students to demonstrate competence in subject matter so that test results accurately reflect the ~~student's~~ students' achievement levels rather ~~that~~ than reflecting ~~the student's~~ limited English language development or impaired sensory or manual skills, except where those skills are the factors which the test purports to measure.

(a) Accommodation for testing purposes is defined as modifications similar to those used to support and accommodate the student in the instructional setting.

(b) Accommodations may include, but are not limited to extended time, small group administration, facilitator reading directions, native language support, student responding orally, or using required assistive technology.

(c) The office of public instruction will provide guidance to schools concerning appropriate accommodations.

AUTH: 20-2-121 MCA
IMP: 20-2-121, 20-7-402 MCA

5. Concerned persons may submit their data, views or arguments, either orally or in writing, at the hearings. Written data, views or arguments may also be submitted by mail to the Office of Public Instruction, P.O. Box 202501, Helena, Montana 59620-2501, or by e-mail to opirules@state.mt.us and must be received no later than 5:00 p.m. on March 13, 2000.

6. Geralyn Driscoll and Janice Frankino Doggett, of the Legal Services Unit, Office of Public Instruction, have been designated to preside over and conduct the hearings.

7. The Board of Public Education maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by the Board. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding student assessment or other school related rulemaking actions. Such written request may be mailed or delivered to the Board of Public Education, or may be made by completing a request form at any rules hearing held by the Board of Public Education.

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

/s/ Storrs Bishop
Storrs Bishop
Chairman
Board of Public Education

/s/ Geralyn Driscoll
Geralyn Driscoll
Rule Reviewer
Office of Public Instruction

Certified to the Secretary of State January 31, 2000.

BEFORE THE STATE LIBRARY COMMISSION
OF THE STATE OF MONTANA

In the matter of the proposed new rules relating to federation advisory boards and base grants	NOTICE OF PUBLIC HEARING

TO: All Concerned Persons

1. On March 13, 2000, at 9:00 a.m., a public hearing will be held in the conference room of the Montana State Library, 1515 E. 6th Avenue, at Helena, Montana, to consider the adoption of new rules relating to federation advisory boards and base grants.

2. The State Library Commission will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the Commission no later than 5:00 p.m. on February 28, 2000, to advise us of the nature of the accommodation you that you need. Please contact Amanda Broadwater, Montana State Library, PO Box 201800, 1515 East 6th Avenue, Helena, Montana 59620-1800, telephone (406) 444-3384, fax (406) 444-5612, TDD (406) 444-3005.

3. The State Library Commission is proposing to adopt the following rules:

NEW RULE I JOINING LIBRARY FEDERATIONS (1) Libraries eligible to join federations include any public, school, special, college, or university library.

(2) Each member of the federation shall designate one person to serve as a voting delegate to the federation. Delegates shall establish in the federation bylaws the size and the composition of the federation board of trustees.

(a) The majority of the board shall be public library trustees and the board must have representatives from each of the other types of libraries that are federation members;

(b) At the spring meeting, the federation delegates shall elect the board members according to federation bylaws.

AUTH: Sec. 22-1-103, MCA;
IMP: Sec. 22-1-103, 22-1-328, 22-1-330, 22-1-331, 22-1-402, 22-1-404, and 22-1-413, MCA.

NEW RULE II BASE GRANTS (1) The commission receives a legislative appropriation to fund the base grants. The total distribution per federation shall remain the same as in FY 1998 unless the legislative appropriation changes.

(2) After receiving recommendations from the advisory board, the federation shall distribute the base grants in two ways:

(a) The federation may use the grants to fund federation projects that maintain or improve cooperative library services and activities; or

(b) The federation may also allocate base grants to public libraries to support the cooperative activities and services of the federation.

(i) The federation shall direct these grants to meet the following objectives:

(A) to increase the amount and quality of unique library resources in the federation and state. Libraries may purchase library materials to accomplish goals established in the federation or state's collection development plan;

(B) to increase the on-line availability of local bibliographical information. Libraries may purchase subscriptions to bibliographic databases such as lasercat and worldcat, add and maintain holdings in these databases, and purchase the necessary equipment and software;

(C) to increase the visibility of libraries in the federation or state. Libraries may use base grants to promote or market libraries through a group project involving more than one library in the federation;

(D) to increase the work-related knowledge, skills, and abilities of library staff and trustees. Libraries may use base grants to support education opportunities and to share this education with other federation members; or

(E) to support other objectives that enhance the cooperative activities and services of the federation.

AUTH: Sec. 22-1-103, MCA;
IMP: Sec. 22-1-103, 22-1-328, 22-1-330, 22-1-331, 22-1-402, 22-1-404, and 22-1-413, MCA.

Reasons: These rules are proposed to clarify new legislation that was passed in the 1999 session regarding federation base grants and advisory boards.

4. Concerned parties 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:

Karen Strege
Montana State Library
PO Box 201800
1515 East 6th Avenue
Helena, Montana 59620-1800

no later than March 20, 2000.

5. Karen Strege, State Librarian, has been designated to preside over and conduct the hearing.

6. The state library maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name

added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding Public Library Grants, State Aid to Libraries, Federation Areas, State Library Services, Scholarship Program, or Depository Procedures for State Documents. Such written request may be mailed or delivered to Karen Strege, Montana State Library, P.O. Box 201800, 1515 East 6th Avenue, Helena, Montana 59620-1800, faxed to the State Library at (406) 444-5612, or may be made by completing a request form at any rules hearing held by the state library.

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

Karen Strege
KAREN STREGE
State Librarian and Rule Reviewer

Certified to Secretary of State January 31, 2000.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the adoption of NEW RULE I; and the amendment of ARM 17.8.321 pertaining to the use of credible evidence in assessing air quality compliance	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT (AIR QUALITY)

TO: All Concerned Persons

1. On March 16, 2000, at 1:00 p.m. in Room 111 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a hearing to consider the proposed adoption and amendment of the above-captioned rules.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., March 8, 2000, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. Two alternatives are proposed, representing the proposed approach of the Department of Environmental Quality (ALTERNATIVE I) and a working group comprised of various owners and operators of affected facilities which would be subject to the rule (ALTERNATIVE II). Paragraphs 5 and 6 of this notice contain rationale statements for each proposed alternative. The rationale statements have been prepared by the proponents of the alternatives. After hearing public comment on the alternatives, the Board will decide which, if any, of the proposed alternatives to adopt.

The alternative new rules and amendments provide as follows:

ALTERNATIVE I

NEW RULE I CREDIBLE EVIDENCE (1) For the purpose of submitting a compliance certification required pursuant to this chapter, or establishing whether or not a person has violated or is in violation of any standard or limitation adopted pursuant to this chapter, nothing in these rules shall preclude the use, including the exclusive use, of any credible evidence or information, relevant to whether a source would have been in compliance with such standard or limitation if the appropriate performance or compliance test procedures or methods had been performed.

AUTH: 75-2-111, 75-2-203, 75-2-217, MCA

IMP: 75-2-203, 75-2-217, MCA

4. The rule proposed to be amended under Alternative I provides as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.8.321 KRAFT PULP MILLS (1) through (14) remain the same.

(15) ~~COMS will be the primary measure of compliance~~ Compliance with the opacity limits specified in (8), (9), and (10) of this rule~~,~~ will be determined by the COMS ~~except that 40 CFR Part 60, appendix A, method 9, may be used as a measure of compliance when there is reason to believe that COMS data is not accurate or when COMS data is unavailable~~.

(16) remains the same.

AUTH: 75-2-111, 75-2-203, MCA
IMP: 75-2-203, MCA

ALTERNATIVE II

NEW RULE I CREDIBLE EVIDENCE (1) For the purpose of submitting a compliance certification required pursuant to this chapter, or establishing whether or not a person has violated or is in violation of any standard or limitation adopted pursuant to this chapter, nothing in these rules shall preclude the use, including the exclusive use, of any credible evidence or information, relevant to whether a source would have been in compliance with such standard or limitation if the appropriate performance or compliance test procedures or methods had been performed. However, when compliance is demonstrated by a test or procedure provided by permit or other applicable requirement, the owner or operator shall then be presumed to be in compliance unless that presumption is overcome by other relevant credible evidence that is clear and convincing.

AUTH: 75-2-111, 75-2-203, 75-2-217, MCA
IMP: 75-2-203, 75-2-217, MCA

5. The Department of Environmental Quality has prepared the following statement of reasonable necessity for ALTERNATIVE I:

The proposed new rule and amendments under this Alternative are intended to remove any potential ambiguity regarding the use of non-reference test data for compliance certifications under Section 114 and Title V of the federal Clean Air Act, and to clarify the use of such data as credible evidence in enforcement actions. As provided in the proposed new rule, facilities may use non-reference test data and information to establish compliance. Similarly, in an enforcement context, evidence other than reference test data may be used to establish noncompliance with applicable

requirements. However, under the new rule as proposed, the alternative data or information would have to be relevant to whether the source would have been in compliance if the applicable reference test had been performed.

The proposed new rule would address the role of existing data in determining compliance, and would not call for the creation or submission of any new emission data. While the proposed rule would not designate any particular data as probative of compliance, and the reference test method would not be the exclusive method of determining compliance, under the rule the reference test would remain the benchmark against which other data, analyses or other information would be evaluated. Given the text of the proposed new rule, information generated from an appropriate and properly conducted reference test method would still be the best indicator of a source's compliance during the test period.

Under the proposed new rule, where information (such as non-reference emissions data, parametric data, or engineering analyses) is equivalent to information generated by reference test methods, the former could be used to establish compliance or noncompliance. This would not require that every test condition specified in a reference test method be matched by a surrogate condition in the method used to generate the comparable information. Typically, a reference test method quantifies the mass or concentration of a given chemical over a specific period of time. As long as the alternate method addresses these two elements and the resulting data relate to the reference test, the data would be technically relevant to assessing compliance.

The proposed new rule would not change either the stringency of underlying emission standards, or the legal burdens associated with establishing compliance or noncompliance. The rule addresses an evidentiary issue. If the evidence or information is credible, and relates to whether the facility would have been in compliance if the appropriate reference test had been performed, it is technically relevant. The rule does not address the weight to be given to the evidence, as this would remain the province of the ultimate fact finder. Administrative and judicial tribunals routinely make determinations concerning the admissibility and weight of evidence on a case-by-case basis.

Alternative I strikes a critical balance. The reference test method must be an important consideration in any determination regarding the admissibility of alternative data. At the same time, creating a blanket "presumption of continuing compliance" for time periods occurring outside of a reference test is inappropriate.

Historically, the Department has made compliance determinations based on available data, whether or not the data are generated as a result of a particular test method. In the enforcement context, the Department has taken the position in some cases that it is not precluded from relying on evidence other than the applicable reference test in proving air quality violations. However, this point has been

subject to dispute, and defendants have argued that the use of non-reference test data to establish a violation is prohibited, no matter how credible and probative that data may be. In certain factual situations, the proposed new rule may be more restrictive than the Department's past interpretation of its rules. Under the proposed new rule, credible evidence must be relevant to showing whether the source would have been in compliance had the appropriate reference test been performed. The Department's past position has not always been premised upon a direct relationship between the alternative evidence and a reference test.

Nevertheless, use of the reference test method as a yardstick against which other types of evidence are measured is an appropriate limitation. Maintaining the focus of the compliance determination on whether or not the appropriate reference test would have shown compliance prevents the use of alternative data in a manner which could have the effect of changing the stringency of the underlying standard. For the specific time period of any properly performed reference test, this has the practical effect of making the data from that test at least "presumptively" credible.

Under this Alternative, a reference test does not create a presumption of continuing compliance or noncompliance. While the reference test method is entitled to weight, it cannot generally be presumed that such a test indicates the compliance status of a facility for any time period outside of the period actually covered by the test itself. This determination is unique to the conditions attendant to each test and facility. The rules of evidence already allow for such a presumption, based upon an appropriate demonstration regarding those fact-specific conditions. In addition, the creation by rule of a generic presumption of continuing compliance or noncompliance alters the nature of the compliance obligation by assuming that the obligation is limited to the time period contained in the reference test method. The obligation to maintain compliance under federal and state laws governing air quality is continuous.

In February 1997, the U.S. Environmental Protection Agency (EPA) adopted final rules regarding the use of credible evidence to determine compliance under the federal Clean Air Act. 62 Fed. Reg. 8,314 (2/24/97). These rule revisions provided clear authority for EPA to use any available information to prove violations of requirements under the Act. EPA has notified the state that similar language must be incorporated into the Montana State Implementation Plan, to ensure that the Plan cannot be interpreted to preclude the use of credible evidence. If Montana fails to address EPA's concerns, EPA could adopt its own credible evidence provisions into the Plan, and seek to impose sanctions against Montana, including cuts in highway funding, emission offsets for new sources, or resource funding for state air programs. The proposed new rule satisfies EPA's concerns.

Finally, the proposed amendment to ARM 17.8.321(15) is necessary to eliminate any inference that the described

methods of determining compliance with kraft pulp mill opacity limits are exclusive, and contrary to the proposed new rule. As proposed to be amended, the rule would still provide for use of the COMS as the reference method in determining compliance. However, this provision would not preclude or otherwise limit the use of any credible evidence in assessing compliance, as provided in the proposed new rule.

6. Alternative II differs from Alternative I only by inclusion of a rebuttable presumption in favor of approved reference test methods, which can be overcome only by other relevant credible evidence that is clear and convincing. Proponents have prepared the following statement of reasonable necessity for ALTERNATIVE II:

Although the Board is proposing two alternative rules, it also has the option of not adopting any rule addressing the use of credible evidence at this time. The issue of credible evidence is unresolved nationally and the D.C. Circuit Court of Appeals has determined the legality of EPA's rule (Alternative I) is not yet ripe for adjudication. Many emission standards have been established based upon specific reference tests and procedures, and use of non-reference information to determine compliance may impose an increased regulatory burden. The D.C. Circuit Court ruled that absent a specific enforcement action, it could not determine whether EPA's rule would illegally impose stricter emission limitations as applied. EPA has granted other Region 8 states extensions of time to respond to its "SIP call" and the State of Montana has requested a similar extension. The Board may determine that it is premature to adopt a credible evidence rule in the form supported by EPA at this time.

If the Board should decide to adopt a rule at this time, it may include a rebuttable presumption in favor of prescribed reference test methods designated by permit or regulation (Alternative II). The presumption would not limit the admissibility of other relevant credible evidence, but would give added weight to approved reference methods or procedures. When compliance is demonstrated by a test or procedure provided by permit or other applicable requirement, then the owner or operator would be presumed to be in compliance unless that presumption is overcome by other, relevant credible evidence that is clear and convincing. The objective of this presumption is to strike a balance by providing owners and operators with reasonable assurance of the standard they must meet to show or certify compliance, while also allowing the Department to consider all relevant credible evidence in determining compliance.

Under Alternative II, the initial burden of demonstrating compliance remains with the source. A rebuttable presumption of compliance arises only if an owner or operator meets its initial burden through reference tests or procedures required by its permit or other applicable requirements. In all cases,

the obligation to maintain compliance under federal and state laws governing air quality is continuous.

All parties appear to agree that the use of an approved reference test is the best and preferred method for determining compliance with applicable standards. The Department has assured the Board that it will not alter the practice of using the reference test method as a "benchmark" or "yardstick" for measuring other credible evidence. However, parties should not have to rely on informal agency practice to avoid legal jeopardy. The informal practice of the Department of relying on the reference test method as the preferred means of demonstrating compliance might erode or be abandoned over time. Additionally, EPA or third parties may not follow this informal practice. Absent the inclusion of a presumption, the credible evidence rule would leave owners and operators who demonstrate or verify compliance based upon the approved reference tests at risk. There is no reason not to place such a "benchmark" explicitly in the rule. If the Board adopts a credible evidence rule, the inclusion of a clear presumption will promote regulatory certainty and compliance.

EPA has asserted that Montana's State Implementation Plan must be amended to ensure that the Plan cannot be interpreted to preclude the use of credible evidence. Because the presumption only addresses the weight of credible evidence and not its admissibility, this presumption meets EPA's concerns without jeopardizing owners and operators who have demonstrated compliance by prescribed reference test methods or procedures.

The proposed amendment to ARM 17.8.321(15) is unnecessary, as the Kraft pulp mill rule already provides that COMS will be the "primary" measure for determining compliance. However, the use of EPA's "method 9" is authorized when there is reason to believe that COMS data is not accurate or when COMS data is unavailable.

7. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than March 22, 2000. To be guaranteed consideration, the comments must be postmarked on or before that date. Written data, views or arguments may also be submitted electronically via email addressed to Leona Holm, Board Secretary, at "lholm@state.mt.us", no later than 5 p.m. March 22, 2000.

8. 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 which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding air quality. Such written request may be mailed or delivered to the Board of Environmental Review, P.O. Box 200901, Helena,

Montana, 59620-0901, faxed to the office at (406) 444-4386, or may be made by completing a request form at any rules hearing held by the Board.

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

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

Reviewed by:

David Rusoff
David Rusoff, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.8.101 pertaining to exclusions from the definition of volatile organic compounds	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT (AIR QUALITY)

TO: All Concerned Persons

1. On March 21, 2000, at 1:30 p.m. in Room 35 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a hearing to consider the proposed amendment of the above-captioned rule.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., March 14, 2000, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rule proposed to be amended provides as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.8.101 DEFINITIONS As used in this chapter, unless indicated otherwise in a specific subchapter, the following definitions apply:

(1) through (39) remain the same.

(40) ~~(a)~~ "Volatile organic compounds (VOC)" means any compound of carbon, excluding carbon monoxide, carbon dioxide, carbonic acid, metallic carbides or carbonates, and ammonium carbonate, which participates in atmospheric photochemical reactions~~, and~~.

(a) This ~~including~~ includes any such organic compound other than the following, which have been determined to have negligible photochemical reactivity:

(i) methane;
(ii) ethane;
(iii) methyl acetate;
(iv) methylene chloride (dichloromethane);
(v) 1,1,1-trichloroethane (methyl chloroform);
(vi) 1,1,2-trichloro-1,2,2-trifluoroethane (CFC-113);
(vii) trichlorofluoromethane (CFC-11);
(viii) dichlorodifluoromethane (CFC-12);
(ix) chlorodifluoromethane (HCFC-22);
(x) trifluoromethane (HFC-23);
(xi) 1,2-dichloro-1,1,2,2 tetrafluoroethane (CFC-114);
(xii) chloropentafluoroethane (CFC-115);
(xiii) 1,1,1-trifluoro-2,2-dichloroethane (HCFC-123);

(xiv) difluoromethane (HFC-32);
(xv) ethylfluoride (HFC-161);
(xvi) 1,1,1,3,3,3-hexafluoropropane (HFC-236fa);
(xvii) 1,1,2,2,3-pentafluoropropane (HFC-245ca);
(xviii) 1,1,2,3,3 -pentafluoropropane (HFC-245ea);
(xix) 1,1,1,2,3-pentafluoropropane (HFC-245eb);
(xx) 1,1,1,3,3-pentafluoropropane (HFC-245fa);
(xxi) 1,1,1,2,3,3-hexafluoropropane (HFC-236ea);
(xxii) 1,1,1,3,3-pentafluorobutane (HFC-365mfc);
(xxiii) chlorofluoromethane (HCFC-31);
(xxiv) 1,2-dichloro-1,1,2-trifluoroethane (HCFC-123a);
(xxv) 1 chloro-1-fluoroethane (HCFC-151a);
(xxvi) 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane ($C_4F_9OCH_3$);
(xxvii) 2-(difluoromethoxymethyl)-1,1,1,2,3,3,3 -heptafluoropropane ($(CF_3)_2CFCF_2OCH_3$);
(xxviii) 1-ethoxy-1,1,2,2,3,3,4,4,4-nonafluorobutane ($C_4F_9OC_2H_5$);
(xxix) 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3 -heptafluoropropane ($(CF_3)_2CFCF_2OC_2H_5$);
(xxx) 1,1,1,2,3,4,4,5,5,5-decafluoropentane (HFC43-10mee);
(xxxi) 3,3-dichloro-1,1,1,2,2,-pentafluoropropane (HCFC-225ca);
(xxxii) 1,3-dichloro-1,1,2,2,3-pentafluoropropane (HCFC-225cb);
(xxxiii) 1,1,1,2-tetrafluoroethane (HFC-134a);
(xxxiv) 1,1-dichloro-1-fluoroethane (HCFC-141b);
(xxxv) 1-chloro-1,1-difluoroethane (HCFC-142b);
(xxxvi) 2-chloro-1,1,1,2-tetra-fluoroethane (HCFC-124);
(xxxvii) pentafluoroethane(HFC-125);
(xxxviii) 1,1,2,2-tetrafluoroethane (HFC-134);
(xxxix) 1,1,1-trifluoroethane (HFC-143a);
(xl) 1,1-difluoroethane (HFC-152a);
(xli) parachlorobenzotrifluoride (PCBTF);
(xlii) cyclic, branched, or linear completely methylated siloxanes;
(xliii) acetone;
(xliv) perchloroethylene (tetrachloroethylene);
(xlv) t-butyl acetate; and
(xlvi) perfluorocarbon compounds which fall into these classes:

(i) through (iv) remain the same, but are renumbered (A) through (D).

(40)(b) through (42) remain the same.

AUTH: 75-2-111, MCA
IMP: Title 75, chapter 2, MCA

4. The proposed rule amendment would revise the definition of volatile organic compounds (VOC) for purposes related to attaining federal and state ambient air quality standards for ozone. This proposed revision would add t-butyl

acetate (also known as tertiary butyl acetate or informally known as TBAC or TBAc) to the list of compounds excluded from the definition of VOC. The proposed amendment is necessary because this compound has negligible contribution to tropospheric ozone formation. The proposed amendment is in response to a change in the federal definition of VOC published at 64 FR 52731 on September 30, 1999, "Air Quality: Revision to Definition of Volatile Organic Compounds--Exclusion of t-Butyl Acetate", to be codified at 40 CFR 51.100(s)(1). Under the proposed amendment if a facility uses or produces t-butyl acetate and is subject to state or federal regulations limiting the use of VOCs in its product, limiting the VOC emissions from the facility, or otherwise controlling the use of VOCs, then the facility would not count t-butyl acetate as a VOC in determining whether the facility meets its regulatory obligation.

5. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than March 24, 2000. To be guaranteed consideration, the comments must be postmarked on or before that date. Written data, views or arguments may also be submitted electronically via email addressed to Leona Holm, Board Secretary, at "lholm@state.mt.us", no later than 5 p.m. March 24, 2000.

6. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

7. 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 which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding air quality. Such written request may be mailed or delivered to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, faxed to the office at (406) 444-4386, or may be made by completing a request form at any rules hearing held by the Board.

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

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

Reviewed by:

David Rusoff
David Rusoff, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.8.302 pertaining to cement manufacturing industry and primary lead smelting maximum achievable control technology	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT (AIR QUALITY)

TO: All Concerned Persons

1. On March 23, 2000, at 1:30 p.m. in Room 35 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a hearing to consider the proposed amendment of the above-captioned rule.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., March 16, 1999, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rule proposed to be amended provides as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.8.302 INCORPORATION BY REFERENCE (1) through (1)(e) remain the same.

(f) 40 CFR Part 63, specifying emission standards for hazardous air pollutant source categories including the final rules published at 64 FR 31897 on June 14, 1999, "National Emission Standards for Hazardous Air Pollutants for the Portland Cement Manufacturing Industry", to be codified at 40 CFR Part 63, Subpart LLL; and at 64 FR 30193 on June 4, 1999, "National Emission Standards for Hazardous Air Pollutants for Primary Lead Smelting", to be codified at 40 CFR Part 63, Subpart TTT;

(2) through (4) remain the same.

AUTH: 75-2-111, 75-2-203, MCA
IMP: 75-2-203, MCA

4. The proposed rule amendment would incorporate by reference the federal portland cement manufacturing industry and primary lead smelting maximum achievable control technology (MACT) standards. The MACT standards are source category-specific emission and control equipment standards for sources of air pollution that emit hazardous air pollutants. The U.S. Environmental Protection Agency (EPA) adopted portland cement manufacuring and primary lead smelting MACT standards on June 14, 1999, and June 4, 1999, respectively. The policy of the Montana legislature has been for the state

to maintain primacy of its environmental regulation programs. It is necessary for the state to adopt these MACT standards to maintain its delegation of authority from the EPA and primacy to enforce the air toxics program. Section 75-2-207, MCA, of the Clean Air Act of Montana prohibits the Board from adopting a rule that is more stringent than comparable federal regulations or guidelines unless the Board has conducted a public hearing and made certain written findings supporting a more stringent state standard. The Board is not proposing more stringent standards because the Board has not conducted a public hearing and has not made such written findings.

5. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than March 29, 2000. To be guaranteed consideration, the comments must be postmarked on or before that date. Written data, views or arguments may also be submitted electronically via email addressed to Leona Holm, Board Secretary, at "lholm@state.mt.us", no later than 5 p.m. March 29, 2000.

6. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

7. 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 which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding air quality. Such written request may be mailed or delivered to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, faxed to the office at (406) 444-4386, or may be made by completing a request form at any rules hearing held by the Board.

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

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

Reviewed by:

David Rusoff
David Rusoff, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.30.630 pertaining to the temporary water quality standards for portions of Mike Horse Creek, Beartrap Creek and the upper Blackfoot River	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT (Water Quality)

TO: All Concerned Persons

1. On March 14, 2000 at 10:00 a.m. in Room 111 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a hearing to consider the proposed amendment of the above-captioned rule.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., March 7, 2000, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rule proposed to be amended provides as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.30.630 TEMPORARY WATER QUALITY STANDARDS ~~FOR NEW WORLD MINING DISTRICT~~ (1) Following are the temporary water quality standards and related provisions for new world mining district:

(1) remains the same, but is renumbered (a).

(2) remains the same, but is renumbered (b).

(2)(a) through (c) remain the same, but are renumbered (1)(c), (d) and (e).

(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) These temporary standards are effective from June 1, 2000, through 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. 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. 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 (N47°1'42.1", W112°21'11.3") to its confluence with Anaconda Creek (N47°2'5.8", W112°21'31.1"), 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 (N47°2'5.8", W112°21'31.1") to the confluence of Stevens Gulch (N47°2'24.8", W112°22'15.8"), are as follows. 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 (N47°2'5.8", W112°21'31.1") to its confluence with Stevens Gulch (N47°2'24.8", W112°22'15.8"), 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 (N47°2'24.8", W112°22'15.8") to the confluence with Pass Creek (N47°2'30.5", W112°22'52.8"), are as follows. 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 (N47°2'24.8", W112°22'15.8") to the confluence with Pass Creek (N47°2'30.5", W112°22'52.8"), 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

4. The duration of the proposed temporary standard is eight years because the Department of Environmental Quality has advised the Board that reclamation can be accomplished within that timeframe. See proposed 17.30.630(2)(c). However, ASARCO's petition (see section 5 below) was for a 15-year duration. The Board is therefore considering adopting the proposed rule with a modification extending the duration to 15 years or an appropriate period less than 15 years. The Board is requesting public comment on the appropriate period for the temporary standards to be in place.

5. ASARCO, Inc. has petitioned the Board of Environmental Review to begin rulemaking for temporary water quality standards for three stream reaches in the upper Blackfoot River watershed. The reaches are: the Blackfoot River from the confluence of Anaconda Creek and Beartrap Creek to about 1.2 miles downstream; the lower portion of Beartrap Creek; and a portion of Mike Horse Creek.

The purpose of the petition is to address the pollution arising from discharges from two historic mine adits owned by ASARCO and nonpoint discharges from historic mining in these drainages. In 1993, the Department of Health and Environmental Sciences, predecessor agency to the Department of Environmental Quality, issued a Montana Pollutant Discharge Elimination System (MPDES) permit for the discharge from two mine adits and a wetland water treatment system associated with the adits. The permit is in effect and includes a compliance schedule and water quality discharge limits that change as the reclamation of the watershed proceeds.

In 1995, the Legislature enacted § 75-5-312, MCA. This statute placed in the Water Quality Act for the first time express authority for the Board to adopt temporary standards. The statute requires that an implementation plan be submitted to eliminate water quality limiting factors to the extent achievable as soon as reasonably practicable.

Although the reclamation and wetland treatment activities are meeting the schedule contained in the permit, it appears with reasonable scientific certainty that the wetland treatment system has not developed and will not develop to meet the next phase of water quality limits, which take effect October 1, 2000. Also, additional reclamation not related to the treatment system and permit will be necessary to achieve compliance with water quality standards. It is therefore necessary to take action that addresses the potential for violation of the Water Quality Act. Adoption of the proposed temporary water quality standards will address this potential. Furthermore, the proposed temporary standards, in conjunction

with the implementation plan proposed by ASARCO, will eliminate the water quality limiting factors to the extent achievable and as soon as is reasonably practicable.

The Board considered two alternative means of addressing this situation under the Water Quality Act. The Board considered recommending that the Department of Environmental Quality amend the MPDES permit. This alternative was rejected in view of the clear policy direction of the 1995 Montana Legislature to deal with this type of situation through the temporary water quality standard process rather than the permit process. The Board also considered recommending that the Department of Environmental Quality adopt a total maximum daily load (TMDL) for these stream segments. The Board rejected this approach because the TMDL process would not achieve cleanup as rapidly as would the temporary standards process.

6. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than March 17, 2000. To be guaranteed consideration, the comments must be postmarked on or before that date. Written data, views or arguments may also be submitted electronically via email addressed to Leona Holm, Board Secretary, at "lholm@state.mt.us", no later than 5 p.m. March 17, 2000.

7. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

8. 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 which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding temporary water quality standards. Such written request may be mailed or delivered to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, faxed to the office at (406) 444-4386, or may be made by completing a request form at any rules hearing held by the Board.

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

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

Reviewed by:

John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE DEPARTMENT OF TRANSPORTATION
OF THE STATE OF MONTANA

In the matter of the amendment of rules 18.8.101, 18.8.414, 18.8.422, 18.8.504, 18.8.508, 18.8.509, 18.8.509A, 18.8.511A, 18.8.511B, 18.8.512, 18.8.513, 18.8.518, 18.8.519, 18.8.601, 18.8.602, and 18.8.801 and the repeal of rules 18.8.418, 18.8.501, 18.8.502, 18.8.514 and 18.8.515 concerning the Motor Carrier Services regulations for overdimensional vehicles and loads.	)))))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On March 22, 2000, at 9 a.m., a public hearing will be held in the auditorium of the Department of Transportation building, 2701 Prospect, Helena, Montana, to consider the amendment and repeal of the above-referenced rules.

2. The Department 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 Department no later than 5 p.m. on March 17, 2000, to advise us of the nature of the accommodation you need. Please contact Carolyn Knuckles, Motor Carrier Services Division, Department of Transportation, P.O. Box 4639, Helena, MT 59604, (406) 444-7629 or TTY users can call (406)444-7696.

3. Each of the proposed changes is reasonably necessary for the reasons given below. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

18.8.101 DEFINITIONS

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

(g) Unless otherwise provided for in statute, or these rules, overhang is the part of a load that extends beyond the rear of a vehicle. Rear overhang is measured from the end of the vehicle or underride protection device.

(h) A special permit is a written document which may be issued for either width, height, length or weight in excess of the statutory limits, or a combination of width, height, length and weight. A special permit shall be issued for a non-reducible load only, except when otherwise expressly set forth in the rules. The duration of a special permit may be either a single trip or a term permit.

(i) "Continuous travel" means unrestricted hours of travel

for certain vehicles or loads operating under special permits. Movement is allowed 24 hours a day, 7 days a week, including holidays and holiday weekends.

(j) "Red route" means those highways upon which certain hours of travel may be prohibited for vehicles or loads operating under special permits. The highways are listed on the "red route restrictions" map which is available from the Motor Carrier Services Division, P.O. Box 4639, Helena, Montana 59604.

(k) A convoy is a group of two to five vehicles or vehicle combinations traveling together.

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary to combine definitions from other rules into sections (g) through (k) and to eliminate repetition and make the rules easier to use.

18.8.414 INCREASE IN WEIGHT AND/OR CHANGE OF CLASSIFICATION (1) through (3) remain the same.

~~(4) The date for determining the proper fees will be based on the date of the current registration.~~

AUTH: 61-10-155, MCA
IMP: 61-10-201, 61-10-202, 61-10-209 and 61-10-233, MCA

REASON: The proposed amendments are reasonable and necessary to eliminate duplication. Language pertaining to quarterly and monthly fees is contained in ARM 18.8.415.

18.8.422 TEMPORARY TRIP PERMITS (1) The time limit on all temporary trip permits shall be 72 hours. For extension of temporary trip permits, see ~~paragraph (8) or (9)~~ additional information in this rule.

(2) and (3) remain the same.

(4) Each single vehicle or each ~~truck or trailer~~ vehicle in a combination ~~of vehicles~~ with a gross weight of over 6,000 pounds ~~traveling under the following conditions is required to purchase~~ requires a temporary trip permit if one or more of the following conditions apply:

(a) through (i) remain the same.

(j) ~~All~~ Any non-resident vehicles not currently licensed in any jurisdiction.

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

(e) Trailers drawn by trucks or tractors licensed under Schedule ~~III~~ II fees are not subject to trip permits if currently licensed and the registration receipt accompanies the vehicle.

(f) through (6) remain the same.

(7) Upon application to an M.C.S. enforcement officer or a highway patrol~~man~~ officer, a trip permit may be extended ~~by the officer's endorsement for up to 15 days in an emergency, such as mechanical breakage or unsafe road conditions.~~ for the

following reasons:

~~(8) Upon application to an M.C.S. enforcement officer or highway patrolman, a permit may be extended for a period of a holiday or weekend where the enforcement officer or patrolman has knowledge that the vehicle could not load or unload. The extension shall be limited to the period of the holiday.~~

(a) a delay due to mechanical breakdown or hazardous conditions, up to 15 days; or

(b) when a weekend or holiday prevents unloading or loading of the vehicle, for the period of the weekend or the holiday.

(9) and (10) remain the same, but are renumbered (8) and (9).

AUTH: 61-10-155, MCA
IMP: 61-10-211 through 61-10-214, MCA

REASON: The proposed amendments are reasonably necessary to revise sections (1), (4), (7) and (8) for clarification and to eliminate redundancy. Section (5)(e) is amended to correct a clerical error.

18.8.504 DURATION OF PERMIT (1) The duration of a single trip special permit is the length of time for the specified move as indicated by the effective date and the expiration date shown on the permit. A single trip special permit may be issued if any of the following conditions apply:

(a) the powered vehicle is operating on a Montana temporary trip permit;

(b) the applicant requests a single trip permit;

(c) the permit is transmitted electronically or by any type of communication service except mail;

(d) dimensions or weight exceed the maximums allowed in 61-10-121 through 61-10-125, MCA.

(2) Term permits issued on financial stationery are valid from January 1 through December 31. Term permits issued on the apportioned registration (cab card) to Montana based vehicles licensed under the International Registration Plan (IRP), expire with the registration. A term permit may only be issued to a power unit which is properly licensed with Montana.

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary to combine provisions pertaining to duration of a special permit contained in ARM 18.8.502 and 18.8.504 into ARM 18.8.504 for clarification and to make the rules easier to use.

18.8.508 SELF-ISSUING PERMIT (1) Upon payment of fees, trip or term self-issuing ~~overdimensional~~ special permits may be obtained from the Helena ~~G.V.W.~~ motor carrier services office for excess width, height, weight, and length. These permits shall be completed for use as needed by the purchaser.

(2) and (3) remain the same.

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary to promote uniformity by using the definition of special permit found in ARM 18.8.101. G.V.W. is changed to motor carrier services to correct a clerical error.

18.8.509 GENERAL PERMIT RESTRICTIONS (1) Unless otherwise ~~specified~~ provided for in statute or in these rules, ~~a special~~ permits ~~is~~ issued under 61-10-121 through 61-10-125, MCA, are subject to the following ~~conditions:~~ requirements.

~~(a) Vehicles or vehicles with a load 9 feet wide, (9 feet 6 inches wide baled hay), or 110 feet long without overhang, or 75 feet long with overhang, or 14 feet 6 inches high may travel continuously.~~

~~(b) Vehicles or vehicles with a load 10 feet wide, or 100 feet long without overhang, or 80 feet long with overhang, or 14 feet 6 inches high may travel continuously on interstate highways only and within a 5 mile radius of an interstate interchange.~~

~~(c) Vehicles or loads which do not exceed the dimensions and requirements of (1)(a) and (b) may travel on holidays and holiday weekends.~~

~~(d) Travel is not allowed from 3 p.m. Friday to sunrise on Saturday and from 12 noon on Sunday to sunrise on Monday for vehicles or loads exceeding 9 feet, (9 feet 6 inches baled hay) in width, or 110 feet in length without overhang, or 75 feet in length with overhang, or 14 feet 6 inches in height on highways indicated on M.C.S. Form 32 permit or "red route restrictions" map, which is available from the Motor Carrier Services Division, Box 4639, Helena, MT 59604, (406) 444 6130, voice, or (406) 444 7696, TDD.~~

~~(e) Vehicles or vehicle combinations with a non built up load to and including 18 feet wide, or 120 feet long, or 18 feet high may travel during daylight hours, 7 days a week, excluding holidays and holiday weekends, on all highways except those indicated on "red route restrictions" map.~~

~~(f) Vehicles or vehicle combinations with a non built up load exceeding 18 feet wide, or 120 feet long, or 18 feet high may travel during daylight hours, Monday through Friday. No travel is allowed Saturday, Sunday, holidays, or holiday weekends. No travel after 3 p.m. on Friday until sunrise on Monday on routes indicated on "red route restrictions" map.~~

~~(g) The holidays are New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day, and Friday preceding any above named holiday when the holiday is on Saturday, and Monday following any above named holiday, when holiday is on Sunday.~~

(2) and (3) remain the same.

(4) The original term permit must be carried in the assigned vehicle. The motor carrier services division adminis-

trator may, under certain circumstances, grant verbal authorization for movement under a single trip ~~overdimensional and/or overweight~~ special permit.

(5) Resident implement dealers may purchase a term special permit for width, length and height determined by the department.

~~(5)~~(6) Extreme caution in the operation of a motor vehicle shall be exercised when hazardous conditions such as those caused by snow, ice, sleet, fog, mist, rain, dust or smoke adversely affect visibility or traction. Speed shall be reduced when such conditions exist. The driver of any vehicle equipped with vehicular hazard warning lights may activate such lights whenever necessary to warn the operators of following vehicles of the presence of a traffic hazard ahead of the signaling vehicle, or to warn the operators of other vehicles that the signaling vehicle may itself constitute a traffic hazard. When conditions become sufficiently dangerous, the company or the operator shall discontinue operations, and operations shall not be resumed until the vehicle can be safely operated. No travel is allowed when a route has been placed under emergency travel conditions as determined by the department of transportation. The department of transportation road report is available between November 1 and May 1, 24 hours a day by calling (800) 332-6171 and on the department of transportation internet site at www.mdt.state.mt.us.

(6) remains the same, but is renumbered (7).

~~(7)~~(8) Convoys ~~of more than one load~~ will not be allowed unless otherwise specified ~~by other regulations~~ in these rules.

(8) and (9) remain the same, but are renumbered (9) and (10).

~~(10)~~(11) Vehicles ~~and/or vehicles with loads with dimensions exceeding 10 feet wide, or 95 feet long, or 14 feet 6 inches in height~~ operating under special permit are restricted to the posted speed limit unless a lower speed is required as a condition of the permit. ~~A vehicle towing a house trailer is restricted to 50 m.p.h. as provided in 61-8-312(4), MCA.~~

~~(11)~~(12) Unless otherwise specified in statute or in these rules, the following travel restrictions apply to vehicles operating under special permits:

(a) Continuous travel is allowed for vehicles or vehicle combinations with load to and including 10 feet wide, or 110 feet long, or 14 feet, 6 inches high;

(b) Vehicles traveling at night must be equipped with lights the full width and length of the vehicle and load which are visible for not less than 500 feet under normal atmospheric conditions at night;

(c) Travel is allowed during daylight hours, 7 days a week for the following vehicles and vehicle combinations:

(i) A single vehicle exceeding 55 feet in length;

(ii) Vehicles or vehicle combinations with load over 10 feet wide to and including 18 feet wide, over 110 feet long to and including 120 feet long, or over 14 feet, 6 inches high to and including 18 feet high;

(iii) No travel on holidays, holiday weekends and "red

routes" from 3 p.m. Friday until sunrise Saturday and from 12 noon Sunday until sunrise Monday;

(d) Travel is allowed during daylight hours, 5 days a week for the following vehicles and vehicle combinations:

(i) Vehicles or vehicle combinations with load exceeding 18 feet wide, or 120 feet long, or 18 feet high;

(ii) No travel on Saturday, Sunday, holidays and holiday weekends, and "red routes" from 3 p.m. Friday until sunrise Monday.

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

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary for the following reasons. Section (4) is amended for uniformity. Special permit refers to either or both overdimensional or overweight and is defined in ARM 18.8.101. Section (5) combines ARM 18.8.513 and 18.8.514 for ease of reference. Section (6) has added the Department's internet address. Sections (8), (11) and (12) are reworded for clarification and reorganized by topic. Section (11) eliminates language regarding speed limits for house trailers. The 56th Montana Legislature enacted legislation which repealed the speed limit for vehicles towing mobile homes. Sections (12)(a) through (c) have been reworded for clarification. Sections (12)(a) and (b) have been amended to provide uniformity with other western states and make it easier for motor carriers to schedule interstate movement of overdimensional loads, while assuring safety of the traveling public. Definitions of holidays and red route restrictions have been moved to ARM 18.8.101.

18.8.509A EMERGENCY ~~MOVES~~ TRAVEL AND EMERGENCY VEHICLES

(1) through (5) remain the same.

(6) The motor carrier services division administrator may exempt the following vehicles from restricted hours of operation in an emergency situation:

(a) government vehicles; and

(b) private sector vehicles providing the same services as government vehicles.

(7) Emergency vehicles traveling at night must be equipped with lights the full width and length of the vehicle and load which are visible for not less than 500 feet under normal atmospheric conditions at night.

AUTH: 61-10-129 and 61-10-155, MCA
IMP: 61-10-121, 61-10-122 and 61-10-124, MCA

REASON: The proposed amendments are reasonably necessary for the following reasons. The catchphrase was amended to include vehicles operating in emergency situations. The amendment assures that the safety of the traveling public is augmented if emergency response vehicles can respond in a timely manner to an emergency situation. These amendments also allow government

agencies to utilize all available equipment to respond to snowstorm events, floods, and other natural or man caused disasters.

18.8.511A WHEN FLAG VEHICLES ARE REQUIRED ~~(1) Flag vehicles are required at the rear of a vehicle on interstate highways if the load or the vehicle exceeds 16.5 feet in width.~~

~~(2) A flag vehicle is required at the front on all highways except interstate highways when the load or the vehicle exceeds 12.5 feet in width.~~

~~(3) Vehicles or loads exceeding 14 feet wide, but not exceeding 16.5 feet wide are not required to have a rear flag vehicle provided they are equipped with "oversize load" signs and flashing lights on both the front and the rear.~~

~~(4) Flag vehicles are required at the front and at the rear on all highways except interstate highways when the load or the vehicle exceeds 16.5 feet in width.~~ (1) Flag vehicles are required for vehicles operating under special permit if one or more of the following conditions apply:

(a) When traveling on interstate highways:

(i) Width over 16.5 feet, one rear flag vehicle;

(ii) Length over 120 feet, one rear flag vehicle;

(b) When traveling on non-interstate highways:

(i) Width over 12.5 feet, to and including 16.5 feet, one front flag vehicle;

(ii) Width over 16.5 feet, one front and one rear flag vehicle;

(iii) Length over 110 feet, one rear flag vehicle.

~~(5)~~(2) ~~A vehicle or load over 10 feet wide must be preceded and followed by a flag vehicle front and rear when it is not equipped with flashing amber lights and "oversize load" signs.~~ A vehicle or load not equipped as required in ARM 18.8.510B must use one front and one rear flag vehicle for all travel.

~~(6) A flag vehicle is required at the rear when the vehicle or load exceeds 105 feet in length on primary or secondary highways.~~

~~(7) A flag vehicle is required at the rear when a vehicle or load exceeds 120 feet in length on the interstate highway.~~

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-124, MCA

REASON: The proposed amendments are reasonably necessary to reword ARM 18.8.511A for clarification.

18.8.511B CONVOY MOVES OF OVERSIZE VEHICLES (1) ~~Overdimensional and overweight vehicles which require flag escorts may be moved in a convoy under the following restrictions:~~ Vehicles operating under special permit conditions which require the use of flag vehicles may be moved in a convoy under the following conditions:

(a) ~~Overwidth vehicles may not exceed 16.5 feet wide.~~ Maximum width is 16.5 feet;

(b) ~~Convoys may not exceed 5 overdimensional or overweight vehicles.~~ Maximum vehicle length is 120 feet;

(c) ~~Total length of any vehicle or combination of vehicles may not exceed 120 feet.~~ A convoy may not exceed five vehicles or vehicle combinations operating under special permit;

(d) There shall be a minimum of 500 feet and a maximum of 1000 feet between all vehicles in a convoy~~.~~;

(e) One properly equipped ~~escort~~ flag vehicle is required at the front and rear of the convoy. In addition to the equipment required in ARM 18.8.510A, each escort vehicle shall be equipped with a sign stating "Oversize Load Convoy~~.~~;"

(f) Loads operating under ARM 18.8.602 conditions ~~will be~~ are required to have a properly equipped flag person as specified in ARM 18.8.602 in each escort vehicle.

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary to reorganize and reword ARM 18.8.511B for clarification and ease of use. In section (e) escort is replaced by flag (vehicle) as defined in 61-1-412, MCA. Section (f), references the rule which specifies the equipment required of a flag person.

18.8.512 HEIGHT

(1) through (3) remain the same.

(4) All loads with a height of 14 feet, 6 inches or less may be issued either a term or single trip ~~overdimensional~~ special permit.

(5) Non-reducible loads with a height in excess of 14 feet, 6 inches will be issued single trip ~~overdimensional~~ special permits.

(6) A term or single trip ~~overdimensional~~ special permit may be issued for height of 15 feet for ~~round hay bales only~~ baled or loose hay.

AUTH: 61-10-155, MCA
IMP: 61-10-121 and 61-10-124, MCA

REASON: The proposed amendments are reasonably necessary for the following reasons. Sections (4) and (5) are amended to change the reference to special permit as defined in ARM 18.8.101. Section (6) is amended to assure uniformity and to change the reference to special permit as defined in ARM 18.8.101.

18.8.513 WIDTH (1) A single trip or term permit may be issued for reducible loads to and including 9 feet in width, (9 feet, 6 inches baled hay or hay racks), if they are hauled by vehicles that do not exceed 9 feet in total width.

~~(2) Permits for reducible and non reducible loads up to and including 9 feet wide may be issued for travel at night, Saturdays, Sundays, and holidays, provided lights are displayed the full width of the vehicle and load.~~

~~(3) Resident implement dealers may purchase a term~~

~~overdimensional permit for widths determined by the department.~~

~~(4) Single trip or term permits for non reducible loads to and including 10 feet wide may be issued for travel on interstate highways only and within a five mile radius of an interstate interchange at night, Saturdays, Sundays, and holidays, provided lights are displayed the full width and length of the vehicle and/or load.~~

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-124, MCA

REASON: The proposed amendment is reasonably necessary to section (1) to include language from 61-10-102(2)(c), MCA. Sections (2) through (4) have been moved to ARM 18.8.509.

18.8.518 SPECIAL VEHICLE COMBINATION DRIVER CERTIFICATION

(1) and (2) remain the same.

(3) The operating company will provide the driver with a certification card, which the driver shall carry at all times when operating a special vehicle combination. The certification card shall be issued at the completion of the annual certification. The certification card shall be valid from January 1 through December 31 of each year. This certification card shall be available for display by the driver when requested by any employee of the department of transportation or the Montana highway patrol.

AUTH: 61-10-155, MCA
IMP: 61-10-124, MCA

REASON: The proposed amendment is reasonably necessary because it corrects a clerical error.

18.8.519 WRECKERS AND/OR TOW VEHICLE REQUIREMENTS

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

(c) ~~Any wrecker or tow vehicle and a vehicle combination exceeding 80,000 pounds must have a restricted route load permit prior to travel on a Montana highway.~~ Double and triple saddle mount configurations may be towed from the emergency scene to its place of business or operator's yard if it is within 100 miles of the emergency scene. If a move exceeds 100 miles, the disabled vehicles may be removed from the emergency scene to the first place where the saddle mount configuration can be safely reduced to a single unit.

(d) remains the same.

(e) Permit ~~restrictions regarding hours of operation shall not apply in emergency move situations. All flag car and signing requirements shall apply.~~ requirements for tow vehicles operating under emergency conditions:

(i) If a tow vehicle or the vehicle being towed exceeds statutory limits, special permits are required and must be carried in the tow vehicle when responding to an emergency. An emergency response does not exempt the tow truck operator from special permit requirements.

(ii) A special permit is valid for both the towing vehicle and the disabled vehicle and load.

(iii) Special permits for overweight are valid for both divisible and non-divisible loads.

(iv) An emergency response exempts the tow truck operation from restricted hours of operation within 100 miles of the emergency scene.

(v) All flag vehicles, lights, and signing regulations apply to wreckers and/or tow vehicles responding to an emergency.

~~(f) Permits are required when a tow vehicle exceeds statutory weight requirements. Permits are also required if the tow vehicle is legal but statutory weights are exceeded on the vehicle being towed. Overweight permits shall be valid for all kinds of loads including built up loads. Only one permit is required for both the tow vehicle and the vehicle plus any load being towed. All permits must be obtained and carried in the tow vehicle prior to operating in excess of statutory limits. The fact that the wrecker or tow vehicle is responding to an emergency does not exempt the wrecker or tow vehicle from oversize and/or overweight permit requirements.~~

AUTH: 61-10-155, MCA
IMP: 61-10-121, 61-10-122, 61-10-124 and 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary because they provide uniform application of regulations for all types of combinations which may be transported by a wrecker or tow vehicle, and reorganize the rules for clarification.

18.8.601 OVERWEIGHT SINGLE TRIP PERMITS (1) The department of transportation hereby adopts and incorporates by reference ~~the Weight Analysis Manual, which sets forth the weights and conditions for movements of various equipment~~ weight tables established by the bridge bureau of the department of transportation for use in determining the conditions for the movement of overweight vehicles or loads. ~~A copy of the weight analysis manual published by the bridge bureau of the department of transportation is on file in~~ Information pertaining to weight tables and special permits for overweight vehicles and loads is available at the Motor Carrier Services Division, 2701 Prospect Avenue, Helena, Montana 59620~~.~~, or by phone at (406) 444-6130.

(2) Unless otherwise specified through route analysis by the bridge bureau of the department of transportation, ~~T~~the maximum axle loads and the minimum axle spacing for which overweight permits may be issued for non-built-up loads shall conform to the requirements of the ~~Weight Analysis Manual~~ weight tables as referenced in (1).

(3) through (5) remain the same.

(6) ~~Overweight permits issued without speed restrictions imposed upon vehicles when crossing bridges with maximum dimensions of 80 feet in length, or 9 feet in width, or 14 feet, 6 inches in height, shall~~ Special permits for weights which do not impose speed restrictions and for dimensions not exceeding

the maximum dimensions allowed in ARM 18.8.509(11)(a) through (c) may be issued for continuous travel.

(7) Permits do not allow travel on any state highway where seasonal load limits are in effect without authorization of the district ~~engineer~~ administrator or his designated representative in the district or area where travel takes place.

(8) The fee will be computed on the total miles traveled ~~which shall include all city streets, county roads, and all primary, secondary, and interstate highways~~ on all public roads.

(9) remains the same.

AUTH: 61-10-155, MCA
IMP: 61-10-121, 61-10-124 and 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary for the following reasons. Sections (1) and (2) have been amended to provide a better definition of the weight reference material used when issuing a special permit for weight. Sections (6) through (8) have been amended for clarification and uniformity with other rules contained in this chapter. The language in section (7) reflects the change in title for agency management personnel.

18.8.602 CONDITIONS IMPOSED FOR MAXIMUM WEIGHT (1) The department may restrict speed and impose additional requirements as a condition of the special permit in cases of extreme overweight.

(2) On interstate highways, unless specifically noted on the ~~overweight~~ special permit, loads may maintain a maximum speed of 55 mph ~~unless otherwise posted for a lower speed~~ or the posted speed limit, whichever is less. The vehicle may remain in its own traffic lane and normal traffic will be allowed to pass. Only one overweight vehicle is allowed on a structure at a time.

(3) On non-interstate ~~primary and secondary~~ highways, when speed restrictions over structures are imposed, two flag vehicles or one flag vehicle and one flag person, equipped with high visibility clothing and hand-signaling devices, are required ~~when speed restrictions over structures are imposed~~. For purposes of this subsection, high visibility clothing shall be a flagger's vest, shirt, or jacket, orange, yellow, strong yellow green or fluorescent versions of these colors. Hand signaling devices shall be a stop/slow paddle 18 inches wide and octagonal in shape, with letters at least 6 inches high. The background of the stop face shall be red with white letters and border.

(4) and (5) remain the same.

(6) For purposes of this rule, ~~T~~the word "structure" shall mean any bridge, overpass, etc.

AUTH: 61-10-155, MCA
IMP: 61-10-121, 61-10-124 and 61-10-125, MCA

REASON: The proposed amendments are reasonably necessary for

clarification and to provide uniformity with other rules contained in this chapter.

18.8.801 INSURANCE (1) A minimum of ~~$100,000/300,000~~ $1 million public liability and a minimum of $50,000 property damage insurance is required before a special ~~size, weight, or restricted route load or special vehicle combination~~ permit may be issued. The permit must show the name of the insurance company.

AUTH: 61-10-155, MCA
IMP: 61-10-121 through 61-10-125, MCA

REASON: The proposed amendment increasing the minimum liability insurance requirements is reasonably necessary for the following two reasons. First, the mere necessity for a special permit invariably is due to the unusual characteristics of the permitted vehicle due to size, weight or width. This creates an inherent risk to public property as well as vehicles. Second, the dollar amounts presently in place do not realistically represent financial risks in 2000 and were adopted in 1988, now 12 years old. Additionally, this increase parallels the current recommended amount of insurance for state contracts as recommended by the Department of Administration.

4. ARM 18.8.418, which can be found on page 18-282 of the Administrative Rules of Montana, is proposed to be repealed because its content is contained in ARM 18.8.414 and 18.8.415.

AUTH: 61-10-155, MCA
IMP: 61-10-209 and 61-10-223, MCA

ARM 18.8.501, which can be found on page 18-401 of the Administrative Rules of Montana, is proposed to be repealed because the definition has been moved to ARM 18.8.101.

AUTH: 61-10-155, MCA
IMP: 61-10-121, 61-10-122, 61-10-124, 61-10-125 and 61-10-127, MCA

ARM 18.8.502, which can be found on page 18-401 of the Administrative Rules of Montana, is proposed to be repealed because the provisions have been moved to ARM 18.8.504.

AUTH: 61-10-155, MCA
IMP: 61-10-121 and 61-10-124, MCA

ARM 18.8.514, which can be found on page 18-414 of the Administrative Rules of Montana, is proposed to be repealed because its content is contained in ARM 18.8.509.

AUTH: 61-10-155, MCA
IMP: 61-10-104, 61-10-121 through 61-10-148, MCA

ARM 18.8.515, which can be found on page 18-414 of the Administrative Rules of Montana, is proposed to be repealed because its content is contained in ARM 18.8.509.

AUTH: 61-10-155, MCA
IMP: 61-10-121 and 61-10-122, MCA

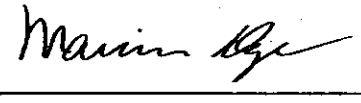
5. Concerned persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to Carolyn Knuckles, Motor Carrier Services Division, Department of Transportation, P.O. Box 4639, Helena, MT 59604, and must be received no later than March 22, 2000.

6. Nick A. Rotering has been designated to preside over and conduct the hearing.

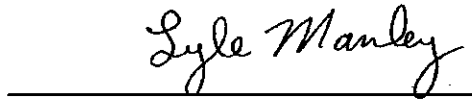
7. The Department of Transportation maintains a list of interested persons who wish to receive notices of the rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies the subject area or areas of interest of the person requesting notice, including, but not limited to, rules proposed by the Administration Division, Aeronautics Division, Highways and Engineering Division, Maintenance Division, Motor Carrier Services Division, and Rail, Transit and Planning Division. Such written request may be mailed or delivered to the Montana Department of Transportation, Legal Services, P.O. Box 201001, Helena, MT 59620-1001, faxed to the office at (406)444-7206, or may be made by completing a request form at any rules hearing held by the Department.

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

MONTANA DEPARTMENT OF TRANSPORTATION

By: 

MARVIN DYE, Director



Lyle Manley, Rule Reviewer

Certified to the Secretary of State January 28, 2000.

BEFORE THE BOARD OF MILK CONTROL
OF THE STATE OF MONTANA

In the matter of amendments of ARM 32.24.301 regarding the pricing of producer milk; and the repeal of ARM 32.24.521 and 32.24.522 and amendment of ARM 32.24.523 in regards to utilization, procedures to purchase and marketing of surplus milk	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENTS AND REPEAL DOCKET NO. 1-00

TO: All Concerned Persons

1. On March 6, 2000, at 9:00 a.m., a public hearing will be held in the Scott Hart Auditorium, 302 N. Roberts St., Helena, MT 59620, to consider amendments of ARM 32.24.301, the repeal of ARM 32.24.521 and 32.24.522, and amendment of ARM 32.24.523. If necessary, the hearing will continue through March 7, 2000.

2. The board of milk control 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 milk control bureau no later than 5:00 p.m. on March 2, 2000, to advise us of the nature of the accommodation that you need. Please contact Marlys Mattfeldt, Milk Control Bureau, 301 N. Roberts St. - Rm. 236, PO Box 202001, Helena, MT 59620-2001; phone: (406)444-2875; TTD number: 1-800-253-4091; fax:(406)444-1432.

3. This proposed action is in response to three petitions for rulemaking, and one action on the board's own motion. Four alternative amendments to the rule and rule repeals are proposed. The four alternatives represent the proposed approach of the Montana Dairy Association (MDA) (ALTERNATIVE I), Meadow Gold Dairies, Inc. (ALTERNATIVE II), Montana Dairy Association (MDA) (ALTERNATIVE III), and the Board of Milk Control (ALTERNATIVE IV). Paragraphs 5, 6, 7, and 8 of this notice contain rationale statements for each proposed alternative. The rationale statements have been prepared by the proponents of the alternatives. After hearing public comment on the alternatives, the board will decide which, if any, of the proposed alternatives to adopt.

4. The proposed alternative amendments and repeals provide as follows, stricken matter interlined, new matter underlined:

ALTERNATIVE I

32.24.301 PRICING RULES

(1) through (2) remain the same.

(3) Formula for fixing the class I price at the producer level.

(a) The minimum class I price per hundredweight at 3.5% butterfat which shall be paid to producers by distributors in the state of Montana, shall be the ~~"basic formula price" as that price is determined pursuant to 7 CFR 1124.51 plus $2.55.~~ monthly federal order price as calculated and published according to 7 CFR part 1000.50(a) through (c) plus a Montana class I location differential of $2.55. If the resulting computation is below $15 per hundredweight, the location differential of $4.30 will be utilized and compared to a $15 after-effect. The lower of the 2 numbers will become the minimum monthly announced Montana class I price.

~~(b) The class I butterfat differential will be calculated by multiplying the most recent Chicago area grade AA butter price as reported by the United States department of agriculture, less an adjustment factor of $.0895, by a factor of .118 and the resulting answer from this calculation shall be rounded to nearest half cent.~~ When milk does not test 3.5 % ~~percent~~ butterfat, the price per CWT will be adjusted for each .1 % ~~percent~~ the butterfat test moves up or down. ~~The derivation of the adjustment factor shall be an average of the difference between the Chicago area grade AA and grade A butter prices over a two-year period ending April 30, 1998.~~

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

AUTH: 81-23-302, MCA
IMP: 81-23-302, MCA

ALTERNATIVE II

ARM 32.24.521 REQUIRED UTILIZATION OF SURPLUS MILK, located at page ARM 32-881, is proposed to be repealed.

AUTH: 81-23-302, MCA
IMP: 81-23-302, MCA

ARM 32.24.522 PROCEDURES, PURCHASE PRICE AND TERMS, located at page ARM 32-882, is proposed to be repealed.

AUTH: 81-23-302,MCA
IMP: 81-23-302, MCA

ARM 32.24.523 MARKETING OF SURPLUS MILK TO NON-POOL HANDLERS (1) All surplus milk not directed to other pool handlers for use in class I and II ~~as required by this subchapter~~ shall be marketed and sold in an economically advantageous manner and any gain or loss shall be exclusively shared by all Montana pool dairymen.

(2) through (5) remain the same.

AUTH: 81-23-302, MCA
IMP: 81-23-302, MCA

ALTERNATIVE III

32.24.301 PRICING RULES

(1) through (2) remain the same.

(3) Formula for fixing the class I price at the producer level.

(a) The minimum class I price per hundredweight at 3.5% butterfat which shall be paid to producers by distributors in the state of Montana, shall be the ~~"basic formula price" as that price is determined pursuant to 7 CFR 1124.51 plus $2.55.~~ monthly federal order price as calculated and published according to 7 CFR part 1000.50(a) through (c) plus a Montana class I location differential of $3.15. If the resulting computation is below $15 per hundredweight, the location differential of $4.30 will be utilized and compared to a $15 after-effect. The lower of the 2 numbers will become the minimum monthly announced Montana class I price.

~~(b) The class I butterfat differential will be calculated by multiplying the most recent Chicago area grade AA butter price as reported by the United States department of agriculture, less an adjustment factor of $.0895, by a factor of .118 and the resulting answer from this calculation shall be rounded to nearest half cent.~~ When milk does not test 3.5 % ~~percent~~ butterfat, the price per CWT will be adjusted for each .1 % ~~percent~~ the butterfat test moves up or down. ~~The derivation of the adjustment factor shall be an average of the difference between the Chicago area grade AA and grade A butter prices over a two year period ending April 30, 1998.~~

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

AUTH: 81-23-302, MCA
IMP: 81-23-302, MCA

ALTERNATIVE IV

32.24.301 PRICING RULES

~~(1) Authority, scope and severability.~~

(a) through (c) remain the same but will be renumbered (1) through (3).

~~(2)~~ (4) ~~Maximum prices.~~ Nothing contained herein shall be construed as prohibiting the payment of higher prices to producers ~~or charging of lower hauling rates from plant to plant as fixed in this rule or in price announcements issued hereunder~~.

~~(3) Formula for fixing the class I price at the producer level.~~

~~(a)~~ (5) The minimum class I price per hundredweight at 3.5% butterfat which shall be paid to producers by distributors in the state of Montana shall be the ~~"basic formula price" as that price is determined pursuant to 7 CFR~~

~~1124.51 plus $2.55.~~ monthly federal order price as calculated and published according to 7 CFR part 1000.50(a) through (c) plus a Montana class I location differential of $2.55.

~~(b)~~(a) ~~The class I butterfat differential will be calculated by multiplying the most recent Chicago area grade AA butter price as reported by the United States department of agriculture, less an adjustment factor of $.0895, by a factor of .118 and the resulting answer from this calculation shall be rounded to nearest half cent.~~ When milk does not test 3.5 % ~~percent~~ butterfat, the price per CWT will be adjusted for each .1 % ~~percent~~ the butterfat test moves up or down. ~~The derivation of the adjustment factor shall be an average of the difference between the Chicago area grade AA and grade A butter prices over a two-year period ending April 30, 1998.~~

(b) The milk control bureau will use the federal order fat and skim prices to calculate the producer prices. Federal order fat and skim prices shall be announced on the Friday previous to the 23rd of each month unless the 23rd falls on a Friday. Montana's producer prices will be announced on or about the 5th of the subsequent month (depending upon weekends and holidays) and will be effective for the next following month.

~~(4) Formula for fixing the class II price to be paid to producers.~~

~~(a)~~(6) Prices paid producers for class II milk will be the last spray process nonfat dry milk solids price per pound quote for the month, Central States area, as most recently reported by the United States department of agriculture, plus a factor of $.0125 per pound for freight, multiplied by 8.2 (which is the amount of solids not fat in skim milk), plus the last Chicago area grade AA butter price quote for the month as most recently reported by the United States department of agriculture, less an adjustment factor of $.0895, ~~as calculated in (3)(b),~~ multiplied by 4.2 (which is the amount of butter in pounds, which can be produced from 100 pounds of 3.5% milk), less a make allowance of 8.5%. In the case of milk containing more or less than 3.5% butterfat, the differential to be employed in computing prices will be determined by multiplying the above-mentioned Chicago area butter price by .111 and the resulting answer from this calculation shall be rounded to nearest half cent ($0.005).

~~(b) Price paid to producers for class II milk will be computed and announced monthly in accordance with the above formula and the price calculated during the current month will be the price paid during the succeeding month.~~

~~(5) Formula for fixing the class III price to be paid to producers.~~

~~(a)~~(7) Prices paid to producers for class III milk will be the last Chicago area grade AA butter price quote for the month as most recently reported by the United States department of agriculture, less ~~and~~ adjustment factor of $.0895, ~~as calculated in (3)(b),~~ less 10% and, in addition, when skim milk is utilized in this classification by any distributor, the last spray process nonfat milk solids price

per pound quote for the month, the Central States area, as most recently reported by the United States department of agriculture, plus a factor of $.0125 per pound for freight, multiplied by 8.2, less 17%.

~~(b)~~ (8) Producers who ship in excess of any beneficial use, and that milk is shipped to a different market and classified by statute and rule as class III, shall receive a ~~reduced~~ price for that milk based on calculations in ~~(a) less the calculations as described below. The total cost to a plant for surplus milk that is shipped to a cheese or powder plant is determined by the following formula~~ ARM 32.24.522.

~~(i) First compare the price paid to the price received for the milk. If the price paid exceeds the price received, add the difference to the cost at $.95 per running mile for hauling, or if the price paid is less than the price received, subtract the difference from the hauling cost.~~

~~(ii) In situations where there is a cost to the plant in disposing of the surplus milk, the volume of milk involved and the net cost of disposing of all surplus milk shall be tabulated on a per plant basis. The above individual plant volumes and costs shall be totaled for all plants.~~

~~(iii) The average cost per hundredweight of surplus milk shall be determined by dividing the total cost by the total volume in hundredweight.~~

~~(iv) Individual plant costs for surplus milk shall be divided by the total surplus milk cost to determine their percentage of the total surplus milk cost.~~

~~(v) The volume of excess milk over quota in CWT's will be multiplied times the average cost per CWT to determine the total cost allocated to excess milk over quota.~~

~~(vi) The allowable cost assignable to excess milk is then allocated back to each individual plant based on the percentage above that each plant's cost is of the total.~~

~~(c) Price paid to producers for class III milk will be computed and announced monthly in accordance with the above formula and the price calculated during the current month will be the price paid during the succeeding month.~~

~~(6) Freight allowances and handling charges for bulk milk involved in inter plant transfers.~~

~~(a) The following maximum freight allowances may be charged producers of a licensed distributor or dealer, whose plant is located within Montana, on transfers of bulk milk, a major portion of which is used class I, between distributors situated more than 25 road miles apart, regardless of the state where the receiving plant:~~

~~DISTANCE~~	~~MAXIMUM FREIGHT ALLOWANCE~~
~~25 to 50 miles~~	~~$ .25~~
~~51 to 75 miles~~	~~.40~~
~~76 to 100 miles~~	~~.50~~
~~101 to 150 miles~~	~~.64~~
~~151 to 200 miles~~	~~.85~~
~~201 to 250 miles~~	~~1.06~~
~~251 to 300 miles~~	~~1.28~~

~~301 to 350 miles 1.49~~

~~(b) Nothing contained herein shall be construed as prohibiting the charging of lower freight allowances to producers of bulk milk involved in interplant transfers or the refusal to charge any allowance at all.~~

~~(c) Freight allowances herein permitted shall not be permitted on interplant transfers of bulk milk where the plants involved are situated less than 25 road miles apart, regardless of the route selected by the involved distributors for transporting such milk.~~

~~(d) The exporting or transmitting distributor of bulk milk involved in interplant transfers must charge no less for said milk than the same price per hundredweight paid local producers historically supplying the importing or receiving distributor during the same pay period.~~

~~(e) Producers must be paid for their bulk milk transferred between plants by the exporting or transmitting distributor in accordance with the current price announcement at the prices therein specified or fixed pursuant to statutory formula for the class or use in which it is ultimately used or sold. A freight allowance which is no more than that fixed in (6)(a) of this rule may be deducted from such payments by the distributor paying the freight charges.~~

~~(f) The importing or receiving distributor of bulk milk involved in interplant transfers must pay no less for said milk than the same price per hundredweight paid local producers historically supplying said importing distributor during the same pay period.~~

(9) The total cost to a plant for surplus milk that is shipped to a cheese or powder plant is determined by ARM 32.24.523.

~~(7)~~(10) ~~Supervening federal or state law.~~ No price established by any formula set forth in this rule shall be charged if the same be contrary to any supervening federal or state law, rule or regulation. Should any minimum prices published by this board under this rule exceed the limitations imposed by such laws, rules or regulations, such prices shall be reduced to the extent of such excess, even though such reduction may impair a uniform or complete application of the price fixing formula, or any of the same, set out in this rule. The prices, as so modified, shall be respected and enforced as the minimum prices established under this rule.

~~(8) Monthly price announcements.~~

~~(a)~~(11) Monthly price announcements for class I, II and III producer milk pricing will be ~~issued pursuant to (3) of this rule.~~ computed by the milk control bureau in accordance with this pricing rule and published by the 10th of each month. The minimum ~~P~~producer prices will be uniform and identical throughout the state of Montana.

~~(b) In the event that recalculation of the formula indices does not indicate a change in producer price, that circumstance also will be announced.~~

AUTH: 81-23-302, MCA

IMP: 81-23-302, MCA

5. The Montana Dairy Association (MDA) has prepared the following statements of reasonable necessity for ALTERNATIVE I:

a. That ARM 32.24.301 is a pricing rule which is no longer appropriate because of economic conditions.

b. That the milk industry is effectively governed by the benchmark price established at the federal level.

c. That the basic formula price (BFP) is the lowest in over 20 years.

d. That the producer level of the Montana milk industry faces collapse if change is not made.

6. Meadow Gold Dairies, Inc. has prepared the following statement of reasonable necessity for ALTERNATIVE II.

a. This is a "protective petition." It is only to be considered and to take effect in the event the board of milk control should act favorably on ALTERNATIVE I, and/or ALTERNATIVE III. ARM 32.24.521 and 32.24.522, which can be found on pages 32-881 through 32-883, are proposed to be repealed; and ARM 32.24.524 is propsed to be amended as ALTERNATIVE II because:

b. If a floor should be imposed as in ALTERNATIVE I, or if a floor and a general price increase should be imposed as in ALTERNATIVE III, with the effect of increasing the cost of Montana milk, then petitioner will be placed at a competitive disadvantage by virtue of being forced to purchase milk that is not competitively priced.

c. Any rule which purports to require a lawful business to purchase milk at a higher price from a domestic supplier to the exclusion of purchasing it at a lower price from a non-domestic supplier is unlawful on its face. Such a rule violates both the Montana and United States Constitutions and specifically, the equal protection, due process and interstate commerce clauses.

d. By the terms of a settlement agreement in 1996, all parties acknowledged and agreed that the principle mutual consideration flowing between the parties were: the pool handlers would receive a $.60 per CWT reduction in class I producer prices; the pool handlers would receive first call on the surplus milk in Montana at quota price; the pool dairymen would be assured that pool handlers would purchase milk so that the raw milk they purchased would be applied to Montana class I and II usage to the fullest extent possible of Montana class I and II sales; and all pool dairymen would receive the

benefits (and risks) associated with the marketing of surplus milk. It was further acknowledged and agreed that none of the parties to that settlement would have entered into the settlement but for the expectation of all those mutual considerations. It was agreed that should any of those separate mutual considerations fail for any reason including, but not limited to, a declaration of invalidity, a failure to perform by a party, administrative repeal, or impossibility of performance, then it would be acknowledged and agreed that the basis for the settlement and the passing of its implementing rules were no longer extant.

7. The Montana Dairy Association (MDA) has prepared the following statement of reasonable necessity for ALTERNATIVE III.

a. This is a "protective petition." It is only to be considered and to take effect in the event the board of milk control should act favorably on ALTERNATIVE II.

b. The unsaid portion of the Meadow Gold ALTERNATIVE II is that the portion of the rule which they constantly request to be changed, is only a part of the settlement agreement reached in 1966, and if this portion is to be changed or voided, then the remaining portion of the agreement should also be changed or voided. The additional portion which should be changed is the figure or amount of the Montana class I location differential, and which change should reflect the situation prior to said agreement.

c. That ARM 32.24.301 is a pricing rule which is no longer appropriate because of economic conditions.

d. That the milk industry is effectively governed by the benchmark price established at the federal level.

e. That the basic formula price is the lowest in over 20 years.

f. That the producer level of the Montana milk industry faces collapse if change is not made.

g. That a floor should be established for class I milk to be paid to the producers.

h. The harm identified above mandates that the board issue an order for a change in the rule establishing the pricing formula in accordance with Montana law.

8. The Milk Control Bureau has prepared for the Board of Milk Control the following statement of reasonable necessity for ALTERNATIVE IV.

a. Because action was taken as an emergency order on

January 3, 2000, the board is asking to implement a standard rulemaking to undertake an amendment to ARM 32.24.301.

b. That the basic formula price (BFP), an economic flexible formula developed by the federal government and used in Montana to establish the class I milk price at the producer level, is no longer available for pricing Montana producer milk.

c. That an economic formula needs to be in place, with no interruption to maintain a pricing structure to calculate what Montana producers are to be paid on a monthly basis. According to statute 81-23-301(2), MCA, the board shall establish prices by a flexible formula that brings about automatic changes in all minimum prices.

d. That the federal government has established an economic flexible price structure to replace the BFP that could be utilized in setting the class I producer price.

e. That the pricing rule, as it currently exists, has language in it that can not be implemented due to newer promulgation by this board in 1996 of ARM 32.24.520 through 32.24.523, which deal with the pricing and handling of surplus milk.

f. To clarify and/or make more workable the language in the pricing rule as it currently exists regarding producer milk pricing.

9. Concerned persons may present their data, views and arguments, either orally or in writing, at the public hearing. Written data, views or arguments may also be submitted to the Milk Control Bureau, 301 N. Roberts Street - Room 236, PO Box 202001, Helena, MT 59620-2001, and must be received no later than March 9, 2000.

10. Norman C. Peterson, Office of the Attorney General, PO Box 201401, Helena, MT 59620-1401, has been designated to preside over and conduct the hearing.

11. The milk control bureau maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding milk issues. Such written request may be mailed or delivered to the Milk Control Bureau, 301 N. Roberts Street - Room 236, PO Box 202001, Helena, MT 59620-2001, or may be made by completing a request form at any rules hearing held by the board of milk control.

12. The bill sponsor notice requirements of 2-4-302,

MCA, do not apply.

By: Marc Bridges
Marc Bridges, Executive Officer
Board of Livestock
Department of Livestock

By: B. A. Jacobs
Bernard A. Jacobs, Rule Reviewer
Agency Legal Services Bureau

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF LAND COMMISSIONERS
AND THE DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION
OF THE STATE OF MONTANA

IN THE MATTER OF ESTABLISHING A NEGOTIATED RULEMAKING COMMITTEE to negotiate and develop proposed rules relating to cabin and homesite lease rates	)))))	NOTICE OF NEGOTIATED RULEMAKING

TO: All Concerned Persons

1. The department of natural resources and conservation intends to establish a negotiated rulemaking committee to negotiate and develop proposed rules relating to cabin and homesite lease rates.

2. The proposed rules must include a lease rate for cabin and homesites.

3. Interests that are likely to be significantly affected by the proposed rules are: the user group referred to as lessees, who will be assessed increased lease fees; the trust beneficiaries, who will realize increased revenues; and the petitioners known as MonTRUST.

4. The individuals proposed to represent the department on the negotiated rulemaking committee are: Clive Rooney, Bureau Chief; and Jeanne Fairbanks, Supervisor Property Management, Special Use Management Bureau. A facilitator will preside over the meetings. All expenses such as travel and meals incurred by the committee members will be each member's responsibility.

5. The department is seeking applications from interested parties to serve on the committee. The committee will have 12 members:

(a) 1 representative of MonTRUST;
(b) 2 representatives of the department;
(c) 3 representatives of the beneficiaries;
(d) 3 representatives of the lessees;
(e) 2-3 representatives of the Land Board.

6. The proposed working schedule for the negotiated rulemaking committee is as follows:

(a) On February 10, 2000, this notice will be published in the Montana Administrative Register (MAR), and in the five major newspapers in Montana. Applications for membership on the negotiated rulemaking committee must be received no later than March 9, 2000. The notice will also be mailed to persons known to the department to have an interest in this matter.

(b) After receipt and consideration of the comments and applications, the department will establish a negotiated rulemaking committee no later than March 20, 2000. The members selected to serve on the committee must be able to adequately

represent the interest of the persons that will be significantly affected by the proposed rules. The committee members will be notified in writing of their selection. Within 10 days from the notification of selection, the committee members will be sent an information packet.

(c) The negotiated rulemaking committee will convene its first meeting on April 3, 2000 to negotiate and develop proposed rules. The committee must have rules developed and ready to present to the Board of Land Commissioners no later than October 1, 2000. Teleconferencing and e-mail correspondence will be utilized as much as possible because of the short time frame necessary to accomplish the rulemaking action. The April 3, 2000 meeting will convene at 2705 Spurgin Road, Missoula, MT 59803. The committee will define the ground rules of meetings including the ability to come to a consensus and work plan.

(d) If the negotiated rulemaking committee is successful in achieving a consensus on the proposed rules, the committee will transmit to the department a report containing the proposed rules. If a consensus cannot be reached on the proposed rules, the committee will transmit to the department a report specifying the areas in which the committee has reached a consensus and the issues that remain unresolved.

(e) Thereafter, and in accordance with Title 2, chapter 4, part 3, MCA (Adoption and Publication of Rules), the department will file with the secretary of state for publication in the Montana Administrate Register the proposed rules relating to cabin and homesite lease rates.

(f) The department may seek the assistance and advice of the negotiated rulemaking committee with respect to comments received during the formal rulemaking process.

7. Any individual or entity interested in applying for or nominating another person for membership on the committee must submit the following information in writing to DNRC Negotiated Rulemaking Committee, no later than March 9, 2000:

(a) The person's name or the nominees's name, address, and contact information including telephone or fax number or e-mail address.

(b) A description of the interests the person or nominee represents.

(c) Evidence that the person or nominee is authorized to represent parties related to the interests of the persons proposed to be represented.

(d) The relationship of the person or nominee to cabin and homesite lease rates, and the name of the establishment or trade association.

(e) A commitment that the person or nominee will be able to participate in the negotiated rulemaking process as contemplated in paragraph 6 and will actively participate in good faith in the development of the rules under consideration.

(f) The ability of the person or nominee to cover committee participation costs (such as telephone calls, travel and per diem expenses).

8. Concerned persons may submit their data, views or arguments concerning the proposed negotiated rulemaking process in writing to DNRC Negotiated Rulemaking Committee, 2705 Spurgin Road, Missoula, MT 59803. Any comments must be received no later than March 9, 2000.

9. Initially, the department proposed to limit the size of the negotiated rulemaking committee to no more than 12 persons. However, after receipt of comments and applications, the department may determine that a smaller or larger number is significantly affected by the proposed rules. The selected committee members will represent all identified interests affected by cabin and homesite lease rates and state and local officials. The selected committee members may represent other parties or agencies that have a significant relationship with cabin and homesite lease rates.

10. The department will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m. on February 18, 2000, to advise us of the nature of the accommodation that you need when applying for membership on the committee. Please contact Shannon Kirby, Department of Natural Resources and Conservation, P.O. Box 201601, Helena, MT 59620-1601; telephone (406)444-2074; FAX (406)444-2684.

11. Please note the following concerning the process of negotiated rulemaking:

(a) "Interest" for the purpose of this process means multiple parties that have similar points of view or that are likely to be affected in a similar manner in relationship to matters affected by the rule(s) (2-5-103(5), MCA).

(b) Negotiated rulemaking is not a substitute for the public notification and participation requirements of the Montana Administrative Procedure Act, and a consensus agreement by a negotiated rulemaking committee may be modified by an agency as a result of the subsequent rulemaking process (2-5-102, MCA).

(c) The negotiated rulemaking committee may not continue to function and must be disbanded after the adoption of the final rule (2-5-106(4), MCA).

12. The specific grant of rulemaking authority authorizing the proposed rules is found in 77-1-209, MCA. The proposed rules will implement 77-1-208 and 77-1-209, MCA.

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

BOARD OF LAND COMMISSIONERS

By: Marc Racicot
MARC RACICOT
Chair

DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION

By: Arthur R. Clinch
Director

Donald D. MacIntyre
DONALD D. MACINTYRE
Rule Reviewer

Certified to the Secretary of State January 31, 2000

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

In the matter of the adoption of rules I through XI, the amendment and transfer of rules ARM 46.12.1401, 46.12.1403, 46.12.1404, 46.12.1405, 46.12.1407, 46.12.1409, 46.12.1411, 46.12.1413, 46.12.1417, 46.12.1426, 46.12.1429, 46.12.1432, 46.12.1436, 46.12.1439, 46.12.1442, 46.12.1445, 46.12.1448, 46.12.1451, 46.12.1454, 46.12.1457, 46.12.1463, 46.12.1469, 46.12.1475 and 46.12.1481 and the repeal of rules 46.12.1402, 46.12.1406, 46.12.1408, 46.12.1412, 46.12.1415, 46.12.1419, 46.12.1425, 46.12.1427, 46.12.1428, 46.12.1430, 46.12.1431, 46.12.1433, 46.12.1435, 46.12.1437, 46.12.1438, 46.12.1440, 46.12.1441, 46.12.1443, 46.12.1444, 46.12.1446, 46.12.1447, 46.12.1449, 46.12.1450, 46.12.1452, 46.12.1453, 46.12.1455, 46.12.1456, 46.12.1458, 46.12.1462, 46.12.1464, 46.12.1468, 46.12.1470, 46.12.1474, 46.12.1476, 46.12.1480 and 46.12.1482 pertaining to the home and community-based services program	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT AND TRANSFER AND REPEAL

TO: All Interested Persons

1. On March 1, 2000, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption, amendment and transfer and repeal of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on

February 25, 2000, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: REIMBURSEMENT (1) Services available through the program are reimbursed as specified in this rule.

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

(a) environmental accessibility adaptations;
(b) homemaking;
(c) adult day health;
(d) habilitation;
(e) personal emergency response systems;
(f) nutrition;
(g) psycho-social consultation;
(h) nursing;
(i) respiratory therapy;
(j) dietetic services;
(k) specially trained attendant care;
(l) behavioral programming;
(m) chemical dependency counseling;
(n) cognitive rehabilitation;
(o) comprehensive day treatment;
(p) community residential rehabilitation;
(q) supported living;
(r) specialized medical equipment and supplies;
(s) specialized child care for children with AIDS;
(t) adult residential care;
(u) respite care not provided by a nursing facility; and
(v) nonmedical transportation.

(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 as a 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 46.12.557 and 46.12.559A;

(b) outpatient occupational therapy as provided at ARM

46.12.528;

(c) outpatient physical therapy as provided at ARM 46.12.528;

(d) speech therapy as provided at ARM 46.12.528; and

(e) audiology as provided at ARM 46.12.538.

(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 46.12.1221, et seq.

(8) Reimbursement is not available for the provision of a service to a person that may be reimbursed through another program.

(9) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with medicaid monies.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA

[RULE II] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT RESIDENTIAL CARE, REQUIREMENTS (1) Adult residential care is the provision of supportive services to a recipient residing in a licensed 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 46.12.555(1) through (5);

(b) homemaking as specified at ARM 46.12.1426;

(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 ARM 46.12.1429;

(b) homemaking services as specified at ARM 46.12.1426;

(c) environmental accessibility adaptation services as specified at ARM 46.12.1417.

(d) respite care as specified at ARM 46.12.1439;

(e) medical alert personal emergency response system as specified at ARM 46.12.1451; and

(f) nutrition as specified in ARM 46.12.1457.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE III] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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 ARM 46.12.1429; and

(b) personal care services as specified at ARM 46.12.555(1) through (5) and 46.12.559 through 46.12.559E.

(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.

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

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE IV] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: BEHAVIORAL PROGRAMMING, REQUIREMENTS (1) Behavioral programming is the continuous in-depth assessment on a short term basis of a recipient with brain injury.

(2) Behavioral programming services includes assessment, if appropriate, of the abilities and effectiveness of caregivers.

(3) A person providing behavioral programming services, must:

(a) have a bachelor's degree;

(b) be employed by a rehabilitation agency; and

(c) be under the direct supervision of a licensed neurologist, board certified psychiatrist, or board certified physiatrist who has experience in working with persons with brain injury.

(4) This service is limited to 80 hours per plan of care year unless otherwise authorized by the department.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE V] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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.

(3) A person providing chemical dependency counseling services for a recipient with brain injury, must be a state certified chemical dependency counselor who has received training in the needs of persons with brain injury and the provision of brain injury services. The counselor must provide

proof of such training in the form of a training certificate or diploma.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE VI] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COGNITIVE REHABILITATION, REQUIREMENTS (1) Cognitive rehabilitation is the provision of therapeutic cognitive activities to meet the functional needs of a recipient with brain injury.

(2) Cognitive rehabilitation services may include:

(a) the reinforcement, strengthening, or reestablishment of previously learned patterns of behavior;

(b) the establishment of new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems; and

(c) training significant others to assist in meeting the functional needs of the recipient.

(3) A person providing cognitive rehabilitation services, must be:

(a) employed by a rehabilitation agency; and

(b) under the direct supervision of a licensed psychologist, licenced neuropsychologist, board certified neurologist, or board certified physiatrist who has experience in working with persons with brain injury.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE VII] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMPREHENSIVE DAY TREATMENT, REQUIREMENTS (1) Comprehensive day treatment is the provision of therapeutic intervention to a recipient with brain injury on a week day basis in a non-residential setting. Comprehensive day treatment assists in reducing the dependency of the recipient and in facilitating the integration of the recipient into the community.

(2) Comprehensive day treatment services may include:

(a) cognitive rehabilitation as specified at [Rule VI];

(b) behavioral programming as specified at [Rule IV];

(c) chemical dependency counseling as specified at [Rule V];

(d) therapeutic recreational activities;

(e) nutrition services as specified in ARM 46.12.1457;

(f) nonmedical transportation as specified at ARM 46.12.1454; and

(g) counseling.

(3) An entity providing comprehensive day treatment services, must provide services from 8 a.m. to 5 p.m. during the 5 working days of the week.

(4) The provision of comprehensive day treatment services must be provided by a provider under the direction of an interdisciplinary team consisting of a licensed psychologist, a licensed neuropsychologist, a board certified physiatrist,

therapists and other appropriate support staff.

(5) An entity providing comprehensive day treatment services must be accredited or in the process of becoming accredited by the commission on accreditation of rehabilitation facilities (CARF) as a community reentry program for persons with brain injury.

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

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE VIII] HOME AND COMMUNITY-BASED SERVICES TREATMENT FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMMUNITY RESIDENTIAL REHABILITATION, REQUIREMENTS (1) Community residential rehabilitation is the provision of 24 hour care to a recipient in both a comprehensive day treatment setting as specified in [Rule VII] and a supervised residential setting.

(2) An entity providing community residential rehabilitation services, must provide services 24 hours a day for 7 days a week.

(3) An entity providing community residential rehabilitation must meet the requirements of [Rule VII].

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

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE IX] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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. It is a comprehensive service designed to support a person with brain injury or other severe disability.

(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 specifed at ARM 46.12.1426;
(f) day habilitation as specified at ARM 46.12.1436;
(g) habilitation aide as specified at ARM 46.12.1436;
(h) behavioral programming as specified at [Rule IV];
(i) supported employment as specified at ARM 46.12.1436;
(j) prevocational training as specified at ARM 46.12.1436;
(k) nonmedical transportation as specified at ARM 46.12.1454; and
(l) specially trained attendants as specified at [Rule III].

(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 2 years experience in providing services to persons with physical disabilities.

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

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE X] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALIZED CHILD CARE FOR CHILDREN WITH AIDS, REQUIREMENTS (1) Specialized child care for children with AIDS is the provision of day care, respite care, and other direct and supportive care to a recipient under 19 years of age who is HIV positive or has a diagnosis of AIDS and who, due to medical and other needs, cannot be served through traditional child care settings.

(2) A person providing specialized child care for children with AIDS services must be:

(a) physically and mentally able to perform the duties;

(b) aware of emergency assistance systems; and

(c) literate and able to follow written orders.

(3) A person providing specialized child care for children with AIDS services may be required, if appropriate to the circumstances of the recipient, to have:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of the recipient's commonly needed medications and the conditions for which they are administered; and

(c) the capability to administer basic first aid.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

[RULE XI] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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 can not 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 care 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: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-6-402, MCA

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

46.12.1401 [37.40.1401] HOME AND COMMUNITY-BASED SERVICES ~~PROGRAM~~ FOR ELDERLY AND PHYSICALLY DISABLED PERSONS~~,~~ AUTHORITY AND SCOPE OF PROGRAM (1) The United States department of health and human services (HHS) has granted the department, through 42 CFR 441.300 through 441.310, the authority to ~~provide~~ establish a program of medicaid funded home and community-based services ~~to~~ for persons who are elderly or who have physical disabilities and who would otherwise have to reside in and receive medicaid reimbursed care in a hospital or ~~institutional setting~~ nursing facility.

~~(2) The program serves persons who are within groups and geographical service areas approved by the United States department of health and human services.~~

(2) The department, in accordance with state and federal statutes and rules governing the provision of medicaid funded home and community-based services and any federal-state agreements governing the provision of medicaid funded home and community-based services 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) There is no entitlement to eligibility for the program.

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA

IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, 53-6-131, 53-6-141 and 53-6-402, MCA

46.12.1403 [37.40.1405] ~~PERSONS WHO MAY BE SERVED~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENROLLMENT ~~(1) Under the home and community services program, services may be provided to those persons who meet all of the following requirements:~~

~~(a) are elderly or physically disabled;~~

~~(i) "Elderly" means a person 65 years of age or older.~~

~~(ii) "Physically disabled" means a person who is certified as disabled by the social security administration.~~

~~(A) Some physically disabled persons are considered to require intensive services. These are persons whose past medical history and current medical prognosis may require them to receive intensive long term care in an inpatient hospital or rehabilitation setting. These persons may receive services under the home and community services program if they otherwise~~

~~would require continued services in an inpatient hospital or rehabilitation setting.~~

~~(b) are medicaid-eligible;~~

~~(c) require the level of care of a nursing facility, as determined by preadmission screening as provided for in ARM 46.12.1305, 46.12.1306, and 46.12.1308;~~

~~(d) reside in approved service areas;~~

~~(e) do not reside in a hospital or long term care facility as defined in 50 5 101, MCA. Long term care facilities include skilled or intermediate nursing care, ICF/MR care and personal care;~~

~~(f) have needs that can be met through the home and community services program at a cost not to exceed the maximum amount allowed in accordance with ARM 46.12.1411; and~~

~~(g) are not receiving services as an enrolled participant of a certified hospice program.~~

~~(2) Priority for receipt of services will be established according to the following criteria:~~

~~(a) the person's need for service;~~

~~(b) the availability of other community services to meet the person's needs; and~~

~~(c) the person's risk of institutionalization or death.~~

(1) A person in order to be considered by the department for enrollment in the program, must be determined by the department to qualify for enrollment in accordance with the criteria in this rule.

(2) A person is qualified to be considered for enrollment in the program if the person:

(a) meets one of the following criteria:

(i) is 65 years of age or older; or

(ii) is certified as disabled by the social security administration but does not have a primary diagnosis of mental retardation or serious mental illness.

(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 46.12.1305, et seq.;

(d) does not reside in a hospital or a nursing facility; and

(e) has needs that can be met through the program.

(3) The department considers for an available opening for services those persons who, as determined by the department:

(a) are actively seeking services;

(b) are in need of the services available;

(c) are likely to benefit from the available services; and

(d) have a projected total cost of plan of care that is within the limits specified at ARM 46.12.1411.

(4) The department offers an available opening for services to the person, as determined by the department, who is most in need of the available services and most likely to benefit from the available services.

(5) Factors to be considered in the determinations of whether a person is in need of the available services and likely to benefit from those services and as to which person is most likely to benefit from the available services include, but are

not limited to, the following:

(a) medical condition;

(b) degree of independent mobility;

(c) ability to be alone for extended periods of time;

(d) presence of problems with judgment;

(e) presence of a cognitive impairment;

(f) prior enrollment in the program;

(g) current institutionalization or risk of institutionalization;

(h) risk of physical or mental deterioration or death;

(i) willingness to live alone;

(j) adequacy of housing;

(k) need for adaptive aids or environmental modifications;

(l) need for 24 hour supervision;

(m) need of person's caregiver for relief;

(n) need, in order to receive services, of a waiver of the medicaid deeming financial eligibility requirement;

(o) appropriateness for person, given the person's current needs and risks, of services available through the program;

(p) status of current services being purchased otherwise for the person; and

(q) status of support from family, friends and community.

(6) A person enrolled in the program 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, 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 to the delivery of services as provided for in the plan of care are unavailable; or

(f) a determination that the total cost of plan of care is not within the limits specified at ARM 46.12.1411.

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113, 53-6-131 and 53-6-402, MCA

46.12.1404 [37.40.1406] HOME AND COMMUNITY-BASED SERVICES, ~~DEFINITION~~ FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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; or

(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, can no longer 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 department may make program services for persons with intensive needs available to a recipient whom it determines, based on past medical history and current medical diagnosis, would otherwise require on a long term basis the level of care of an inpatient hospital or a rehabilitation service setting.

~~(1)~~ (6) The following services may be provided ~~under the home and community based services~~ through the program:

(a) case management ~~services, as defined in ARM 46.12.1406~~;

(b) homemaking ~~homemaker services, as defined in ARM 46.12.1425~~;

(c) personal ~~care~~ assistance ~~services, as defined in ARM 46.12.1428~~;

(d) adult day ~~care~~ health ~~services, as defined in ARM 46.12.1431~~;

(e) habilitation ~~services, as defined in ARM 46.12.1435~~;

(f) respite care ~~services, as defined in ARM 46.12.1438~~;

(g) ~~medical alert and monitoring~~ personal emergency response systems~~, as defined in ARM 46.12.1450~~;

(h) nutrition services~~, as defined in ARM 46.12.1456~~;

(i) environmental ~~modifications/adaptive~~ accessibility adaptations ~~equipment, as defined in ARM 46.12.1415~~;

(j) ~~social~~ nonmedical transportation ~~services, as defined~~

~~in ARM 46.12.1453~~;

(k) outpatient physical therapy ~~services, as defined in ARM 46.12.1444~~;

(l) outpatient occupational therapy ~~services, as defined in ARM 46.12.1441~~;

(m) speech pathology and audiology ~~services, as defined in ARM 46.12.1447~~;

(n) respiratory therapy ~~services, as defined in ARM 46.12.1474~~;

(o) nursing ~~services, as defined in ARM 46.12.1468~~;

(p) ~~psychological~~ psycho-social consultation ~~services, as defined in ARM 46.12.1462~~; and

(q) dietetic services; ~~dietitian services, as defined in ARM 46.12.1480.~~

(r) adult residential care;

(s) specially trained attendant care;

(t) chemical dependency counseling;

(u) cognitive rehabilitation;

(v) comprehensive day treatment;

(w) community residential rehabilitation;

(x) supported living;

(y) specialized medical equipment and supplies;

(z) specialized child care for children with AIDS; and

(aa) behavioral programming.

(7) Monies available through the program may not be expended on the following:

(a) room and board; or

(b) special education and related services as defined at 20 USC 1401(16) and (17).

(8) A service available through the program is not available to any extent that a service of another program is otherwise available to a recipient to meet the recipient's need for that service.

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1405 [37.40.1407] HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: GENERAL REQUIREMENTS (1) ~~Home and community services~~ Services of the program ~~will~~ may only be provided ~~only~~ by or through a ~~providers under~~ that is enrolled with ~~contract with~~ the department as a medicaid provider or ~~with contracts approved by the department~~ that is under contract with a provider the department is contracting with for home and community-based case management services.

~~(2) 42 CFR 441.302 mandates that a recipient's health and safety needs will be met through requiring:~~

~~(a)~~ (2) ~~all~~ A ~~facilities~~ facility providing services to a recipient must meet all ~~applicable~~ licensing requirements including fire and safety standards ~~in order to receive reimbursement under the home and community program; and~~.

~~(b)~~ (3) ~~all providers~~ A provider of service must meet the requirements ~~contained in ARM 46.12.301 through 46.12.308~~

necessary for the receipt of reimbursement with medicaid monies.

~~(3) Services may be provided only when indicated in an individual plan of care as defined in ARM 46.12.1409 or 46.12.1410.~~

~~(4) The cost of room and board is not reimbursable except when provided as part of respite care.~~

~~(5) Reimbursement for home and community services for elderly and physically disabled persons shall not be made to a member of the person's immediate family. Immediate family includes the following:~~

~~(a) husband or wife;~~

~~(b) natural parent;~~

~~(c) natural child;~~

~~(d) natural sibling;~~

~~(e) adopted child;~~

~~(f) adopted parent;~~

~~(g) step parent;~~

~~(h) step child;~~

~~(i) step brother or step sister;~~

~~(j) father in law or mother in law;~~

~~(k) son in law or daughter in law;~~

~~(l) brother in law or sister in law;~~

~~(m) grandparent;~~

~~(n) grandchild;~~

~~(o) foster parent; or~~

~~(p) foster child.~~

(4) 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) a spouse; and

(b) a natural or adoptive parent of a minor child.

~~(6) Pre vocational, educational and supported employment services are not reimbursable under the home and community services program.~~

~~(7) No co-payment will be imposed on home and community services but persons enrolled in the home and community services program will be responsible for co payment on other medicaid services as defined in ARM 46.12.204.~~

~~(8) Home and community services providers must be age 18 or older.~~

~~(9)~~ (5) ~~Home and community services~~ A providers~~,~~ may~~, under certain circumstances,~~ also provide ~~assistance~~ support to other family members in the recipient's household during hours of program reimbursed service~~.~~ if ~~The decision to allow this will:~~

~~(a) be made~~ approved by the case management team~~; and~~ after a determination that

~~(b) be based on whether~~ the needs of the recipient can safely be met under this arrangement.

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA

IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1407 [37.40.1430] ~~CASE MANAGEMENT SERVICES~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: CASE MANAGEMENT, REQUIREMENTS ~~(1) Case management services may be provided only by providers under contract with the department.~~

(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 may 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.

~~(2)~~ (3) The case management team ~~must:~~

~~(a)~~ consists of a registered nurse ~~licensed to practice in the state of Montana,~~ and a social worker ~~and appropriate clerical staff;~~.

(4) The case management team must:

~~(b)~~ (a) function ~~in such manner~~ as directed by the department;

(b) ~~to~~ assure that services provided to recipients are of appropriate quality and ~~least costly~~ cost effective; ~~and~~

(c) ~~(b)~~ provide case management services to no more than the number of persons specified ~~in the case management contract.~~ by the department;

(d) manage expenditures within the allocated monies; and

(e) meet the department's reporting requirements.

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1409 [37.40.1420] ~~PLANS OF CARE~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PLANS OF CARE (1) A plan of care is a written plan of ~~treatment developed on the basis of an~~ supports and interventions based on an assessment ~~and determination~~ of the status and needs of a recipient, that describes the needs of the recipient and the services available through the program and otherwise which 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 and the amount, scope and duration of those services must be specifically authorized in writing through an individual plan of care for the person.

~~(2)~~ (3) The plan of care ~~shall be~~ is initially developed ~~prior to~~ upon the person's entry into the ~~home and community~~

~~services~~ program ~~and be formally reviewed and approved by the department~~. The plan must be reviewed and, if necessary, revised ~~and approved~~ at intervals of at least 6 months beginning with the date of the initial plan of care.

~~(3)~~ (4) Each plan of care ~~shall be~~ is developed, reviewed and revised by the case management team.

~~(4)~~ (5) The case management team in developing the plan of care ~~shall consult~~ consults with the recipient or the recipient's legal representative, ~~and attending physician~~ with treating and other appropriate health care professionals. ~~The case management team may also consult~~ and others who have knowledge of the recipient's needs.

~~(5)~~ (6) Each plan of care ~~shall include~~ must include ~~at least~~ the following:

(a) diagnosis, symptoms, complaints and complications indicating the need for ~~home and community based~~ services;

(5)(b) through (5)(g) remain the same, but are renumbered (6)(b) through (6)(g).

~~(6)~~ (7) The case management team ~~shall~~ must provide a copy of the plan to the recipient.

~~(7)~~ (8) Plan of care approval ~~will be~~ is based on:

(7)(a) through (7)(c) remain the same, but are renumbered (8)(a) through (8)(c).

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1411 [37.40.1421] ~~COST OF PLAN OF CARE AS REASON FOR DENYING SERVICES~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COST OF PLAN OF CARE ~~(1) Home and community services are limited to recipients whose home and community service costs, as determined in accordance with subsection (1)(a) of this rule, are no more than what medicaid would pay for the recipient's care, as determined in accordance with subsections (1)(b) and (1)(c) of this rule. The department may, within its discretion, authorize exceptions to this limit. Cost determinations will be made before implementation of the proposed plan of care has been approved by the department.~~

~~(a) The plan of care cost shall be the cost of all home and community services provided to the recipient that are reimbursed by medicaid in accordance with these rules.~~

~~(b) The costs of institutional care shall be determined as follows:~~

~~(i) For nursing facility level of care, payment rates projected in accordance with ARM 46.12.1204 are based on the statewide weighted average medicaid nursing home per diem rate.~~

~~(c) For recipients in need of intensive services, the home and community service costs shall not exceed what the medicaid payment for that recipient would have been in an inpatient hospital or rehabilitation setting. Home and community services for recipients in need of intensive services must be prior authorized by the department.~~

~~(d) The cost comparison shall be made on the basis of projected annualized costs.~~

~~(c) Exceptions to the plan of care cost limit may be authorized by the department at its discretion based on the following criteria:~~

~~(i) the service causing the recipient to exceed costs is a one time purchase; or~~

~~(ii) intensive services of 90 days or less result in a temporary increase of the cost limit necessary to:~~

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

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

~~(C) prevent institutionalization during the absence of the normal caregiver.~~

(1) In order to maintain the program cost within the appropriated monies, 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 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 only 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.

(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) A 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: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1413 [37.40.1426] ~~NOTICE AND FAIR HEARING~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NOTICE AND FAIR HEARING (1) The department ~~will provide~~ provides written notice to an applicant~~s~~ for and recipient~~s~~ of ~~home and community~~ services when a determination~~s~~

~~are~~ is made by the department concerning ~~their status pertaining to~~:

(1)(a) and (1)(b) remain the same.

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

(d) termination of recipient's eligibility for ~~home and community services~~ the program.

(2) The department ~~will provide~~ provides a recipient of ~~home and community~~ services with notice 10 working days before termination of services due to a determination of ineligibility.

~~(3) The department will provide recipients of home and community services at least 30 days notice before any termination of home and community services due to insufficient program funds. Such terminations are those made in accordance with ARM 46.12.1402.~~

~~(4)~~ (3) A person ~~may request a fair hearing for~~ aggrieved by any adverse final determinations as listed in ~~subsections~~ (1)(a) through (1)(d) ~~made by the department with which he is dissatisfied~~ or ~~for~~ any adverse determinations regarding services in the plan of care may request a fair hearing as provided in [Rule XVII], [Rule XVIII], and ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212 and 46.2.214.

~~(5)~~ (4) Fair hearings will be conducted as provided for in ~~ARM 46.2.201 et seq~~ [Rule XVII], [Rule XVIII], and ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212 and 46.2.214.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1417 [37.40.1485] ~~ENVIRONMENTAL MODIFICATIONS/ADAPTIVE EQUIPMENT~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENVIRONMENTAL ACCESSIBILITY ADAPTATION, REQUIREMENTS (1) Environmental accessibility adaptations are modifications to a recipient's home designed to maintain or improve the recipient's ability to remain at home.

(2) Environmental accessibility adaptation services may include:

(a) modifications to a personal vehicle that allow the recipient to be more independent;

(b) the installation of specialized electrical and plumbing systems to accommodate necessary medical equipment and supplies;

(c) consultation regarding the appropriateness of an adaptation; and

(d) facilitation of the ability of a caregiver or service provider to maintain a recipient at home.

~~(1)~~ (3) ~~All~~ An environmental ~~modifications and adaptive equipment~~ accessibility adaptation must:

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

~~(b) have a specific adaptive purpose;~~

~~(c)~~ (b) provide for the recipient's ~~accessibility~~ access to the home environment and increased independence and safety in the home;

(c) be reasonably expected to promote the recipient's functional ability or the ability of the caregiver to maintain the recipient at home;

~~(d) assist the recipient to remain at home;~~

~~(e)~~ (d) be the most cost effective adaptation among the adaptations that are available to meet the recipient's needs; and

(e) meet the 1980 specifications set by the American national standards institute.

~~(f) not constitute:~~

(4) Environmental accessibility adaptation services do not include:

~~(i)~~ (a) general housing maintenance, including but not limited to plumbing, heating systems, or appliance repair; or

(b) measures to facilitate leisure time activities.

~~(ii) ineligible room and board;~~

~~(iii) additions which increase the square footage of existing structures; and~~

~~(iv) items of clothing.~~

~~(2) Environmental modifications must meet the specifications set by the American national standards institute of 1980.~~

~~(3) The cost of environmental modifications cannot exceed $4,000 per modification, however, the department may, within its discretion, authorize an exception to this limit. Any exception must be prior authorized by the department.~~

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

(6) The department may require review and approval by a consultant for certain types of environmental accessibility adaptations.

(7) A recipient may only receive any one environmental accessibility adaptation once unless the department specifically authorizes the repurchase of an adaptation.

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, and 53-6-402, MCA

46.12.1426 [37.40.1450] ~~HOMEMAKER~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: HOMEMAKING, REQUIREMENTS ~~(1) Homemaker services will be provided only after homemaker services provided through department employees or through programs funded with state and federal funds other than medicaid have been exhausted.~~

(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 in 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 46.12.555 and 46.12.559A.

~~(2)~~ (4) ~~Homemakers~~ 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: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1429 [37.40.1436] ~~PERSONAL CARE~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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 by a provider enrolled in the medicaid program as a personal assistance provider.

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

(a) personal care services as specified at ARM 46.12.555(1) through (5) and 46.12.559 through 46.12.559E;

(b) homemaking services as specified at ARM 46.12.1426;

(c) supervision for health and safety reasons; and

(d) nonmedical transportation as specified at ARM 46.12.1454.

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 46.12.559 through 46.12.559E.

~~(1)~~ (4) The requirements for the delivery of personal care services ~~are found in ARM 46.12.556~~ specified at ARM 46.12.555 et seq. and 46.12.559A govern the provision of personal assistance services.

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, ~~53-6-131,~~ 53-6-141 and 53-6-402, MCA

46.12.1432 [37.40.1445] ~~ADULT DAY CARE~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT DAY HEALTH~~, REQUIREMENTS (1) To be eligible to receive reimbursement under the home and community services program:~~

(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.

~~(a) Adult day care providers~~ An entity providing adult day health services must be licensed ~~by the department of health and environmental sciences~~ as provided ~~in ARM 16.32.356 and 16.32.357~~ at ARM 16.32.1001, et seq.

~~(2) Facility records must be current and contain specific~~

~~information about the medical condition of the recipient.~~

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111,~~ 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1436 [37.40.1448] ~~HABILITATION~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: HABILITATION, REQUIREMENTS ~~(1) A provider of habilitation services may be any person or agency qualified to meet the recipient's defined habilitation needs.~~

~~(2) All professional providers of habilitation services must meet licensing and certification requirements otherwise provided in Title 46, chapter 12, subchapter 14.~~

(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 physical 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 include 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: Sec. 53-2-201, 53-6-101, ~~53-6-111,~~ 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~ and 53-6-402, MCA

46.12.1439 [37.40.1451] ~~RESPITE CARE~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPITE CARE, REQUIREMENTS ~~(1) A nursing facility, which provides respite care to a recipient of the home and community services program must meet the requirements of ARM 46.12.1203.~~

(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.

~~(2)~~ (4) ~~Persons who provide~~ A person providing respite care services ~~to a recipient~~ must be ~~determined by the case management team to be~~:

(a) physically and mentally qualified to provide this service to the recipient; and

(b) aware of emergency assistance systems.

~~(3)~~ (5) ~~Persons~~ 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.

~~(4) Respite care is limited to 25 days in a fiscal year; however, the department may, within its discretion, authorize further specified hours of respite care in excess of this limit. Additional respite care must be authorized by the department.~~

~~(5) Approval for additional respite will be based on the following criteria:~~

~~(a) the provision of excess respite can be made while staying within plan of care cost limits; and~~

~~(b) the need for excess respite is caused by:~~

~~(i) an unexpected family emergency requiring the normal caregiver to be away;~~

~~(ii) unusually high stress in the normal caregiver; or~~

~~(iii) other unusual or unexpected circumstances which make excess respite more reasonable than alternative placements such as an institution.~~

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111,~~ 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111, 53-6-131,~~ 53-6-141 and 53-6-402, MCA

46.12.1442 [37.40.1460] ~~OUTPATIENT OCCUPATIONAL THERAPY~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS

(1) Outpatient occupational therapy services may include:

(a) occupational therapy services as specified at ARM 46.12.525A; and

(b) services for habilitative or maintenance purposes.

~~(1)~~ (2) ~~Requirements~~ The requirements for the delivery of outpatient occupational therapy services ~~are as~~ provided ~~in~~ at ARM 46.12.525A, et seq., govern the provision of outpatient occupational therapy services. ~~through 46.12.527A except that under the home and community services program:~~

~~(a) maintenance therapy can be reimbursed; and~~

~~(b)~~ (3) ~~no~~ No visit limitation exists for maintenance therapy.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, ~~53-6-111~~, ~~53-6-131~~, 53-6-141 and 53-6-402, MCA

46.12.1445 [37.40.1461] ~~OUTPATIENT PHYSICAL THERAPY~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT PHYSICAL THERAPY, REQUIREMENTS

(1) Outpatient physical therapy services may include:

(a) physical therapy services as specified at ARM 46.12.525A; and

(b) services for habilitative or maintenance purposes.

~~(1)~~ (2) ~~Requirements~~ The requirements for the delivery of outpatient physical therapy services ~~are as provided for in~~ at ARM 46.12.525A, et seq., govern the provision of outpatient physical therapy services. ~~through 46.12.527A except that under the home and community services program:~~

~~(a) maintenance therapy can be reimbursed; and~~

~~(b)~~ (3) ~~no~~ No visit limitation exists for maintenance therapy.

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, ~~53-6-131~~, 53-6-141 and 53-6-402, MCA

46.12.1448 [37.40.1462] ~~SPEECH PATHOLOGY AND AUDIOLOGY~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPEECH PATHOLOGY AND AUDIOLOGY, REQUIREMENTS

(1) Speech pathology and audiology services may include:

(a) speech therapy services as defined at ARM 46.12.525A;

(b) audiology services as defined at ARM 46.12.534;

(c) services for habilitative or maintenance purposes;

(d) screening and evaluation with respect to speech and hearing functions;

(e) comprehensive audiological assessment, as indicated by screening results, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;

(f) assessments of the use of amplification;

(g) provision for procurement, maintenance and replacement

of hearing aids, as specified by a qualified audiologist;

(h) comprehensive speech and language evaluation, as indicated by screening results, including appraisal of articulation, voice, rhythm and language;

(i) participation in the continuing interdisciplinary evaluation for purposes of beginning, monitoring and following up on individualized habilitation programs; and

(j) treatment services as an extension of the evaluation process, that include:

(i) direct counseling with a recipient;

(ii) consultation with appropriate persons involved with a recipient for speech improvement and speech education activities; and

(iii) work with an appropriate recipient to develop specialized programs for developing communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization and skills in expression, including improvement in articulation, voice, rhythm and language.

~~(1)~~ (2) ~~Requirements~~ The requirements for the delivery of speech ~~pathology and audiology~~ therapy services are ~~as provided in ARM 46.12.525A through 46.12.527A, 46.12.533 and 46.12.534 except that under the home and community services program:~~ at ARM 46.12.526A and 46.12.527A and for audiology services at ARM 46.12.533 and 46.12.534 govern the provision of speech pathology and audiology services.

~~(a) maintenance therapy can be reimbursed; and~~

~~(b)~~ (3) ~~no~~ No visit limitation exists for maintenance therapy.

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, ~~53-6-131~~, 53-6-141 and 53-6-402, MCA

46.12.1451 [37.40.1486] ~~MEDICAL ALERT~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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.

~~(1)~~ (2) ~~Medical alert systems~~ A personal emergency response system must be connected to a local emergency response system with the capacity to activate emergency medical personnel.

~~(2)~~ (3) ~~Reimbursement is not available for~~ 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: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, ~~53-6-131~~, 53-6-141 and 53-6-402, MCA

46.12.1454 [37.40.1488] ~~NON-MEDICAL TRANSPORTATION~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NON-MEDICAL 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.

~~(1)~~ (2) ~~Transportation~~ Nonmedical transportation services ~~will be~~ are provided only after volunteer transportation services, or transportation services funded by ~~public~~ other programs ~~other than medicaid~~, have been exhausted.

~~(2)~~ (3) ~~Transportation~~ 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.

~~(3)~~ (4) ~~Transportation~~ Nonmedical transportation services must be provided by the most cost effective mode.

~~(4)~~ (5) ~~Transportation~~ Nonmedical transportation services ~~must be provided~~ are available only ~~when necessary to~~ for the transport of recipients to and from activities that are included in the individual plan of care.

AUTH: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, ~~53-5-205~~, 53-6-101, ~~53-6-111~~, ~~53-6-131~~, 53-6-141 and 53-6-402, MCA

46.12.1457 [37.40.1476] ~~NUTRITION~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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.

~~(1)~~ (2) The requirements for ~~congregate or home delivered meal~~ the delivery of nutrition services ~~are as provided in ARM 46.4.303~~ as specified at ARM 37.41.306 through ~~46.4.306~~ 37.41.315 govern the provision of nutrition services.

~~(2)~~ (3) A full nutritional regimen of three meals a day may not be provided through this service ~~congregate or home delivered meals~~.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, and 53-6-402, MCA

46.12.1463 [37.40.1464] ~~PSYCHOLOGICAL~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: 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 46.12.578 and 46.12.579.

~~(1)~~ (3) Requirements for the delivery of psychological services ~~are defined as provided in~~ as specified at ARM

~~46.12.581~~ 46.12.578 and 46.12.579 govern the provision of psycho-social consultation.

~~(2) Psychological services as defined in ARM 46.12.1462 (1)(a) are limited to six hourly visits or the equivalent per fiscal year. The department may within its discretion authorize further specified hours of psychological services in excess of this limit. Any services in excess of this limit must be prior authorized by the department.~~

~~(3) When the psychologist consults with a provider or caregiver as part of the recipient's treatment, the consultation time shall be billed to medicaid under the recipient's name. The provider shall indicate on the claim that the recipient is the patient and state the recipient's diagnosis. He shall also indicate consultation was with a provider or caregiver.~~

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-141 and 53-6-402, MCA

46.12.1469 [37.40.1477] ~~NURSING~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NURSING, REQUIREMENTS (1) ~~Nursing services must be provided by a registered nurse or licensed practical nurse. Persons providing nursing services must meet the licensure and certification requirements provided in ARM 8.32.401 et seq.~~ Nursing is the provision of individual and continuous nursing care.

(2) ~~Nursing services must be provided to a recipient in his own home.~~ Nursing services ~~shall~~ may not be provided to a recipient residing in a hospital~~,~~ or nursing facility~~,~~. ~~or licensed personal care facility.~~

~~(3) Nursing services can be provided only when home health agency services as provided in ARM 46.12.550 are not available.~~

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-141 and 53-6-402, MCA

46.12.1475 [37.40.1463] ~~RESPIRATORY THERAPY~~ HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPIRATORY THERAPY, REQUIREMENTS (1) ~~Respiratory therapy services must be provided by a registered respiratory therapist as defined by the national board for respiratory care.~~ Respiratory therapy is the provision of direct respiratory treatment, ongoing assessment of respiratory and medical conditions, equipment monitoring and upkeep, pulmonary education and respiratory rehabilitation.

(2) remains the same.

~~(3) Respiratory therapy services must be furnished in the recipient's home and be limited to recipients who, without respiratory care at home, would require care as an inpatient in a hospital or nursing facility.~~

~~(4) Respiratory therapy services may be provided only to recipients who have adequate support services to be cared for at~~

~~home.~~

~~(5) Respiratory therapy services are limited to a maximum of 24 hours per fiscal year. The department may within its discretion authorize further specified hours of respiratory therapy services in excess of this limit. Any services exceeding this limit must be prior authorized by the department.~~

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-141 and 53-6-402, MCA

46.12.1481 [37.40.1475] ~~DIETITIAN~~ HOME AND COMMUNITY SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: DIETETIC SERVICES, REQUIREMENTS ~~(1) Dietitian services must be provided by a registered dietitian or a licensed nutritionist. Registered dietitians must meet the qualifications in 37-21-302, MCA and licensed nutritionists must meet the licensing requirements in 37-25-302, MCA.~~

(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.

~~(2)~~ (3) ~~Dietitian~~ Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status.

~~(3) Dietitian services are limited to a maximum of 12 hours per fiscal year. The department may, within its discretion, authorize further specified hours of dietitian services in excess of this limit. Any services exceeding this limit must be prior authorized by the department.~~

AUTH: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, ~~53-6-111~~, 53-6-141 and 53-6-402, MCA

4. The rule 46.12.1402 as proposed to be repealed is on page 46-1929 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1406 as proposed to be repealed is on page 46-1949 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1408 as proposed to be repealed is on page 46-1953 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 63-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

The rules 46.12.1412 and 46.12.1415 as proposed to be repealed are on pages 46-1977 and 46-1981 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1419 as proposed to be repealed is on page 46-1982 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-111, and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1425 as proposed to be repealed is on page 46-1983 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rules 46.12.1427 and 46.12.1428 as proposed to be repealed are on page 46-1989 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1430 as proposed to be repealed is on page 46-1995 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

The rule 46.12.1431 as proposed to be repealed is on page 46-1995 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

The rule 46.12.1433 as proposed to be repealed is on page 46-1995 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, and 53-6-402, MCA

The rules 46.12.1435, 46.12.1437 and 46.12.1438 as proposed to be repealed are on pages 46-2001 through 46-2013 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rule 46.12.1440 as proposed to be repealed is on page 46-2014 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 52-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rules 46.12.1441, 46.12.1443, 46.12.1444, 46.12.1446, 46.12.1447 and 46.12.1449 as proposed to be repealed are on pages 46-2021 through 46-2037 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

The rules 46.12.1450, 46.12.1452 and 46.12.1453 as proposed to be repealed are on pages 46-2037, 46-2041 and through 46-2043 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA

The rule 46.12.1455 as proposed to be repealed is on page 46-2043 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-402, MCA

The rules 46.12.1456 and 46.12.1458 as proposed to be repealed are on page 46-2049 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-113, and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, and 53-6-402, MCA

The rules 46.12.1462, 46.12.1464, 46.12.1468, 46.12.1470 and 46.12.1474 as proposed to be repealed are on pages 46-2049 through 46-2053 and 46-2058 of the Administrative Rules of Montana.

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

The rules 46.12.1476, 46.12.1480 and 46.12.1482 as proposed to be repealed are on pages 46-2055 and 46-2056 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-141 and 53-6-402, MCA

5. PURPOSES GENERALLY OF PROPOSED RULE ADOPTIONS, AMENDMENTS, AND REPEALS

The Department is proposing to extensively change the rules that govern the provision of services through the program of home and community services for medicaid eligible persons who are elderly or who have disabilities. The program, funded with federal medicaid monies and matching state general fund monies, currently provides an array of services for persons who otherwise may need the level of care available in a hospital or nursing facility. The services support a person's continued presence at home and in their community close to long established personal and community supports.

Elderly are persons who are 65 years of age or older. Persons with disabilities are persons with physical disabilities as certified by the federal Social Security Administration. The program in accordance with federal direction does not serve persons with mental retardation or serious mental illness since those two populations may receive services through other medicaid funded programs.

Programs of home and community services, funded with federal medicaid monies, are authorized generally under federal authority and must conform with certain requirements under those authorities. The responsible federal agency is the Health Care Financing Administration (HCFA) of the U.S. Department of Health & Human Services.

State implementation of a program of home and community services, funded with medicaid monies, must proceed under a so-called "waiver" received from HCFA. The implementation of services is expressly predicated upon the approval of HCFA via the "waiver" process. The choice of services must be approved by HCFA.

The purpose of the proposed rule adoptions, amendments and repeals generally are fivefold: 1) to conform the rules with current nomenclature relating to the program generally and to particular services; 2) to improve the language and structure of provisions for purposes of improved comprehension; 3) to eliminate duplicative language and provisions; 4) to conform the rules with current federal requirements; and 5) to provide for changes and additions that have been made in programmatic features.

NUMBER OF PERSONS IMPACTED AND FISCAL IMPACT

The proposed rule changes would impact the approximately 2,000 persons who are currently recipients of services through the

home and community program for persons who are elderly or who have disabilities other than mental retardation and serious mental illness. The fiscal impact of the proposed rule changes, providing for additional services, is difficult to calculate. The calculation of actual costs to the Department involves consideration of the costs arising out of implementation of the newer services, of any increase in the number of persons participating in the program over time and of the cost savings, if any, realized through provision of home and community services rather than nursing or hospital services. The substantive changes in program services have been implemented prior to the time of rule adoption. The impacts from the addition of the new services have already been budgeted for and appropriated monies received for those purposes. The other proposed rule changes would have no fiscal impacts.

CHANGES RESULTING FROM ADVISORY COUNCIL STUDY AND RECOMMENDATIONS

The majority of the substantive changes in the proposed rules and proposed amendments to rules, providing for additional services, are the result of a study with recommendations made by the gubernatorially appointed "Select An Independent Life Style" Advisory Council, "SAIL". The SAIL Advisory Council extensively studied the needs of persons who are elderly or who have disabilities other than mental retardation or serious mental illness and considered the possible ways to meet those needs, inclusive of possible new types of services to be incorporated into the program.

The SAIL Advisory Council recommended changes to the program to provide services that would meet the needs of persons with brain injury and that would meet the residential service needs of persons who are participating in the program. The services, implemented based upon the SAIL Advisory Council recommendations, available to meet the needs of persons with brain injury include: comprehensive day treatment, community residential rehabilitation, supported living, specially trained attendant, behavioral programming, cognitive rehabilitation, chemical dependency counseling, prevocational services, and supported employment. Proposed Rules III, IV, V, VI, VII, VIII, and IX and the amendments to Rule 46.12.1436 would implement in rule these services. The services implemented to provide community residential services generally for persons participating in the program include: adult residential care, specially trained attendant care, and supported living. Proposed Rules II, III, and IX would implement in rule these services.

The SAIL Advisory Council determined that the state service system, then in existence, did not have a comprehensive system of services that could provide a continuum of care to persons with brain injury. Consequently, the SAIL Advisory Council rejected the course, represented by the status quo, since needs would continue to be unmet with persons continuing to be placed

in more restrictive settings and being at risk of harm at home and in the community due to the lack of services. The course selected by the SAIL Advisory Council was to expand, to the extent permitted by HCFA, the medicaid funded home and community services program for elderly and disabled persons.

The home and community-based services program is funded to a large extent with federal medicaid monies that are matched to state general fund monies. The medicaid match funding provides the best course by which the State can realize the greatest federal funding to apply towards services.

The home and community-based services program, as a nonentitlement program of services, is not subject to detailed federal specifications and constricting parameters. It is therefore possible to develop an array of services that meets a continuum of need.

The option of implementing the needed services for persons with brain injury through the home and community-based program is the best course in that it provides a continuum of services to meet the needs of persons with brain injury in the less restrictive settings of community-based services while maximizing federal financial participation.

CHANGES TO CONFORM WITH FEDERAL DIRECTION

Changes in the administration of the home and community-based program for elderly persons and persons with disabilities imposed upon the State during the most recent federal "waiver" approval include:

1) the addition of specialized equipment and supplies as a separate service category;
2) the provision of services by family members;
3) the provision of pre-vocational and supported employment services to persons who have no prior institutionalization; and
4) the removal of the prohibition on the enrollment of persons receiving medicaid funded hospice services.

These changes are incorporated into proposed changes to the rule set.

Previously, specialized equipment and supplies had generally been available through the environmental modifications/adaptive equipment service specified at ARM 46.12.1415 through ARM 46.12.1419. HCFA in the course of "waiver" approval directed the State to establish the separate service for specialized equipment and supplies. Proposed Rule XI, SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS, is for the purpose of implementing the new service. This change is further explained in more detail in the rationale for Proposed Rule XI.

Until recently, family members generally were precluded by federal direction from serving as providers. HCFA now defines the family members to which the prohibition applies more narrowly. Family members under the HCFA prohibition now only include spouses and natural or adoptive parents of a minor child. Consequently, it is feasible to use the often available and committed resource of the other family members as providers. This change is proposed for implementation through an amendment to ARM 46.12.1405. This change is further explained in the rationale for the amendments to ARM 46.12.1405.

Prevocational and support employment services, previously, were under federal law only available for persons who had actually been institutionalized. A change in federal law now allows for the provision of the services to noninstitutionalized persons. This change is proposed for implementation through an amendment to ARM 46.12.1436. This change is further explained in the rationale for the amendments to ARM 46.12.1436.

A federal direction prohibiting persons receiving medicaid funded hospice services from participation in the home and community-based services program has been removed by HCFA. With this change the Department has begun to allow hospice recipients to participate in the program. This change is proposed for implementation by the deletion of the prohibition from ARM 46.12.1403. This change is further explained in the rationale for the amendments to ARM 46.12.1403.

THE PROPOSED ADOPTION OF RULE I AND THE PROPOSED REPEAL OF RULES 46.12.1408, 46.12.1419, 46.12.1427, 46.12.1430, 46.12.1433, 46.12.1437, 46.12.1440, 46.12.1443, 46.12.1446, 46.12.1449, 46.12.1452, 46.12.1455, 46.12.1458, 46.12.1464, 46.12.1470, 46.12.1476, AND 46.12.1482, PERTAINING TO REIMBURSEMENT

Proposed Rule I, REIMBURSEMENT, is to provide a comprehensive rule to govern all reimbursement for services provided through the program. Currently, each category of service has an individual rule to govern reimbursement of that category of service. There are, however, only two basic reimbursement schemes with almost all the services falling under one or the other. There is much duplication of language and provisions among the various reimbursement provisions currently in place.

It is necessary to adopt Rule I and to repeal ARM 46.12.1408, 46.12.1419, 46.12.1427, 46.12.1430, 46.12.1433, 46.12.1437, 46.12.1440, 46.12.1443, 46.12.1446, 46.12.1449, 46.12.1452, 46.12.1455, 46.12.1458, 46.12.1464, 46.12.1470, 46.12.1476, and 46.12.1482, as proposed, in order to eliminate duplicative language and provisions, significantly consolidate rules and text, and to provide a convenient and comprehensive rule on reimbursement.

This option, as opposed to not consolidating reimbursement material from many rules into one comprehensive rule, would be the best course. It will provide consumers, providers of

services, and program managers with a single comprehensive and accessible reimbursement rule. This course also serves the legislative goal of reducing the volume of rule material while providing the public with more accessible and understandable rules. The option of not consolidating the reimbursement rule material would perpetuate the current scheme of numerous duplicative rules and rule text on reimbursement. That would be counter to the legislative goal.

The rule, as proposed, would not change any of the current actual reimbursement rates being provided for the services. The rule would place in rule some reimbursement changes that have been previously implemented in practice. Since those changes have been implemented previously, there would be no negative impact upon any providers.

The reimbursement for case management, as proposed in the rule, would change from being solely upon the basis of a per diem rate to being upon the basis of either a per diem or hourly rate. That change is necessary to implement in rule the current reimbursement practice. The use of an hourly reimbursement rate, in addition to a per diem rate, is necessary to accommodate case management needs that are short term in nature. No rates of reimbursement are specified for case management because the reimbursement rates are established contractually with each provider relative to the costs of the service provision incurred by the provider.

THE PROPOSED REPEAL OF RULES 46.12.1406, 46.12.1415, 46.12.1425, 46.12.1428, 46.12.1431, 46.12.1435, 46.12.1438, 46.12.1441, 46.12.1444, 46.12.1447, 46.12.1450, 46.12.1453, 46.12.1456, 46.12.1462, 46.12.1468, 46.12.1474, AND 46.12.1480, PERTAINING TO DEFINITIONS AND THE PROPOSED ADOPTION OF MATERIAL FROM THE DEFINITION RULES IN THE EXISTING REQUIREMENTS RULES

Rules 46.12.1406, 46.12.1415, 46.12.1425, 46.12.1428, 46.12.1431, 46.12.1435, 46.12.1438, 46.12.1441, 46.12.1444, 46.12.1447, 46.12.1450, 46.12.1453, 46.12.1456, 46.12.1462, 46.12.1468, 46.12.1474, and 46.12.1480 currently provide pertinent definitions for the purposes of establishing the various services available through the home and community-based services program for the elderly and persons with disabilities. Some of these rules, however, contain material that is more in the nature of purpose statements and requirements than in the nature of definition. In addition, many of the current definitions are limited in extent. Some consist only of a single definitional statement.

The proposed repeal of these rules is necessary for two purposes. The first is to place statements of purpose and of requirements, now appearing in these rules, into the existing requirements rules where they appropriately belong. The second is to provide for a significant consolidation of rules and thereby reduce the number of rules and the amount of text material in rules. This option, in consolidating material as to

the nature and requirements of the services into comprehensive and understandable provisions, would be the best course. It will provide consumers, providers of services, and program managers with a more accessible and useful governing rule set. This option also serves the legislative goal of reducing the volume of rule material while providing the public with more accessible and understandable rules.

The option of not consolidating the rules and rule material would perpetuate the current scheme of numerous rules which would be counter to the legislative goal. It would also perpetuate the confusion for consumers, providers of services, and program managers fostered by some of the requirements material appearing outside the requirements rules.

The rules proposed for amendment generally for the purpose of incorporating material from definition rules proposed for repeal include the following: ARM 46.12.1426, HOMEMAKING, ARM 46.12.1429, PERSONAL ASSISTANCE, ARM 46.12.1432, ADULT DAY HEALTH, ARM 46.12.1442, OCCUPATIONAL THERAPY, ARM 46.12.1445, OUTPATIENT PHYSICAL THERAPY, ARM 46.12.1448, SPEECH PATHOLOGY AND AUDIOLOGY, ARM 46.12.1451, PERSONAL EMERGENCY RESPONSE SYSTEMS, ARM 46.12.1454, NONMEDICAL TRANSPORTATION, ARM 46.12.1457, NUTRITION, and ARM 46.12.1481, DIETETIC SERVICES.

Other rules proposed for amendment in part for the purpose of incorporating material from definition rules proposed for repeal include the following: ARM 46.12.1407, CASE MANAGEMENT, ARM 46.12.1417, ENVIRONMENTAL ACCESSIBILITY ADAPTATION, ARM 46.12.1436, HABILITATION, ARM 46.12.1439, RESPITE CARE, ARM 46.12.1463, PSYCHO-SOCIAL CONSULTATION, ARM 46.12.1469, NURSING, AND ARM 46.12.1475, RESPIRATORY THERAPY.

THE PROPOSED ADOPTION OF RULE II, PERTAINING TO ADULT RESIDENTIAL CARE

Proposed Rule II, ADULT RESIDENTIAL CARE, would implement in rule the provision of adult residential care as a service in the program. Adult residential care encompasses the services that support a person who resides in a personal care facility, an adult foster care home, or a residential hospice.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services. The service is already available through the home and community-based services program.

Adult residential care services includes a set of supportive services. The rule is necessary to maintain persons in community residential settings and thereby foregoing their placement in the more restrictive and expensive nursing facility settings. This service is necessary to assure the availability of supportive services in the specified residential settings. The supportive services make those residential service settings viable alternatives to nursing facilities for those recipients

of home and community program services who need intensive residential settings.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE III, PERTAINING TO SPECIALLY TRAINED ATTENDANT CARE

Proposed Rule III, SPECIALLY TRAINED ATTENDANT CARE, would implement in rule the provision of specially trained attendant care as a service in the program. Specially trained attendant care encompasses the services that support a person who resides at home and is similar to the existing personal care and personal assistance services available through the regular program of medicaid funded services and the home and community-based services program.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program.

Specially trained attendant care encompasses specialized personal care services. The rule is necessary to maintain persons with involved disabilities at home in the community and thereby foregoing their placement in the more restrictive and expensive nursing facility settings. This service is necessary to assure the availability of personal care services in a person's home setting delivered by personnel who are specifically and comprehensively trained to deliver services to persons who have significant disabilities along with resulting special needs. This service makes residence in a home setting a viable alternative to residence in a nursing facility for those persons who become recipients of services through the home and community program.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through specially trained attendant care would be the best option. This service was specifically designed by the Sail Advisory Council to encompass the features most desirable for meeting the identified need.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to paternalistic treatment and placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE IV, PERTAINING TO BEHAVIORAL PROGRAMMING

Proposed Rule IV, BEHAVIORAL PROGRAMMING, would implement in

rule the provision of behavioral programming as a service in the program. Behavioral programming is a continuous in-depth assessment on a short term basis of a person with brain injury. This service, identified as an important service need by the SAIL Advisory Council, has been implemented.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program. Behavioral programming provides the insight necessary for professionals, case managers, and providers to craft effective services delivery so as to maintain persons with brain injury at home in the community. This service is necessary to provide specific guidance in determining the design, course and features of provision for the services to be provided to a person with brain injury.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through the behavioral programming would be the best option. The Council determined that there is no efficacious alternative service to consider for the purpose of accomplishing the results sought through the provision of behavioral programming. This service was specifically designed by the Sail Advisory Council to encompass the features most desirable for meeting the identified need.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to paternalistic treatment and placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE V, PERTAINING TO CHEMICAL DEPENDENCY COUNSELING

Proposed Rule V, CHEMICAL DEPENDENCY COUNSELING, would implement in rule the provision of chemical dependency counseling as a service in the program.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program.

Drug and alcohol problems are significant for many persons receiving services through the home and community-based services program. This proposed rule is necessary to prevent those problems which can cause the failure of community life for persons. Chemical dependency counseling meets the need for intervention and prevention in relation to serious chemical dependency and thereby foster residential stability in the community. This service can foster further participation in the services of the home and community program.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through the chemical dependency counseling would be the best option. The Council determined that there are no efficacious and legally permissible alternative services to consider for the purpose of accomplishing the results sought through the provision of chemical dependency counseling.

The option of not making this service available through the program was rejected since, in the absence of this service, persons with significant abuse problems who are recipients of home and community-based services would likely be subjected to placement into very restrictive settings to prevent further abuse and enforced recovery.

THE PROPOSED ADOPTION OF RULE VI, PERTAINING TO COGNITIVE REHABILITATION

Proposed Rule VI, COGNITIVE REHABILITATION, would implement in rule the provision of cognitive rehabilitation as a service in the program. Cognitive rehabilitation provides compensatory skills to a person with brain injury.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program.

Cognitive rehabilitation provides the skills necessary for persons with brain injury to function at a higher level of independence at home and in the community. This service is necessary to make available to persons with brain injury and their personal care givers a rehabilitation service that specializes in instruction on the skills that may allow the person to overcome the cognitive limitations imposed by the disability.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through cognitive rehabilitation would be the best option. The Council determined that there are no efficacious alternative services to consider for the purpose of accomplishing the results sought through the provision of cognitive rehabilitation.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to paternalistic treatment and placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE VII, PERTAINING TO COMPREHENSIVE DAY TREATMENT

Proposed Rule VII, COMPREHENSIVE DAY TREATMENT, would implement in rule the provision of comprehensive day treatment as a

service in the program. Comprehensive day treatment is an array of services from a single provider available to a person with brain injury on a week day basis in a non-residential setting.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program.

Comprehensive day treatment provides the skills necessary for persons with brain injury to function at a higher level of independence at home and in the community. This service is designed to meet the needs of persons who principally need intensive day services. This service is necessary to make available to persons with brain injury a comprehensive service that encompasses an array of services during the day that can make feasible a person's continued successful presence in the community.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through comprehensive day treatment would be the best option. This service was specifically designed by the Sail Advisory Council to encompass the features most desirable for meeting the identified need. Other possible options based on other services were rejected as not as effectively serving the needs of the population of persons who may potentially receive this service. The Council determined that there are no efficacious alternative services to consider for the purpose of accomplishing the results sought through the provision of comprehensive day treatment.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE VIII, PERTAINING TO COMMUNITY RESIDENTIAL REHABILITATION

Proposed Rule VIII, COMMUNITY RESIDENTIAL REHABILITATION, would implement in rule the provision of community residential rehabilitation. Community residential rehabilitation is the provision on a 24 hour basis in a residential setting of an array of services necessary to foster a recipient's rehabilitation through improvements in physical performance and coping skills. This service may be delivered in supervised residential settings or in a comprehensive day treatment setting as specified in Rule VII.

This proposed rule is necessary to implement in rule community residential rehabilitation as a service that meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program. This service provides the skills

necessary for persons with brain injury to enable them to reestablish important functional activities at a higher level of independence at home and in the community. This service can make feasible a person's continued presence in the community.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through community residential rehabilitation would be the best option. This service was specifically designed by the Sail Advisory Council to encompass the features most desirable for meeting the identified need. Since most aspects of community residential rehabilitation were already available as separate services through the program, the Council considered implementation of specific services to fill in the gaps in the array of services that would be necessary to meet the comprehensive needs of more involved recipients. The Council, however, rejected this course when it realized that piecemeal service design would further complicate the administration of service delivery for the recipients, confuse recipients and providers as to service coverage, and complicate provider billing.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE IX, PERTAINING TO SUPPORTED LIVING

Proposed Rule IX, SUPPORTED LIVING, would implement in rule the provision of supported living as a service in the program. Supported living is the provision of supportive services to a person residing at home or a group living situation.

This proposed rule is necessary to implement in rule this service which meets a significant need in the provision of services to persons with brain injury. The service is already available through the home and community-based services program.

Supported living provides the skills necessary for persons with brain injury to function at a higher level of independence at home and in the community. This service is necessary to make available to persons with brain injury who have need of continuous intensive services an array of services that can make feasible a person's continued presence in the community.

The SAIL Advisory Council, with its expertise and knowledge, determined that the adoption of the particular service coverage established through supported living would be the best option. This service was specifically designed by the Sail Advisory Council to encompass the features most desirable for meeting the identified need. Other possible options based on other services were rejected as not as effectively serving the needs of the population of persons who may potentially receive this service. Supported living as a service is a comprehensive service that

encompasses many other services. It is intended to provide a single billable service for persons who need a full array of services. Since many aspects of supported living were already available as separate services through the program, the Council considered implementation of specific services to fill in the gaps in the array of services that would be necessary to meet the comprehensive needs of more involved recipients. The Council, however, rejected this course when it realized that piecemeal service design would further complicate the administration of service delivery for the recipients, confuse recipients and providers as to service coverage, and complicate provider billing.

The option of not making this service available through the program was rejected since, in the absence of this service, persons would probably be subjected to placement into more restrictive settings.

THE PROPOSED ADOPTION OF RULE X, PERTAINING TO SPECIALIZED CHILD CARE FOR CHILDREN WITH AIDS

Proposed Rule X, SPECIALIZED CHILD CARE FOR CHILDREN WITH AIDS, would implement in rule the provision of specialized child care for children with AIDS as a service in the program. Specialized child care for children with AIDS is the provision of child care by specially trained child care providers.

This service is necessary to make available to children who have AIDS and their families child care that can meet their unique health requirements. This service can make feasible a child's continued residence at home.

It was clear from the information received from the public and medical experts that existing group based models of child care were not appropriate sites and circumstances for providing child care to children with AIDS.

The option of not making this service available through the program was rejected since, in the absence of this service, children with AIDS in need of this service would probably be subjected to placement into more restrictive settings away from their families.

THE PROPOSED ADOPTION OF RULE XI, PERTAINING TO SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Proposed Rule XI, SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, would implement in rule the provision of specialized medical equipment and supplies as a service in the program. Specialized medical equipment and supplies is the provision of medical equipment and supplies that are not generally reimbursable through the regular medicaid program.

This proposed rule is necessary to implement in rule this service which is already available through the home and

community waiver program as a reimbursable service specifically under the existing service of environmental modifications/adaptive equipment at ARM 46.12.1417. The Health Care Financing Administration (HCFA) has directed the State to designate this as a separate service in the program. The proposed amendments to ARM 46.12.1417 would remove the current material in that rule relating to specialized medical equipment and supplies.

The Department has received approval to include in this service the provision of dogs with sophisticated training to act as assistants to persons with disabilities. This feature of this service was sought by interested consumers. This service adds a new innovative dimension to the service. An assistant dog can live with a person and meet some of the basic needs for daily activities of the person. This rule is necessary in order to provide a service that can make feasible a person's continued residence in their own home without resorting to more costly and intrusive interventions.

The option of adding medical equipment and supplies as an explicit service is the only feasible course in that it has been directed by federal officials as a matter of compliance with the governing federal authority for the program. In addition, the inclusion of assistant dogs as an aspect of this service has been selected as the best option by which to provide some basic assistance in daily living activities at a reasonable cost and in a compatible form. The Department did not choose the option of not implementing this aspect of this service since persons who could benefit from this service would probably resort to more costly and intrusive services or would be at risk of placement into more restrictive settings away from their communities.

NOTE ON CAPTIONS FOR RULES THAT ARE TO BE AMENDED

The captions of most of the existing rules are proposed to be revised. Those revisions are necessary because the existing captions were not properly structured when adopted and because many do not currently or after implementation of the changes to these rules would not accurately reflect the subjects of the rules.

The presentation of rationale for each proposed amendment below is presented under the proposed captions since those are more pertinent generally to the existing material as well as proposed material.

THE PROPOSED AMENDMENTS TO RULES PERTAINING TO CHANGES IN LANGUAGE AND STRUCTURE

Many of the proposed amendments to the various rules governing the program modify the existing terminology, language and structure of provisions without changing the substantive requirements and criteria of the provisions being modified.

The proposed amendments to restructure rule provisions, to modify language, and to change terminology are necessary to bring more clarity and therefore better comprehension to the text of the rule. This option, as opposed to not making improvements in the structure, language and terminology, is the best course in that it makes this rule serve its legal role for the public. Recipients and providers will have improved understanding of the various requirements and criteria for purposes of receipt and delivery of the services. Failure to improve the language and structure for purposes of comprehension would leave in place poorly stated language and structured provisions that may mislead the public and providers as to the nature of the sets of requirements and criteria imposed generally upon clients and upon the providers.

THE PROPOSED AMENDMENTS TO RULE 46.12.1401, PERTAINING TO THE AUTHORITY FOR AND LIMITATIONS APPLICABLE TO THE PROGRAM, AND THE REPEAL OF 46.12.1402, PERTAINING TO LIMITING ENROLLMENT ON BASIS OF FUNDING, AND 46.12.1412, PERTAINING TO FREEDOM OF CHOICE

Rule 46.12.1401, AUTHORITY, states the basis for federal approval to use medicaid funding for a program of home and community-based services and the limitation as to coverage based on federal approval. Rule 46.12.1402, LIMITING ENROLLMENT ON BASIS OF AVAILABLE FUNDS, states the authority of the Department to change the nature and scope of services based on available funding. Rule 46.12.1412, FREEDOM OF CHOICE, states the federal requirement that a person seeking long term care need not accept the particular medicaid funded program of services for long term care needs that may be made available by the Department.

The proposed amendments to ARM 46.12.1401 would include a new provision that would state the authority of the Department to limit the nature and scope of the program in various aspects. These proposed changes are necessary to expressly state in rule the authority of the Department, based on statutory authorities governing the implementation of the program and the administrative activities of the Department, to design and establish the nature and scope of the program and thereby inform the public of the authority.

Another proposed amendment to ARM 46.12.1401 would explicitly state that there is no entitlement for eligibility to the program. This proposed provision is necessary to inform the public of this fundamental aspect of the program which differs significantly from the general set of medicaid funded services administered by the Department.

The Department has determined that, stating the authority of the Department to determine the nature and the scope of the program's various features and denoting the lack of entitlement, is the best option. This option, as opposed to leaving the authority and limitation unstated, apprises the public fully of the nature of and the limitations upon the program.

The repeal of ARM 46.12.1402 is necessary in that the limitations expressed in that rule would be expressed in the proposed amendment language for ARM 46.12.1401 and thereby consolidating rule material from ARM 46.12.1402 logically and comprehensively together with that material appearing in ARM 46.12.1401.

The consolidation of the rule material on limitations due to funding into the proposed amended version of ARM 46.12.1401, along with the concurrent repeal of ARM 46.12.1402, is the best option by which to provide for the public a comprehensive rule that states clearly the authority of the Department to design and establish the nature and scope of the program. In addition, this option would best serve the Legislative policy of seeking reduction in rule material where appropriate and feasible.

The repeal of ARM 46.12.1412 is necessary in that the opportunity for a person to seek long term care through the other medicaid funded program of long term care services, the nursing care program, is addressed through the process of applying and is not subject matter establishing the nature and scope of the home and community-based services program. This option, as opposed to leaving the rule in effect, is the best option in that the matter is not suitable to the rule set.

THE PROPOSED AMENDMENTS TO RULE 46.12.1403, PERTAINING TO ENROLLMENT

Rule 46.12.1403, PERSONS WHO MAY BE SERVED, states the basic criteria governing the selection of persons who may receive services through the program.

The proposed amendments to ARM 46.12.1403 generally would reorganize the criteria that governs the eligibility of persons to be enrolled in the program and provide further criteria for purposes of selecting persons who could enter the program. The criteria provided in the rule includes the basic criteria as derived from the governing federal authority, the criteria governing the selection of a person to receive one of the openings for the services of the program, and the criteria applicable to the removal of a recipient from the program. The basic criteria has previously appeared in the text of the rule.

These proposed rule amendments would not change any of the current actual criteria being applied to the selection of persons to be offered services. These amendments would place in rule the criteria that is currently in use, having been previously implemented. Those changes would not negatively impact any recipient or potential recipient.

The changes, proposed for amendment into this rule, are the best option in that the resulting presentation of criteria in this rule would provide consumers with a concise statement of the criteria governing eligibility to be considered for enrollment in the program and governing selection of the persons who are to

be offered enrollment in the program.

The basic criteria, as mandated by the federal authorities would not be changed in substance. However, some criteria would be removed. The criteria that would be removed include the criteria relating to the provision of "intensive" forms of the services available through the program, the criteria for residence in approved service areas, the inclusion of personal care settings within the scope of long term care facilities and thereby prohibiting persons who reside in them from receiving services through the program, and the criteria that prohibits a person who is receiving services through a certified hospice program from being a recipient.

In addition, the provision providing a priority list for selection to receive services is proposed for deletion. The removal of the priority list for selection to receive services is necessary in that the list is not necessary for purposes of management of enrollment and the program therefore does not currently rely upon the list. The criteria of the priority list does appear in the new criteria governing the selection of persons to be offered the opportunity to become recipients of the program and as such continues to have significance for the program in a different manner. This option is the best course, as opposed to leaving the priority list in this rule, in that the continued presence of the priority list in this rule would be misleading for recipients and the public.

It is necessary to remove the criteria relating to the receipt of intensive services since that criteria is not related to eligibility and enrollment in the program. The criteria is proposed for amendment into ARM 46.12.1404, pertaining to the provision of services, since the criteria concerns access to certain levels of services necessary to meet more involved service needs. This option is the best course, as opposed to leaving the criteria in the enrollment rule, in that the continued presence of the criteria in this rule would be misleading for recipients and the public.

The removal of the criteria for residence in approved service areas is necessary in that the provision of services is no longer predicated, as it was in the early years of the program, upon limited geographic implementation in the State. At the time the program was first implemented, it was geographically limited in order to allow the Department to initially pilot the program and to allow for a scaled implementation that would foster over time the resources and skills by which it could be more broadly implemented. The program now encompasses all areas of the State. The availability of this program of services for the state as a whole allows for broad participation and thereby meets the needs of many more persons throughout the State. This limitation is consequently meaningless at present. This option is the best course, as opposed to retention of the limitation, in that the change would reflect the real nature of service provision and the continued presence of the criteria in this

rule would be misleading for recipients and the public.

The removal of the requirement that precludes a person residing in a personal care facility from enrolling in and receiving services through the program is necessary in that the program in response to public concerns accepts a broader notion of what constitutes a community residence for older persons and persons with disabilities. Many persons with incapacities are seeking out and residing in supportive settings. The availability of the services through the program fosters their residence at home and in the community. While federal authorities continue to preclude the provision of services through the program to persons residing in hospitals and nursing facilities, personal care facilities are not considered under the federal authority to be nursing facilities. This option, as opposed to leaving the limitation in place, is the best course in that it fosters the continued provision of services to recipients and thereby maintaining their residence at home and in the community.

The removal of the criteria that prohibits a person who is receiving services through a certified hospice program from being a recipient is necessary in that this federally imposed requirement is no longer applicable and the Department no longer imposes the prohibition as a result. Allowing persons who are recipients of medicaid funded hospice services to participate in the home and community-based services program is critical for many recipients of hospice services to maintain themselves at home and in the community. This option, as opposed to retaining the existing limitation, is the best course in that recipients of hospice services may continue to reside at home and in the community if also in receipt of additional services available through the home and community-based services program. This rule is necessary, otherwise, without the services many recipients of hospice services would face placement into the more restrictive settings of hospitals and nursing facilities.

THE PROPOSED AMENDMENTS TO RULE 46.12.1404, PERTAINING TO SERVICES

Rule 46.12.1404, SERVICES, states the services that are available through the program.

These proposed amendments to ARM 46.12.1404 would add the proposed new services to the existing list in this rule of the services available through the program, provide criteria governing receipt of specific services by recipients, provide criteria for the selection of persons who may receive services delivered through an intensive approach, state the bases upon which a person will be denied a service, state certain limitations upon the expenditure of monies available through the program and provide that a program service is not available when there are other sources for this service.

The proposed addition to the services list of the new services now available through the program is necessary to

comprehensively state the services of the program for the purposes of this rule. This is the appropriate and best option in that it apprises the public in one comprehensive list of the various services available through the program. The only other option, to not update the list, would leave the public without a concise comprehensive listing in the rules of the available services.

The implementation of the criteria to govern the selection of services for recipients is necessary in that it is an essential aspect of the program to assure that the recipients receive services through the program for which they are appropriate and from which they can be expected to benefit. The criteria encompass consideration of a recipient's needs for services generally so as to remain at home and in the community and the fit of the recipient to each particular service that may be of value in meeting the needs. The criteria in addition includes consideration of impacts upon programmatic administration particularly the financial considerations. The criteria is to be applied within the discretion of the Department. The Department must in exercising its discretion weigh the recipient's needs in relation to the nature and capabilities of the services available and the fiscal parameters placed on the cost of a plan of services.

The option of establishing the particular criteria stated in the proposed amendments to reflect the need of a recipient in relation to available services and the fiscal impact on the program is the best course. These considerations are those necessary to meet the purposes of the program as established in federal and state law and regulations. Stating these considerations in rule is the appropriate course by which to inform recipients of the considerations relied upon by the Department in its determinations. The particular criteria selected is the most appropriate for giving consideration to individual need in the context of the capabilities of services to meet the varying aspects of need and the parameters of the program. Since the criteria is drawn in relation to the purposes and parameters of the program other criteria would not be suitable.

The listing of criteria that the Department relies upon in denying a recipient a particular service is necessary to assure that recipients are not maintained in services that are inappropriate for them on an individual basis or excessively costly in relation to the allowable plan of care cost. These criteria are currently used by the program.

The particular criteria selected is the most appropriate for appropriate denials of services. The criteria is predicated upon the recipient's need, the capabilities of the service and the allowable plan of care cost. Since the criteria is drawn in relation to the purposes and parameters of the program other criteria would not be suitable.

The proposed inclusion of criteria to govern who may receive services that are delivered through an intensive approach is necessary in that such an approach to service delivery is intended only for a select population of recipients who have needs that necessitate a much more involved regime of service delivery in certain services. The development of intensive services as a service, in the first place, was necessary to establish a level of service delivery consummate with the more involved needs of some recipients resulting in a need for more staff and for more hours of service.

The option of presenting the criteria in rule by which to determine who may receive services through an intensive approach is the best course in that it controls access to the extra resources that comprise this form of service delivery, thereby preserving the resources for those who are most in need of intensive services. In addition, this course is the best in that it expressly states the governing criteria. The option of not expressing the criteria is not acceptable in that it would leave the public without any guidance to the criteria or any assurance of the uniform criteria in the selection of the persons to have services provided through the intensive approach.

The option of establishing intensive service approach is also the best option in that the need for more involved staffing to serve these persons was apparent and there were no alternative service modes for delivery of this service. The absence of an intensive service approach would result in certain placement of those persons in need of more involved services into the restrictive settings of hospitals and nursing facilities.

The establishment in rule of the requirement providing that program services are only available to the extent that the services of other programs are not available is necessary to conserve the financial and service resources of the program to assure the broadest reach of the program in terms of numbers of persons served and service needs met.

The option of establishing in rule the requirement for the prior use of the services of other programs, as opposed to not establishing the requirement, is the best course in that the program can be available to a larger number of persons while meeting the federal mandate that it be fiscally responsible given its limited resources.

THE PROPOSED AMENDMENTS TO RULE 46.12.1405, PERTAINING TO GENERAL REQUIREMENTS

Rule 46.12.1405, GENERAL REQUIREMENTS, states certain general requirements applicable to the delivery of services through the program. Those requirements include a requirement that providers be enrolled in the program or be under contract with the Department, that facilities in which service delivery occurs meet applicable licensing requirements, that providers meet all

standard provider requirements under the regular medicaid program, that subject to approval other members of the recipient's household may be supported; and that family members, with the exception of parents and spouses, may be providers.

The proposed removal of language generally limiting prevocational, educational and supported employment as services, is necessary in that federal law now allows the provision of these services generally to all program recipients. The federal requirement that this limitation was based upon has been removed. Consequently, the Department submitted to and received approval from HCFA, to provide these services generally. This option is the best course, as opposed to retaining the limitations, in that the availability generally of these now federally recognized services adds these very important services to the menu of services available through the program and thereby significantly benefits a large number of program recipients.

The proposed amendment, narrowing the list of family members that can not be reimbursed as providers for purposes of service delivery, is necessary to comport with direction from HCFA. The prohibition is now limited to spouses and the natural or adoptive parents of minor children. This is the best option in that it allows greater flexibility in meeting the needs of participants in the program by taking advantage of readily available persons who generally have a long term commitment to seeing to the continued presence of their relative at home and in the community. This option, not previously allowed under federal authority, is now available and was provided for in the recent "waiver" approval granted to the State.

The provisions, prohibiting reimbursement of room and board and prohibiting payment of copayment, are proposed for removal from this rule because it is necessary to place them in the more appropriate rule setting of the new reimbursement rule, Rule I, which is a comprehensive compilation of reimbursement related matters. The proposed amendments to ARM 46.12.1405, removing the prohibitions on payment of the cost of room and board and on copayment, are the best option in that these matters are more appropriately presented in the proposed Rule I which is to be a comprehensive rule on reimbursement. Rule I, as proposed, provides for these prohibitions.

<u>THE PROPOSED AMENDMENTS TO ARM 46.12.1407, PERTAINING TO CASE MANAGEMENT SERVICES REQUIREMENTS</u>

ARM 46.12.1407, CASE MANAGEMENT SERVICES REQUIREMENTS, states requirements that are specifically applicable to the delivery of case management services. Case management is an essential feature of home and community services. The case management team with the participation of the recipient determines what the needs of the recipient are, which of the available services are appropriate for meeting those needs, arranges for the services and monitors and guides the delivery of the services.

These proposed amendments to ARM 46.12.1407 would provide a comprehensive description of case management services, rewrite some provisions, remove clerical staff as a member of the case management team, and provide the case management team with the additional responsibility to manage expenditures within the allocated monies or provide the department with required reports.

The inclusion in this rule of the comprehensive responsibilities describing the services to be performed by the case management team is necessary in that these responsibilities are currently stated in ARM 46.12.1407, CASE MANAGEMENT SERVICES DEFINITIONS, which, along with all other definition rules, is proposed in this notice for repeal as a measure to consolidate the rules.

The proposed case management requirements include three additional requirements not currently applicable, prior authorization of all services, management of expenditures and provision of required reports.

The prior authorization requirement would replace a requirement for the case management team to authorize payment claims. This proposed change is necessary in that it would clearly state the prior authorization requirement in a broadly applicable manner. This option, as opposed to leaving the current requirement that the case management team authorize payment of claims after the fact of performance, is the best option in that providers and recipients will know prior to the delivery of services that the delivery of the services is covered and reimbursable. This will avoid the problem of issues of coverage that arise after the fact of delivery.

The proposed requirement that would have the team manage expenditures is a new requirement which expressly provides for this function. Currently, under Department policy teams are directed to manage expenditures within budget. This is implied in rule, but does not appear expressly. The proposed change is necessary in that it would provide an express requirement in rule that the teams manage expenditures. This is the best option, as opposed to leaving the production unexpressed in rule, since it provides for a mandatory duty that compels fiscal accountability as required by HCFA and the Legislature. Without the fiscal discipline imposed by the rule the continued existence of the program would be jeopardized and with the possible result of the then current recipients losing services.

The proposed change, providing that the case management provide required reports, is necessary to assure accountability in the delivery of case management services. This is the best option, as opposed to leaving the production unexpressed in rule, since it provides for a mandatory duty that compels production of reports necessary to overall program accountability for HCFA and the Legislature. Without the rule the continued existence of the program would be jeopardized and with the possible result of the then current recipients losing services.

The proposed amendment that removes clerical staff as a member of the case management team is necessary in that as stated the clerical person would be a member of the team even though the appropriate role of the clerical staff is one of administrative support. This amendment is the best option given that clerical staff operationally are not to be members and in practice are not members. To not make this change would perpetuate this mistaken reference and thereby make the rule set less coherent.

The proposed change removing requirements for the case management team from a definition rule to the requirements rule, is the best option in that it would consolidate the separate definition rules into the pertinent requirements rules. That rule, as are all other definition rules, is proposed for repeal in order to reduce the number of rules. The pertinent material would be moved into general requirements rules. This option would fulfill the express direction of the Legislature that programs seek ways to reduce the volume of rules.

THE PROPOSED AMENDMENTS TO ARM 46.12.1409, PERTAINING TO PLANS OF CARE

ARM 46.12.1409, PLANS OF CARE, describes the role of the plan of care in the program, specifies the procedures governing the application of the plan of care, and specifies the constituent aspects of the plan of care. The plan of care is the essential feature of case management in the provision of services through the home and community services program.

The proposed amendments to ARM 46.12.1409 would include additional language further describing the nature and role of the plan of care in service delivery. These proposed changes are necessary in that they would provide guidance in relation to the use of the plan of care and clearly predicate service delivery upon the plan of care.

The option, represented by the proposed changes, is the best course in that the other option of leaving the role of the plan of care relatively unspecified and failing to clearly predicate service delivery upon the plan of care would cause the public to be subject to ongoing confusion in the matters addressed by this rule.

THE PROPOSED AMENDMENTS TO ARM 46.12.1411, PERTAINING TO COST OF PLAN OF CARE

ARM 46.12.1411, COST OF PLAN OF CARE, provides for the limitations applied to the cost of plans of care. The cost of plans of care, collectively and individual, is the principal feature of the cost control upon the program as a whole and upon each plan of care.

These proposed amendments to ARM 46.12.1411 in part would remove dated material relating to calculations of institutional costs as an aspect of the plan of care cost, would remove dated

material relating to the calculation of plan of care costs for intensive services, and would change aspects of the language and structure of this rule. The removal of the dated materials is necessary in that those aspects of calculating limits upon plans of care are no longer necessary for maintaining fiscal responsibility in the program. The removal of the materials is further necessary in that it allows more flexibility for the program in arriving at the total cost calculation on a per case basis and in allowing for the exceptions to that limitation provided in this rule.

The option, represented by the proposed changes, deleting the dated material concerning the costing of the plan of care, is the best course in that the other option of leaving the material intact would result in the rules not providing the calculations in light of the current federal requirements and the changes already implemented for the program.

The proposed amendments establishing a formula for calculation of the maximum plan of care total annual cost is necessary to meet the fiscal responsibilities mandated for the program under federal and state law. The formula, in existence under the rule in its current form, is modified in that the dated requirements in relation to the cost of ICF/MR services are removed as noted previously.

The proposed amendments also provide for the Department in its discretion to allow the plan of care cost for a recipient to exceed the individual maximum in certain circumstances. This allowance currently exists but the proposed amendments would modify the criteria that are to guide the Department in exercising its discretion. The revised criteria would provide for the possibility of allowance for exception when the excess arises out of adult residential services or is occurring over time but the amounts in excess of the maximum are minor. These additional criteria are necessary to address these circumstances that do arise on occasion and sometimes merit the allowance in that there is little fiscal impact upon the program and the needs of the person are accommodated thereby.

The option of adding the two further circumstances for the allowance of exceptions to the maximum annual amount placed on plans of care cost, as opposed to not incorporating them, is the best course in that these circumstances are ones in which benefit to the recipient may be warranted and the fiscal impact upon the program may not be significant.

<u>THE PROPOSED AMENDMENTS TO ARM 46.12.1413, PERTAINING TO NOTICE AND FAIR HEARING</u>

ARM 46.12.1413, NOTICE AND FAIR HEARING, provides for the criteria and procedures applicable to due process hearings for applicants for and recipients of services.

These proposed amendments to ARM 46.12.1413 would change aspects

of the language of this rule and would remove the notice procedure relating to the circumstance of loss of services due to insufficient program funding. The changes to language are necessary in order to improve comprehension.

The change, removing the notice procedure in relation to insufficient program funding, is necessary in that such a circumstance is a matter of a programmatic change arising out of funding rather than an individual determination of eligibility status under the programmatic rules. The provision is confusing as is in that there is no right to a hearing for a change to a person's services arising out of a programmatic change predicated upon the loss of funding. The notice stated in the provision is a courtesy notice and not a notice for a right to fair hearing. The rule is concerned with due process and therefore the notice provisions should be limited to that purpose. This circumstance has not arisen in the nearly 20 years of the existence of the program. It is unlikely that it would occur. If the circumstance were to occur the Department, even without a rule requirement, would proceed to provide notice as part of the case management function of adjusting the plan of care accordingly.

The option, represented by the proposed deletion of the notice relating to a programmatic change arising out of funding, is the best course in that the option of leaving this unnecessary notice in place as a courtesy notice would result in confusion in the event of a programmatic change driven by a funding decline.

THE PROPOSED AMENDMENTS TO ARM 46.12.1417, PERTAINING TO ENVIRONMENTAL ACCESSIBILITY ADAPTATION, REQUIREMENTS

ARM 46.12.1417, ENVIRONMENTAL ACCESSIBILITY ADAPTATION, REQUIREMENTS, provides for the criteria and procedures for the provision of environmental modifications as a service in the program.

The proposed amendments to ARM 46.12.1417 would incorporate the rule material that currently appears in ARM 46.12.1415, the definitions rule for environmental modifications, which is proposed for repeal. The proposed changes to this rule include aspects of the service not currently specifically stated in rule that encompass certain activities inclusive of modifications to a personal vehicle, installation of specialized electrical and plumbing systems, consultations, and measures to facilitate the caregiver's or provider's ability to provider services. Specifically, the current term "environmental modifications" would be replaced with the term "environmental accessibility adaptation services". The criteria would be modified by the deletion of the prohibition on expenditure for additions and items of clothing and by the addition of criteria requiring the service would be the "most cost effective", be "an adequate adaptation", be "reasonably expected to promote functional ability", not include measures relating to leisure activities,

and be limited to a one-time purchase.

The proposed amendments that would specifically include the additional coverage of modifications to a personal vehicle, installation of specialized electrical and plumbing systems, consultations, and measures to facilitate the caregiver's or provider's ability to provider services are necessary to address in rule the specified measures and thereby reduce the time and effort of providers, program officers and recipients devoted to checking on these aspects of coverage which have been unstated in rule. These measures are currently acceptable service measures. This option of specifying these measures is the best course, as opposed to not specifying them, in that they are significant measures that can foster a more independent life for a recipient and therefore their availability can be critical in preventing a more restrictive placement for the recipient.

The proposed amendments, providing for the deletion of the prohibition on expenditure for additions and items of clothing, are necessary in that there is the potential for more flexibility in coverage. The Department would retain the ability to control for inappropriate coverage of these measures in that the rule would otherwise provide for prior authorization of all services and provide substantive standards for determining the appropriateness and cost effectiveness of measures to be reimbursed through the program. This option, as opposed to the current restrictions, is the best course in that it allows for the flexibility by which to meet extenuating circumstances of need while retaining the fiscal and programmatic control of the Department. Consequently, some recipients with such need may continue to reside at home and in the community on an active basis.

The proposed amendments, explicitly stating the criteria requiring the service be the "most cost effective", be "an adequate adaptation", be "reasonably expected to promote functional ability", and not be for leisure activities are necessary to inform recipients and providers of these fundamental features that must be accounted for in this service. The further requirements that certain adaptation measures must be prior authorized by the Department and may be subject to consultation are likewise necessary to assure the provision of this service is predicated upon and subject to adequate controls to prevent misuse of the service. The imposition of the utilization criteria and close scrutiny procedures upon the provision of environmental adaptations is necessary in that this service is very different from the other services and unlike the other services does not have a specialized provider class. This option, as opposed to not explicitly stating these requirements and limitations, is the best course in that it clearly informs the recipients and providers of these so that there may be improved compliance with the requirements and the avoidance of expenditures upon inappropriate services.

The proposed amendment, explicitly limiting each recipient to

the provision of one of each environmental modification unless authorized by the Department, is necessary to limit program expenditures to those that would obtain adequate coverage of the environmental adaptation measure for a recipient. Most measures are only needed once or remain adequate for the needs of the person for an extended period. Often, though, there is a desire to not have an older though adequate version of a measure. The requirement is necessary in substance to preclude recipients and providers engaging in unnecessary updating to the financial detriment of the program.

The aspect of the provision allowing for Department approval of an exception allows for the flexibility to meet recipient needs. This option, imposing the single limit, as opposed to not imposing it, is the best course in that it provides in part for the presence of fiscal responsibility in the purchase of measures without sacrifice of appropriate and necessary service. While the requirement for prior authorization which is also proposed for amendment into this rule provides for significant control to prevent the purchase of inappropriate or unnecessary adaptation measures, the use of it as a control requirement, without the single purchase limit, is not adequate for purposes of apprising recipients and providers of the cautious approach that the Department is exercising so as to prevent the purchase of inappropriate or unnecessary adaptation measures.

THE PROPOSED AMENDMENTS TO ARM 46.12.1436, PERTAINING TO HABILITATION, REQUIREMENTS

ARM 46.12.1436, HABILITATION, provides for the criteria and procedures for the provision of habilitation as a service in the program.

The proposed amendments to ARM 46.12.1436 would incorporate the rule material that currently appears in ARM 46.12.1435, the definitions rule for habilitation, which is proposed for repeal. The criteria in the definition rule, excluding from habilitation prevocational, educational or supported employment, is not proposed for inclusion in this rule. The exclusion of prevocational, educational or supported employment from habilitation services was based on a prior legislative exclusion that the U.S. Congress has removed. This change has been implemented by the program and is significantly benefiting many recipients by further integrating them into the community through these activities. The proposed amendments also provide new provisions describing the component features of habilitation including residential, day, prevocational, educational, supported employment, and habilitation aide.

The removal of the exclusion of prevocational, educational and supported employment is necessary in that the program has previously implemented this service expansion in response to the federal legislative change and it is providing these very beneficial activities to many recipients. The addition of the descriptions of the component features of habilitation,

including residential, day, prevocational, educational, supported employment, and habilitation aide, is necessary to provide the scope of the habilitation service through its components and thereby apprise recipients and providers of that scope.

The option of removal of the limitation upon the provision of prevocational, educational and supported employment activities along with their specific inclusion as component services of habilitation is the best course, as opposed to continued preclusion, in that the predicate federal restriction is removed and numerous recipients can substantially benefit through the provision of these services. To not implement the change would leave those recipients and other recipients in the future without services appropriate to furthering their community integration through activities fostering work.

THE PROPOSED AMENDMENTS TO ARM 46.12.1439, PERTAINING TO RESPITE CARE, REQUIREMENTS

ARM 46.12.1439, RESPITE CARE, provides for the criteria and procedures for the provision of respite care as a service in the program.

The proposed amendments to ARM 46.12.1439 would incorporate the rule material that currently appears in ARM 46.12.1438, the definitions rule for respite care, which is proposed for repeal and would remove a 25 day annual limitation upon the service along with the exceptions to that limitation.

The proposed amendments, removing from this rule the 25 day annual limitation along with the exceptions to that limitation, are necessary to conform this rule with current practice in service delivery. The expansion of the service to cover extenuating though exceptional circumstances often encountered by family caregivers is necessary in that a programmatic assessment has determined that the broader scope of the respite service coverage can be critical to holding together familial based informal care that allows the recipient to remain at home and in the community. This option, as opposed to the current scheme of limited respite, is the best option in that it fosters continued residence at home and in the community-based on informal care from family and friends. This course meets social goals supporting family involvement and commitment and allows for the wise utilization of program resources.

THE PROPOSED AMENDMENTS TO ARM 46.12.1463, PERTAINING TO PSYCHO-SOCIAL CONSULTATION, REQUIREMENTS

ARM 46.12.1463, PSYCHO-SOCIAL CONSULTATION, provides for the criteria and procedures for the provision of psycho-social consultation as a service in the program.

The proposed amendments to ARM 46.12.1463 would incorporate the rule material that currently appears in ARM 46.12.1462, the

definitions rule for psycho-social consultation, which is proposed for repeal, would remove a limitation on the number of visits annually and would remove an instruction as to billing procedure.

The proposed amendment, removing from this rule the limit of 6 hourly visits annually, is necessary to conform this rule with current practice in service delivery. The removal of the limitation is necessary in that a programmatic assessment has determined that it is important to provide the various caregivers and providers with more support in understanding the conditions and circumstances of recipients and in providing needed coping skills. The ability of caregivers and providers to meet the needs of the recipient can be improved. This option, as opposed to the current scheme of limited access, is the best course in that it fosters the continued provision of services to recipients and thereby maintaining their residence at home and in the community.

The proposed amendment, removing the billing direction, is necessary in that the provision is instructional in nature and need not be expressed in rule. This option is the best course, as opposed to leaving the instruction in rule, in that billing instructions are best stated in manual material prepared for providers and do not constitute substantive requirements and criteria to govern the access to and the provision of program services.

THE PROPOSED AMENDMENTS TO ARM 46.12.1469, PERTAINING TO NURSING, REQUIREMENTS

ARM 46.12.1469, NURSING, provides for the criteria and procedures for the provision of nursing as a service in the program.

The proposed amendments to ARM 46.12.1469 would incorporate a definition of nursing care, remove language as to professional requirements, remove a requirement limiting the provision of the service to a recipient's home, remove a prohibition on the provision of the service in a personal care facility, and remove a limitation that the service may only be provided when home health nursing care is not available.

The removal of the requirements that limit the provision of nursing services to the home setting of the recipient and preclude the provision of services in a personal care facility setting is necessary in that the program in response to public concerns accepts a broader notion of what constitutes a community residence for older persons and persons with disabilities. Many persons with incapacities are seeking out and residing in supportive settings. The availability of nursing coverage through the program, in addition to the other services of the program, fosters their residence at home and in the community. This option, as opposed to leaving these limitations in place, is the best course in that it fosters the

continued provision of services to recipients and thereby maintaining their residence at home and in the community.

The removal of the professional requirements is necessary in that the rules generally governing the status of providers for purposes of reimbursement of medical services funded with medicaid monies provide for the requirements that all licensing standards be met by the would be providers. Consequently, it is redundant and potentially confusing to separately state such requirements in particular for each of the services. This is the best option in that it avoids redundancies that reduce rule volume as requested by the Legislature and in that it maintains provider requirements in a centralized rule grouping.

The removal of the requirement that the services only be provided by a home health agency is necessary in that nursing services are available from many types of providers in varying circumstances. The limitation due to costs and other considerations has been limiting the opportunities of recipients to receive necessary services in some circumstances. This is the best option, as opposed to maintaining the restriction to a single provider type, in that a broader spectrum of providers makes the services more readily available and affordable thereby fostering the continued provision of services to recipients and maintaining their residence at home and in the community.

THE PROPOSED AMENDMENTS TO ARM 46.12.1475, PERTAINING TO RESPIRATORY THERAPY, REQUIREMENTS

ARM 46.12.1475, RESPIRATORY THERAPY, provides for the criteria and procedures for the provision of respiratory therapy as a service in the program.

The proposed amendments to ARM 46.12.1475 would incorporate the rule material that currently appears in ARM 46.12.1474, the definitions rule for respiratory therapy, which is proposed for repeal, remove a requirement that the service only be provided in a recipient's home, remove a requirement that the recipient, absent the service, would require care as an inpatient in a hospital or nursing facility, remove a requirement that the service be provided only to a recipient who has adequate support services to be cared for at home, and remove an annual hourly limit upon the service.

The removal of the requirement that limits the provision of respiratory therapy services to the home setting of the recipient is necessary in that the program in response to public concerns accepts a broader notion of what constitutes a community residence for older persons and persons with disabilities. Many persons with incapacities are seeking out and residing in supportive settings. The availability of respiratory therapy coverage through the program, in addition to the other services of the program, fosters their residence at home and in the community. This option, as opposed to leaving this limitation in place, is the best course in that it fosters

the continued provision of services to recipients and thereby maintaining their residence at home and in the community.

The removal of the limitation that the service be provided only to a recipient who has adequate support services to be cared for at home is necessary in that this limitation is an unnecessary feature to place upon this service. The plan of care in planning, implementation and monitoring inherently accounts for the need to assure that the array of services provided to a person is properly balanced to assure that the respiratory therapy is delivered only in circumstances that make its delivery effective as a critical aspect of the recipient's residency. The statement of such a limitation in this particular rule is duplicative in effect. This option, as opposed to maintaining redundant requirements, is the best course.

The proposed amendment, removing from this rule the requirement that a recipient may not qualify for the service unless the recipient would in the absence of the service require care as an inpatient in a hospital or nursing facility, is necessary in that the criteria is a level of care criteria that pertains to eligibility for services generally and is not pertinent to a particular service. The level of care criteria appears for purposes of general application at ARM 46.12.1403. The statement of such a requirement in this particular rule is duplicative in effect. This option, as opposed to maintaining redundant requirements, is the best course.

The proposed amendment, removing from this rule the limit of 24 hours of service per fiscal year, is necessary to conform this rule with current practice in service delivery. The removal of the limitation is necessary in that a programmatic assessment has determined that it is important to provide recipients in need of the service with ready access to more hours. This option, as opposed to the current scheme of limited access, is the best course in that the access to more hours of service allows those recipients to maintain their residence at home and in the community.

THE DELETION OF CERTAIN STATUTORY AUTHORITIES IN RELATION TO IMPLEMENTATION

The existing citations of statutory authorities constituting the bases for implementation of the rules contain incorrect authorities. Those authorities are proposed for removal through this notice.

Several existing rules providing for particular home and community-based services contain a citation as implementing authority to 53-5-205, MCA. That statute has been subsequently renumbered since those citations were introduced and now is 52-3-205, MCA. That statute provides the Department with authority by which to implement a program of protective services for aged persons and disabled adults. The citation of that authority is

inappropriate for purposes of implementing the program of medicaid funded home and community-based services for persons who are elderly or who have disabilities. The program does not serve as a protective services program. There is a separate protective services program administrated by the Department partly under the authority of 52-3-205, MCA.

Several existing rules providing for particular home and community-based services contain a citation as implementing authority to 53-6-111, MCA. That statute provides the Department with authority by which to undertake all the necessary activities to establish a vendor payment system along with measures to prevent, uncover, and sanction abuse and fraud in provider billing for medicaid funded services. The citation of that authority is inappropriate for purposes of implementing the particular services constituting the program of medicaid funded home and community-based services for persons who are elderly or who have disabilities.

6. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on March 9, 2000. Data, views or arguments may also be submitted by facsimile (406) 444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the adoption of rules I through XVIII and the amendment, transfer and repeal of rules from ARM Titles 11, 16, 37 and 46 relating to fair hearings and contested case proceedings	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, TRANSFER AND REPEAL

TO: All Interested Persons

1. On March 2, 2000, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption, amendment, transfer and repeal of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on February 25, 2000, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] APPLICABLE HEARING PROCEDURES (1) This chapter specifies the fair hearing procedures applicable to department actions in the various programs administered by the department. This chapter does not grant any right to a hearing, but specifies the hearing rules that apply where a right to hearing is otherwise granted by law or rule.

AUTH: Sec. 50-1-202, 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 41-3-1142, 42-10-104, 50-1-202, 50-4-612, 50-5-103, 50-6-103, 50-6-402, 50-15-102, 50-15-103, 50-15-121, 50-15-122, 50-31-104, 50-52-102, 50-53-103, 52-1-103, 52-2-111, 53-2-201, 53-2-904, 52-3-406, 53-4-202, 53-4-212, 53-4-606, 53-4-1004, 53-6-111, 53-6-113, 53-6-131, 53-6-402, 53-20-305, 53-24-208 and 69-8-412, MCA

[RULE II] PUBLIC ASSISTANCE, DAYCARE, MEDICAL, LICENSURE AND REFUGEE ASSISTANCE PROGRAMS: APPLICABLE HEARING PROCEDURES (1) Hearings contesting adverse department actions under the programs specified in (1)(a) through (1)(k) are available to the extent granted in and according to the provisions of [Rule

XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A, except as otherwise provided by department rule.

(a) aging services;

(b) day care benefits, except the child and adult food program;

(c) families achieving independence in Montana (FAIM) financial assistance;

(d) food stamps;

(e) foster care maintenance services;

(f) foster care support services;

(g) low income energy assistance program (LIEAP);

(h) low income weatherization program (LIWAP);

(i) medical assistance program (medicaid);

(j) refugee assistance; and

(k) licensure and registration of day care centers, family day care homes and group day care homes under Title 52, chapter 2, part 7, MCA.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-2-904, 52-3-406, 53-4-212, 53-4-606, 53-6-111, 53-6-113, and 69-8-412, MCA

[RULE III] NURSING FACILITY RELATED CASES: APPLICABLE HEARING PROCEDURES (1) Hearings contesting a transfer or discharge of a nursing facility resident by a nursing facility are available to the extent granted in 42 CFR part 431, subpart E and shall be conducted in accordance with [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A. A resident shall be considered a claimant for purposes of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

(a) Although the department is required by federal law to provide a hearing forum for hearings contesting a transfer or discharge of a nursing facility resident by a nursing facility, the department is not a party to the hearing. The contested action is the action of a nursing facility rather than the department. In such cases, relief may not be granted against the department.

(2) Except as provided in (2)(a), department fair hearings for nursing facilities contesting a department action denying or terminating the facility's medicaid provider agreement or imposing civil monetary penalties or other alternative remedies for noncompliance with the nursing facility participation requirements in 42 CFR part 483 are not available, because a hearing regarding the same action is available from the federal medicare/medicaid agency.

(a) A nursing facility that participates only in the Montana medicaid program, and not in the medicare program, and for whom no federal appeal is available with respect to the same issue is entitled to a hearing before the department to the extent granted in 42 CFR part 431, subpart D, with respect to a department action to deny or terminate participation in medicaid

or otherwise sanction the facility for noncompliance with the nursing facility participation requirements in 42 CFR part 483. To the extent a hearing is available under this rule, the hearing shall be conducted in accordance with and subject to the provisions of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A and 42 CFR part 431, subpart D.

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

[RULE IV] STATE INSTITUTIONS, ADMISSION, DISCHARGE AND ABILITY TO PAY FOR CARE: APPLICABLE HEARING PROCEDURES

(1) Hearings relating to determinations of ability to pay for cost of care in a state institution are available to the extent granted in 53-1-407, MCA and shall be conducted in accordance with [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The resident or financially responsible person shall be considered a claimant for purposes of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) Persons contesting denial of admission to or involuntary discharge from a state institution shall have only such rights of appeal or hearing as is specifically granted by statute or department rule, including but not limited to ARM 37.45.501 and 37.66.130. The provisions of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to appeals under ARM 37.45.501 or 37.66.130.

(3) Persons contesting denial of admission to or discharge from the Montana developmental center and the Eastmont human services center shall have such rights of appeal or hearing as provided in [Rule VIII].

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-1-407, 53-21-402, 53-21-411 and 53-21-413, MCA

[RULE V] CHEMICAL DEPENDENCY PROGRAM CERTIFICATION: APPLICABLE HEARING PROCEDURES (1) Hearings contesting adverse department actions regarding denial, suspension, revocation, limitation or restriction of approval of chemical dependency treatment programs and chemical dependency education courses are available to the extent provided and according to the procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The person or entity aggrieved by the adverse department action shall be considered a provider for purposes of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) Hearings contesting denial, suspension, revocation, limitation or restriction of chemical dependency treatment programs under ARM Title 37, chapter 27, subchapter 1 shall be conducted as provided in [Rule VIII].

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-24-208, MCA

[RULE VI] MENTAL HEALTH SERVICES PLAN: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the mental health services plan (MHSP), are available to the extent provided in ARM 46.20.123. The procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A apply to such hearings, subject to the provisions of ARM 46.20.123.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-1-601, MCA

[RULE VII] DEVELOPMENTAL DISABILITIES PROGRAMS: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the developmental disability services program are available as follows:

(a) except as otherwise provided by department rule, hearings contesting adverse department actions in the developmental disabilities services program are available to the extent provided and according to the procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A;

(b) hearings contesting a determination by the residential facility screening team that a person is not seriously developmentally disabled and therefore that a commitment or recommitment is not appropriate are available to the extent provided and according to the procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A, subject to the provisions of ARM 37.34.2313;

(c) hearings contesting adverse determinations by the developmental disabilities screening review board are available to the extent provided and according to the procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A, subject to the provisions of ARM 37.34.2313;

(d) hearings contesting adverse department determinations regarding services under the medicaid home and community services program for persons with developmental disabilities are available to the extent provided and according to the procedures specified in [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A, subject to the provisions of ARM 37.34.919;

(e) hearings contesting adverse department actions regarding certification of a person to assist or supervise clients in taking medication are available to the extent provided and according to the procedures specified in ARM 37.34.114, and the provisions of [Rule XVII], and ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings;

(f) hearings contesting adverse actions regarding the individual planning process are available to the extent provided and according to the procedures specified in ARM 37.34.1114 and

37.34.1115, and the provisions of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings;

(g) hearings contesting adverse actions regarding the residential facility screening process are available to the extent provided and according to the procedures specified in ARM 37.34.234, and the provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings; and

(h) hearings contesting adverse department actions regarding aversive procedures approved for habilitation of a person with developmental disabilities are available to the extent provided and according to the procedures specified in ARM 37.34.1426, and the provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-6-101, 53-6-402, 53-20-125, 53-20-127, 53-20-128, 53-20-129, 53-20-133, 53-20-203, 53-20-204, 53-20-205, 53-20-206, 53-20-209 and 53-20-504, MCA

[RULE VIII] CERTAIN TITLE 50 PROGRAMS AND OTHER PROGRAMS FOR WHICH NO PROCEDURE IS OTHERWISE SPECIFIED: APPLICABLE HEARING PROCEDURES (1) Hearings under the programs specified in (1)(a) through (1)(u) are available to the extent specifically provided by law, including the Montana Code Annotated and department rules. The provisions of [Rule XVII] and 46.2.208 do not apply to such hearings. Such hearings shall be conducted in accordance with the Montana Administrative Procedure Act and ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212 and 46.2.214.

(a) vital statistics under Title 50, chapter 15, MCA;

(b) food establishment licensure and enforcement under Title 50, chapter 50, MCA;

(c) lodging space accommodation establishment licensure and enforcement under Title 50, chapter 51, MCA;

(d) campground and trailer court licensure and enforcement under Title 50, chapter 52, MCA;

(e) laboratory licensure under 50-1-210, MCA;

(f) public swimming pool and bathing place licensure and enforcement under Title 50, chapter 53, MCA;

(g) emergency medical services licensure and enforcement under Title 50, chapter 6, MCA;

(h) designation of health care facilities as trauma facilities under Title 50, chapter 6, part 4, MCA;

(i) health care facility licensure and enforcement under Title 50, chapter 5, MCA;

(j) denial or revocation of a certificate of public advantage under Title 50, chapter 4, part 6, MCA;

(k) enforcement of the Montana Food, Drug, and Cosmetic Act, Title 50, chapter 31, MCA;

(l) department findings or determinations of abuse, neglect or misappropriation of resident funds by a nurse aide in

a nursing facility under 42 CFR 488.335, subject to the provisions of 42 CFR 488.335;

(m) refusal, revocation or suspension of a certificate of sanitation under ARM Title 16, chapter 10, subchapter 16;

(n) denial of an application for approval of chemical dependency treatment programs under ARM Title 37, chapter 27, subchapter 1;

(o) requests for departmental review of final grievance decisions by contractors under the Children's Health Insurance Plan (CHIP);

(p) denial, suspension, restriction, revocation or reduction to provisional status of a child placing agency license under ARM Title 37, chapter 93, subchapter 2;

(q) denial, suspension, revocation or non-renewal of a youth foster care license or youth care facility license under ARM Title 37, chapter 97, subchapter 1;

(r) denial of a license for a community home for persons with developmental disabilities under ARM Title 37, chapter 100, subchapters 3 and 4;

(s) assessment of a tobacco education fee against an employee or owner of an establishment under 16-11-308, MCA;

(t) denial or other determinations of the amount, duration or continuation of an adoption subsidy under ARM Title 37, chapter 52, subchapter 2; and

(u) any department program with respect to which a right to hearing is specifically granted by law, including department rule, but for which a hearing process is not otherwise provided by department rule.

AUTH: Sec. 50-1-202, 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 41-3-1142, 42-10-104, 50-1-202, 50-4-612, 50-5-103, 50-6-103, 50-6-402, 50-15-102, 50-15-103, 50-15-121, 50-15-122, 50-31-104, 50-52-102, 50-53-103, 52-2-111, 53-2-201, 53-4-1004, 53-6-111, 53-6-113, 53-6-402, 53-20-305 and 53-24-208, MCA

[RULE IX] HEALTH CARE FACILITY CERTIFICATE OF NEED: APPLICABLE HEARING PROCEDURES (1) Hearings relating to a health care facility certificate of need are available to the extent granted and as provided in 50-5-306, MCA, ARM 16.32.112 and 16.32.118. The provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

(2) Hearings relating to a health care facility certificate of need will be conducted in person in Helena, Lewis and Clark County, Montana, at a location designated by the department, unless the parties mutually agree to conduct the hearing telephonically.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 50-5-306, MCA

[RULE X] WOMEN, INFANTS, CHILDREN (WIC) PROGRAM: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the

women, infants, children (WIC) program are available to the extent provided in and according to the procedures specified in ARM Title 16, chapter 26. The provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

AUTH: Sec. 50-1-202 and 53-2-201, MCA
IMP: Sec. 50-1-202, MCA

[RULE XI] CHILD AND ADULT CARE FOOD PROGRAM: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the child and adult care food program are available to the extent granted and as provided in 42 CFR 226.6(k). The provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

(a) Review of actions under the child and adult care food program will be limited to a review of written information, unless the affected institution requests a hearing in addition to, or in lieu of, a review of written information. The notice of action required by 42 CFR 226.6(k) must state that in the event the institution chooses to appeal an action, a hearing will be held by the review official in addition to, or in lieu of, a review of written information, only if the institution so requests in the letter of notice of appeal.

(b) Hearings relating to the child and adult care food program will be conducted in person in Helena, Lewis and Clark County, Montana, at a location designated by the department, unless the parties mutually agree to conduct the hearing telephonically.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

[RULE XII] VOCATIONAL REHABILITATION AND VISUAL SERVICES PROGRAMS: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the vocational rehabilitation services program or visual services program are available to the extent granted and as provided in ARM 37.30.1401 and 37.30.1403. The provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-7-102, 53-7-315 and 53-19-112, MCA

[RULE XIII] TELECOMMUNICATIONS ACCESS PROGRAM: APPLICABLE HEARING PROCEDURES (1) Hearings relating to the telecommunications access program are available to the extent granted and as provided in ARM 37.36.901 and 37.36.902. The provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A do not apply to such hearings.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-19-305, MCA

[RULE XIV] CHILD SUPPORT ENFORCEMENT: APPLICABLE HEARING PROCEDURES (1) Hearings relating to child support enforcement matters are available to the extent granted and as provided in ARM Title 46, chapter 30, subchapter 6. Unless specifically referenced in that subchapter, the provisions of any other rule do not apply to such hearings.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 17-4-105, 40-5-202, 40-5-262, 40-5-273, 40-5-405, 40-5-713, 40-5-825 and 40-5-906, MCA

[RULE XV] DEPARTMENT HEARING PROCEDURES, SCOPE AND SUBORDINATION TO CERTAIN OTHER LAW (1) There is no right to a hearing in any matter except as specifically provided by law, including department rule.

(2) There is no right to a hearing in a contract dispute between the department and any other person or entity except as specifically provided by the terms of the contract or as specifically provided by state law.

(3) The rules in this chapter are subject to the provisions of any applicable federal statute or regulation, whether now in existence or hereafter adopted.

(4) The rules in this chapter are subject to any other provision of Montana statute or department rule applicable to the particular program or matter at issue.

AUTH: Sec. 50-1-202, 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 41-3-1142, 42-10-104, 50-1-202, 50-4-612, 50-5-103, 50-6-103, 50-6-402, 50-15-102, 50-15-103, 50-15-121, 50-15-122, 50-31-104, 50-52-102, 50-53-103, 52-1-103, 52-2-111, 53-2-201, 53-2-904, 53-3-406, 53-4-202, 53-4-212, 53-4-606, 53-4-1004, 53-6-111, 53-6-113, 53-6-131, 53-6-402, 53-20-305, 53-24-208 and 69-8-412, MCA

[RULE XVI] APPLICABILITY (1) This rule and ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A apply only to hearings in the program areas specified in [Rules I through XVI], and shall not be construed to grant a right to hearing in any other matter.

(2) The provisions of this rule, [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A are subject to the provisions of [Rules I through Rule XV].

(3) Where a right to a hearing is granted in [Rules II through XIV] or any other rule of the department, the right to hearing is not absolute but is subject to all applicable provisions of these rules and other applicable law.

AUTH: Sec. 50-1-202, 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 41-3-1142, 42-10-104, 50-1-202, 50-4-612, 50-5-103, 50-6-103, 50-6-402, 50-15-102, 50-15-103, 50-15-121, 50-15-122, 50-31-104, 50-52-102, 50-53-103, 52-1-103, 52-2-111, 53-2-201, 53-2-904, 52-3-406, 53-4-202, 53-4-212, 53-4-606, 53-4-1004, 53-6-111, 53-6-113, 53-6-131, 53-6-402, 53-20-

305, 53-24-208 and 69-8-412, MCA

[RULE XVII] INFORMAL RECONSIDERATION (1) A provider or other person may request an informal reconsideration of a department action in the following cases:

(a) where the hearing is to be held after the effective date of a denial, termination, or non-renewal of enrollment, certification or registration;

(b) where the department intends to withhold or suspend payments to a medical assistance provider pursuant to ARM 46.12.408; or

(c) as otherwise provided by department rule.

(2) The informal reconsideration includes:

(a) written notice to the provider of the department action and the findings upon which it was based, if not otherwise already provided;

(b) the provider's written refutation of the department's findings, which must be received by the department within 15 days after mailing of the department's notice under (2)(a); and

(c) the department's written determination modifying, affirming or reversing its decision.

(3) This rule does not require that the informal reconsideration or any hearing be conducted prior to the department action.

(4) An informal reconsideration under this rule is not subject to the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA.

(5) An informal reconsideration is a different and separate form of procedure from an administrative review and/or fair hearing. A provider or other person is not entitled to an administrative review, fair hearing or other process in addition to an informal reconsideration unless specifically provided by department rule or otherwise required by law.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

[RULE XVIII] APPLICABILITY OF NOTICE REQUIREMENTS (1) [Rule XIX], 46.2.203 and 46.2.204 apply only to claimants under the following programs:

(a) developmental disabilities program;

(b) families achieving independence in Montana (FAIM) financial assistance;

(c) food stamps;

(d) medical assistance program (medicaid);

(e) low income energy assistance program (LIEAP);

(f) low income weatherization program (LIWAP);

(g) mental health managed care services;

(h) refugee assistance;

(i) day care benefits, except child and adult food care;

(j) foster care maintenance services;

(k) foster care support services; and

(l) any other program as provided by department rule.

AUTH: Sec. 50-1-202, 53-2-201 and 53-6-113, MCA
IMP: Sec. 41-3-1103, 50-1-202, 52-1-103, 53-2-201, 53-2-904, 53-4-202, 53-4-606, 53-6-111, 53-6-113, 53-6-131, 53-20-305 and 69-8-412, MCA

3. The Department is amending and transferring the rules as follows. Matter to be added is underlined. Matter to be deleted is interlined.

11.11.113 [37.93.210] CHILD PLACING AGENCY, HEARING PROCEDURES (1) Any person ~~dissatisfied because of denial, revocation, suspension, or restriction of~~ aggrieved by an adverse department action denying, revoking, suspending or restricting a license may request a hearing as provided in ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 52-2-111, 52-2-403, 53-4-111 and 53-4-403~~(3)~~, MCA
IMP: Sec. 52-2-113, 53-4-113~~(4)~~ and 53-4-403, MCA

11.12.110 [37.97.118] YOUTH CARE FACILITY, HEARING PROCEDURE (1) Any person ~~dissatisfied because of either the department's refusal to grant a license or the department's revocation of~~ aggrieved by an adverse department action denying or revoking a license for a community home for persons with developmental disabilities may request a hearing as provided in ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 41-3-503, 41-3-1103, 41-3-1142, 52-2-111 and 53-4-111, MCA
IMP: Sec. 41-3-503, 41-3-1103, 41-3-1142, 52-2-113, 53-2-201 and 53-4-113, MCA

11.18.121 [37.100.316] FAIR HEARING (1) Any person, corporation or other entity ~~dissatisfied because of either the department's refusal to grant a license or the department's revocation or suspension of~~ aggrieved by an adverse department action denying, revoking or suspending a license may request a fair hearing in accordance with ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.
(2) remains the same.

AUTH: Sec. 53-20-305, MCA
IMP: Sec. 53-20-305, MCA

11.19.109 [37.100.416] PHYSICALLY DISABLED GROUP HOMES, FAIR HEARING (1) Any person, corporation or other entity ~~dissatisfied because of either the department's refusal to grant a license or the department's revocation or suspension of~~ aggrieved by an adverse department action denying, revoking or suspending a license may request a fair hearing in accordance

with ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) remains the same.

AUTH: Sec. 53-19-112, MCA
IMP: Sec. 53-19-112, MCA

46.2.201 [37.5.304] DEFINITIONS For purposes of this subchapter, unless the context requires otherwise, the following definitions apply:

(1) "Department" means the department of ~~social and rehabilitation~~ public health and human services provided for in ~~section~~ 2-15-2201, MCA.

(2) "Adverse action" means:

(2)(a) remains the same.

(b) a failure of the department to act ~~promptly~~ within a reasonable time on a claimant's application for benefits;

(c) an action by the department denying, suspending, reducing or terminating benefits of a claimant, or an action by the department demanding repayment of or to recover an overpayment of benefits to a claimant;

(d) an action by the department establishing conditions on the manner or form of benefits, including restrictive benefits or protective payments, or establishing conditions for the receipt of benefits, including a work requirement;

(e) an action by the department to deny, terminate or fail to renew certification or a provider agreement for the medicaid program to any ~~skilled~~ nursing facility or intermediate care facility for the mentally retarded;

(f) an action by the department to deny, suspend, reduce, revoke or terminate licensure, registration, certification or enrollment of a provider or to fail to renew certification, enrollment, licensure or the registration certificate of a provider who has applied for renewal;

(g) an action by the department establishing the rate of reimbursement for a medical assistance provider or denying in whole or in part a medical assistance provider's claim for services or items; ~~or~~

(h) ~~any other department action or determination with respect to which a right to hearing is specifically granted by department rule, but for which a hearing process is not otherwise provided.~~ an action by the department demanding repayment of or to recover an overpayment made to a medical assistance provider, or to impose a penalty or sanction against a medical assistance provider under ARM Title 46, chapter 12, subchapter 4;

(i) a department determination of ability to pay for the cost of care in an institution under 53-1-405, MCA;

(j) a department determination that a medicaid applicant or recipient is permanently institutionalized;

(k) a determination that the department intends to impose a lien upon the applicant's or recipient's real property pursuant to 53-6-171, MCA.

(3) "Authorized representative" means legal counsel,

relative, friend or other spokesman specifically authorized by the claimant in writing or by law to represent the claimant in matters pertaining to the receipt of benefits from this department~~, but it does not include an employee of the department~~.

(4) "Benefit" means any form of assistance provided by or through the department to an eligible recipient under the ~~Administrative Rules of Montana, Title 46~~ department's administrative rules.

(5) "Board" means the board of ~~social and rehabilitation appeals~~ public assistance provided for in ~~section~~ 2-15-2203, MCA.

(6) "Claimant" means:

(a) an applicant for or recipient of benefits from the department whether an individual or household and includes the claimant's authorized representative;

(b) a resident or financially responsible person as defined in 53-1-401, MCA;

(c) a medical assistance provider appealing an eligibility determination as a real party in interest; or

(d) any other person or entity as provided by department rule.

(7) through (10) remain the same.

(11) "Medical assistance provider" means any individual or organization providing services to eligible claimants under ~~Title 46, chapters 12 or 25 of the Administrative Rules of Montana~~ the Montana medicaid program established under Title 53, chapter 6, MCA.

(12) "Provider" means an individual or organization licensed, enrolled or registered by the department or authorized by the department to provide services to a person eligible for benefits. For purposes of this subchapter, "provider" includes:

(a) any individual or organization seeking to obtain or retain any license, enrollment or certification required to provide services to eligible persons or the general public;

(b) a medical assistance provider;

(c) any individual or organization that is not a claimant; or

(d) any other person or entity as provided by department rule.

AUTH: Sec. 2-4-201, 41-3-1142, 52-2-111, 52-2-112, 52-2-403, 52-2-704, 52-3-304, 52-3-804, 53-2-201, 53-2-606, 53-2-803, 53-3-102, 53-3-107, 53-4-111, 53-4-212, 53-4-403, 53-4-503, 53-5-304, 53-5-504, 53-6-111, 53-6-113, 53-7-102 and 53-20-305, MCA

IMP: Sec. 2-4-201, 41-3-1103, 53-2-201, 53-2-306, 53-2-606, 53-2-801, 53-3-107, 53-4-112, 53-4-404, 53-4-503, 53-4-513, 53-5-304, 53-6-111, 53-6-113 and 53-20-305, MCA

46.2.202 [37.5.307] OPPORTUNITY FOR HEARING (1) A claimant who is aggrieved by an adverse action of the department shall be afforded the opportunity for a hearing as provided in this ~~chapter~~ subchapter.

(1)(a) and (b) remain the same.

(c) ~~The~~ A request for a hearing by a claimant ~~shall have a reasonable time from an adverse action, not to exceed~~ must be received by the department within 90 days after the date of mailing of notice of the adverse action, ~~in which to request a hearing~~ except as otherwise provided in these rules.

(i) A hearing request from a claimant must be received in writing within 30 days of the date of mailing of notice of the adverse action regarding:

(A) a department determination of ability to pay for the cost of care in an institution under 53-1-405, MCA; or

(B) a nursing facility's transfer or discharge of a nursing facility resident.

(ii) Hearing requests must be mailed or delivered to the department's Office of Fair Hearings, P.O. Box 202953, Helena, MT 59620-2953.

(1)(d) remains the same.

(2) ~~Providers contesting actions by the department regarding payment for services performed by providers or actions by the department to deny, suspend, terminate or fail to renew registration, certification or licensure,~~ A provider other than a medical assistance provider who is aggrieved by an adverse action of the department shall be granted the right to hearing as provided in this ~~chapter~~ subchapter, except as ~~specifically~~ otherwise provided in other department rules.

(a) A request for a hearing from a provider must be ~~submitted~~ received by the department in writing within ~~thirty (30)~~ days ~~of~~ after the date of mailing of notice of the department's adverse action~~, except that day care provider must submit a request for fair hearing within ten (10) days of the date of notice of the department's adverse action~~.

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

~~(4)~~ (3) Medical assistance providers ~~of inpatient psychiatric services for individuals under age 21, inpatient hospital services, outpatient hospital services, swing bed hospital services, federally qualified health center services and case management services for high risk pregnant women contesting~~ aggrieved by adverse department actions, other than medical assistance providers appealing eligibility determinations as a real party in interest, shall be granted the right to a hearing as provided in ARM 46.12.509A.

(a) A medical assistance provider appealing a recipient eligibility determination as a real party in interest is entitled to a hearing according to the procedures and subject to the requirements applicable to claimants except as provided in (3)(b).

(b) It is the provider's responsibility to verify that medicaid eligibility has been established. If a medical assistance provider receives information from the department indicating that a recipient has not or may not have been determined eligible for medicaid, as, for example, in an

explanation of benefits code on a statement of remittance, the provider must take appropriate action to verify or establish eligibility. A hearing request by the medical assistance provider as a real party in interest regarding the recipient's medicaid eligibility will not be considered timely if received by the department more than 90 days after the earlier of:

(i) receipt of the information indicating that the recipient has not or may not have been determined medicaid eligible; or

(ii) adequate notice to the claimant of the adverse action.

(c) A medical assistance provider is not entitled to notice from the department of an adverse action regarding a claimant's eligibility for medical assistance, except that:

(i) if the medical assistance provider has submitted to the county office making the eligibility determination a written request for notice of a determination on a pending application for medical assistance, the county office must mail to the provider a copy of the same notice provided to the claimant; and

(ii) if the medical assistance provider has submitted to the county office responsible to monitor and administer a recipient's ongoing eligibility a written request for notice of termination of eligibility for medical assistance, the county office must mail to the provider a copy of any notice of termination provided to the claimant.

~~(5) Medical assistance providers contesting actions by the department to withhold or suspend payments or sanction a provider in accordance with ARM 46.12.401 et seq. shall be granted the right to hearing if a written request for a hearing is submitted within 30 days of the date of notice of the department's action.~~

~~(6)~~(4) There is no opportunity for hearing under this subchapter on departmental activities that are not defined as an adverse action in ARM 46.2.201~~(2)~~, unless a right to hearing under this subchapter is specifically granted by other department rule. A dispute regarding a contract between the department and a provider or other person or entity is not an adverse action by the department and there is no opportunity for fair hearing concerning such disputes.

AUTH: Sec. 2-4-201, 41-3-1142, 52-2-111, 52-2-112, 52-2-403, 52-2-704, 52-3-304, 52-3-804, 53-2-201, 53-2-606, 53-2-803, 53-3-102, 53-4-111, 53-4-212, 53-4-403, 53-4-503, 53-5-304, 53-6-111, 53-6-113, 53-7-102 and 53-20-305, MCA

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

46.2.203 [37.5.503] NOTICE UPON APPLICATION FOR PUBLIC ASSISTANCE (1) At the time of application for benefits administered by the department, including but not limited to FAIM, food stamps, medicaid, LIEAP, LIWAP, refugee assistance and day care benefits, a claimant shall be informed in writing of:

~~(1)~~ (a) the claimant's right to a hearing;
~~(2)~~ (b) how a hearing may be obtained;
~~(3)~~ (c) the right to representation by legal counsel, relative, friend or other spokesman; ~~and~~
(d) notice of the possible penalties for intentional program violations; and
~~(4)~~ (e) ~~the availability of free legal representation~~ any other information specifically required by applicable law, including department rule.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.2.204 [37.5.505] NOTICE UPON ADVERSE PUBLIC ASSISTANCE ACTION (1) Upon an adverse action by the department affecting benefits administered by the department, including but not limited to FAIM, food stamps, medicaid, LIEAP, LIWAP, refugee assistance and daycare benefits, the claimant ~~or provider~~ shall be provided adequate and timely notice.

~~(1) If the adverse action proposed by the department is the denial of benefits to a claimant, notice is timely if it is transmitted or mailed within one (1) day following the end of the period allowed for the processing of applications under the rules of the applicable program.~~

(2) If the adverse action proposed by the department is the suspension, reduction or termination of benefits of the claimant, notice is timely if it is mailed at least ~~ten (10)~~ days prior to the time the proposed adverse action is to become effective.

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

(iii) a member of claimant household is disqualified for fraud, or the benefits of the claimant household are reduced or terminated to reflect the disqualification of the member as provided for in 7 CFR §273.16; and

(iv) the department initiates a mass change as described in 7 CFR §273.12(e).

(f) in the case of benefits received under all programs except the food stamp program:

(3)(f)(i) through (3)(f)(iii) remain the same.

(iv) claimant is a child receiving benefits under the ~~aid to dependent children program~~ FAIM program and is removed from his home by judicial determination or is voluntarily placed in foster care by legal guardian;

(3)(f)(v) and (vi) remain the same.

(4) In the case of probable fraud in all programs except the food stamp program, notice of adverse action is timely if mailed at least ~~five (5)~~ days prior to the effective date of the adverse action.

(5) Notice is adequate if it includes:

(5)(a) and (b) remain the same.

(c) ~~the specific regulations supporting the proposed adverse action;~~

~~(d) an explanation~~ a statement of the claimant's right to

a hearing and~~,~~

~~(e)~~ how to obtain a hearing;

~~(f) telephone number to call for additional information;~~

~~(g) the right to be represented by legal counsel, friend, relative or other spokesman;~~

~~(h) the availability of free legal assistance; and~~

~~(i)~~ (d) if applicable, whether or not benefits are to be continued and the liability of the claimant for benefits received pending hearing if the hearing decision is adverse; and

(e) any other information as specifically required by applicable law, including department rule.

~~(6) If the adverse action proposed by the department is to deny, terminate or refuse to renew a provider, the notice is timely if it is mailed at least thirty (30) days prior to the time the proposed adverse action is to become effective.~~

(6) A notice is effective for purposes of this rule if the notice substantially complies with the requirements of (5). A notice shall not be considered inadequate for purposes of this rule based upon good faith errors or omissions that are not prejudicial to the substantial rights of the claimant.

(7) A claimant is not entitled to advance notice of an adverse determination regarding medical necessity of services under the medicaid program. The department may review medical necessity as provided in ARM 46.12.306 and notice of any adverse action may be provided within a reasonable time after a determination, even though the services may have been provided at an earlier date.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113, 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.2.205 [37.5.313] DENIAL OR DISMISSAL OF HEARING (1) A hearing need not be granted or may be dismissed when:

~~(1)~~ (a) the request for a hearing is withdrawn by the claimant or provider or his representative;

~~(2)~~ (b) the claimant or provider or his representative without good cause fails to appear at the hearing;

~~(3)~~ (c) the request is not received within the specified time;

~~(4)~~ (d) either federal or state law requires automatic benefit changes for a class of claimants unless the issue is incorrect benefit adjustments; ~~or~~

~~(5)~~ (e) the department does not have jurisdiction over the subject matter or the appeal procedure~~.~~;

(f) the contested action is not an adverse action;

(g) the contested action is not an action of the department, but rather an action of a provider or other person or entity, unless department rule specifically grants a right to hearing with respect to actions by the person or entity;

(h) the claimant or provider is not aggrieved by the contested adverse action;

(i) the hearing request, considered together with other documentation in the record, demonstrates that the only issue is

one of constitutionality or other issue beyond the hearing officer's power or jurisdiction; or

(j) the provisions of any other department rule so provides.

(2) A pending hearing may be dismissed when the claimant or provider or his representative fails to respond to or comply with a request or order from the hearing officer, including but not limited to a request or order to inform the hearing officer whether the party wishes to proceed further with the fair hearing case, if the party has been warned that failure to respond or comply will result in dismissal. A hearing dismissed under this subsection may be reinstated by the hearing officer only if the claimant, provider or his representative demonstrates good cause for the failure to respond or comply upon which dismissal was based.

(3) The list of grounds for dismissal in this rule is not exclusive. Unless inconsistent with particular rules in this chapter or other applicable law, dismissal may be granted based upon other principles of general law.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113, 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.2.206 [37.5.316] CONTINUATION OF PUBLIC ASSISTANCE BENEFITS (1) This rule regarding continuation of benefits applies only to benefits under the following programs:

(a) FAIM cash assistance;

(b) food stamps; and

(c) medicaid, subject to (2).

(2) For purposes of this rule, benefits do not include services under the medicaid home and community-based services program for persons who are elderly or who have a disability, or developmental disability services funded under the medicaid program.

~~(1)~~ (3) If a claimant requests a hearing within the period between the date of the notice and the date of the adverse action and the claimant is receiving benefits at that time, at the request of the claimant benefits shall be continued until the earlier of the expiration of the current eligibility or authorization period or issuance of a ~~until after a final~~ hearing decision ~~is rendered~~, except as provided in ~~paragraph (4)~~ (7) and (8) of this ~~section~~ rule.

~~(2)~~ (4) If the claimant establishes that his failure to request a hearing within the notice period was for good cause the department shall at the request of the claimant, reinstate the benefits to their prior level ~~pending the~~ until the earlier of the expiration of the current eligibility or authorization period or issuance of a hearing decision, except as provided in (6) and (7) of this rule.

~~(3)~~ (5) If an ~~In any case where~~ action is taken without timely notice and the ~~applicant~~ claimant requests a hearing within 10 days of the mailing of the notice of the action, at the request of the claimant benefits shall be reinstated and

continued until the earlier of the expiration of the current eligibility or authorization period or issuance of a hearing decision if the case is one in which the applicant is entitled to a hearing and the hearing is not subject to dismissal under ARM 46.2.205 ~~is rendered, unless the action resulted solely from an application of or change in state or federal law or policy~~.

(6) A claimant is not entitled to continued benefits if, after a hearing, the hearing officer makes a determination in writing that the sole issue is one of state or federal law or policy and no valid issue of improper benefit calculation, or misapplication or misinterpretation of state or federal law or policy exists. Benefits to a claimant may continue if the only issue is the appropriateness, terms or requirements of a family investment agreement (FIA), so long as all other eligibility requirements are met.

~~(4)~~ (7) Except as provided in (6), o~~O~~nce continued or reinstated, benefits may not be reduced or terminated prior to a ~~final~~ hearing decision unless:

(a) the ~~certification~~ eligibility, ~~or grant~~ or authorization period expires, although the claimant may reapply and may be determined eligible for benefits~~.~~ ;

(b) a subsequent change affecting claimant's benefits occurs while the hearing is pending and a subsequent hearing is not requested after notice of adverse action resulting from the subsequent change; or

(c) ~~the hearing officer makes a preliminary determination, in writing and at the hearing, that the sole issue is one of state or federal law or policy and no issue of improper benefit calculation, or misapplication or misinterpretation of state or federal law or policy exists; or~~

~~(d)~~ a mass change affecting claimant's eligibility or benefit level occurs while the hearing decision is pending.

(8) If a claimant requests a hearing on an adverse action concerning food stamp benefits and does not positively indicate whether continued benefits are requested, the department shall assume that continuation of benefits is desired and the benefits shall be issued on the same basis as authorized immediately prior to the notice of adverse action. If a recipient specifically waives continuation of food stamp benefits, the department shall terminate benefits pending a hearing decision in the contested case. This subsection applies only to food stamp benefits, and not to benefits of any other kind.

(9) Regardless of any other provision of this rule, a claimant is not entitled to continuation of benefits unless the decision at issue is a recission by the department of a specific eligibility or authorization period previously granted by the department, such as eligibility for a specified time period or authorization for a particular service or quantity of services. A claimant is not entitled to a continuation of benefits where the department granted the benefit for a particular period of time or in a particular quantity and the contested action is the department's denial of an additional grant of benefits for an additional period of time or quantity of services.

(10) A claimant is not entitled to continuation of

benefits if the department demonstrates at the hearing that continuation of benefits would pose a risk of harm to the claimant or another person.

~~(5)~~ (11) Benefits paid to a claimant pending a hearing decision are subject to recovery by the department if the adverse action is sustained.

(12) This rule shall not be construed to provide continuation of benefits with respect to an action taken by a provider rather than the department.

~~(6)~~ (13) This rule shall not be construed to prevent or delay a department action against a provider. If an adverse action is taken against a provider, payments may be withheld pending the final hearing decision.

AUTH: Sec. 53-2-201, 52-2-111, 53-2-606, 53-2-803, 53-3-102, 53-4-111, 53-4-212, 53-6-111, 53-6-113 and 53-7-102, MCA
IMP: Sec. 52-2-112, 53-2-201, 53-2-306, 53-2-606, 53-2-801, 53-3-107, 53-4-112 and 53-6-111, MCA

46.2.207 [37.5.322] HEARING OFFICER, POWERS AND DUTIES

(1) A hearing shall be conducted by an impartial individual appointed or hired by the department as hearing officer who has had no direct involvement in the initial determination of the adverse action.

~~(1)~~ (2) The hearing officer may:

(1)(a) remains the same but is renumbered (2)(a).

(b) except in a hearing to which the department is not a party, order the department or, where appropriate, the local office to pay witness fees, mileage and other actual and necessary expenses as provided under the Rules of Civil Procedure for district courts of the state of Montana of a witness subpoenaed at the request of a claimant if, in the judgement of the hearing officer, the testimony of that witness is essential to the claimant's case;

(1)(c) remains the same but is renumbered (2)(c).

(d) direct the parties to appear and confer in a pre-hearing conference to consider definition and simplification of the issues ~~by consent of the parties~~ or other matters to aid in the orderly and efficient conduct of the hearing;

(1)(e) remains the same but is renumbered (2)(e).

(f) grant a continuance ~~not to exceed thirty (30) days~~ at the request of a ~~claimant~~ party for good cause shown or with the consent of all parties ~~, or at the request of the department or another party for good cause shown if the claimant agrees to such continuance in writing~~; ~~and~~

(g) take judicial notice of state and federal laws and regulations and facts within the general knowledge of the public;~~.~~

(h) grant summary judgment according to the provisions of Rule 56, Montana Rules of Civil Procedure; and

(i) require a party to comply with reasonable and appropriate orders or requests not in conflict with these rules and necessary to assure the orderly conduct of pre-hearing and hearing procedures or to avoid unnecessary proceedings or

expense.

~~(2)~~ (3) A hearing officer shall:

(2)(a) through (2)(e) remain the same but are renumbered (3)(a) through (3)(e).

(4) In provider hearings, if a motion is filed, or as otherwise ordered by the hearing officer in a particular claimant hearing, the following rules apply to motions:

(a) Upon filing of a motion or within 5 days thereafter, the moving party must state the reasons. The statement may be accompanied by appropriate supporting documents. Within 10 days thereafter, the adverse party must file an answer statement which also may be accompanied by appropriate supporting documents. Within 10 days thereafter movant may file a reply brief or other appropriate responsive documents.

(b) Failure to file a statement required under (4)(a) may subject the motion to summary ruling. Failure to file a statement within 5 days by the moving party shall be deemed an admission that the motion is without merit. Failure to file an answer statement within 10 days by an adverse party shall be deemed an admission that the motion is well taken. Reply statements by movants are optional and failure to file will not subject a motion to summary ruling. The hearing officer may grant extensions of these filing time limits.

(c) The hearing officer may order oral argument with or without request of a party.

(d) Unless oral argument is ordered, the motion is deemed submitted at the expiration of any applicable time limit without supporting briefs having been filed. If oral argument is ordered, the motion will be deemed submitted at the close of argument unless the hearing officer orders additional briefs in which case the motion will be deemed submitted as of the date designated as the time for filing the final brief.

(5) For purposes of this rule, time computation shall be governed by Rule 6(a), Montana Rules of Civil Procedure.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.2.208 [37.5.318] ADMINISTRATIVE REVIEW (1) Upon the request for a hearing by a claimant or a provider, other than a medical assistance provider, the department shall conduct an administrative review with the purpose of resolving the case and avoiding an unnecessary hearing. This review may be conducted in person or by telephone. In person reviews shall be conducted at a place designated by the reviewer and reasonably convenient to the claimant or as designated by the hearing officer.

(a) No administrative review is required by this rule:

(i) if the department provides by other rule for an administrative review or other substantially equivalent process prior to a hearing request. If the department provides by rule for such a process, a hearing may not be granted unless the claimant or provider has exhausted the process in a timely manner; or

(ii) in any of the following matters:

(A) hearings pursuant to [Rule III] contesting a transfer or discharge of a nursing facility resident by a nursing facility;

(B) hearings pursuant to the Youth Access to Tobacco Act, Title 16, chapter 11, part 3, MCA;

(C) as otherwise provided by department rule.

(2) An administrative review includes:

(a) ~~at the claimant or provider's discretion,~~ an informal conference with the department, subject to (3); and

(b) a review of relevant facts, ~~regulations~~ legal authority and circumstances involved in the adverse action by the department and the preparation of an administrative review report for submission to the hearing officer within ~~fifteen (15)~~ 20 days from the date the request for administrative review is mailed from the hearing officer to the person responsible for conducting the review, or within such other longer period specified by the hearing officer or agreed upon by the parties.

(3) The department official designated to conduct the administrative review may schedule the administrative review conference and must notify the claimant or provider of the date, time and place of the conference. If the claimant or provider cannot appear at the date and time set for the conference, the claimant or provider shall be given a reasonable opportunity to reschedule the conference. An additional opportunity or opportunities to reschedule may be granted for good cause shown.

(a) The conference shall be conducted at the office of the department official designated to conduct the administrative review, or may be conducted telephonically.

(b) The notification of the date, time and place may inform the claimant or provider that if the claimant or provider fails to appear at the date, time and place scheduled or fails to cooperate reasonably in scheduling and completing the conference, the conference will not be rescheduled and the administrative review report will be completed without a conference.

(c) The official designated to conduct the administrative review may proceed to conduct and complete the administrative review report without a conference if:

(i) the notification permitted by (3)(b) has been provided and the claimant or provider does not appear at the conference at the time scheduled and the conference has not been rescheduled; or

(ii) the claimant or provider does not cooperate reasonably in scheduling and completing the conference.

~~(3)~~ (4) An adverse action may be reversed or modified by the ~~department's local supervisor or the appropriate division administrator~~ department or ~~his~~ its designee at any time before, during or after the administrative review, in which case a hearing will not be held unless the claimant or provider is aggrieved by the modified adverse action and requests that the hearing be held.

~~(4)~~ (a) If the adverse action is modified or reversed by the ~~division administrator~~ department and the benefits which are

the subject of the adverse action include county funds, a county human services or welfare office ~~department~~ may request the hearing officer to hold the hearing if it ~~disagrees with~~ is aggrieved by the action of the division administrator.

~~(5) If the hearing requested by a provider is to be held after the effective date of a denial, termination, or nonrenewal, the department shall offer the provider an informal reconsideration.~~

~~(a) The informal reconsideration includes:~~

~~(i) written notice to the provider of the denial, termination, or nonrenewal and the findings upon which it was based;~~

~~(ii) the provider shall refute within fifteen (15) days and in writing the findings by the department; and~~

~~(iii) the department shall in writing affirm or reverse its decision.~~

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.2.209 [37.5.325] HEARING PROCEDURE (1) ~~The~~ A claimant's hearing shall be conducted:

(a) by telephone conference, unless a party to the hearing requests ~~in writing~~ an in-person hearing; and

(1)(b) remains the same.

(2) ~~The~~ Except as otherwise provided by department rule, a claimant's hearing shall be held in the county seat of the county of the claimant's residence, unless the parties to the hearing agree to a different location ~~or, in.~~ In the case of an appeal of an adverse action by a county human services or welfare office ~~department~~ which is not the county of the claimant's residence, the hearing may be held in the county whose adverse action is being appealed at that county's option, if that county agrees to pay all the actual and necessary expenses incurred by the claimant and necessary witnesses to attend the hearing.

~~(a)~~ (3) ~~All provider hearings~~ Hearings for medical assistance providers shall be held at ~~the place designated by the department~~ Helena, Montana and shall be in person except that the hearing may be conducted by telephone as mutually agreed by the parties. The department may designate the place of hearing either by notifying the office of fair hearings in writing that hearings in a particular program will generally be held in a particular place or by designating the place of hearing on a case by case basis.

~~(3)~~ (4) The ~~department~~ hearing officer shall notify the claimant or provider or his authorized representative by ~~registered~~ certified mail at least ~~ten (10)~~ days in advance of the time and place of the hearing. The claimant or provider may waive in writing the right to ~~ten (10)~~ days notice.

(a) The notice of hearing shall include:

(i) the name, address and telephone number of the person to notify in the event that it is not possible for the claimant

or provider to attend the hearing;

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

(iii) with respect to claimants only, the department's hearing procedures and any other information that would contribute to claimant's understanding of the proceedings and effective presentation at the hearing; ~~and~~

(iv) an explanation of claimant's or provider's rights as enumerated in ~~subsection (4)~~ (5) of this rule; and

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

~~(4)~~ (5) The claimant or provider shall have adequate opportunity:

(a) to examine the contents of his case file, except for those portions which the claimant is precluded from examining by state or federal law or regulation or directive of a medical professional, and all documents and records to be used by the department at the hearing at a reasonable time prior to the hearing as well as during the hearing. Portions of the case file, documents and records that the claimant is not allowed to examine are not admissible as evidence at the hearing;

(4)(b) through (4)(f) remain the same but are renumbered (5)(b) through (5)(f).

~~(5)~~ (6) Discovery shall be available to the parties. The department ~~of social and rehabilitation services~~ hereby adopts and incorporates by reference the attorney general's model rule 13 found in ARM 1.3.217 which sets forth the procedures for discovery in contested cases. A copy of the model rule may be obtained by contacting either the Attorney General's Office, ~~State Capitol~~ 215 North Sanders, P.O. Box 201401, Helena, Montana ~~59604~~ 59620-1401 or Department of ~~Social and Rehabilitation~~ Public Health and Human Services, Office of Legal Affairs, 111 Sanders, P.O. Box 4210, Helena, Montana 59604-4210.

AUTH: Sec. 2-4-201, 53-2-201, 53-2-206, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 2-4-602 and 53-2-201, MCA

46.2.210 [37.5.328] PROPOSAL FOR DECISION BY HEARING OFFICER (1) The proposal for decision shall:

(a) be based on the facts and evidence ~~produced at~~ admitted in the hearing record as applied to pertinent state and federal law and ~~policy~~ regulation; ~~and~~

(b) consist of proposed findings of fact, proposed conclusions of law and a recommended order; and

(c) include a statement of a party's right to request an appeal or review of the decision according to law.

(2) A copy of the proposal for decision shall be mailed to all parties and, if applicable, the local department office, regional office, central office or other interested persons. ~~The proposal for decision, the verbatim transcript, if requested by a party, together with all exhibits, papers and requests filed in the proceeding shall constitute the exclusive record. The record shall be available to the claimant for inspection and copying at a place accessible to him at a reasonable time.~~

AUTH: Sec. 53-2-201, 53-2-606, 53-4-111, 53-4-212, 53-6-111, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, 53-2-306, 53-4-112 and 53-6-111, MCA

46.2.211 [37.5.331] NOTICE OF APPEAL~~, FILING AND SERVICE OF BRIEFS,~~ AND ~~BOARD~~ REVIEW OF PROPOSAL FOR DECISION (1) ~~A copy of the proposal for decision shall be mailed to the claimant or provider, the local office and all other parties.~~

~~(2)~~ If a party ~~disagrees with the~~ is aggrieved by an adverse proposal for decision, a request for ~~board~~ review may be made by filing notice of appeal in accordance with this rule.

(2) The notice of appeal must be made to and shall be decided by the ~~Montana Department of Social and Rehabilitation Services~~ Board of Public Assistance, Department of Public Health and Human Services, Office of Fair Hearings, P.O. Box ~~4210~~ 202953, Helena, Montana ~~59604~~ 59620-2953 in cases arising from the following programs:

(a) FAIM;
(b) food stamps;
(c) medicaid;
(d) block grant child care;
(e) developmental disabilities services;
(f) low income energy assistance program (LIEAP);
(g) low income weatherization assistance program (LIWAP);
(h) refugee assistance; and
(i) mental health services plan.

(3) The notice of appeal must be received by the office of fair hearings within ~~fifteen (15)~~ days of the date of mailing of the proposal for decision.

(4) The following procedures apply in a board of public assistance review of a proposal for decision:

(a) Parties may file briefs no later than ~~five (5)~~ 10 days before the meeting of the board for review, except that reply briefs may be filed within 5 days after actual receipt of an initial brief.

(i) Copies of all briefs shall be served upon all parties.

(ii) An original and ~~four (4)~~ copies of each brief shall be filed with the ~~Chairman,~~ Board of ~~Social and Rehabilitation Appeals~~ Public Assistance, P.O. Box ~~4210~~ 202953, Helena, Montana ~~59604~~ 59620-2953.

(b) Oral arguments to the board are permitted at the board hearing ~~if so requested by any of the parties. The request for oral argument must be made within thirty (30) days from the date of the hearing officer's proposal for decision. Notice of this request shall be served upon all parties~~.

(c) The board's review and decision must comply with the provisions of 2-4-621, MCA. For purposes of 2-4-621, MCA, the board shall be considered the "agency", but this rule shall not be construed to confer upon the board any authority to determine department policy.

(d) The board may not consider or make a part of the record any evidence not admitted in evidence by the hearing officer for purposes of the hearing. If the admission or consideration of additional evidence is necessary to the

decision, the matter shall be remanded to the hearing officer for additional proceeding as ordered by the board.

(5) Except as otherwise provided by department rule, in all cases not specified in (2), the notice of appeal must be made to the department director in accordance with 2-4-621, MCA. The review shall be conducted and decided by the director or the director's designee.

(6) A notice of appeal of a matter appealed to the director may be made in writing to the Director, Department of Public Health and Human Services, P.O. Box 4210, Helena, Montana 59604-4210. The request must be received by the director within 15 days of the mailing of the proposal for decision.

~~(3)~~ (7) The proposal for decision prepared by the hearing officer is the final agency decision, without further action by the board, the director or the director's designee, unless a request for ~~board~~ review is received within ~~fifteen (15)~~ days of the date of mailing of the proposal for decision. The ~~fifteen (15)~~ day time limit may be extended if a party can show good cause but in no event shall the period of time be extended beyond 45 days.

~~(4)~~ (8) If a request is received within the specified time period, the board, the director or the director's designee shall consider the proposal for decision, the exceptions filed, briefs or oral argument presented and the record of the hearing, and shall:

(a) notify the ~~claimant~~ parties and, if applicable, the local office, regional office, central office, or other interested person ~~and any other party~~ of the ~~board's~~ decision; and

(4)(b) remains the same but is renumbered (8)(b).

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201 and 53-2-606, MCA

46.2.212 [37.5.334] JUDICIAL REVIEW (1) A party ~~to an appeal~~ who is aggrieved by a final decision may seek judicial review of that decision by filing a petition in district court within 30 days after ~~receipt of notice~~ service of the final decision as provided in ~~section~~ 2-4-702, MCA.

~~(2) A board of county commissioners may seek judicial review of a final decision involving a program funded entirely with county funds.~~

~~(3) The department, but not the board of county commissioners, may seek judicial review of a final decision involving a program funded in whole or in part with federal or state funds.~~

~~(4) If a provider seeks judicial review, venue shall be in the First Judicial District in and for the County of Lewis and Clark, state of Montana.~~

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201 and 53-3-113, MCA

46.2.214 [37.5.337] AVAILABILITY OF HEARING RECORDS (1) The proposal for decision, the verbatim transcript, if requested by a party, all exhibits, papers and requests filed in the proceeding, and, if applicable, the decision of the board or the director or the director's designee on review under ARM 46.2.211 and of a court on any subsequent judicial review shall constitute the exclusive record. The record shall be available to the claimant for inspection and copying at a place accessible to him at a reasonable time.

~~(1)~~ (2) All hearing decisions ~~and records~~ shall be available to the public for inspection and copying, except that the names and addresses and any other identifying information of claimants shall be kept confidential.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.12.216 [37.85.205] RECIPIENT RESTRICTION OF ACCESS TO MEDICAL SERVICES (1) through (9)(c) remain the same.

(10) ~~The~~ A recipient aggrieved by an adverse ~~has the right to appeal any~~ departmental action under this rule may request a fair hearing in accordance with ~~ARM 46.2.202~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 53-6-113, MCA
IMP: Sec. 53-6-104, MCA

46.12.307 [37.85.411] PROVIDER RIGHTS (1) Except as otherwise provided in these rules, a provider ~~may appeal~~ who is aggrieved by an adverse department action which directly affects the rights or entitlements of the provider under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A. ~~Appeals are subject to the requirements of ARM Title 46, chapter 2, subchapter 2.~~

(2) Except as otherwise provided in these rules, a provider ~~may appeal on behalf of an applicant or recipient~~ who is aggrieved by an adverse department action affecting the applicant's or recipient's eligibility under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A. ~~Appeals are subject to the requirements of ARM Title 46, chapter 2, subchapter 2.~~

(3) remains the same.

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

46.12.310 [37.85.416] STATISTICAL SAMPLING AUDITS (1)

remains the same.

(a) A line item consists of a single service, under one procedure rate with one or more units of service, procedure or item on a medicaid claim form for which a provider has received payment.

(2) through (5) remain the same.

(a) If the audit shows an overpayment amount which is different from the overpayment amount determined by sampling and extrapolation, the amount determined by the audit shall be used by the department in assessing an overpayment against the provider. A provider who ~~disagrees with~~ is aggrieved by a department determination based upon the results of the audit may appeal by means of the fair hearing procedures set forth in ~~ARM 46.2.202~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

(5)(b) remains the same.

(6) A provider who ~~disagrees with~~ is aggrieved by an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ~~ARM 46.2.202~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

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

46.12.408 [37.85.513] SUSPENSION OR WITHHOLDING OF PAYMENTS PENDING FINAL DETERMINATION (1) remains the same.

(2) Where the department intends to withhold or suspend payments it shall notify the provider in writing at least 10 days prior to commencement of withholding and shall include a statement of the provider's right to request ~~formal review~~ an informal reconsideration of such decision as provided in [Rule XVIII]. This rule does not require that an informal reconsideration or any hearing be conducted prior to the withholding or suspension of payments.

(3) remains the same.

AUTH: Sec. 52-2-111, 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA
IMP: Sec. 52-2-112, 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA

46.12.509 [37.86.2801] ALL HOSPITAL REIMBURSEMENT, GENERAL

(1) through (7)(e) remain the same.

(8) Providers ~~may appeal~~ aggrieved by adverse determinations by the department may request ~~through the~~ an administrative review and fair hearing ~~procedures set forth in ARM 46.12.509A~~ as provided in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

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

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

46.12.509A [37.5.310] ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS FOR MEDICAL ASSISTANCE PROVIDERS (1) The following administrative review and fair hearing process applies to all medical assistance providers ~~of inpatient and outpatient hospital services, swing bed hospital services, inpatient psychiatric services for individuals under age 21, targeted case management and federally qualified health center services~~ that are aggrieved by an adverse action of the department, except medical assistance providers appealing eligibility determinations as a real party in interest.

(2) ~~Within 30 days of mailing of the department's written determination, the provider~~ A medical assistance provider, other than a medical assistance provider appealing an eligibility determination as a real party in interest, aggrieved by an adverse action of the department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the department to consider in the administrative review. The request must be ~~submitted~~ mailed or delivered to the Department of Public Health and Human Services, ~~Medicaid Services Division,~~ 111 Sanders, P.O. Box 4210, Helena, MT 59604-4210 and should be addressed or directed to the division of the department that issued the contested determination. The request for administrative review must be received by the department within 30 days of mailing of the department's written determination.

(a) Within the 30 days a provider may request in writing an extension of up to 15 days for submission of a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the ~~medicaid services division~~ department within the period of any previous extension, and must demonstrate good cause for the extension.

(b) The provider may also request a conference as part of the administrative review. If the provider requests an administrative review conference, the conference must be held ~~no later than 30 days after the department or its designee receives the provider's written request for a conference~~ at a time scheduled by the department as provided in ARM 46.2.208(3) through (3)(c)(ii). If a provider requests a conference as part of the administrative review, any substantiating materials the provider wishes the department to consider as part of the review may be submitted no later than the time of the conference. The conference may be conducted by the department or its designee and shall be based on the department's records and determination and the provider's written objections and substantiating materials, if any.

(2)(c) remains the same.

(d) A provider must exhaust in a timely manner the administrative review process provided in this rule before requesting a fair hearing. A provider that has not exhausted

the administrative review process, including a provider that fails to timely request an administrative review, is not entitled to a fair hearing before the department or the board.

(3) In the event the provider ~~does not agree with the department's~~ is aggrieved by an adverse department administrative review determination, the following fair hearing procedures will apply. ~~The~~ In addition to the authority granted in ARM 46.2.205, the hearings officer may dismiss a fair hearing request if a provider fails to meet any of the requirements of (3)(a) through (3)(e).

(a) The written request for a fair hearing must be mailed or delivered to the Department of Public Health and Human Services, Quality Assurance Division, Office of Fair Hearings, P.O. Box 202953, Helena, MT 596~~04~~20-2953.

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

(e) The provider must serve a copy of the hearing request upon the department's ~~medicaid services~~ division that issued the contested determination within 3 working days of filing the request. Service by mail is permitted.

(f) The hearings officer will conduct the fair hearing ~~and may hold a pre hearing conference and grant extensions of time as he deems necessary~~ in accordance with the applicable provisions of this subchapter at Helena, Montana. The hearing shall be in person except that the hearing may be conducted by telephone as mutually agreed by the parties.

(3)(g) remains the same.

(4) In the event the provider or department ~~disagrees with the~~ is aggrieved by a hearings officer's proposed decision, ~~a~~ the provider or department may request ~~for appeal to~~ review by the board of public ~~health and human services appeals~~ assistance as provided in ARM 46.2.211 ~~(effective 7/1/95) may be made by filing notice of appeal with the Montana Department of Public Health and Human Services, Office of Fair Hearings, P.O. Box 4210, Helena, MT 59604-4210~~.

~~(a) The notice of appeal must be received in the office of fair hearings within 30 days of mailing of the hearings officer's written proposed decision. The provider must serve a copy of the notice of appeal upon the medicaid services division within 3 working days of filing the notice of appeal.~~

~~(b) The notice of appeal must set forth the specific grounds for appeal. If no notice of appeal is filed within 30 days, the hearings officer's proposed decision shall become the final agency decision.~~

~~(c) All evidence in the record and offers of proof shall be transmitted to the board of public health and human services appeals (effective 7/1/95) by the hearings officer. The decision of the board shall be based solely on the record transmitted by the hearings officer. Written briefs and oral arguments based on the record may be presented personally or through a representative of the provider or the department to the board.~~

~~(d) The board shall reduce its decision to writing and mail copies to the parties within 90 days of final submission of the matter to it. The provider shall be notified of its right~~

~~to judicial review under the provisions of Title 2, chapter 4, part 7, MCA.~~

~~(5) This section applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings relating to inpatient psychiatric services, other than medical assistance providers appealing eligibility determinations as a real party in interest, occurring on or after November 1, 1991. This section applies to all administrative reviews, hearings, appeals to the board, related proceedings and any requests for such proceedings relating to medical assistance providers listed in ARM 46.2.202(4), other than medical assistance providers appealing eligibility determinations as a real party in interest, occurring on or after July 17, 1992.~~

~~(6)~~ (5) The provisions of this ~~section~~ rule apply in addition to the other applicable provisions of ~~ARM 46.2.201, et seq.~~ this subchapter, except that the provisions of this ~~section~~ rule shall control in the event of a conflict with the other provisions of ~~ARM 46.2.201, et seq~~ this subchapter.

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

46.12.513 [37.40.406] SWING-BED HOSPITALS, REIMBURSEMENT

(1) remains the same.

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

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

(5) Swing-bed hospital service providers ~~may appeal~~ aggrieved by adverse determinations by the department ~~through the~~ may request administrative review and fair hearing ~~procedures specified~~ as provided in ~~ARM 46.12.509A~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

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

46.12.556 [37.40.1102] PERSONAL CARE SERVICES, REQUIREMENTS (1) through (24) remain the same.

(25) A person ~~may request a fair hearing for any~~ aggrieved by an adverse department determination ~~made by the department~~ may request a fair hearing as provided in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. ~~Fair hearings will be conducted as provided for in ARM 46.2.201, et seq.~~

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

46.12.558 [37.40.1106] PERSONAL CARE SERVICES, PROVIDER COMPLIANCE (1) through (8) remain the same.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM ~~46.12.402 through 46.12.409~~ Title 46, chapter 12, subchapter 4.

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

46.12.559F [37.40.1315] SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, COMPLIANCE REVIEWS (1) through (4) remain the same.

(5) Providers have two opportunities to achieve a 90% compliance rate or the following may occur:

(a) providers shall be subject to department sanctions as provided in ARM ~~46.12.402 through 46.12.409~~ Title 46, chapter 12, subchapter 4.

AUTH: Sec. 53-6-113 and 53-6-145, MCA
IMP: Sec. 53-6-101 and 53-6-145, MCA

46.12.1221 [37.40.301] SCOPE, APPLICABILITY AND PURPOSE (1) ~~ARM 46.12.1221 through 1268 specify~~ This subchapter specifies requirements applicable to provision of and reimbursement for medicaid nursing facility services, including intermediate care facility services for the mentally retarded. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) remains the same.

(3) Unless otherwise provided in these rules, ~~ARM 46.12.1221 through 1268~~ this subchapter applies to rate years beginning on or after July 1, 1991. Reimbursement and other substantive nursing facility requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption.

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

46.12.1232 [37.40.315] PATIENT ASSESSMENT, SCORING AND STAFFING REQUIREMENTS (1) through (6)(b) remain the same.

(c) Subject to the provisions of ~~subsection~~ (6)(d), if the department determines that a significant difference exists, the provider may request administrative review and fair hearing regarding the determination of significant difference in accordance with ~~ARM 46.12.1268~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. For purposes of administrative review and fair hearing under ~~ARM 46.12.1268~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A, documentation which was not made available to the monitor team at the time of the initial

monitor is inadmissible and may not be considered by the department or the hearing officer.

(d) For providers who object to the monitor team's sampling technique used to select the abstracts to be monitored, the 100% monitor procedure described in ~~subsection~~ (6)(e) through (6)(e)(ii) will be the only appeal available with respect to the sampling technique issue.

(i) A provider wishing to object to both the sampling technique and to other issues relating to the determination of a significant difference, must first timely request a 100% monitor as provided below. The provider may request administrative review and fair hearing regarding other issues relating to the determination of a significant difference in accordance with ~~ARM 46.12.1268~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A only after the department has made a determination based upon the 100% monitor as provided in this ~~section~~ rule.

(A) For purposes of administrative review regarding other issues after a determination based upon the 100% monitor, the deadline for requesting such review shall begin running on the date of mailing of the department's written determination on the 100% monitor. If the provider does not request a 100% monitor, the deadline for requesting administrative review on issues other than the sampling technique is as provided in ARM ~~46.12.1268~~ 46.12.509A.

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

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

(6)(e)(i) through (7)(a) remain the same.

(i) Providers who acquire a new patient assessment score under ~~this subsection~~ (7) must staff in relation to the new patient assessment score as required by ~~subsection~~ (8).

(7)(b) remains the same.

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

(8)(a) through (9) remain the same.

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

46.12.1260 [37.40.346] COST REPORTING, DESK REVIEW AND AUDIT (1) Providers must use generally accepted accounting principles to record and report costs. The provider must, in preparing the cost report required under this ~~section~~ rule, adjust such costs in accordance with ARM 46.12.1258 to determine

allowable costs.

(2) through (4)(a)(ii) remain the same.

(b) If a provider files an incomplete cost report or reported costs are inconsistent, the department may return the cost report to the facility for completion or correction, and may withhold payment as provided in (4)(c).

(4)(c) through (6)(e) remain the same.

(7) A provider aggrieved by an adverse department action may request administrative review and a fair hearing ~~regarding adverse audit findings according to the provisions of ARM 46.12.1268~~ as provided in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

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

46.12.1919 [37.86.3411] CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN, FINANCIAL RECORDS AND REPORTING (1) through (8) remain the same.

(9) A provider who is ~~dissatisfied with~~ aggrieved by the department's interim rate determination, determination of overpayment or underpayment, or other adverse determination may request an administrative review or fair hearing in accordance with the requirements and procedures of ~~ARM 46.12.509A~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

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

46.12.3223 [37.82.435] MEDICAID REAL PROPERTY LIEN, NOTICE AND RIGHT TO HEARING (1) remains the same.

(2) The applicant or recipient upon whose property the department proposes to impose a lien under 53-6-171, MCA is entitled to a fair hearing according to the provisions of ~~ARM 46.2.201, et seq~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The applicant or recipient must request the hearing within 90 days of receipt of the notice required under (1).

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

AUTH: Sec. 2-4-201 and 53-6-189, MCA
IMP: Sec. 2-4-201, 53-6-171 and 53-6-172, MCA

46.12.3227 [37.82.437] MEDICAID REAL PROPERTY LIEN, SPOUSE'S LIMITED RECOVERY EXEMPTION (1) and (1)(a) remain the same.

(2) A recipient's spouse may request the exemption by filing an application on the form prescribed by the department. Application forms may be obtained from and must be filed with the Department of Public Health and Human Services, ~~Medicaid Services~~ Quality Assurance Division, Lien Recoveries, ~~111 N.~~

~~Sanders, P.O. Box 4210~~ 1400 Broadway, P.O. Box 292951, Helena, MT ~~59604-4210~~ 59620-2951. Application forms may also be obtained from county human services or welfare offices, but must be filed with the ~~medicaid services~~ quality assurance division office in Helena at the above address.

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

(4) An applicant aggrieved by the department's determination on an application for a spousal exemption under this rule is entitled to a fair hearing according to the provisions of ~~ARM 46.2.201, et seq~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The applicant or recipient must request the hearing within 30 days of receipt of the notice required under (3).

(5) remains the same.

AUTH: Sec. 2-4-201, 53-6-182 and 53-6-189, MCA
IMP: Sec. 2-4-201 and 53-6-182, MCA

46.12.4815 [37.86.5012] HEALTH MAINTENANCE ORGANIZATIONS: PARTICIPATING PROVIDERS (1) through (6) remain the same.

(7) A participating provider has no right to an administrative hearing as provided in ~~ARM 46.2.201, et seq., 46.12.409 and 46.12.509A~~ [Rule I], [Rule VIII] or other department rule for a denial of payment by the HMO to the provider for a service provided to an enrollee.

(8) through (10) remain the same.

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

46.12.4824 [37.86.5025] HEALTH MAINTENANCE ORGANIZATIONS: GRIEVANCE PROCEDURES (1) An enrollee has the right of appeal as provided at ~~ARM 46.2.201, et seq~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) remains the same.

(3) An enrollee must exhaust the HMO's grievance procedure before appeal of the matter may be made to the department under the provisions of ~~ARM 46.2.201, et seq~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(4) remains the same.

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

46.12.5014 [37.86.5120] PASSPORT TO HEALTH PROGRAM: FAIR HEARING (1) An enrollee or a provider has the right to appeal an adverse action in accordance with ~~ARM 46.2.201, et seq~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

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

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

16.24.108 APPLICATION PROCEDURE (1) and (2) remain the same.

(3) If the application is denied, the department will send the applicant a notice of denial stating the reasons for denial and explaining how ~~a fair hearing~~ an informal reconsideration may be obtained pursuant to ARM 16.24.109.

(4) remains the same.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

16.24.109 ~~FAIR HEARING~~ INFORMAL RECONSIDERATION PROCEDURE (1) An applicant who has been denied participation in the children's special health services program (CSHS), a provider who has been denied reimbursement for CSHS-eligible services, or anyone who is otherwise adversely affected by an action taken by CSHS may have ~~a fair hearing~~ an informal reconsideration before the department ~~director~~ by requesting such a ~~hearing~~ reconsideration within 60 days after notice of the adverse action in question has been placed in the mail or otherwise communicated to the aggrieved party.

(2) A request for a ~~hearing~~ reconsideration, in order to be effective, must be in writing and postmarked at least by the 60th day after notice of the adverse action referred to in (1) above was given.

(3) If the department receives a request for ~~a fair hearing~~ an informal reconsideration, it will ~~hold~~ conduct the ~~hearing~~ reconsideration within 30 days after the date the request is received unless both the requestor and the department agree to a later date.

~~(4) The department will send a hearing requestor written notice of the date, time, and place of the hearing.~~

~~(5)~~ (4) ~~A fair hearing~~ An informal reconsideration will be conducted in accordance with the procedures prescribed for informal ~~proceedings in section 2-4-604, MCA~~ reconsideration in [Rule XVIII]. Such informal reconsideration is not subject to the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA, or, except as provided in this rule, the provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(5) In addition to the procedures specified in [Rule XVII], an applicant shall be provided an opportunity to appear and present evidence and arguments in person.

(6) The decision by the ~~department's director~~ department after ~~a fair hearing~~ an informal reconsideration is final.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

16.25.104 FAMILY PLANNING PROGRAM TERMINATION PROCEDURES (1) Except as provided in ~~section~~ (3), upon a finding of major uncorrected program deficiencies as set forth in ARM 16.25.103, the department will notify the local board and project director of its intent to terminate the local program. This notice will identify the program deficiencies upon which the termination action is based, and will offer the opportunity for the local program to request an informal ~~hearing~~ reconsideration before the department to contest the termination decision. Such request for ~~a hearing~~ an informal reconsideration must be received in writing by the department no later than ~~two~~ 2 weeks after issuance of the notice of intent to terminate.

(2) If a timely request for ~~a hearing~~ an informal reconsideration is received, the ~~hearing~~ reconsideration will be ~~held~~ conducted within 30 days following the receipt of the request. Such ~~hearing~~ informal reconsideration shall be conducted in accordance with the procedures specified for informal reconsiderations in [Rule XVIII], and is not subject to the contested case provisions of the Montana Administrative Procedure~~s~~ Act, ~~(~~Title 2, chapter 4, MCA~~)~~ or, except as provided in this rule, the provisions of [Rule XVII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The department's final decision on termination will be made within 30 days following the ~~hearing~~ reconsideration. The final decision will be accompanied by a brief statement of the department's findings.

(3) remains the same.

AUTH: Sec. 50-1-202~~(9)~~, MCA
IMP: Sec. 50-1-202~~(9) and (16)~~, MCA

16.30.301 AMBULANCE PERMITS: DISPLAY, REVOCATION AND INFORMAL RECONSIDERATION (1) through (3) remain the same.

(4) The decision to deny or revoke an ambulance permit may be appealed to the department if the emergency medical service submits a written request for ~~a hearing~~ an informal reconsideration to the department within 30 days after the service receives written notice of the decision to revoke or deny the permit.

(a) If a timely request for an informal reconsideration is received, the reconsideration will be conducted within 30 days following the receipt of the request. Such informal reconsideration shall be conducted in accordance with the procedures specified for informal reconsiderations in [Rule XVII], and is not subject to the contested case provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA or, except as provided in this rule, the provisions of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(5) The decision of the department ~~director~~ after ~~a hearing held pursuant to (4) above~~ an informal reconsideration conducted pursuant to this rule is a final agency decision.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

16.32.917 PERSONAL CARE FACILITIES: RESIDENCY APPLICATION PROCEDURES (1) through (2)(a)(i) remain the same.

(ii) the right to ~~appeal~~ an informal reconsideration of the decision ~~to~~ by the department according to the informal reconsideration procedures specified in [Rule XVII] within 15 days after the date of the written notice; and

(iii) the information that the ~~appeal~~ reconsideration request must contain, as delineated in (2)(b) below.

(b) A person or facility ~~appealing~~ requesting informal reconsideration of a rejection or relocation must send the department, within 15 calendar days after the date of written notice of rejection or relocation, written notice containing the following:

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

(c) Unless the ~~appealing~~ requesting party agrees to a time extension, the director of the department must make a final decision regarding the ~~appeal~~ reconsideration within 15 working days after receipt of the notice.

(3) through (6) remain the same.

AUTH: Sec. 50-5-103, 50-5-226, 50-5-227, MCA
IMP: Sec. 50-5-226, 50-5-227, MCA

16.35.104 RIGHT TO ~~HEARING~~ RECONSIDERATION OF ADVERSE END-STAGE RENAL DISEASE PROGRAM DECISION (1) Any claimant who is ~~dissatisfied with the~~ aggrieved by an adverse department end stage renal disease (ESRD) action on an application may, upon request, have ~~a fair hearing~~ an informal reconsideration in accordance with the procedures prescribed for informal ~~proceedings in section 2-4-604, MCA~~ reconsiderations in [Rule XVII]. The informal reconsideration is not subject to the contested case provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA or, except as provided in this rule, the provisions of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 53-6-202, MCA
IMP: Sec. 53-6-202, MCA

37.2.101 PROCEDURES FOR ADOPTING, AMENDING, AND REPEALING AGENCY RULES (1) The department of public health and human services, for purposes of establishing departmental rule making procedures, hereby adopts and incorporates by reference the attorney general's model procedural rules 1 through 7 found in ARM 1.3.102 through ~~ARM 1.3.211~~ 1.3.210 ~~which set forth the rule making procedures for the department rules~~, except for the attorney general's sample rule notice forms. A copy of the ~~amended~~ attorney general's model rules may be obtained by contacting the Attorney General's Office, Justice Building, 215 North Sanders, P.O. Box 201401, Helena, ~~Montana~~ MT 59620-1401.

~~Phone~~ , telephone 444-2026. The department utilizes its own rule notice forms which meet all Montana Administrative Procedure Act (MAPA) requirements. Samples of these forms can be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena MT 59601-4210, telephone 444-5622.

AUTH: Sec. 2-4-201, MCA
IMP: Sec. 2-4-201, MCA

37.2.102 PROCEDURES FOR THE ISSUANCE OF DECLARATORY RULINGS (1) The department of public health and human services hereby adopts and incorporates by reference the attorney general's model procedural rules 22 through 24 and 28 found in ARM 1.3.227 through ~~ARM 1.3.230~~ 1.3.229 and 1.3.233 which set forth the procedures for the issuance of declaratory rulings. A copy of the amended model rules may be obtained by contacting the Attorney General's Office, Justice Building, 215 North Sanders, P.O. Box 201401, Helena, ~~Montana~~ MT 59620-1401, ~~. Phone~~ telephone 444-2026.

AUTH: Sec. 2-4-202, MCA
IMP: Sec. 2-4-501, MCA

37.2.301 PURPOSE AND SCOPE (1) Except as provided in (2), this subchaper ~~These rules~~ implements for the department and the ~~state auditor's office~~ department of revenue the mechanisms provided in Title 17, chapter 4, MCA, for recovery and offset of monetary sums owing to the state of Montana related to the provision of services through the programs administrated by the department.

(2) The recovery and offset of debts being enforced or collected by the department under Title IVD of the Social Security Act is implemented by ARM 46.30.1301, 46.30.1303 and 46.30.1305.

(3) The provisions of this subchapter are not the department's exclusive means of debt collection, but are in addition to any other means of offset, recovery or other debt collection procedures authorized by law.

AUTH: Sec. 17-4-110 and 53-2-201, MCA
IMP: Sec. 17-4-104, 53-2-108 and 53-2-201, MCA

37.2.302 DEFINITIONS (1) and (2) remain the same.

(3) "Offset" means a deduction from monies due to a person or entity from the state for the purpose of recovering in total or in part a debt owed by the person or entity to the state. An offset is undertaken by the ~~state auditor's office~~ department of revenue under the authority of 17-4-105, MCA in accordance with that agency's rules and policies. Offset may include but is not limited to an offset of a person or entity's state tax return.

(4) and (5) remain the same.

AUTH: Sec. 17-4-110 and 53-2-201, MCA

IMP: Sec. 17-4-104, 53-2-108 and 53-2-201, MCA

37.2.305 REFERRAL FOR RECOVERY AND OFFSET (1) The department under the authority of 17-4-104, MCA may refer to the ~~state auditor's office~~ department of revenue for recovery and offset a debt owed to the department by a program recipient or by a provider of program services.

(2) The department may refer to the ~~state auditor's office~~ department of revenue any debt of a program recipient or a provider of program services including but not limited to those arising out of intentional or unintentional actions of the recipient or provider and those due to mistake upon the part of the department.

(3) The department must determine that a debt is uncollectable by the department before the debt may be referred to the ~~state auditor's office~~ department of revenue.

AUTH: Sec. 17-4-110, MCA
IMP: Sec. 17-4-104, 53-2-108 and 53-2-201, MCA

37.2.720 ~~APPEALS PROCEDURE~~ ABILITY TO PAY, ADMINISTRATIVE REVIEW AND FAIR HEARING (1) If the resident or a financially responsible person is aggrieved by the department's determination of ability to pay, that person may request an administrative review regarding the determination. The administrative review is subject to and shall be conducted in accordance with this rule.

(2) The request for administrative review must be submitted to the department in writing, must state the reasons the person contends that the determination is incorrect or fails to comply with legal requirements, and must include any additional information and substantiating documentation which the person wishes the department to consider in the administrative review.

(a) A request for administrative review must be received by the department within 30 days of mailing of the department's ability to pay determination letter. Administrative review requests must be mailed or delivered to the Department of Public Health and Human Services, Institutional Reimbursement Bureau, 111 North Sanders, P.O. Box 6420, Helena, MT 59604-6420.

(3) A resident or financially responsible person aggrieved by an adverse department administrative review determination under this rule, may request a fair hearing in accordance with [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.207, 46.2.209 through 46.2.212, 46.2.214 and 46.12.509A.

~~(1) A resident or financially responsible person aggrieved by an ability to pay determination may request a hearing as provided in ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.~~

AUTH: Sec. 53-1-403, MCA
IMP: Sec. 53-1-407 and 53-1-408, MCA

37.8.126 ACCESS TO VITAL STATISTICS RECORDS (1) ~~Pursuant~~

~~to 50-15-113, MCA, the board of health and environmental sciences~~ The department hereby adopts the following statement of policy to guide the department ~~of health and environmental sciences~~ in handling requests for access to vital statistics records and information. This statement of policy is made in recognition of the public's constitutional right of access to documents (Article II, Sec. 9, Montana Constitution), the right of individual privacy (Article II, Sec. 10, Montana Constitution), and the provisions of Title 50, chapter 15, part 1, MCA.

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

(3) Unless disclosure is otherwise authorized by law, the department shall restrict access to vital statistics information so as to prevent identification of individuals. ~~Requests for information which, in the department's judgment, could result in the improper identification of individuals must be referred to the board~~.

~~(4) Any affected person may appeal a decision by the department regarding access under this rule to vital statistics information to the board. The board will consider the request for access, pursuant to 50-15-113, MCA, at its next regularly scheduled meeting.~~

AUTH: Sec. 50-15-113 and 50-15-122, MCA
IMP: Sec. 50-15-113 and 50-15-122, MCA

37.30.2570 INFORMING VENDORS OF RIGHTS AND RESPONSIBILITIES (1) and (2) remain the same.

(3) Blind vendors aggrieved by adverse department actions shall be provided the opportunity for an administrative review and a fair hearing in accordance with ~~ARM 46.2.201 through 46.2.214~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A in any contested matter.

(3)(a) remains the same.

AUTH: Sec. 18-5-414, MCA
IMP: Sec. 18-5-404 and 18-5-405, MCA

37.34.226 ELIGIBILITY: APPEAL PROCEDURES (1) ~~An~~ A person aggrieved by an adverse ~~decision~~ department action regarding eligibility for any service of the developmental disabilities program, except as otherwise provided in this rule, ~~is appealable under the provisions of ARM 46.2.202, et seq~~ may request a hearing as provided in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) An adverse decision regarding eligibility for family education and support services, other than for federally funded Part H family education and support services, is appealable through the internal grievance procedure provided by the contractor. If a resolution to the adverse decision regarding eligibility cannot be reached through the internal grievance procedure, the adverse decision is appealable by an aggrieved

party in accordance with [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A ~~under the provisions of ARM 46.2.202, et seq~~.

(3) remains the same.

AUTH: Sec. 53-20-204, MCA
IMP: Sec. 53-20-203 and 53-20-209, MCA

37.34.919 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: NOTICE AND FAIR HEARING (1) through (2) remain the same.

(3) A person aggrieved by an adverse department determination ~~may request a fair hearing as provided in ARM 46.2.201 et seq.~~ for a level of care determination finding the person ineligible for services may request a fair hearing as provided in [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(4) remains the same.

AUTH: Sec. 53-2-201, 53-6-113, 53-6-402 and 53-20-204, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-402 and 53-20-205, MCA

37.34.2313 RESIDENTIAL FACILITY SCREENING: APPEAL OF SCREENING TEAM DETERMINATION OR RECOMMENDATION (1) If the residential facility screening team determines that the individual is not seriously developmentally disabled and therefore a commitment or recommitment is not appropriate, the individual or the individual's authorized representative aggrieved by the determination may request a fair hearing as provided in ~~ARM 46.2.201 et seq.~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A, from the department, within 30 days of the determination that the individual is not seriously developmentally disabled.

(2) remains the same.

AUTH: Sec. 53-20-133, MCA
IMP: Sec. 53-20-125, 53-20-127, 53-20-128, 53-20-129 and 53-20-133, MCA

37.41.109 ~~DIVISION~~ AGING SERVICES HEARING PROCEDURES

~~(1) The division shall provide a hearing, when requested according to the provision of ARM 11.2.203, to:~~

~~(a) a designated area agency when the division:~~

(1) A designated area agency is entitled to a hearing if it is aggrieved by an adverse department determination which:

~~(i)~~ (a) disapproves a plan or plan amendment submitted by the agency;

~~(ii)~~ (b) disapproves an area plan for failure to comply substantially with the requirements of the act or manual; or

~~(iii)~~ (c) withdraws the agency's designation~~; and~~ .

~~(b) any~~ (2) A unit of general purpose local government, a district or a combination of districts ~~that~~ is entitled to a hearing if it is aggrieved by an adverse department action denying ~~denied~~ designation as a planning and service area.

~~(2)~~ (3) The hearing will be conducted according to the applicable provisions of ~~ARM 11.2.203 through 11.2.207~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A. The entity contesting the adverse department action shall be considered a provider for purposes of [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 52-3-406 and 53-5-606, MCA
IMP: Sec. 52-3-402, 52-3-404, 53-5-602 and 53-5-604, MCA

37.50.306 RIGHT TO FAIR HEARING (1) Any person ~~denied substitute care placement or~~ aggrieved by an adverse department determination denying foster care maintenance payments ~~by the department or against whom~~ or demanding recovery of a foster care overpayment ~~recovery is demanded by the department~~ may request a hearing as provided in ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 2-4-201 and 41-3-1103, MCA
IMP: Sec. 41-3-302 and 41-3-1103, MCA

37.50.316 FOSTER CARE CLASSIFICATION (1) through (3) remain the same.

(4) If the facility disagrees with the classification assigned by the department, the facility may submit a request for informal reconsideration within 30 days of written notification of the classification level.

(4)(a) remains the same.

(b) The request for informal reconsideration shall be submitted to the Department of Public Health and Human Services, Child and Family Services Division, Operations and Fiscal Bureau, P.O. Box 8005, Helena, Montana 59604.

(5) The department shall conduct an ~~administrative review~~ informal reconsideration of the classification within 15 days of receipt of the request for reconsideration and shall submit a decision in writing as to whether the classification will be changed.

(6) If the facility is dissatisfied with the result of the ~~administrative review~~ informal reconsideration, it may request ~~a~~ an informal hearing before a panel comprised of the director, the evaluation bureau chief and a representative from another facility.

(a) The request for an informal hearing must be submitted in writing within 10 days of the receipt of the results of the ~~administrative review~~ informal reconsideration.

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

(7) The facility's current classification shall remain in effect pending the outcome of any ~~review~~ reconsideration or appeal.

(8) The provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA do not apply to informal reconsideration or hearing proceedings under this rule.

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

37.50.525 FOSTER CARE SUPPORT SERVICES, HEARING (1) Any person ~~dissatisfied because of actions by~~ aggrieved by an adverse action of the department or its representatives regarding foster care support services may request a hearing as provided in ARM ~~11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

AUTH: Sec. 2-4-201, 41-3-1103, 52-2-111 and 53-4-111, MCA
IMP: Sec. 41-3-1103, 52-2-111 and 53-4-111, MCA

37.70.106 FAIR HEARINGS (1) Any person who is ~~dissatisfied with~~ aggrieved by an adverse department action taken on ~~an~~ a LIEAP application, benefit status, form or condition of payment, may request a fair hearing as provided in ~~ARM 46.2.202~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) remains the same.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-201, MCA

37.71.106 FAIR HEARINGS (1) Any person who is ~~dissatisfied with~~ aggrieved by an adverse department action taken on his application, benefit status, form or condition of services, may request a fair hearing as provided in ~~ARM 46.2.202~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) remains the same.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 90-4-201 and 90-4-202, MCA

37.100.135 ADULT FOSTER HOME, FAIR HEARING (1) Any person ~~dissatisfied because of denial, revocation or suspension of~~ aggrieved by an adverse department action denying, revoking or suspending a license may request a fair hearing in accordance with ~~ARM 11.2.203~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A.

(2) remains the same.

AUTH: Sec. 2-4-201, 50-1-202, 52-3-304, and 53-5-304, MCA
IMP: Sec. 50-5-227, 52-3-303 and 53-5-303, MCA

46.18.332 FAIM EMPLOYMENT AND TRAINING: FAIR HEARING PROCEDURE (1) A recipient participating in any work-related program or activity under FAIM employment and training, including on-the-job training and alternative work experience programs, is entitled to a fair hearing ~~and appeal~~ as provided in ~~ARM 46.2.201 et seq.~~ [Rule XVII], [Rule XVIII], 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.509A

with respect to on-the-job working conditions.

(2) Benefits may be continued only as provided in ARM 46.2.206 pending the fair hearing decision.

AUTH: Sec. 53-4-212, MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-601 and 53-4-613, MCA

5. The rules as proposed to be repealed are:

11.2.201 DEFINITIONS on page 11-23 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.203 OPPORTUNITY FOR HEARING on pages 11-23 and 11-24 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.205 NOTICE UPON ADVERSE ACTION on pages 11-24 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.207 DENIAL OR DISMISSAL OF HEARING on pages 11-24 and 11-25 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.209 HEARING OFFICER, POWERS AND DUTIES on page 11-27 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.210 ADMINISTRATIVE REVIEW on pages 11-27 and 11-28 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.211 HEARING PROCEDURE on page 11-28 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.212 PROPOSAL FOR DECISION BY HEARING OFFICER on page 11-29 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.214 NOTICE OF PROPOSAL FOR DECISION, FILING AND SERVICE OF BRIEFS, AND DIRECTOR REVIEW OF PROPOSAL FOR DECISION on page 11-30 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.215 JUDICIAL REVIEW on page 11-31 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

11.2.220 AVAILABILITY OF HEARING RECORDS on page 11-31 of the Administrative Rules of Montana.

AUTH: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA
IMP: Sec. 2-4-201~~(2)~~ and 52-1-103~~(17)~~, MCA

46.2.213 IMPLEMENTATION OF HEARING DECISIONS on page 46-43 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-2-606, 53-4-212, 53-6-113 and 53-7-102, MCA
IMP: Sec. 53-2-201, MCA

46.12.409 FAIR HEARING PROCEDURES on page 46-1214 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-108 and 53-6-113, MCA
IMP: Sec. 53-6-106, 53-6-107, 53-6-111, 53-6-141 and 53-2-201, MCA

46.12.1268 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES on pages 46-1771 through 46-1773 of the Administrative Rules of Montana.

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

6. The proposed rule changes are necessary to consolidate and organize the various hearing rules from the department's predecessor agencies into a single set of rules governing hearing procedures in all the administrative contested cases heard by the department, and to transfer the rules into a single chapter of ARM Title 37. The department's goal generally is to apply a consistent framework of hearing rules to each program the department administers, with some revisions and special exceptions to address the special needs of a few programs.

Proposed new Rule I makes it clear that the hearing rules do not grant a right to hearing, but specify the procedures that apply when a right to hearing is otherwise granted by rule or law.

Rules II through XIV cite for each department program the administrative rule, Montana statute or other legal authority that governs applicable hearing procedures. Because the existing hearing rules often do not specify the programs to which they apply, Rules II through XIV are necessary to specify the hearing rules applicable in each case. Although current administrative rules may specify the applicable procedures for certain cases, the various rules are not located together in a single part of the administrative rules and it may be difficult for members of the public to identify the hearing procedures which apply. Proposed Rules II through XIV address this inconvenience by bringing together in one subchapter a guide to the hearing rules for the department's various programs.

Rule VIII lists programs for which hearings are conducted under Montana Administrative Procedure Act (MAPA) procedures, which do not contemplate an administrative review. The department considered the alternative of including the listed programs in Rule II, which provides for an administrative review as standard procedure. The department rejected the alternative because its experience shows that administrative reviews have not been effective in helping to resolve contested cases that occur in the programs listed in Rule VIII. The department does not intend that this rule limit a hearing officer's discretion to order an administrative review in an appropriate case.

Proposed new Rules XV through XVIII, when combined with existing ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212 and 46.2.214, are necessary to provide a set of generally applicable hearing procedures for the numerous programs administered by the department. Certain individual programs are subject to other procedural rules set forth in statute, administrative rule or federal regulation. When a right to hearing is specifically granted by law but no department rule specifies the hearing procedures, the hearing will be conducted as specified in Rule VIII.

Hearings related to licensure of adult foster care homes previously were conducted under Title 11 procedures similar to the proposed general hearing rules. A 1995 amendment to 50-5-101, MCA referred to adult foster care homes as health care facilities. Under the proposed rules, the hearings would be conducted under the provisions of Rule VIII for health care facility licensure and enforcement.

Rules XV and XVI are necessary to specify the scope of the department's hearing rules and the hierarchy among various authorities that may apply with respect to hearing procedures in a given case. Hearings are available only when granted by law or department rule. Hearings are not available in contract

disputes. Many department programs are subject to federal requirements, which may include specific hearing requirements, and in such cases those requirements apply and control in the event of a conflict with the more general hearing rules. There may be particular hearing related provisions in the rules relating to a particular program, in which case such rules will control in the event of a conflict with the more general hearing rules. Rules XV and XVI are necessary to make these provisions clear, rather than relying solely upon interpretation and argument in contested cases.

The proposed changes reorganize, with amendments, the rules contained in current ARM Title 46, chapter 2, subchapter 2, into new Title 37, chapter 5, subchapters 3 and 5. Proposed subchapter 3 contains hearing procedures and proposed subchapter 5 contains notice requirements. The hearing procedure rules in subchapter 3 will serve in a broader array of programs so changes were necessary to permit the rules to function in more types of cases. Further, the various hearing rules that currently exist for certain medicaid providers (for example, ARM 46.2.201, et seq., 46.12.409, 46.12.509A and 46.12.1268) are consolidated into proposed subchapter 3 and ARM 46.12.409 and 46.12.1268 are repealed. The administrative review and fair hearing procedures will be identical for all medicaid providers, simplifying the existing structure which provides two separate forms of procedure for different provider groups.

The proposed changes to ARM 46.2.201 are necessary to address the additional classes of cases that will be covered by the rule, such as overpayment recoveries, medicaid provider sanctions, ability to pay determinations for state institution residents, and permanent institutionalization determinations for purposes of medicaid real property liens. The definitions of "claimant" and "provider" are revised to function with a broader set of cases. The definitions of "benefit" and "adverse action" must be read with the limitation that proposed ARM Title 37, chapter 5, subchapter 3 applies to the program areas specified in Rules II through XIV. Otherwise, subchapter 3 could be read incorrectly to grant hearing rights in a much broader variety of cases. The proposed change to subsection (3), "authorized representative", is necessary to allow department employees such as social workers to represent claimants. Previously such employees were in a different department and could represent a claimant, but after reorganization are prevented by this rule from doing so. This change restores the option to have a department employee represent a claimant.

The department considered the alternative of transferring the rule unchanged and rejected it in an effort to clearly and thoroughly define the specialized terms applicable to the department's consolidated hearing rules.

The proposed changes to ARM 46.2.202 specify the time within which a claimant must request a hearing. The general rule is

that the hearing request must be received by the department within 90 days after mailing of the department's notice of the adverse action. The previous rule allowed a claimant to request a hearing within 90 days, without specifying how the beginning of the period was to be calculated and without requiring department receipt of a hearing request within that period. The proposed change provides greater specificity and will help to avoid disputes about whether a hearing request was made in a timely fashion. Shorter time periods are specified for certain programs. These specific periods are consistent with current practice or with state or federal requirements in the programs named. The proposed rule also adds directions as to where the hearing request must be mailed or delivered. The proposed rule specifies the time periods for hearing requests by providers generally and medical assistance providers in particular.

Proposed amendments to subsections (3)(a) through (c)(ii) of ARM 46.2.202 are necessary to specify how the rules apply when medicaid providers appeal eligibility determinations for particular medicaid recipients and applicants. These amendments address problems that have commonly occurred when determining whether a provider's hearing request was timely submitted. Generally, when a medicaid provider appeals an eligibility determination as a real party in interest, it is subject to the same rules applicable to the claimant. The proposed rule specifies certain exceptions, however. A provider has a responsibility to verify eligibility and, if the provider receives information suggesting that eligibility has not been established, the provider must inquire and take appropriate action to establish eligibility. Most providers understand this basic responsibility and take appropriate action to inquire and to follow up on eligibility questions. However, some providers have failed to verify or inquire about eligibility. After the passage of long periods of time the providers have sought to appeal eligibility determinations, even though they actually knew or should have known that eligibility was not established. Because of the large numbers of providers a medicaid recipient potentially may visit, the department cannot notify providers of eligibility determinations. However, the department maintains various automated systems which allow providers to inquire and follow up on eligibility questions.

While the department generally is not required to notify providers regarding eligibility determinations, the proposed rule does require the department to notify a provider of an eligibility determination if the provider has submitted a written request for notice to the appropriate county office. The proposed rules are necessary to assure that eligibility issues are pursued and resolved on a timely basis while pertinent information is available. An early determination of eligibility will prevent the accrual of large unpaid balances based upon a mistaken assumption (rather than an actual determination) that medicaid eligibility exists.

The proposed changes to ARM 46.2.202, and to the hearing rules generally, clarify and continue the requirement that in order to receive a hearing, a claimant or provider must be aggrieved by an adverse department action. It is not sufficient that the complaining party disagrees with, is dissatisfied with or wishes to contest the determination. The complaining party must be granted a right to a hearing, and must be aggrieved by an adverse action of the department. Department resources are not sufficient to hear all complaints and the law does not require that hearings be granted and scarce resources expended when there is no actual harm that can be redressed in a department hearing.

Proposed Rule XIX and the changes to ARM 46.2.203 and 46.2.204 are necessary to specify notice requirements applicable to certain department programs and to limit the rules to the appropriate programs. The notice provisions contained in current rules ARM 46.2.203 and 46.2.204 were originally intended to implement certain federal requirements. The requirements in those rules were more stringent for some programs than the law requires. While some of the requirements applied to a few of the programs administered by the former Department of Social and Rehabilitation Services, they apply to a smaller proportion of programs administered by the department as it is currently organized. The universal application of the notice rules to all programs administered by the department resulted in unnecessary expenditure of scarce resources in programs not required by law to have stringent notice procedures. Moreover, the notice requirements applicable to particular programs are specified in the particular rules related to each program. The proposed notice rules have been separated from the proposed hearing procedure rules and their more limited applicability has been specified to avoid confusion. Since these rules do have some general applicability within a number of programs, the requirements have been pared down to those requirements more generally applicable to all covered programs, but the rule specifies that specific notice requirements applicable to each particular program must be followed.

The proposed changes to ARM 46.2.204 are necessary to update terminology to reflect changes in the other proposed rules. The department is proposing elimination of the special time line for notifying an applicant of a denial of benefits. The department considered retaining the special provision and rejected it in consideration of consistency and uniformity throughout its procedures. If adopted as proposed, amended ARM 46.2.204 would require notice of denial of benefits and other adverse actions to be adequate and timely as provided in subsection (1) of this rule.

Subsection (6) would clarify the standards for adequacy of notices of adverse department action. The department proposes that good faith errors and omissions should not be the basis for declaring a notice inadequate so long as the notice is in

substantial compliance with due process requirements. The department considered options that would have made the notice requirements more stringent or more lenient. It decided to reject these options based on its experience with challenges to its notices in past cases. The department believes that the proposed rule is balanced and that it is desirable to leave the matter largely to the discretion of the hearing officer. The proposed rule would allow case-by-case application of due process principles to the unique facts of each dispute.

The department is proposing new subsection (7) to clarify that advance notice of adverse action is not necessary in cases involving determinations of medical necessity for Medicaid. The department did not consider an alternative because ARM 46.12.306 allows determinations of medical necessity after services have been provided. The urgency of medical services may preclude sufficient time for the department to make a prior determination of medical necessity. Therefore, the department believes it is desirable to make the rule as clear as possible so that medical service providers can make informed treatment decisions.

The proposed changes to ARM 46.2.205 expand the list of grounds upon which a hearing request may be dismissed. The department believes that the additional grounds are available under the current rules and general law, but hearing officers have been reluctant to dismiss a hearing without express authority in department rules. The additions address several grounds explicit in other hearing rules. For example, dismissal may be granted when the action is not adverse, the claimant or provider is not aggrieved by the action, or the action was taken by a person or entity other than the department. Also, a hearing may be dismissed when the action complained of does not entitle the person or entity to relief, including relief that the hearing officer is authorized to grant. Other grounds for dismissal may be present in the specific law applicable to the case or in the law generally, and the rule authorizes hearing officers to grant dismissal of appropriate cases.

Proposed subsection (2) specifically authorizes the hearing officer to dismiss a case when the claimant or provider fails to respond to or comply with an order of the hearing officer to inform the hearing officer whether the party wishes to proceed further. This provision is necessary to address cases in which a party does not respond to inquiries and the department is forced to needlessly prepare for and appear at a hearing at which the aggrieved party does not appear and does not wish to pursue. The proposed rule contains a provision allowing reinstatement of the hearing right for good cause, to address cases in which the aggrieved party had a good reason for the failure to respond or comply.

The proposed changes to ARM 46.2.206 are necessary to limit the continuation of benefits to programs when it is required by federal law. The proposed changes are also necessary to specify

the circumstances in which continuation of benefits are available. Continuation of benefits is available only to the extent that the benefits have already been granted, and not to obtain an additional grant of benefits. Continuation of benefits would not be available if the benefits would pose a risk of harm to the claimant or another person. For example, the continued benefit's rule would not prevent or delay transfer of a resident from a state facility because the resident is endangering other residents of the facility.

The department considered and rejected the option of transferring the rule unchanged. In its current form, ARM 46.2.206 does not address the special rule for food stamp applicants, and other specific provisions of federal law. The proposed amendments address those issues. The department did not consider other options because the amended provisions restate federal law.

The proposed changes to ARM 46.2.207 are necessary to address several issues that occur in practice before the department's hearing officers. The proposed changes would allow the hearing officer to require a prehearing conference in aid of the orderly and efficient conduct of a hearing, regardless of whether the parties request or consent to a conference. The proposed amendment would allow the hearing officer to grant a continuance for good cause shown or by consent of the parties. The proposed rule allows either party to obtain a continuance for good cause. The proposed rule also recognizes Montana case law in providing for summary judgment in the manner provided in Rule 56, Montana Rules of Civil Procedure (M.R.Civ.P.). The proposed rule expressly authorizes the hearing officer to require the parties to comply with reasonable and appropriate orders to assure orderly discovery, prehearing and hearing procedures or to avoid unnecessary proceedings and expense. For example, the hearing officer may require a party to inform the hearing officer whether the party wishes to go forward with a hearing. The proposed rules provide a framework for the efficient disposition of motions in all provider cases and in claimant cases as required by the hearing officer. This rule fills a void in the current rules, which are silent on the handling of motions. All of the changes to ARM 46.2.207 are necessary to allow the hearing officer to conduct the prehearing and hearing process in an orderly and efficient manner and to avoid undue delays, moot proceedings or unnecessary expenses.

The department considered other options for orderly administration of the hearing process and chose to model the proposed amendments on the M.R.Civ.P. The department determined that other options were less desirable because M.R.Civ.P. are the judicial standard procedures familiar to attorneys and litigants throughout the state.

The proposed changes to ARM 46.2.208 are necessary to specify when administrative review is available and to make the rule

applicable to provider cases as well as claimant cases. The proposed changes address cases in which the claimant or provider does not appear at the time scheduled for a conference. To permit the case to move forward, the department must have a means to decide the case without a conference after reasonable efforts have been made to allow the provider or claimant to appear. The provisions regarding informal reconsideration are deleted because they appear in a separate rule, ARM 37.5.319.

Proposed Rule XVIII specifies an informal reconsideration process that applies only in certain specified classes of cases in lieu of or in addition to administrative review and fair hearing. Informal reconsideration is available only as specified in department rule. Generally, it is available when no hearing is available, although it is available at an early stage of certain classes of cases when the department takes a certain action and a full hearing will be available at a later time. The proposed rule changes are necessary to specify what an informal reconsideration entails. Current rules refer to informal reconsideration, but do not specify how the process will be conducted.

The department considered the alternative of transferring the rule unchanged, but rejected it in an effort to clearly and thoroughly describe the administrative review procedures.

The proposed changes to ARM 46.2.209 are necessary to specify the place of hearing and to make the rule function for providers as well as claimants. The proposed changes to ARM 46.2.210 and ARM 46.2.214 are necessary to reword the rules for clarity and to organize the subject matter in a more logical fashion. The proposed changes to ARM 46.2.212 are necessary to make the rule consistent with 2-4-702, MCA. Subsections (2), (3) and (4) are deleted because they address matters controlled by the Montana Administrative Procedure Act. Current ARM 46.2.213 is repealed because it unnecessarily repeats or summarizes the provisions of statute or other department rules.

The department considered an option that would have allowed the department to designate the place provider grievances would be heard. The department determined that the option would have unnecessarily complicated the hearing process. The proposed amendment would designate Helena as the venue for all provider hearings. The proposed provision allowing telephone hearings should alleviate inconvenience to providers that designating a single venue may cause. The department also considered an option that would have allowed the parties to petition the Hearing Officer for a change of the venue. The department rejected the option because it would have introduced unnecessary delay and complication into the hearing procedure. The department believes that the simple provision allowing telephone hearings will accomplish the same purpose with fewer delays.

The proposed changes to ARM 46.2.211 are necessary to specify

the cases in which appeals are heard by the board of public assistance and those in which the department director hears the appeal. The intent of the rule is to preserve the current division of cases between the board and the director. The rule specifies the procedures applicable in an appeal to the board or to the director.

The department did not consider alternatives to the proposed amendments because state law governs functions of the board.

The proposed inclusion of current ARM 46.12.509A will incorporate into subchapter 3 a single form of procedure for all medicaid providers. This rule adopts the form of procedure currently applicable to hospitals, nursing facilities and certain other provider types. It requires a provider to request and exhaust the administrative review process through the department division before requesting a fair hearing. The proposed changes to ARM 46.12.509A revise the rule to function for medicaid providers generally and to update the rule to reflect current department organizational structure. The bulk of subsection (4) is proposed for deletion because board appeal procedures are already addressed in ARM 46.2.211.

The department did not consider an alternative, because the amendments were not intended to create new rights or obligations. The amendments are intended to unify and simplify hearing procedures and to eliminate duplication.

The proposed changes to ARM 11.11.113, 11.12.110, 11.14.114, 11.16.139, 11.18.121, 11.19.109, 16.24.108, 16.24.109, 16.25.104, 16.30.301, 16.32.917, 16.35.104, 37.2.720, 37.8.126, 37.30.2570, 37.34.226, 37.34.335, 37.34.919, 37.34.2313, 37.41.109, 37.50.306, 37.50.316, 37.50.525, 37.70.106, 37.71.106, 37.95.125, 37.100.135, 46.12.216, 46.12.307, 46.12.310, 46.12.408, 46.12.509, 46.12.513, 46.12.556, 46.12.558, 46.12.559F, 46.12.1221, 46.12.1232, 46.12.1260, 46.12.1413, 46.12.1919, 46.12.3003, 46.12.3223, 46.12.3227, 46.12.3401, 46.12.4815, 46.12.4824, 46.12.5014, 46.18.332 and 46.20.123 are necessary to reword the rules for clarity, limit hearings to cases in which the specified party is aggrieved by an adverse department action, specify the cases in which an informal reconsideration rather than a contested case hearing is available, and revise internal citations to hearing and notice rules to conform with the proposed changes to, repeal of and/or renumbering of the hearing procedure rules.

The proposed repeal of ARM 11.2.201, 11.2.203, 11.2.205, 11.2.207, 11.2.209, 11.2.210, 11.2.211, 11.2.212, 11.2.214, 11.2.215, 11.2.220, 46.12.409 and 46.12.1268 is necessary because they will be replaced by proposed Title 37, chapter 5, subchapter 3, which will apply to the same programs.

7. 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 March 9, 2000. Data, views or arguments may also be submitted by facsimile (406) 444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Thomson
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the adoption of new rules I, II and III pertaining to guardianship services	))))	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On March 11, 2000, the Department of Public Health and Human Services proposes to adopt 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. If you request an accommodation, contact the department no later than 5:00 p.m. on March 9, 2000, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; Email dphhslegal@state.mt.us.

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

[RULE I] GUARDIANSHIP AND HOME APPROVAL (1) The prospective guardian and the home of the prospective guardian must meet the youth foster home requirements contained in ARM 37.97.1001 through 37.97.1019.

(2) The child for whom guardianship is being considered must have resided with the prospective guardian for a minimum of 6 months.

(3) A written assessment of the prospective guardian and home of the prospective guardian shall be completed. The assessment must include a determination that the prospective guardian and home of the prospective guardian meet the requirements of this rule. The assessment must demonstrate the appropriateness of the proposed guardian to become the legal custodian for a specific child. Factors to be considered in determining the appropriateness of the proposed guardian include the proposed guardian's acceptance of the child's cultural, racial and religious heritage; knowledge of the child's history, including placement and loss history and the potential effect on the child's development and future functioning; understanding and acceptance of the continued role of the child's birth family; understanding and acceptance of the powers and duties of a guardian; and the desire of prospective guardian to become the child's guardian.

AUTH: Sec. 41-3-1103, MCA
IMP: Sec. 41-3-421, MCA

[RULE II] STATE SUBSIDIZED GUARDIANSHIP (1) A child is eligible to have state subsidized guardianship payments made on the child's behalf if the child has been adjudicated a youth in need of care pursuant to Title 41, chapter 3, part 4, MCA.

(2) Subsidized guardianship payments may be made to the guardian of an eligible child when:

(a) the child meets the guardianship criteria found in 41-3-421, MCA;

(b) the prospective guardian and guardian's home meet the requirements of [Rule I];

(c) the court has issued a decree of guardianship;

(d) an agreement describing the terms and conditions of the guardianship subsidy has been negotiated by the department with the prospective guardian; and

(e) the prospective guardian and the department have signed an agreement describing the negotiated terms and conditions of the subsidy prior to the issuance of the guardianship decree.

(3) Monthly payments and medical coverage as provided under Montana medicaid programs may be provided under a subsidized guardianship agreement. A child in a subsidized guardianship arrangement is not eligible for the foster care support services as provided for in ARM 37.50.501 through 37.50.525.

(4) The monthly payment must not exceed the family foster care maintenance payment for which the child is eligible at the time the guardianship is established.

(5) The subsidized guardianship agreement may be renegotiated at the request of either the guardian or the department.

(6) The subsidized guardianship agreement may be terminated if requested by or agreed to by the guardian.

(7) The subsidized guardianship agreement shall be terminated if the guardianship is revoked by the court or if the department determines that the subsidy is not being used to support the child.

AUTH: Sec. 41-3-1103, MCA
IMP: Sec. 41-3-421, MCA

[RULE III] FEDERALLY SUBSIDIZED GUARDIANSHIP (1) Under a child welfare demonstration project awarded by the federal department of health and human services, the department is authorized to utilize federal funds to pay guardianship subsidy on behalf of children who meet the requirements established under the terms and conditions of the demonstration project. The terms and conditions contract between the federal department of health and human services and the department is hereby adopted and incorporated by reference. Copies of the contract may be obtained on the department's web site at http://www.dphhs.state.mt.us or from the Department of Public Health and Human Services, Child and Family Services Division, 1400 Broadway, P.O. Box 8005, Helena, MT 59620-8005.

(2) Federally subsidized guardianship payments may be made to the guardian of an eligible child when:

(a) the requirements established under the demonstration project terms and conditions and the requirements of [Rule II(2)(b) through Rule II(7)] are met.

(3) Children who meet the eligibility requirements established under the demonstration project will be randomly assigned to a service group or a control group.

(4) Only children assigned to the service group will be eligible to receive federally subsidized guardianship payments.

(5) The department must make an annual visit to the home of each child receiving a federally subsidized guardianship.

AUTH: Sec. 41-3-1103, MCA
IMP: Sec. 41-3-421, MCA

3. In the 1999 legislative session, the legislature passed House Bill 180, codified at 41-3-421 and 41-3-1103, MCA. These statutes allow the department or the child's guardian ad litem to petition for appointment of a guardian for a youth found to be a youth in need of care, provide for the revocation of guardianships, and clarify the authority of the department to provide financial subsidies for guardianships meeting department criteria.

Section 41-3-1103, MCA, specifically states that "the department may provide a subsidy for a guardianship of a child who is in the department's legal custody if the guardianship has been approved by the department pursuant to 41-3-421, MCA, and in accordance with eligibility criteria established by department rule".

The department believes that there will not be added cost as a result of these rules. Some cost savings are anticipated. The children for whom subsidized guardianship is provided would be receiving monthly foster care maintenance payments in the absence of subsidized guardianship payments, and some of the children would also be receiving other foster care support services. The subsidized guardianship payments will be less than the foster care maintenance payment which would otherwise be made on behalf of the child. Equivalent support services, in addition to the guardianship payment, will not be part of the subsidized guardianship benefit.

Proposed Rule I is necessary to assess the prospective guardian and the home of the prospective guardian. In order for the department to confidently consent to the appointment of a guardian for a child, which is required by 41-3-421, MCA, prior to the appointment of such guardian, the department must have objective criteria on which to determine that the guardianship is in the best interests of the child.

The assessment is intended to determine if the guardian is willing and capable of providing a safe and appropriate

environment for the child until the child becomes an adult. Section 41-3-421(2)(f), MCA, requires that "the child has lived with the potential guardian in a family setting and that the potential guardian is committed to providing a long-term relationship with the child". The department has determined that a placement of at least six months is necessary to determine that the prospective guardian is committed to a long-term relationship. A thorough assessment of a guardianship home as provided for by this rule is necessary to optimize the future well being of a child.

The department considered the option of requiring no assessment but determined that option to be inappropriate. Failure on the department's part to conduct an assessment of a prospective guardian and home of a prospective guardian could result in harm to a child. Conducting an assessment is necessary to ensure the child's safety and well being.

The department considered the option of adopting new rules to establish guardianship home requirements, but elected instead to use the existing rules on youth foster home requirements via cross reference to avoid unnecessary duplication. The department determined that requiring compliance with the youth foster care rules would provide a reasonable basis for assessing the appropriateness of the prospective guardian and home of the prospective guardian. The youth foster care rules have previously been determined by the department to be necessary to ensure that the needs of a child will be appropriately met. The department has an obligation to ensure, as much as possible, that a prospective guardian is able to provide safe, stable long term environment for a child.

The department considered the option of not requiring a written assessment but determined this to be inappropriate. A written assessment provides documentation of the steps taken by the department to assure the safety of the child and the appropriateness of the home. A written assessment is necessary to document the factors considered in the assessment in a format that can be provided to relevant parties, such as the court, the child's guardian ad litem, the prospective guardian, etc.

Proposed Rule II is necessary to meet 41-3-1103, MCA, which specifically states that eligibility criteria for a guardianship subsidy is to be established by department rule. The proposed rule references all of the specific eligibility requirements as provided in 41-3-421, MCA, and provides the framework for the department to operationalize the subsidized guardianship program. Proposed Rule II provides information to prospective guardians regarding the financial and medical assistance that may be provided under subsidized guardianship.

The state subsidized guardianship program, as proposed to the 1999 legislature, was intended to mirror the subsidized adoption program as much as possible. The monthly financial payment made

under the subsidized adoption program can not exceed the monthly maintenance payment for which the child would be eligible in a youth foster home. Within the allowable limitations as determined by the department, the amount of financial assistance and inclusion of medical coverage provided under the subsidized adoption program are negotiated with the prospective adoptive family based on the needs of the child. The amount of the financial assistance provided and the provision of Medicaid coverage are determined based on the individual needs of an eligible child, the family's ability to meet the child's needs and the family's expressed need to receive a subsidy in order to adopt the child. The guardianship subsidies will be negotiated in this same way, based on these same parameters. Proposed Rule II is modeled after the subsidized adoption program rule.

Proposed Rule III is necessary because the federally subsidized guardianship program, although administered by the department, must meet the requirements contained in the terms and conditions contract with the federal Department of Health and Human Services. The eligibility of a child to receive federally subsidized guardianship is determined both by the terms and conditions contract with the federal Department of Health and Human Services and 41-3-421 and 41-3-1103, MCA. The provision of the federally subsidized guardianship payments will be made by the department and should be made following the same process as the state subsidized guardianship payments. The department determined that a specific rule which reflects that there are different requirements depending on the funding source for the subsidy was necessary.

There are some particularly notable differences between the state subsidized guardianship program and the federally subsidized guardianship program. The two most significant differences are the numbers of children who are eligible and the service and control groups.

Under the state subsidized guardianship program there are no established limits on the number of eligible children on whose behalf subsidized guardianship payments may be made. Under the federally subsidized guardianship program, the number of otherwise eligible children is limited to the number approved in the terms and conditions.

Under the federally subsidized guardianship program, otherwise eligible children will be randomly assigned to either a service or a control group. Children in the service group may have federally subsidized guardianship payments made on their behalf. Children in the control group may not have federally subsidized guardianship payments made on their behalf. Children in the control group will remain eligible for all foster care services for which they are otherwise eligible, including monthly foster care maintenance payments. Children in the control group are not precluded from having a guardianship established. However, the guardianship will not be subsidized.

The federally subsidized guardianship program is available to eligible children because the department applied for and was approved by the federal Department of Health and Human Services to initiate a child welfare demonstration project. There are specific requirements of all child welfare demonstration projects including the requirement to have service and control groups. The specific requirements to which the department has agreed to are detailed in the terms and conditions contract with Health and Human Services. The department has elected to adopt and incorporate this document by reference.

4. Interested persons may submit their data, views or arguments concerning the proposed action in writing to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than 5:00 p.m. on March 9, 2000. Data, views or arguments may also be submitted by facsimile (406) 444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments 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 March 9, 2000.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those who are directly affected by the proposed action, from the Administrative Rule Review Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date and a notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be 15 based on the 150 guardian families affected by rules covering guardianship services.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the adoption of rules I through XXIX pertaining to the children's health insurance program (CHIP)	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Interested Persons

1. On March 2, 2000, at 3:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the Department no later than 5:00 p.m. on February 25, 2000, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

[RULE I] CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) (1) The rules in this subchapter implement the children's health insurance program (CHIP). This program is jointly funded by the federal and state government. The purpose of the program is to provide health care to uninsured children of low income families who are not eligible for the Montana medicaid program.

AUTH: Sec. 53-4-1004 and 53-4-1009, MCA
IMP: Sec. 53-4-1003, 53-4-1004 and 53-4-1009, MCA

[RULE II] DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) "Advanced practice registered nurse (APRN)" means a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the board of nursing pursuant to 37-8-202(5)(a), MCA.

(2) "Applicant" or "child" means a person under the age of 19 years and who is the applicant for CHIP services.

(3) "Benefits" means the services the child is eligible for as outlined in this subchapter. All benefits with the exception of dental and eyeglass services, are provided to the child through the insurer.

(4) "Beneficiary" means a child who is eligible to receive CHIP benefits as determined by the department under this subchapter. A child is not a beneficiary pending issuance of a hearing decision or during any period a hearing officer determines the child was not eligible for CHIP benefits.

(5) "Benefit year" means the period from October 1st through September 30th of a calendar year. If a child is enrolled after October 1st, the benefit year is the period from the date of enrollment through September 30th of the calendar year.

(6) "Children's health insurance program (CHIP)" means the children's health insurance program described in this subchapter and administered by the department under Title XXI of the Social Security Act.

(7) "Earned income" means income of any kind received from employment, self-employment activity, profession, vocation or pastime and includes wages, salaries, tips, commissions, profits, farm income and honoraria.

(8) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(b) serious impairment of bodily function; or

(c) serious dysfunction of any bodily organ or part.

(9) "Eyeglasses" means corrective lens and/or frames prescribed by an ophthalmologist or by an optometrist to aid and improve vision.

(10) "Family" means a group of two or more persons related by birth, marriage or adoption who live together. Family members must be children and parents. Grandparents, aunts, uncles, cousins and other relatives are not considered to be family members for purposes of this subchapter. Family members are considered to live together even though a family member may reside temporarily in a residential treatment setting. For purposes of this subchapter, a self-declared emancipated minor living alone shall be considered a family.

(11) "Federal poverty level (FPL)" means the poverty guidelines for the contiguous 48 states and the District of Columbia most recently published in the Federal Register as of the end of the month immediately preceding the month in which an application is submitted.

(12) "Guardian" means the custodial parent or other person granted legal custody of a child by court order, judgment or decree.

(13) "Incarcerated" or "inmate of a public institution" means a child living in a facility which would be termed a public institution under medicaid regulations at 42 CFR 435.1009.

(14) "Institution for mental disease (IMD)" means a

facility which would be termed an institute for mental disease under medicaid regulations at 42 CFR 435.1009.

(15) "Insurer" means an authorized insurer, health service corporation or health maintenance organization (HMO) with a valid certificate of authority issued by the Montana commissioner of insurance to transact business in the state of Montana.

(16) "Medicaid screening" means a determination by the department of a child's potential eligibility to receive medicaid benefits applying the criteria set forth in ARM Title 46, chapter 12 and certain medicaid rules which disregard income.

(17) "Medically necessary" or "medically necessary covered services" means services and supplies which are necessary and appropriate for the diagnosis, prevention or treatment of physical or mental conditions as described in this subchapter and that are not provided only as a convenience. The medicaid program definition of medically necessary services in ARM 46.12.102 does not apply to this subchapter.

(18) "Mid-level practitioner" is defined at ARM 46.12.2011.

(19) "Montana resident" means a U.S. citizen or qualified alien who declares himself to be living in the state of Montana, including migrant and other seasonal workers.

(20) "Physician's assistant (PA)" or "physician assistant-certified" means a member of a health care team, approved by the board of medical examiners, who provides medical services that may include examination, diagnosis, prescription of medications, and treatment, as approved by the board of medical examiners, under the supervision of a licensed physician.

(21) "Premium" means the amount of money the department pays monthly to an insurer for the provision of covered benefits to each child. The premium is paid whether or not the enrollee received covered benefits during the month for which the premium is intended. All benefits outlined in this subchapter, except eyeglass and dental services, are paid by the department through this premium.

(22) "Qualified alien" means a person residing legally in the United States, as defined by federal immigration laws and regulations and in ARM 46.18.140.

(23) "State employee" means a person, including the CHIP child, employed on a permanent basis by the state of Montana.

(24) "Total family income" means earned and unearned income when appropriate. Regular, continuing and intermittent sources of income will be annualized for purposes of determining the annual income level.

(a) Total family income does not include:

(i) earned income of children in the household, unless they are of school age and are not attending school or are emancipated minors;

(ii) money received as assets drawn down such as withdrawals from a bank or the sale of a house or a car;

(iii) gifts, loans, one-time insurance payments, except as

beneficiary of a life insurance policy, or compensation for injury; or

(iv) per capita income to enrolled members of Native American tribes.

(25) "Unearned income" means income of any kind which is not earned under this subchapter and includes interest, dividends, distributions from trusts or estates, social security benefits, veteran's benefits or payments, workers' compensation, unemployment compensation benefits and does not include per capita income to enrolled members of Native American tribes, or income excluded under federal medicaid regulations.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE III] ELIGIBILITY (1) Children who have not been determined by the department to be eligible for or potentially eligible for medicaid are eligible for covered services under CHIP if:

(a) the child is under 19 years of age;

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

(c) the child is a Montana resident;

(d) the child is a U.S. citizen or qualified alien as defined under federal statute;

(e) the child does not have or has not had creditable health insurance coverage as defined in 42 USC 300gg(c) during the 3 months prior to application for CHIP. This 3 month waiting period shall not apply if the guardian providing the insurance:

(i) dies;

(ii) is fired or laid off;

(iii) can no longer work due to a disability;

(iv) has a lapse in insurance coverage due to new employment; or

(v) has an employer who does not offer dependent coverage.

(2) For purposes of determining the total family income under this rule, family debts, medical expenses or other financial circumstances are not considered.

(3) The applicant's guardian must submit a statement of income with the completed and signed application form and the necessary documentation to verify the income reported.

(4) For purposes of this rule, necessary income verification may include one or more of the following or other appropriate and persuasive documentation:

(a) pay stubs or other pay statements;

(b) employee's W-2 forms;

(c) state or federal income tax returns and associated forms and schedules;

(d) union records;

(e) check copies;

(f) self-employment bookkeeping records;

(g) sales and expenditure records;
(h) employer's wage or payroll records;
(i) award notices or award letters;
(j) correspondence from an employer specifying a benefit; or
(k) records of any government payer.

(5) Children eligible to receive services from the Indian health services (IHS) program administered by the United States department of health and human services are eligible for CHIP if they meet the criteria specified in this rule.

(6) Children and their guardians must comply with the procedures specified by the insurer or the department or both as necessary to obtain or access services.

(7) CHIP coverage does not start until the child is enrolled with the insurer even though the child may have been found eligible for CHIP prior to the date of enrollment.

(8) If a family fails to pay the fee specified in [Rule XIX], the child will not be enrolled with an insurer even though he/she is otherwise eligible.

(9) CHIP eligibility is redetermined within 1 year after the initial eligibility period, and annually thereafter. Guardians must complete all necessary forms and verifications by a specified date for purposes of eligibility redetermination. Prior eligibility for CHIP does not guarantee continued eligibility nor enrollment with an insurer.

(10) CHIP eligibility and services are not an entitlement. If funding is insufficient, the department may reduce eligibility to a lower percentage of the federal poverty level to reduce the number of individuals who are eligible to participate.

AUTH: Sec. 53-4-1004 and 53-4-1009, MCA
IMP: Sec. 53-4-1003 and 53-4-1004, MCA

[RULE IV] CHILDREN NOT ELIGIBLE (1) Children determined by the department to be eligible for medicaid through a medicaid application and eligibility determination process are not eligible to receive covered services under CHIP.

(2) Children determined by the department to be potentially eligible for medicaid during CHIP eligibility determination must be screened and found ineligible for medicaid through a medicaid application and eligibility determination process before they are eligible to receive covered services under CHIP.

(3) Children who are themselves eligible or who have a guardian who is eligible for state employee insurance benefits are not eligible for CHIP.

(4) Children who apply for the CHIP program while they are patients in an institution for mental disease (IMD) shall not be eligible for CHIP until they are discharged from the IMD. A CHIP beneficiary who becomes a patient in an IMD shall not lose CHIP eligibility solely because they are a patient in an IMD.

(5) Children who are incarcerated in a public institution are not eligible for CHIP.

AUTH: Sec. 53-4-1004 and 53-4-1009, MCA
IMP: Sec. 53-4-1003 and 53-4-1004, MCA

[RULE V] ELIGIBILITY REDETERMINATION, NOTICE OF CHANGES (1) Eligibility determinations shall be effective for a period of 1 year unless one or more of the following changes occurs:

(a) the federal poverty level decreases;

(b) the child moves from the state of Montana;

(c) the child is found to have other creditable health coverage;

(d) the child becomes an inmate of a public institution;

(e) the child reaches his 19th birthday;

(f) the child's guardian or the child himself is employed by the state before the expiration of the 1 year eligibility period;

(g) the child dies; or

(h) the child becomes eligible for medicaid.

(2) Eligibility may be redetermined sooner than 1 year after the most recent determination upon a change in residency, insurance status, medicaid eligibility status, incarceration in a public institution, age, eligibility of the guardian or child for state employee benefits, or the federal poverty level decreases. Guardians may be required to submit completed forms and verification by a specified date for purposes of eligibility redetermination.

(3) CHIP guardians must give notice of a change as specified in (1) within 30 days of the change. Failure to give notice will be grounds for termination of eligibility until such time as complete and accurate information is provided.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE VI] TERMINATION OF ELIGIBILITY AND GUARDIAN LIABILITY (1) CHIP eligibility terminates immediately upon:

(a) death of the CHIP beneficiary;

(b) incarceration of the CHIP beneficiary;

(c) a move out of the state of Montana by the CHIP beneficiary.

(2) CHIP eligibility terminates at the end of the month:

(a) the child attains the age of 19 years;

(b) the guardian or child becomes eligible for state employee insurance benefits;

(c) the child becomes a beneficiary of other creditable health insurance; or

(d) voluntary disenrollment of the CHIP beneficiary.

(3) Termination of eligibility, based upon a decrease in the federal poverty level or insufficient funding at the department, may not be effective earlier than the end of the month after notice of determination to the beneficiary is given.

(4) A guardian is liable to the department and the department may collect from the guardian the amount of actual premiums or payments or both to providers for any services

furnished to the child because of misrepresentation of income or a failure to give the required notice of changes as required by this subchapter.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE VII] COVERED BENEFITS (1) An insurer must provide medically necessary benefits including inpatient and outpatient hospital services, physician services, advanced practice registered nursing services, prescription drugs, laboratory and radiology services, mental health services, chemical dependency services, vision services and eyeglasses, audiology services and dental services as provided in this subchapter unless specific limitations to benefit coverage are noted.

(2) Emergency services, including urgent care and emergency room screening to determine if a medical emergency exists, shall be available 24 hours per day, 7 days per week. In emergency situations, no pre-authorization is required to provide necessary medical care and children may seek care from nonparticipating providers. The insurer may, however, require prior authorization for any needed follow-up care.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE VIII] COVERAGE LIMITATIONS (1) The lifetime maximum benefit coverage is one million dollars per child per insurer.

(2) Pre-existing conditions of each child are covered as of the effective date of enrollment if the condition would be otherwise covered except in the following conditions:

(a) a child, hospitalized prior to the date of enrollment, who remains in the hospital on the effective date of initial CHIP coverage shall not be covered for inpatient benefits for such hospitalization only. Upon discharge, the child shall become eligible for benefits for any subsequent inpatient hospitalizations. This exclusion shall not apply to children who are renewing their CHIP enrollments.

(b) the insurer shall provide covered benefits to a child who is receiving inpatient hospital services up to and including the 11th day after the effective date of losing CHIP eligibility.

(c) a newborn child of a mother covered by CHIP shall have all medically necessary benefits covered by the insurer for 31 days after the newborn's date of live birth. Coverage for the newborn shall begin the day of live birth, without regard to whether the newborn is hospitalized on the date of coverage.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE IX] SERVICES NOT COVERED (1) In addition to any exclusions noted elsewhere in these rules, the following

services are not covered benefits:

(a) experimental services or services generally regarded by the medical profession as unacceptable treatment;

(b) custodial care;

(c) personal comfort, hygiene and convenience items which are not primarily medical in nature;

(d) whirlpools;

(e) organ and tissue transplants;

(f) treatment for obesity;

(g) acupuncture;

(h) biofeedback;

(i) chiropractic services;

(j) cosmetic surgery;

(k) radial keratotomy;

(l) private duty nursing;

(m) treatment for which other coverage such as workers' compensation is responsible;

(n) routine foot care;

(o) ambulance or other medical transportation;

(p) abortions which are not performed to save the life of the mother or to terminate a pregnancy which is the result of an act of rape or incest;

(q) in vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery or fertility enhancing treatment beyond diagnosis;

(r) benefits for a child incarcerated in a criminal justice institution; and

(s) any treatment which is not medically necessary.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE X] INPATIENT HOSPITAL BENEFITS (1) Inpatient hospital benefits are provided, including but not limited to:

(a) a semi-private room;

(b) intensive and coronary care units;

(c) general nursing;

(d) drugs;

(e) oxygen;

(f) blood transfusions;

(g) laboratory;

(h) imaging services;

(i) physical, speech, occupational, heat and inhalation therapy;

(j) operating, recovery, birthing and delivery rooms;

(k) routine and intensive nursery care for newborns; and

(l) other medically necessary benefits and prescribed supplies for treatment of injury or illness.

(2) Coverage of postpartum care for at least 48 hours for vaginal delivery and 96 hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending provider and the mother.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XI] OUTPATIENT HOSPITAL BENEFITS (1) Outpatient hospital benefits provided include all benefits described in the inpatient hospital rule, [Rule X], which are provided on an outpatient basis in a hospital or ambulatory surgical center, and also include:

(a) chemotherapy;

(b) emergency room benefits for surgery, accident or medical emergency; and

(c) other services for diagnostic or outpatient treatment of a medical condition, accident or illness.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XII] PHYSICIAN AND ADVANCED PRACTICE REGISTERED NURSE BENEFITS, LIMITATIONS AND EXCLUSIONS (1) The services of physicians and advanced practice registered nurses are covered benefits.

(2) Prenatal care is covered as described for other medical conditions in these rules.

(3) Well-baby, well-child, and immunization services as recommended by the American academy of pediatrics and the advisory committee on immunizations practices are covered.

(4) Routine physicals for sports, employment or as required by a governmental authority are covered.

(5) Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered providing that surgical and/or hospital services are also covered.

(6) Hypnosis, local anesthesia and consultations prior to surgery are not covered.

(7) Surgical benefits are covered as described in [Rules X and XI] and this rule. In addition, professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

(8) Medical or surgical treatment to reverse surgically induced infertility, fertility enhancing procedures beyond diagnosis and sex change operations are excluded.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XIII] PRESCRIPTION DRUG BENEFITS (1) Prescription drug benefits include drugs prescribed by a health care provider acting within the scope of his practice.

(2) Chemotherapy drugs approved for use in humans by the U.S. food and drug administration, vaccines, prenatal vitamins, and drugs needed after an organ or tissue transplant are covered.

(3) Prescribed diabetic supplies including insulin, test

tape, syringes, needles and lancets are covered as a prescription drug.

(4) Food supplements and vitamins are not covered except prenatal vitamins and medical foods for treatment of inborn errors of metabolism. The need for a prescription to obtain a food supplement or vitamins shall not affect the application of this rule.

(5) The insurer shall use the medicaid formulary if it chooses to employ a formulary.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XIV] LABORATORY AND RADIOLOGY BENEFITS

(1) Laboratory and radiological benefits include imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness or medical condition that are not described elsewhere in these rules.

(2) X-ray, radium or radioactive isotope therapy are covered.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XV] MENTAL HEALTH BENEFITS (1) Inpatient mental health benefits include services furnished in a hospital, including a state-operated mental hospital, a residential service or a partial hospitalization program.

(2) Mental health benefits shall be provided at least to the extent required by state law.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XVI] CHEMICAL DEPENDENCY BENEFITS (1) Inpatient chemical dependency treatment benefits include treatment in an inpatient hospital or residential chemical dependency treatment center.

(2) Chemical dependency benefits shall be provided at least to the extent required by state law.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XVII] VISION BENEFITS (1) Vision benefits and medical eye care includes:

(a) services for the medical treatment of diseases or injury to the eye;

(b) annual vision exams; and

(c) a dispensing fee for eyeglasses provided by a licensed physician, opthamologist, optometrist or opticians working within the scope of his/her license.

(2) Eyeglasses shall be paid by the department through a single volume purchase contract.

(3) A child is limited to one pair of eyeglasses per 365 day period unless additional pairs are necessary due to any of the following circumstances:

(a) cataract surgery;

(b) .50 diopter change in correction in sphere;

(c) .75 diopter change in cylinder;

(d) .5 prism diopter change in vertical prism;

(e) .50 diopter change in the near reading power;

(f) a minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters;

(g) a minimum of 3 degree change in axis of any cylinder greater than 3.00 diopters;

(h) any 1 prism diopter or more change in lateral prism; or

(i) the inability of the recipient to wear bifocals because of a diagnosed medical condition.

(4) When the child meets one or more of the conditions in (3)(a) through (3)(i), the recipient may be allowed two pairs of single vision eyeglasses every 365 day period.

(5) Contact lenses are not a covered benefit.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XVIII] AUDIOLOGY BENEFITS (1) Audiological benefits include hearing exams for assessment and diagnosis.

(2) Newborn hearing screens in a hospital or outpatient setting are covered.

(3) Hearing aides are not a covered benefit.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XIX] DENTAL BENEFITS (1) Dental services will be reimbursed at 85% of the billed charges up to a maximum of $200 per benefit year for each beneficiary by the department.

(a) Providers may not balance bill the child's guardian for the remaining 15% of the billed charges.

(b) Providers may bill the child's guardian for services in excess of the $200 per benefit year covered by the department.

(2) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the American Dental Association Manual of Current Dental Terminology Third Edition (CDT-3).

(3) The following procedures are not a benefit of the CHIP dental program:

(a) procedure codes D5900-D5999; D6000-D6199; D7160-D7780; and D7940-D7999.

(4) Providers must comply with all applicable state and federal statutes, rules and regulations, including the United States Code governing the children's health insurance program and all applicable Montana statutes and rules governing licensure and certification.

(5) Providers must also comply with the requirements of ARM Title 46, chapter 12, subchapters 3 and 4 to the extent those provisions are not inconsistent with this subchapter.

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

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XX] COST-SHARING PROVISIONS (1) An annual enrollment fee of $12 shall be assessed for a family of one whose income is greater than 100% of the federal poverty level.

(2) An annual enrollment fee of $15 shall be assessed for a family of two or more whose income is greater than 100% of the federal poverty level.

(3) Except as provided in (4) and (5), each CHIP enrollee whose family income is greater than 100% of the federal poverty level must pay to the provider of service the following copayments not to exceed the cost of service:

(a) $25 per admission for inpatient hospital services including hospitalization for physical, mental and substance abuse reasons;

(b) $5 per visit for emergency room services;

(c) $5 per visit for outpatient hospital visits including outpatient treatment for physical, mental and substance abuse reasons;

(i) outpatient hospital visits for x-ray or laboratory services are excluded from this copayment requirement;

(d) $3 per visit for physician, APRN, PA, optometrist, audiologist, mental health professional, substance abuse counselor or other covered health care provider services;

(i) dentist, pathologist, radiologist or anesthesiologist services are not subject to this copayment.

(e) $3 per prescription or refill of an outpatient generic drug; and

(f) $5 per prescription or refill for an outpatient brand-name drug;

(4) No copayment shall apply to well-baby or well-child care, including age-appropriate immunizations.

(5) The total copayment for each family shall not exceed $200 per family per beneficiary year.

(6) No annual enrollment fee or copayment shall apply to a child who declares himself to be a Native American Indian or Alaska native.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXI] ENROLLMENT WITH AN INSURER (1) Children eligible for the CHIP program must enroll with an insurer under contract with the department.

(2) When more than one insurer contracts with the department to provide services in the area in which a family lives, the family may request enrollment with a particular insurer.

(a) If the family fails to choose an insurer, the department may assign an insurer.

(3) All eligible CHIP family members must enroll with the same insurer.

(4) An insurer must accept without restriction eligible children in the order in which they are received for enrollment by the state or its designee for CHIP until the insurer's maximum enrollment under the contract is reached.

(5) The effective date of enrollment for an eligible child must be no later than the first day of the 2nd month subsequent to the date on which the state or its designee determines a child is eligible for CHIP or the family picks an insurer, whichever is later.

(6) The insurer must issue an appropriate identification card to a child.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003 and 53-4-1007, MCA

[RULE XXII] ACCESS TO SERVICES (1) A child must have the opportunity to choose a primary care provider to the extent possible and medically appropriate from the providers available at the time of enrollment. The insurer may assign a child to a primary care provider if a child fails to chose one after being notified to do so. The assignment must be appropriate to the child's age, sex and residence. The child may change primary care providers once annually without good cause as defined in Montana insurance law and rules.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXIII] DISENROLLMENT WITH AN INSURER

(1) Participation in CHIP is voluntary and a child may withdraw from the program at any time.

(2) A child who wishes to remain on CHIP may request, without good cause, disenrollment from one insurer and enrollment with another insurer annually.

(3) An insurer, based on good cause, may request that the department disenroll a child. The request with the reason for the request must be in writing.

(a) A child may be terminated for good cause if the child has violated rules adopted by the Montana commissioner of insurance for enrollment with an insurer.

(b) Good cause does not include an adverse change in health status.

(4) Disenrollment takes effect, at the earliest, the first day of the month after the month in which the state or its designee contractor for CHIP receives the request for disenrollment, but no later than the first day of the 2nd

calendar month after the month in which the request for disenrollment is received. The child remains enrolled with the insurer and the insurer is responsible for services covered under the contract until the effective date of disenrollment, which is always the first day of a month.

(5) The department will disenroll a child from a particular insurer if:

(a) the contract between the department and the insurer is terminated;

(b) the child permanently moves outside the insurer's enrollment area; or

(c) the child becomes ineligible for CHIP.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXIV] CONTRACTS FOR SERVICES (1) The department may enter into a contract with an insurer with a certificate of authority issued by the Montana commissioner of insurance to provide any of the services specified in these rules.

(2) An insurer entering into a contract with the department for the delivery of services assumes the risk that the costs of performance may exceed the consideration available through the premium.

(3) An insurer must provide the department with documented assurances to show that the insurer is not likely to become insolvent. This requirement may be satisfied by documenting compliance with rules adopted by the commissioner of insurance.

(4) An insurer may not in any manner hold a child or guardian responsible for the debts of the insurer.

(5) The department may contract with one or more insurers in an enrollment area.

(6) The department may contract with a vendor to purchase eyeglasses under a volume purchase contract.

(7) The department may contract with individual dentists to provide dental services as specified in [Rule XIX].

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXV] PROVISION OF SERVICES (1) An insurer may impose the following requirements in the provision of services:

(a) the use of certain types of providers to the extent allowed by law;

(b) preauthorization for services other than emergency services;

(c) directing a child to the appropriate level of care for receipt of covered services; and

(d) denial of payment to a provider for services provided to a child if the participation requirements in this rule are not met by the child or the child's guardian.

(2) A child must use an insurer's participating providers unless:

(a) the insurer authorizes a nonparticipating provider to

provide a service; or

(b) the child receives services provided for an emergency or emergency room screen.

(3) An insurer must provide covered services as listed in this subchapter to children in the same manner as those services are provided to non-CHIP enrollees.

(4) An insurer may at its discretion offer services to children beyond the scope of CHIP benefits defined in this subchapter.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXVI] PARTICIPATING PROVIDERS (1) An insurer, unless otherwise provided in this rule or Montana law, may select the providers of medical services it deems necessary to meet its contractual obligations with the department.

(2) An insurer may establish its own enrollment and reimbursement criteria for participating providers.

(3) The insurer must offer to federally qualified health centers (FQHCs), rural health clinics (RHCs), Title X family planning providers, Indian health services providers, tribal health providers, urban Indian centers, migrant health centers and county public health departments terms and conditions that are at least as favorable as those offered to other contract providers, if these entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the insurer.

(4) Upon written notice by the department, the insurer must exclude from providing covered services to CHIP children a provider who is currently suspended or terminated by the medicaid or the medicare program in any state.

(5) Participating providers shall be licensed or certified in Montana or in the case of out-of-state providers, in the state in which they practice.

(6) Physicians, advance practice registered nurses and physician assistants shall either have admitting privileges to at least one general or critical shortage area hospital or shall have a mechanism in place to ensure hospitalization when appropriate.

(7) An insurer may set notification and claim filing time limitations relating to the provision of care by nonparticipating providers. Failure to give notice or file claims within those time limitations, however, does not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

(8) A participating provider has no right to an administrative hearing with the department for a denial of payment by the insurer to the provider for a service provided to a child.

(9) A participating provider, in providing services under contract with an insurer, is not subject to any requirements or

rights provided in this rule.

(10) An insurer may not prohibit a participating provider from discussing a treatment option with a child or guardian from advocating on behalf of a child within the utilization review or grievance processes established by the insurer.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXVII] REIMBURSEMENT OF INSURERS (1) In consideration for all services rendered by an insurer under a contract with the department, the insurer will receive a payment each month for each child. This payment is the premium. Unless otherwise provided in this rule, the premium represents the total obligation of the department with respect to the costs of medical care and services provided to each child under the contract. Payment of the premium is considered to be payment in full and the insurer may not bill the child or guardian, nor let its providers bill the child or guardian, for any medical care provided beyond the cost-sharing provisions outlined in [Rule XX].

(2) The insurer may retain any savings realized by the insurer from the expenditures for necessary health services by the enrolled population totaling less than the premium paid by the department.

(3) The department may recover from the insurer any payments made to a provider who is used by the insurer in a manner that is not consistent with the provider's licensure.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXVIII] UTILIZATION REVIEW AND QUALITY ASSURANCE

(1) The insurer shall have adequate staff and procedures to assure that health care provided to children is medically necessary and appropriate.

(2) The insurer shall comply with and cooperate in any external quality review that may be implemented by the department or its designee. An external quality review may include participation in the design of the review, collection of data and making data available to the department or its designee.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

[RULE XXIX] GRIEVANCE PROCEDURES, APPEAL PROCEDURES

(1) An insurer must have a written procedure, approved in writing by the department before implementation, for resolution of grievances brought by beneficiaries or their guardians either individually or as a class. In a situation requiring urgent care or emergency care, the department may require the insurer to expedite resolution of a grievance within a time line established by the department.

(2) Except when CHIP eligibility has been denied, a beneficiary or guardian must exhaust the insurer's grievance procedure before appeal of the matter may be made to the department.

(3) An applicant or guardian aggrieved by a denial, suspension or termination of CHIP eligibility or a beneficiary or guardian aggrieved by a final grievance decision of an insurer, including but not limited to a reduction or denial of benefits, may request a fair hearing in accordance with ARM 46.2.201, 46.2.205, 46.2.207, 46.2.209, 46.2.210, 46.2.212 and 46.2.214. The provisions of [Rule XVIII, as proposed for adoption in MAR Notice No. 37-149] and 46.2.209 do not apply to such hearings.

(4) If a written request for hearing is not received by the department within 30 days after the date a notice of adverse action is mailed by the department or a final grievance decision is mailed by an insurer, the hearing officer may deny a hearing as provided in ARM 46.2.205.

(5) A proposal for decision by the hearing officer is a final agency decision for purposes of 2-4-702, MCA and is subject to judicial review as provided in Title 2, chapter 4, part 7, MCA.

AUTH: Sec. 53-4-1009, MCA
IMP: Sec. 53-4-1003, MCA

3. The proposed rules are necessary to implement 1999 Montana Laws Chapter 571 approved May 5, 1999, which added part 10 to Montana Code Annotated Title 53, Chapter 4, and allows the Department to establish rules necessary for the administration of the Montana Children's Health Insurance Program (CHIP).

CHIP is a state administered program to provide health insurance to low-income children, federally authorized under Title XXI of the Social Security Act. All references to "federal law" are to Title XXI, Section 4901 of the Balanced Budget Act of 1997. References to "federal guidelines" are proposed federal rules published in the Federal Register November 8, 1999 at pages 60882 through 60963. Montana has chosen to adopt the separate child health program option. The state elected to use its state employee health benefits as a benchmark. Under federal statutes, CHIP coverage under this benchmark equivalent plan must be actuarially equivalent to state employee health benefits and must include coverage for the following services: inpatient and outpatient hospital, physicians' surgical and medical, laboratory and radiology, immunizations, and well-baby/well-child care. CHIP coverage of prescription drugs, mental health, vision, and hearing services must also be provided at 75% of the actuarial value of these services under state employee health benefits coverage. The proposed rules implement the intent of both the federal and state authorizing statutes, rules, and regulations. [Rule I] references the establishment of the Children's Health Insurance Program (CHIP) as jointly funded by the federal and state government.

The definitions contained in [Rule II] are necessary to explain the meaning of the terms used in the other proposed rules. The Department proposes to define "emergency medical condition" as it is used in the federal guidelines. The Department considered and rejected the definitions in state law at 33-22-1703 and 33-36-103, MCA because they would not have met the proposed federal requirements.

[Rule III] defines which children are eligible for CHIP. Subsections (1), (5), (9), and (10) are necessary in order to establish requirements mandated in federal and state enabling legislation. Therefore, the Department did not consider an alternative. Subsection (2) specifies that families may not deduct debts, medical expenses, or other financial obligations from their family income. The Department considered and rejected options that would have allowed certain deductions because the enabling legislation made it clear that CHIP should serve those families who have the fewest financial resources available to purchase private health insurance. Subsections (3) and (4) are necessary for ease of administration. These subsections specify that families must submit evidence of their income in a form the Department can verify. The Department considered the option of not requiring documentation and rejected it because income verification is a means of assuring that CHIP will serve only those families who meet the financial eligibility requirements. Because the Department will accept a variety of income verification documents, this requirement is not burdensome on the applicant.

Subsection (6) specifies that to access benefits children must comply with procedures established by the insurer or for benefits administered by the Department, the Department. The Department evaluated and rejected the alternative, not requiring such compliance. CHIP payment is payment in full and if a provider who has not agreed to accept this payment sees a child, the insurer might be liable to pay provider charges in excess of CHIP benefits. This could result in fewer children being served by CHIP as medical costs rose. Unfettered access to medical services would also make it difficult to meet the federal requirement that CHIP health care be purchased prudently. Children and their guardians may appeal denial of benefits as provided in proposed [Rule XXIX]. Consequently, subsection (6) of [Rule III] is not burdensome.

The provision in subsection (7) that CHIP coverage does not begin until the child is enrolled with an insurer is necessary because the Department will be purchasing insurance for most of the services children will receive. The Department will be paying only for eyeglasses and dental care directly. The Department considered and rejected the option of beginning coverage on the date of eligibility. This may have been a much more costly way of purchasing insurance since a child could have waited until a medical crisis occurs before making a CHIP application. The increased cost of purchasing insurance with

this type of coverage would limit the number of children the Department could insure. This condition is reasonable since CHIP coverage will include preexisting conditions and because the cost of insurance to a family is nominal.

Subsection (8) specifies that CHIP will not cover children from a family required to pay an annual enrollment fee until the fee is paid. The Department considered the alternative of trying to collect the fee after enrollment and rejected it as administratively burdensome and expensive. The alternative would have been unnecessarily confusing to families, insurers, and providers because the Department could have issued some children an enrollment card suggesting they were CHIP eligible when they were not. The enrollment fee of $15 annually/family is a nominal amount and is not burdensome to families.

[Rule IV] defines the conditions under which children would not be eligible for CHIP. The rule is necessary in order to implement conditions specified in federal enabling legislation. Therefore, alternatives were not considered.

[Rule V] defines the conditions under which eligibility determinations may be effective for less than one year. If a child moved from the state of Montana, the Department must be able to stop paying CHIP premiums because the child would be unlikely to find a participating provider out-of-state and the family would be unlikely to be a taxpayer in this state. A child who becomes covered by medicaid, other creditable health coverage, is incarcerated, reaches his 19th birthday, becomes employed or whose guardian becomes employed by the state is not eligible for CHIP under federal regulations. If the Department was not notified of a child's death, it would continue to pay insurance premiums for benefits the child could no longer use.

Subsections (2) and (3) of [Rule V] specify that guardians must notify the Department within 30 days of a significant change and they may be required to submit verification for eligibility determination. The Department considered and rejected the option of not reconsidering eligibility until the annual redetermination period. The Department's legislatively directed goal is to target CHIP coverage to children whose families have the fewest financial resources to provide private health insurance coverage. The Department rejected as unduly burdensome to the public the option of requiring the guardian to notify the Department in fewer than 30 days. The Department rejected as unduly lenient the option of allowing more time than 30 days for notification. It would have resulted in the Department unnecessarily paying premiums for ineligible children.

[Rule VI] contains provisions for ending CHIP eligibility. CHIP eligibility ends immediately upon notification that the child is incarcerated or has moved from the state of Montana. Incarceration of a child requires immediate termination under

federal law and the Department considered no alternative provision. Termination when a child moves from the state must be immediate because the child would be unlikely to find a participating provider out-of-state and the Department cannot guarantee access to one. Eligibility would continue until the end of the month for a child who attained the age of nineteen or became eligible for state insurance. Federal law requires eligibility to end under these conditions, but because the Department would have already paid the premium through the end of the month, coverage can continue through that month. No alternatives were considered.

Eligibility terminates at the end of the month after the child attains the age of 19 years or becomes eligible for other creditable health insurance. It must also end when the Department has insufficient funding to continue paying a CHIP premium. The option of continuing eligibility until the annual eligibility redetermination was considered and rejected. The Department intends to use CHIP to cover children whose families have the least financial resources available to provide private health insurance coverage. Federal regulations prohibit the coverage of children over the age of 19 under CHIP.

Subsection (4) of this rule would allow the Department to hold the guardian financially responsible for the cost of premiums or services if the guardian fails to notify the Department of changes or misrepresents any of the information given. The alternative of not holding the guardian financially responsible was considered and rejected. Families must meet certain financial guidelines to qualify for this program. Serving children who exceed these financial resources would result in less available funding to serve the targeted children.

[Rule VII] specifies that a CHIP insurer must provide medically necessary benefits unless these rules grant specific limitations to benefits. The Department considered the alternative of not covering medically necessary care and rejected the idea because it would not adequately protect the health of covered children. The alternative of covering all care, whether medically necessary or not, was considered and rejected for being unnecessarily inflationary when limited public resources are available to support this program.

Subsection (2) specifies that CHIP insurers must cover emergency services 24 hours per day, 7 days per week according to Montana law. No alternatives were considered because emergency services are essential to health care. Subsection (2) specifies that covered children may get emergency medical care from a nonparticipating provider, although the insurer may require prior authorization for any needed follow-up care. This is a protection for the child who might be living in an area or traveling to an area where no participating providers of emergency care exist. The Department rejected as too restrictive the alternative of not paying for this kind of care

because of the possibility the child might never be able to live or travel outside the geographic service area and have CHIP coverage. The alternative of covering all care, emergency or not, was considered and rejected as unreasonable since a consumer would have no incentive to see a participating provider. This could prove inflationary for health care costs and would limit the number of children the Department could ultimately cover under CHIP.

[Rule VIII] is necessary in order to ensure the program does not exceed legislative appropriations. The rule specifies an overall program limitation of one million dollars per child per insurer. More and less stringent criteria were considered and rejected. This amount will cover the vast majority of children and many purchasers of insurance accept such a limitation to contain insurance costs. The Department determined, upon advice of an actuary, that a lesser amount was not adequate.

Subsection (2) specifies that CHIP insurers must cover preexisting medical conditions. The alternative of not covering a preexisting condition was considered and rejected. Although covering preexisting conditions raises the cost of insurance premiums, it is essential that children from families at CHIP income levels have coverage from the time of enrollment. Children who have a medical condition often require immediate attention that parents might not otherwise have private funds available to purchase care. Not covering preexisting conditions would put children's health at risk and be at odds with the goals of this program.

Subsection (2)(a) includes an exception to coverage for a preexisting condition. The Department considered the alternative of covering children from the moment of enrollment whether or not they were hospitalized and rejected it because the benefit to a few children would not be sufficient to justify the resulting increase in insurance premiums. This increased expense would mean that the Department could cover fewer children.

Subsection (2)(c) is necessary to specify that the exception for hospitalization does not apply for the newborn child of a mother covered by CHIP. This is consistent with state insurance regulations and no alternatives were considered.

Subsection (2)(b) ensures that a child covered by CHIP will continue to have hospital benefits for up to the 11th day after the effective date of losing CHIP eligibility. This is a provision in the state employee health benefits plan that the Department used as a benchmark in establishing CHIP benefit coverage, no alternatives were considered.

[Rule IX] is necessary in order to ensure the program does not exceed legislative appropriations. The rule specifies which services CHIP does not cover. Federal guidelines for

establishing a CHIP program allow a state to choose the state employee health benefits plan, the most popular HMO, or the federal employee benefit plan as a benchmark plan to base CHIP coverage on. In Montana, Blue Cross and Blue Shield administers these plans. All are similar. The Department, after consulting with an advisory committee and conducting several public meetings, chose the state employee health benefits plan as the benchmark. The benchmark plan does not cover most of the exclusions noted in [Rule IX]. More or fewer exclusions were considered and rejected because these exclusions are reasonable without being too restrictive. Subsection (1)(e), (o), (p), and (r) are exclusions determined by the Department to be reasonable.

The Department chose not to cover organ and tissue transplants and ambulance and other medical transportation because the low utilization rate and minimal benefit to covered children were not sufficient to justify the cost of purchasing these benefits. The Department considered and rejected the alternative of covering the benefits because the Department wanted to cover more children with a less comprehensive benefit, rather than serve fewer children with a more comprehensive benefit. Federal law prohibits covering abortions other than ones necessary to save the life of the mother or end a pregnancy that is the result of rape or incest. The Montana legislature did not make alternative state-only funds available to cover these services.

[Rules X, XI and XIV] are necessary to specify which inpatient and outpatient hospital, laboratory, and radiology services are covered. The benefits described are identical to those found in the state employee health benefits plan that the Department used as a benchmark for CHIP. Thus, this benefit package complies with federal guidelines. The Department considered the alternative of covering more services and rejected it because the Department wanted to cover more children with a less comprehensive benefit, rather than to serve fewer children with a more comprehensive benefit.

[Rule XII] is necessary to describe benefits provided by physicians and advanced practice registered nurses. The provider types described are also listed in 53-4-1005, MCA. Subsection (2) and (3) outline coverage of prenatal and well-child services according to federal regulations. No other alternatives were considered.

Subsection (4) provides for payment of routine physicals for sports, employment, or as required by a governmental authority. The Department considered and rejected the alternative of not covering these physicals. Participation in sports and jobs is an important developmental tool for many children but some may not have been able to participate if CHIP did not pay for physicals. Evaluation of a child's mental health and physical status would be necessary for out-of-home placement. After discussing coverage of these types of physicals with members of

the legislature, the CHIP advisory council, and in public forums, the Department determined that coverage of physicals required by governmental agencies is a reasonable expenditure of state/federal funds.

Subsections (5), (6), and (7) describe benefits and limitations found in the state employee health benefits plan that the Department used as a benchmark for CHIP. The alternative of covering more services was considered and rejected because the Department wished to cover more children with a less comprehensive benefit, rather than to serve fewer children with a more comprehensive benefit.

Subsection (8) is a federally specified limitation. Therefore, the Department did not consider an alternative provision.

[Rule XIII] is necessary to define what is a prescription drug for purposes of CHIP coverage. Subsection (1) allows a health care practitioner to prescribe drugs within the scope of his or her practice. The alternative of restricting prescribing powers under CHIP was considered and rejected as unduly burdensome to the provider and CHIP consumer while not improving health status.

Subsections (2) and (3) specify that coverage of chemotherapy drugs, prenatal vitamins, anti-rejection and other drugs needed for post-transplant care, and diabetic supplies are considered covered prescription drugs under CHIP. The proposed rule expressly lists these items as covered services because they are outside the normal scope of insurance coverage, including the state benchmark plan. The alternative of not covering these services was considered and rejected. All of these services are necessary. Ongoing treatment of special conditions or diseases would be too expensive for a family in the income brackets covered by CHIP. The proposed rule lists vaccines as covered because of the necessity to protect both the individual's health and the health of the public through the prevention of communicable diseases. Federal CHIP regulations also require that vaccines be covered. Alternatives to vaccine coverage were not considered.

Subsection (4) is added according to 1999 Montana Laws Chapter 434. Insurers, including CHIP insurers must cover these supplements for these specific services whether they require a prescription or not. Alternative coverage was not considered.

Subsection (5) specifies that if an insurer wishes to employ a formulary to limit the drugs it covers it must use the Medicaid formulary. The Department contracts with the pharmacy department of the University of Montana and the state peer review organization to develop this formulary. The formulary includes the efficacies of drugs and guidelines for the use of certain drugs. To consider other alternative formularies would be unduly expensive and administratively burdensome.

[Rules XV and XVI] are necessary to outline the extent of covered services and covered settings for inpatient and outpatient mental health and chemical dependency benefits. These benefits are not a mandatory service category under federal CHIP regulations but state law requires that an insurer operating in Montana must offer these benefits. To comply with state law, alternatives were precluded.

[Rule XVII] is necessary to explain the CHIP vision benefit. CHIP provides vision benefits two ways. CHIP insurers will cover vision exams, dispensing fees, and medical eye care. The Department will provide eyeglasses through a volume purchase contract. The Department did not consider the option of not providing eyeglasses because state enabling legislation specified it as a covered benefit. The Department after consulting with insurers considered and rejected the option of providing eyeglasses through insurance because the Department can purchase glasses for less. Eyeglasses and a dispensing fee benefits are limited to once every 365 days unless a medical condition specified in the rule is present. The Department consulted with vision service providers in developing this list. These are the conditions that they have recommended. Contact lenses would not be covered.

[Rule XVIII] outlines coverage of audiological benefits. State enabling legislation specified coverage of newborn and other hearing exams. The Department did not consider alternatives. Coverage for hearing aides is not a covered benefit. The Department considered and rejected the alternative of covering this service because the Department wished to cover more children with a less comprehensive benefit, rather than to serve fewer children with a more comprehensive benefit.

[Rule XIX] is necessary to describe dental coverage. The CHIP dental benefit is $200 per benefit year. A benefit year is every October 1 through September 30 of the following year. The Department will reimburse dental benefits directly. The Department reimburses 85% of billed charges and the dental provider may not bill the client for the balance. The Department uses American Dental Association codes, modifiers and billing forms. The Department vigorously discussed CHIP dental coverage with the dental provider community, insurers, legislators, and the public. The Department explored and rejected the option of covering this benefit through insurance because insurance companies were unable to guarantee statewide access to dental care. The Department will pay providers directly for this benefit to guarantee that dollars are only expended for services received by CHIP children.

The Department considered and rejected the option of providing a more generous dental benefit package because it would have raised the per child per month cost. Consequently, the Department would have been able to serve fewer children. The Department finds that a benefit of less than $200 per child

annually would not have been sufficient to provide dental care for children. A committee of the Montana Dental Association suggested a $200 baseline for a reasonable basic dental program, although not all members agreed. Paying 85% of charges, rather than a set fee schedule, is a way to attempt to ensure access to dental services.

The Department's Medicaid beneficiaries have had trouble in obtaining services when the Department has set a fee schedule that on the average reimburses 73% of billed charges for children. The Department did not want to duplicate this difficulty by setting reimbursement levels at Medicaid levels. Some dentists advocated paying 100% of charges. This alternative was considered and rejected for being inherently inflationary and inappropriate for a publicly funded program. Few, if any, third party payers reimburse 100% of billed charges. Federal regulations bar a CHIP provider from balance billing a client. The Department did not discuss other options. The Department did not consider alternatives to using ADA codes, modifiers, and billing forms because they are the standards for dental billing. Our fiscal agent already accepts these standards. Therefore, extensive changes to accept alternatives would not be necessary.

Subsection (3) outlines procedures that are not a benefit of CHIP. These procedures are either cosmetic in nature or covered under the medical portion of the insurance benefit. The alternative of covering these benefits was considered and rejected as duplicative of services already paid for through the insurance premium or not medically necessary in nature. A more restrictive benefit package was considered and rejected because we believe that the $200 benefit year limit will curtail unnecessary use of dental services.

Subsections (4), (5), and (6) state that providers must comply with applicable federal and state statutes, rules, and regulations. The Department proposes adoption of Medicaid rules by reference. The Department considered not adopting these regulations and rejected the idea because safeguarding the rights of CHIP beneficiaries without these statutes, rules, and regulations would have been difficult. This adoption notifies providers that they are subject to these regulations. The option of repeating these rules, regulations, and statutes would have been administratively unwieldy and out of compliance with general guidelines used in this state for administrative rules.

[Rule XX] outlines CHIP cost-sharing provisions. The proposal would continue the cost-sharing provisions of the pilot project. The Department chose an annual family enrollment fee with copayments on certain services. These provisions are the least burdensome to families and the easiest and most cost effective mechanisms to administer. Cost-sharing is a means to ensure proper use of services because families share in the costs. They also meet the stated goals of many members of the

legislature and from citizens across Montana that parents share in the cost of the CHIP program. The Department discussed the amounts in public forums and in presentations to various legislative committees for the past two years. State and federal enabling legislation give the Department authority to assess cost-sharing for CHIP enrollees. For these reasons, the Department evaluated and rejected the option of not assessing cost-sharing measures. Federal law precludes the option of assessing higher cost-sharing mechanisms unless they are implemented on a sliding fee scale. The cost of administering such a mechanism would be prohibitive for both the Department and the CHIP insurers.

Subsection (6) prohibits the annual enrollment fee or copayments from being applied to Native Americans and Alaska natives. This is a new directive from the Health Care Financing Administration (HCFA) which administers CHIP at the federal level. HCFA has publicly stated in a letter to states that they will not approve state plans that do not meet this exception. Therefore, the option of not complying was considered but rejected since approximately 80% of the funding of this program is federal. The Department considered and rejected the option of requiring Native Americans to provide proof of tribal affiliation. Such a requirement would have been unduly burdensome and in conflict with the goal of keeping CHIP as administratively simple as possible.

[Rule XXI] describes the Department's authority to enroll a child with an insurer. Subsection (1) is necessary to implement CHIP as an insurance program rather than an expansion of the Medicaid program. This follows the requirements of 53-4-1003 and 53-4-1007, MCA.

Subsections (2) and (3) allow a family to choose an insurer when more than one insurer is available. All family members must choose the same insurer. The Department reviewed the option of assigning families to an insurer and rejected it as unduly restrictive. The Department also reviewed the option of letting families choose different insurers for each child, but rejected it because the cost-sharing provisions are applied on the family level. The administrative cost of coordinating these provisions between insurance companies outweighed the nominal amounts involved.

Subsection (4) prohibits the insurer from picking which children they wish to cover but does allow them the option of limiting their caseload once they reach the maximum contractual number. The Department considered the option of letting insurers choose which children they wished to insure and rejected it because of the possibility that an insurer would pick only children with few health care needs. This would invalidate the actuarial determination of premiums, which was based on overall health costs of the whole population.

Subsection (5) outlines the latest date an insurer may enroll a child once the Department establishes CHIP eligibility. The Department is purchasing insurance monthly and must inform the insurer that children are eligible for coverage before the beginning of each month.

[Rule XXII] allows the insurer to assign a child to a primary care provider if they wish to and if the child fails to choose on his own. Insurers commonly use primary care providers to assure continuity and quality of care for beneficiaries while also providing cost containment. The Department reviewed and rejected the option of not letting an insurer use a primary care provider to regulate use of CHIP benefits. That option would have been excessively restrictive of the insurers' freedom to manage risk. The designation of a primary care provider must be appropriate for the CHIP beneficiaries' age, sex and residence. The child would have a right to appeal the designation to the insurer, the insurance commissioner, and the Department.

[Rule XXIII] is necessary to define when disenrollment with an insurer may occur. Participation in CHIP is voluntary and a child may withdraw anytime. Alternatives were not considered. When more than one insurer is available, a child may switch insurers annually. The Department evaluated the option of allowing children to change insurers more or less frequently than once a year. The rule, as proposed, protects the child without being unduly burdensome to the insurer or the Department.

Subsection (3) provides for disenrollment of a child from an insurer or termination from CHIP for "good cause" as determined by the commissioner of insurance. In discussions with the insurance commissioner's staff, the Department learned that "good cause" is rarely invoked. However, the Department deems it necessary to retain the option in order to protect insurers from beneficiaries who are truly abusive of their benefits. The Department rejected the option of requiring insurers to serve all children because it would have been unduly burdensome for the family to have duplicate appeal rights through both the insurance commissioner's office and the Department should "good cause" ever be invoked.

Subsections (4) and (5) describe when disenrollment would become effective and the instances in which the Department may disenroll a child. The Department considered and rejected other options because the timing of monthly enrollment transmittals to insurers limits how quickly a child can be disenrolled. The Department did not consider alternatives to enrolling a child with a particular insurer in cases where a contract is terminated, the child moves outside the service area or becomes ineligible for CHIP. In the first two instances, an alternative would not have allowed the Department to comply with federal and state guidelines for CHIP. In the last instance, the child's ineligibility would preclude an alternative.

[Rule XXIV] defines that the Department may contract with multiple insurers, may purchase glasses under a volume purchase contract, and may contract directly with dental providers. Please see the discussion concerning vision and dental services in the rationale to [Rules XVII and XIX]. The Department considered the option of contracting with just one insurer for CHIP and rejected the idea because it would be too restrictive without offering substantial advantages to the beneficiaries or the state.

Subsection (4) prohibits an insurer from holding a family responsible for its debts. Alternatives were not considered.

[Rule XXV] describes how services may be provided. Within the limits of state licensure standards, a CHIP insurer may restrict the use of certain types of providers, may require preauthorization of services and may require that children use participating providers. The Department rejected as unreasonable the option of requiring an insurer to contract with all providers. Since CHIP insurers are assuming the risk of providing care for a fixed premium, they should be allowed to decide with whom they want to contract to provide that care. The Department also rejected as unreasonable the option of not allowing an insurer to set prior authorization requirements or restrict beneficiaries to using a participating provider. The beneficiary would have no incentive to use a participating provider if insurers could not restrict the use of nonparticipating providers. The Department recognizes that prior authorization is a widely accepted method of controlling medical costs. Ultimately, if the Department did not allow these measures, the cost of premiums would rise and it would be able to serve fewer children.

Exceptions for emergency care were discussed in the rationale for [Rule VII].

Subsections (3) and (4) outline that an insurer must provide at a minimum the services listed in this subchapter but may offer additional services at its discretion. The Department considered and rejected the option of not letting an insurer provide additional services at its discretion. An insurer may wish to offer alternative cost-effective services such as outpatient physical therapy through a privately licensed individual rather than through an outpatient hospital department. The Department finds that freedom to innovate could benefit both the beneficiary and the insurer.

[Rule XXVI] is necessary to circumscribe the restrictions that may be placed on contracts with participating providers. A CHIP insurer may limit the number of providers it contracts with, may establish its own reimbursement levels, claim filing procedures and enrollment criteria. The Department considered and rejected the options of requiring an insurer to pay a set amount to service providers or to contract with all providers. Since the

insurers are assuming the risk for nearly all the health care needed by CHIP beneficiaries, they need the flexibility to manage the risk without undue oversight from the Department.

Subsection (3) is necessary to assure that an insurer will offer contracts to certain "safety net" providers who have traditionally served low income and uninsured populations. The Department rejected the option of not requiring insurers to offer contracts to the "safety net" providers because these providers who do not generally have sources of reimbursement beyond government programs. Furthermore, many of the providers' federal grants would require them to provide care to CHIP eligible children in any event. The Department believes the proposed rule requiring insurers to offer a contract to these providers is a reasonable accommodation to help safeguard the providers' ability to continue to offer care.

Subsection (4) is necessary to implement the federal rule that requires a CHIP insurer to terminate any contract with a provider suspended or terminated by the Medicare or Medicaid program of any state for fraud or abuse. Since this is a mandate of federal law, the Department considered no alternatives.

Subsections (5) and (6) require that CHIP providers be licensed and that physicians, advanced practice registered nurses and physician assistants have hospital admitting privileges or a mechanism in place to ensure hospitalization when appropriate.

Subsections (8) and (9) are necessary to prevent confusion by some providers about whether they were contracting with the Department or the insurer. The Department rejected the alternative of not including this language because its experience has been that some providers were confused in the absence of a clear statement.

Subsection (10) is necessary to prevent CHIP insurers from imposing a gag clause on providers. The Department determined that the prohibition was necessary for consumer protection. The Department rejected more strict criteria as unduly burdensome. More lenient criteria would not adequately protect the CHIP beneficiary.

[Rule XXVII] outlines the reimbursement principles the Department will apply to insurers. The Department will pay a per child per month payment for CHIP coverage. This payment is payment in full and the insurer may not bill the child or guardian except as allowed under the cost-sharing provisions in [Rule XX]. If the insurer can provide care for less than this amount, they may keep the profit. If it costs the insurer more than the premium for care, they assume the risk. The Department did not consider the option of having the Department assume the risk because state enabling legislation does not envision this possibility. The Department discussed the option of limiting

the profit an insurer could make in several legislative forums but the enabling legislation did not authorize it. The Department believes that such a limit would not be appropriate considering the risk it is asking CHIP insurers to assume.

[Rule XXVIII] is necessary to implement federal requirements for minimum utilization review and quality assurance mechanisms that a CHIP insurer must have. Therefore, the Department did not consider the option of omitting this rule. The Department rejected more extensive utilization review and quality assurance rules as unnecessary because insurers are subject to state insurance regulations and contractual obligations.

[Rule XXIX] provides a grievance procedure for children adversely affected by a CHIP insurer's decision. An expedited resolution by the insurer would be available at the Department's discretion. The Department reviewed and rejected the alternative of not including an appeal directly to the Department except when eligibility is denied or terminated. An appeal is necessary for the protection of CHIP beneficiaries. However, the Department did not deem it necessary to have a more stringent appeal process than the one proposed. The Department has had a great deal of experience in administering a variety of medical programs and found appeals processes similar to the one proposed to be adequate.

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 March 9, 2000. Data, views or arguments may also be submitted by facsimile (406) 444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the adoption of ARM 2.21.312 and the amendment of ARM 2.21.306 for disaster leave for trained American red cross volunteers	)))))))	NOTICE OF THE ADOPTION OF ARM 2.21.312 AND AMENDMENT OF ARM 2.21.306 RELATED TO DISASTER LEAVE FOR TRAINED RED CROSS VOLUNTEERS

TO: All Concerned Persons

1. On October 21, 1999, the Department of Administration published notice of the proposed adoption of ARM 2.21.312 (Rule I) and the amendment of ARM 2.21.306 related to disaster leave for trained red cross volunteers at page 2315 of the Montana Administrative Register, issue number 20.

2. The department has amended ARM 2.21.306 and adopted ARM 2.21.312 (Rule I) with the following changes.

2.21.306 POLICY AND OBJECTIVES (1) and (1)(a) remain the same.

(b) provide paid time off not charged to an employee's accrued leave or compensatory time for an employee who is a trained and certified ~~member of the~~ American red cross ~~disaster services human resources~~ volunteer to provide specialized disaster relief services for the red cross ~~in the event of a level III disaster or above as defined by the red cross~~; and

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

AUTH: 2-18-102, MCA
IMP: 2-18-102, MCA

2.21.312 AMERICAN RED CROSS DISASTER SERVICE As used in this subchapter, the following definitions apply:

(1) and (2) remain the same.

~~(3) "Level III disaster" means, as defined by the American red cross disaster regulations and procedures, any disaster in which the anticipated loss is $250,000 or above.~~

(4) through (12) remain the same, but are renumbered (3) through (11).

AUTH: 2-18-102, MCA
IMP: 2-18-102, MCA

3. The following comments were received.

COMMENT #1: The notice of proposed amendment of ARM 2.21.306 did not provide a sufficient rationale for the amendment.

RESPONSE: The department disagrees. The purpose of the amendment is to add disaster service leave for Red Cross volunteers to a rule which lists the types of disaster leave available to state employees. This is the only purpose of the rule and the department believes the rationale is sufficient.

COMMENT #2: Two comments were received asking the department to change the disaster level designation from Level 3 to Level 2 in order for employees to be eligible to take paid disaster service leave.

RESPONSE: The department has removed all reference to the level of disaster that would qualify for this leave. Granting of leave to employees who are certified American red cross disaster volunteers called upon by the red cross to provide specialized services is entirely at the discretion of the agency. The affected employees' supervisors are in the best position to know if such leave can be granted regardless of the size of the disaster. This change eliminates the need for further amendment of this rule should the American Red Cross change its disaster level descriptions.

BY: *Dal Smilie*	*Lois Menzies*
Dal Smilie	Lois Menzies
Rule Reviewer	Director

Certified to the Secretary of State January 31, 2000.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 2.21.1423 and ARM 2.21.1424 in the Persons with Disabilities Preference Policy	)))))	NOTICE OF THE AMENDMENT OF ARM 2.21.1423 AND ARM 2.21.1424 IN THE PERSONS WITH DISABILITIES PREFERENCE POLICY

TO: All Concerned Persons

1. On October 21, 1999, the Department of Administration published notice of the proposed amendment of ARM 2.21.1423 and ARM 2.21.1424 related to the Persons with Disabilities Preference Policy at page 2312 of the Montana Administrative Register, issue number 20.

2. The department has amended ARM 2.21.1424 as proposed and amended ARM 2.21.1423 with the following changes:

2.21.1423 APPLYING PREFERENCE (1) through (4) remain the same.

(5) A current employee of an agency who meets eligibility requirements may claim and shall receive the persons with ~~a~~ disabilities preference when the employee is considered an applicant for a position which is an initial hire as that term is defined in this policy, whether or not the agency originally limited recruitment for the position to current employees.

(6) remains the same.

(7) Substantially equal qualifications does not mean a situation in which two or more applicants are exactly equally qualified. It means a range within which two applicants must be considered to be substantially equal in view of the qualifications set for the job. Qualifications shall include job-related competencies, which are knowledge, skills, and behaviors.

(8) and (9) remain the same.

AUTH: 39-30-106, MCA
IMP: 39-30-101 et seq., MCA

3. Two comments were received.

COMMENT #1: There was a request for additional clarification of ARM 2.21.1423(5) concerning eligibility of current employees of an agency during an initial hiring by an agency.

RESPONSE: The department has expanded this section in an effort to clarify its intent.

COMMENT #2: Eliminating the term abilities in ARM 2.21.1423(7) will lead to greater discrimination against disabled persons.

RESPONSE: The department disagrees. The department believes eliminating the term abilities, which will be done in all personnel policies as part of the Human Resources Competency Project, actually enhances employment opportunities for persons with disabilities by focusing the hiring process on qualifications which are observable and measurable.

BY: *Dal Smilie*
Dal Smilie
Rule Reviewer

Lois Menzies
Lois Menzies
Director

Certified to the Secretary of State January 31, 2000.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 2.21.3602, 2.21.3603, 2.21.3607, 2.21.3615 through 2.21.3619 and the repeal of ARM 2.21.3608 through 2.21.3610, related to the Veterans' Employment Preference Policy	)))))))	NOTICE OF THE AMENDMENT OF ARM 2.21.3602, 2.21.3603, 2.21.3607, 2.21.3615 THROUGH 2.21.3619 AND REPEAL OF ARM 2.21.3608 THROUGH 2.21.2610, RELATED TO THE VETERANS' EMPLOYMENT PREFERENCE POLICY

TO: All Concerned Persons

1. On October 21, 1999, the Department of Administration published notice of the proposed amendment of ARM 2.21.3602, 2.21.3603, 2.21.3607, 2.21.3615 through 2.21.3619 and the repeal of ARM 2.21.3608 through 2.21.3610 related to the Veteran's Employment Preference Policy at page 2304 of the Montana Administrative Register, issue number 20.

2. The department has amended and repealed the rules as proposed.

3. One comment in support of the proposed changes was received at the public hearing that was held on November 15, 1999.

BY: *Dal Smilie* — Dal Smilie, Rule Reviewer

Lois Menzies — Lois Menzies, Director

Certified to the Secretary of State January 31, 2000.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 4.5.202 Category 1 and 4.5.203 Category 2 relating to noxious weeds	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On December 16, 1999, the Montana Department of Agriculture published a notice of proposed amendment of ARM 4.5.202 Category 1 and 4.5.203 Category 2 concerning noxious weeds at page 2796 of the 1999 Montana Administrative Register, Issue No. 24.

2. The department has amended the ARM 4.5.202 Category 1 and 4.5.203 Category 2 rules exactly as proposed.

3. The department received eight written comments. The comments received and the department's response is as follows:

COMMENT 1: Seven commentors supported the rules as proposed.

RESPONSE: The department concurs.

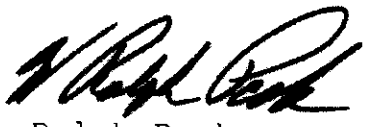
COMMENT 2: One commentor stated that a weed district may write a management plan which states they will in effect ignore a noxious weed designation for a plant and not control the plant. The commentor stated that the state designation is worthless because counties can choose to ignore the designation.

RESPONSE: The noxious weeds proposed to be added to the noxious weed list are either relatively new invaders or invaders that are starting to rapidly expand their infestations. These types of infestations are those which counties are extremely interested in controlling. Once the state designates the plant as a noxious weed, all counties are required to develop a management plan and cannot ignore the designation. The management plan strategy for any given noxious weed can range from eradication to greatly reduced, minimum control efforts. Minimum control efforts are usually an option; when the infestation is so great, it becomes uneconomical to intensively manage by either the weed district, the government or private landowners and managers.

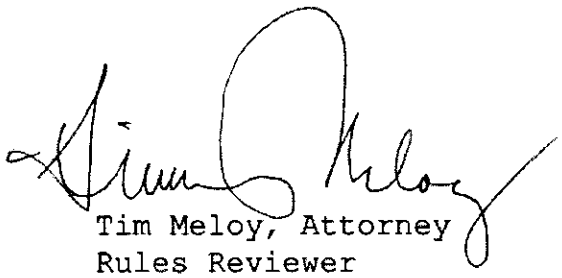
COMMENT 3: The same commentor stated that counties are allowed to add plants to their county noxious weed list and, if they do add such weeds, maybe they would be more interested in controlling them.

RESPONSE: Even if counties add a plant to their county noxious weed list, a management plan must be developed as previously described. The advantage of a statewide listing is the cooperative efforts among the counties and private landowners to manage the noxious weed. It is important also to recognize that each landowner is responsible to manage the noxious weed on his or her property. Typically, counties provide technical and, in many cases, economic assistance to landowners.

DEPARTMENT OF AGRICULTURE

By: 

Ralph Peck
Director

By: 

Tim Meloy, Attorney
Rules Reviewer

Certified to the Secretary of State January 31, 2000.

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

In the matter of the amendment of rule 6.6.1110 pertaining to determination of reasonableness of benefits in relation to premium charged in credit disability and credit life insurance	)))))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On August 12, 1999, the State Auditor's Office published a notice of public hearing to consider the proposed amendment of rule 6.6.1110 pertaining to determination of reasonableness of benefits in relation to premium charged in credit disability and credit life insurance at page 1717, 1999 Montana Administrative Register, issue number 15. The hearing was held September 27, 1999, in Helena, Montana.

2. The Department has amended ARM 6.6.1110 as proposed, but with the following changes (new text is underlined; text to be deleted is interlined):

6.6.1110 DETERMINATION OF REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED (1) through (1)(b) will remain the same.

(2) Creditor, agent and general agent compensation must not be more than a combined total of 37.5% of the net written prima facie premium. This compensation must be apportioned with not more than 30% to the producing creditor or agent and not more than 7.5% to the producing general agent. ~~These compensation limits include any compensation received from creditor, agent or general agent owned reinsurance arrangements.~~

(2)(a) through (3)(b) will remain the same.

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

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

Comment 1: Two commentors stated that the commissioner of insurance should not be involved in regulating how commissions paid for credit life and disability insurance are apportioned between creditors or agents and general agents.

Response: The existing rule language has long limited the compensation paid to creditors, agents and general agents. The proposed amendment merely specifies how the existing percentage limitation may be split between the creditor or agent and general agent. The commissioner has received

several requests from members of the industry to further specify how the general limitation is to be divided between creditors or agents and general agents and believes such a clarification is warranted. Such a step will help assure that general agents will be compensated in those situations in which insurers desire to use general agent services.

Comment 2: One commentor suggested capping only the percentage which could be paid to creditors or agents thus allowing an insurer to pay more than the proposed cap of 7.5% to general agents.

Response: The commissioner believes that the proposed cap of 7.5% to general agents will adequately compensate those agents for the services involved.

Comment 3: One commentor suggested that the proposed rule will reduce the compensation which could be paid to creditors or agents.

Response: The commissioner believes the proposed cap of 30% to creditors or agents is adequate compensation for the services involved.

Comment 4: One commentor expressed philosophical opposition to any regulation by the commissioner of commission limitations for credit life and disability insurance saying they reduce competition in the industry and discourage products from being offered.

Response: Commission limitations for credit life and disability insurance have been implemented in many states because of solvency concerns which are shared by the commissioner. The general 37.5% limitation has been in place for many years and has not been shown to impact either industry competition or the availability of products.

Comment 5: Five commentors argued against the inclusion of creditor, agent or general agent owned reinsurance agreements in the compensation limits. These commentors were primarily concerned that the limitations on reinsurance compensation would preclude those types of arrangements because not enough compensation would be available to fund commissions for creditors, agents, general agents and reinsurers out of the 37.5% total. The commentors argued that allowing reinsurance of credit life and disability insurance by creditors, agents and general agents creates incentives to insure only the most appropriate credit risks thus helping to keep the cost of credit life and disability insurance down. In addition, allowing reinsurers to receive compensation outside of the 37.5% limitation would not affect solvency as the reinsurance itself operates to reduce the financial exposure of the credit insurers.

Response: The commissioner agrees with these commentors and has deleted that portion of the proposed amendment which includes reinsurance arrangements in the 37.5% cap.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: _____
Peter Funk
Deputy Insurance Commissioner

By: _____
Janice S. VanRiper
Rules Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF ALTERNATIVE HEALTH CARE
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to direct-entry midwife apprenticeship requirements) NOTICE OF AMENDMENT OF ARM 8.4.503 DIRECT-ENTRY MIDWIFE APPRENTICESHIP REQUIREMENTS

TO: All Concerned Persons

1. On September 23, 1999, the Board of Alternative Health Care published a notice of the proposed amendment of the above-stated rule at page 1933, 1999 Montana Administrative Register, issue number 18.

2. The Board has adopted ARM 8.4.503 DIRECT-ENTRY MIDWIFE APPRENTICESHIP REQUIREMENTS exactly as proposed.

3. The Board received three comments. The comments received and the Board's response is as follows:

COMMENT: The commentators voiced concerns that a newly-licensed midwife should not be allowed to supervise a Level I apprentice as this would lower the educational requirements for licensure and the licensee would not have the ability or experience to supervise a Level I apprentice.

RESPONSE: The Board responded that a Level I apprentice is only allowed to observe 40 births and perform 20 prenatal exams, which is a minimal part of the total experience requirement. The Board determined that this level of skill could be supervised by a newly-licensed midwife. The education and experience requirements for licensure would remain unchanged. There is a shortage of apprentice supervisors and this change has been proposed to mitigate the problem. It was also noted that public safety would be enhanced as the new language would allow an apprentice to accompany the newly-licensed midwife to births.

BOARD OF ALTERNATIVE HEALTH CARE
MICHAEL BERGKAMP, ND, CHAIRMAN

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY:

Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment and adoption of rules pertaining to nursing tasks that may be delegated, general nursing tasks that may not be delegated, nursing tasks related to gastrostomy feeding that may be delegated	) NOTICE OF AMENDMENT OF) 8.32.1702 NURSING TASKS WHICH) MAY BE DELEGATED, 8.32.1709) GENERAL NURSING TASKS THAT) MAY NOT BE DELEGATED AND) ADOPTION OF NEW RULE I) NURSING TASKS RELATED TO) GASTROSTOMY FEEDING THAT MAY) BE DELEGATED

TO: All Concerned Persons

1. On October 7, 1999, the Board of Nursing published a notice of the proposed amendment of the above-stated rules at page 2150, 1999 Montana Administrative Register, issue number 19. The hearing was held October 27, 1999.

2. The Board has adopted ARM 8.32.1702 NURSING TASKS THAT MAY BE DELEGATED, 8.32.1709 GENERAL NURSING TASKS THAT MAY NOT BE DELEGATED exactly as proposed. NEW RULE I was adopted as proposed with a minor change to the catchphrase as follows: (ARM 8.32.1713) NURSING TASKS RELATED TO GASTROSTOMY FEEDING THAT MAY BE DELEGATED.

3. The Board received five comments. The comments received and the Board's responses are as follows:

COMMENT 1: Ms. Sami Butler testified on behalf of the Montana Nurses Association and voiced opposition from the perspective of who must determine whether the gastrostomy tube is patent and the site well-healed.

RESPONSE: The Board felt that these proposed rule amendments and new rule will only be used for patients with normal well-healed tubes and these patients should need only minimal observation and not assessment. The nurse will still be involved but not with gastrostomy tubes.

COMMENT 2: Ms. Cindy Walton, stated her concern that an employer would be able to force a nurse to delegate such a task.

RESPONSE: The Board responded that an employer may not force a nurse to do anything that the nurse does not feel is safe because the nurse is responsible for his or her own practice.

COMMENT 3: Ms. Marlene Piazzola stated that she felt it would be ok for the mother of a child to be allowed to reinsert a gastrostomy tube.

the public must come first and should involve nurse involvement.

COMMENT 4: Numerous comments were received which were similar in vein from the Montana Association of School Nurses and other educational personnel stating their opposition to the proposed rule changes because of the burden it would place upon schools and school nurses.

RESPONSE: The Board stated that parents are crying for help. The Board believes that allowing delegation where the nurse is still involved is a compromise which serves the best interests of all parties.

COMMENT 5: Numerous parents testified and submitted comments generally stating their approval of the proposed changes and new rule because of the hardships they must endure.

RESPONSE: The Board stated that "If the rule changes are adopted along with the New Rule, there would still be a delegation of nursing tasks and the nurse would still be present in some sense. Delegation requires nurse involvement at least every other week in some way. The parent would still not be the person training the delegatee. The Board is sensitive to the frustration of the families, but safety is paramount. These changes would not be a carte blanche delegation to the family in this area and in no way will this include delegation of medications. If it is not safe in a particular situation, the task should not be delegated."

BOARD OF NURSING
KIM POWELL, RN, BSN, PRESIDENT

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF PHARMACY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to definitions	)))	NOTICE OF AMENDMENT OF ARM 8.40.702 DEFINITIONS

TO: All Concerned Persons

1. On October 21, 1999, the Board of Pharmacy published a notice of the proposed amendment of the above-stated rule at page 2330, 1999 Montana Administrative Register, issue number 20. The hearing was held November 17, 1999.

2. The Board has adopted ARM 8.40.702 exactly as proposed.

3. The Board received one comment at the hearing. The comment received and the Board's response is as follows:

COMMENT: One individual was concerned that allowing ambulatory surgi-centers to have licensed pharmacies would increase the competition for pharmacies.

RESPONSE: The Board's response was that competition did not impact the protection of the public and the Board is not charged with monitoring competition within the profession.

BOARD OF PHARMACY
JOHN POUSH, R.Ph., CHAIRMAN

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF PUBLIC ACCOUNTANTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to licensure of foreign-trained applicants, credit for formal individual study programs and basic requirements	)))))))	NOTICE OF AMENDMENT OF ARM 8.54.416 LICENSURE OF FOREIGN-TRAINED APPLICANTS, 8.54.802 BASIC REQUIREMENT, 8.54.816 CREDIT FOR FORMAL INDIVIDUAL STUDY PROGRAMS, AND 8.54.821 REPORTING REQUIREMENTS

TO: All Concerned Persons

1. On October 21, 1999, the Board of Public Accountants published a notice of the proposed amendment of the above-stated rules at page 2332, 1999 Montana Administrative Register, issue number 20.

2. The Board has adopted ARM 8.54.416 LICENSURE OF FOREIGN-TRAINED APPLICANTS, 8.54.802 BASIC REQUIREMENT, 8.54.816 CREDIT FOR FORMAL INDIVIDUAL STUDY PROGRAMS, and 8.54.821 REPORTING REQUIREMENTS exactly as proposed.

3. The Board received one written comment. The comment received and the Board's response is as follows:

COMMENT: One individual commented that evidence of experience attested by a foreign-trained Chartered Accountant should be accepted by the Board as evidence of experience for a permit to practice.

RESPONSE: The Board will take the matter under consideration and will research the issue prior to adopting any rule changes on whether the Board will accept evidence of experience attested by a foreign-trained Chartered Accountant.

BOARD OF PUBLIC ACCOUNTANTS
ELLEN G. SOLEM, CHAIRPERSON

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of ARM 8.94.3001, 8.94.3002, and 8.94.3003 pertaining to the monumentation of surveys and to the form, accuracy, and descriptive content of records survey)	))))))	NOTICE OF AMENDMENT OF ARM 8.94.3001, 8.94.3002, AND 8.94.3003

TO: All Concerned Persons

1. On October 7, 1999, the Local Government Assistance Division of the Department of Commerce published a notice of public hearing on the proposed amendment of rules pertaining to the monumentation of surveys and to the form, accuracy and descriptive content of records of survey at page 2156, 1999 Montana Administrative Register, issue number 19. The hearing was held on October 27, 1999, in Helena, Montana.

2. The Department has amended ARM 8.94.3001, 8.94.3002, and 8.94.3003 as proposed but with the following changes:

"8.94.3001 UNIFORM STANDARDS FOR MONUMENTATION

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

(b) All metal monuments must be at least one-half inch in diameter and ~~24~~ 18 inches in length with a cap not less than 1 inch in diameter marked in a permanent manner with the ~~registration~~ license number of the surveyor in charge of the survey and either the name of the surveyor or the company employing the surveyor. ~~A monument may also consist of a cap as described above set firmly in concrete.~~ Metal monuments marking a ~~U.S. government~~ public land survey corner as described in 70-22-101, MCA, must be at least ~~30~~ 24 inches long and ~~3/4~~ 5/8 inch in diameter with an appropriately stamped metal cap at least ~~3~~ 2 inches in diameter. A monument marking a public land survey corner may also consist of a cap as described in this rule set firmly in concrete.

(c) Before a subdivision plat or certificate of survey may be filed for record the surveyor shall confirm the location of as many monuments as, in the surveyor's professional judgment, are necessary to reasonably assure the perpetuation of any corner or boundary established by the survey and to enable other surveyors to reestablish those corners and boundaries and retrace the survey. The surveyor shall clearly identify on the face of the plat or certificate of survey all monuments pertinent to the survey, and the descriptions of these monuments must be sufficient to identify the monuments ~~without reference to another record of survey although additional references may be included~~.

(d) The surveyor shall set all monuments prior to the filing of a plat or certificate of survey except those

monuments that will be disturbed by the installation of improvements or that, because of severe weather conditions, may, in the surveyor's judgment, be more appropriately and accurately set after the weather has improved. In these two circumstances the surveyor may set monuments after the survey document is filed if the surveyor certifies on the survey document that the monuments will be set by a specified date ~~and if the survey document bears the following language in at least 14 point, bold faced type: "This (certificate of survey or subdivision plat) shows the location of certain monuments that have not been set in the ground. The land depicted in this document may not be sold, rented, leased, or otherwise conveyed by the owner until a registered land surveyor has filed an affidavit, to be attached to this (certificate of survey or subdivision plat), certifying that all of these monuments have been set."~~. The surveyor shall set monuments, the placement of which has been deferred because of severe weather conditions, within 240 days of the date on which the survey document was filed.

(d)(i) through (f) remain as proposed."

Auth: 76-3-403, MCA
IMP: 76-3-403, MCA

"8.94.3002 UNIFORM STANDARDS FOR CERTIFICATES OF SURVEY

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

(i) A title or title block including the quarter-section, section, township, range, principal meridian, and county, and, if applicable, city or town in which the surveyed land is located. Except as provided in (1)(f)(v), ~~A~~ a certificate of survey must not bear the title "plat," "subdivision," or any title other than "Certificate of Survey."

(d)(ii) through (d)(v) remain as proposed.

(d)(vi) ~~The kind, diameter and length (if known), any stamping or scribing on, the.~~ The location of, and other information relating to all monuments found, set, reset, replaced or removed as required by ARM 8.94.3001(1)(c).

(d)(vi)(A) remains as proposed.

(d)(vi)(B) All monuments ~~and other evidence~~ found during ~~retracements~~ a retracement that influenced the position of any corner or boundary indicated on the certificate of survey must be clearly shown as required by ARM 8.94.3001(1)(c).

(d)(vii) through (x) remains as proposed.

(xi) Lengths of all lines shown to at least tenths of a foot, and all angles and bearings shown to at least the nearest minute. Distance measurements must be stated in English units, but their metric equivalents, shown to the nearest hundredth of a meter, may be noted parenthetically.

(d)(xii) remains as proposed.

(xii)(A) If the parcel surveyed is either an aliquot part of a U.S. government section or a U.S. government lot, the information required by this subsection is the aliquot or government lot description of the parcel.

(d)(xii)(B) through (D) remain as proposed.

(E) The requirement of this rule does not apply to certificates of survey that depict a partial retracement of the boundaries of an existing parcel or establish the location of lines or corners that control the location of an existing parcel.

(1)(d)(xiii) through (1)(g) remain as proposed."

Auth: 76-3-403, MCA
IMP: 76-3-403, MCA

"8.94.3003 UNIFORM STANDARDS FOR FINAL SUBDIVISON PLATS

(1) through (2) remain as proposed.

(2)(a) A title or title block indicating the quarter section, township, range, principal meridian, ~~and~~ county, and, if applicable city or town, in which the subdivision is located. The title of the plat must contain the words "plat" and either "subdivision" or "addition".

(b) through (d) remain as proposed.

(e) The ~~kind, diameter and length (if known), any stamping or scribing on, the~~ location of, and other information relating to all monuments found, set, reset, replaced or removed as required by ARM 8.94.3001(1)(c).

(e)(i) remains as proposed.

(ii) All monuments ~~and other evidence~~ found during a retracement that influenced the position of any corner or boundary indicated on the plat must be clearly shown as required by ARM 8.94.3001(1)(c).

(f) through (i) remain as proposed.

(j) Lengths of all lines shown to at least tenths of a foot, and all angles and bearings shown to at least the nearest minute. Distance measurements must be stated in English units, but their metric equivalents, shown to the nearest hundredth of a meter, may be noted parenthetically.

(k) through (l) remain as proposed.

(m) All streets, alleys, avenues, roads, and highways; their widths (if ascertainable) from public records, bearings, and area; the width and purpose of all road rights-of-way and all other easements that ~~will affect or~~ will be created by the filing of the plat; and the names of all streets, roads and highways.

(n) through (p) remain as proposed.

(p)(i) If the parcel being subdivided is either an aliquot part of a U.S. government section or a U.S. government lot, the information required by this subsection is the aliquot or government lot description of the parcel.

(ii) through (3) remain as proposed.

(3)(a) If applicable, the owner's certificate of dedication of streets, parks, ~~or~~ playgrounds~~,~~ easements, or other public improvements.

(b) If applicable, a certificate of the governing body expressly accepting any dedicated land, ~~and~~ easements, or improvements. An acceptance of a dedication is ineffective without this certification.

(c) through (h) remain as proposed.

(i) If a street created by the plat will intersect with a state highway, a copy of the state highway access or encroachment permit.

(j) remains as proposed."

Auth: 76-3-403, MCA
IMP: 76-3-403, MCA

3. The Department has thoroughly considered all commentary received regarding the proposed amendments. The comments received and the Department's response to each follow:

Proposed Amendments to 8.94.3001 - Standards for Monumentation

COMMENT NO. 1: The minimum size for metal monuments should be 18 inches in length and one-half of an inch in diameter rather than the 24 inches proposed by the Department.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendment.

COMMENT NO. 2: The term "license" should be used instead of the term "registration" in describing the number issued to surveyors by the Board of Professional Engineers and Land Surveyors.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendment.

COMMENT NO. 3: The minimum size for metal monuments used to replace public land survey corners should be 24 inches in length and five-eighths of an inch in diameter rather than the 30-inch length and three-fourths inch diameter proposed by the Department.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendment.

COMMENT NO. 4: The Department's proposal would allow for the deferral of monumentation due to harsh weather conditions. This proposal should be withdrawn because deferred monuments may not be set as promised, and a land purchaser may be forced to bear the expense of surveying his or her property.

RESPONSE: Although the Department has shared the concerns raised by the commentor, it is convinced that the serious legal consequences that would likely flow from a surveyor's failure to set deferred monuments as promised will greatly minimize if not eliminate entirely the risk to the public. A surveyor who failed to set monuments as promised would risk suspension or revocation of his or her license to practice.

Furthermore, if deferred monuments are not set by the date promised, the division of land depicted in the document may be declared void in which case the surveyor could be held liable for damages suffered by his or her client as well as by purchasers of the surveyed property. Property owners commissioning surveying work will have an equally compelling interest in seeing that deferred monuments are timely set. Finally, if experience does not bear out the Department's expectations regarding the timely completion of deferred monumentation, the Department will not hesitate to revisit the matter in future rule revisions.

COMMENT NO. 5: The Department's proposal would allow for the deferral of monumentation due to harsh weather conditions but would prohibit the sale of unmonumented parcels until the monuments have been set. This prohibition defeats the purpose of allowing deferred monumentation and should be deleted.

RESPONSE: The Department has deleted the prohibition on sale, but has specified monumentation which has been deferred due to harsh weather conditions must be set within 240 days of the filing of the COS or plat.

COMMENT NO. 6: Currently ARM 8.94.3001(1)(g) allows a properly detailed and complete description of a corner on a certificate of survey or subdivision plat to substitute for the filing of corner record under sections 70-22-104 and 70-22-105, MCA, of the Corner Recordation Act of Montana. The Department should withdraw its proposal to delete this language.

RESPONSE: The Department has no authority, through its administrative rules or otherwise, to modify a surveyor's obligation to file corner records under the Corner Recordation Act. Consequently, the Department has deleted the language in question precisely because, as indicated by the comment, it could be interpreted as providing an alternative to compliance with that Act.

Proposed Amendments to 8.94.3002 - Standards for Certificates of Survey

COMMENT NO. 7: The Department should not authorize new sizes for certificates of survey and subdivision plats because this change may create confusion as to whether a survey document is a plat or a certificate.

RESPONSE: There has been general support for and only limited opposition to allowing two sizes for COS's and plats to accommodate different drafting situations. The Department believes that if these documents are labeled in accordance with the Department's rules, confusion between the two types of documents should be minimal.

COMMENT NO. 8: The Department is proposing that certificates of survey bear the name of the person who has commissioned the survey rather than the name(s) of the owner(s) of the land surveyed as provided in the current requirement. This change will cause problems if the person commissioning the survey is not the owner and 1. the owner did not consent to the survey, 2. an exemption is being claimed on the COS, or 3. there is a dispute involving the land.

RESPONSE: In most cases the person who commissions a survey is also the owner of the land involved. However, the Department is proposing the rule change in question because surveys conducted over large distances may involve scores or hundreds of property owners whose identity may be irrelevant to the preparation of the COS. The identification of these owners is very time consuming and costly and serves no useful purpose. It should be noted that, under Montana law, property can be surveyed without the owner's consent (section 70-16-111, MCA).

COMMENT NO. 9: The proposed requirement that modifications of subdivisions exempted from subdivision review by section 76-3-201 or 76-3-207, MCA be identified as plat amendments contradicts the earlier provision of the "certificate of survey."

RESPONSE: The Department has addressed this contradiction in the final amendment by noting that the plat amendment requirement is an exception to the general prohibition.

COMMENT NO. 10: If the surveyed land is located within a city or town, the title or title block of the certificate of survey should indicate this fact. (This comment applies to subdivision plats as well.)

RESPONSE: The Department agrees and has incorporated this suggestion in the final amendment with respect to both certificates of survey and subdivision plats.

COMMENT NO. 11: The proposal is unduly restrictive with regard to the information that must be provided regarding found monuments. The extent of this information should be left more to the professional judgment of the surveyor. (This comment applies to subdivision plats as well.)

RESPONSE: The Department agrees and has incorporated this suggestion in the final amendment with respect to both certificates of survey and subdivision plats.

COMMENT NO. 12: The Department of Transportation is required to use metric measurements for its surveys, but the Department of Commerce's rules governing certificates of survey allow distances to be shown only in English units. Accommodation

should be made for metric units. (This comment applies to requirements for subdivision plat.)

RESPONSE: The Department concurs and has modified its proposal to allow for the optional use of metric equivalent measurements which are to be shown parenthetically. In the interest of uniformity, the final amendment gives priority to the use of English units which is still mandatory and primary.

COMMENT NO. 13: The Department should delete the long-standing requirement that surveyors include a "narrative legal description of the parcel surveyed" in certificates of survey because, contrary to one of the purposes of the Subdivision and Platting Act, this description will be used to identify the parcels or parcels depicted on a COS rather than the COS and parcel number. This invites the introduction of errors into land conveyances. (This comment applies to a corresponding requirement for subdivision plats.)

RESPONSE: The Department is sensitive to this concern and, in fact, initially proposed to delete the legal description requirement. However, the Department has since learned that within the next few years the Department of Revenue plans to implement a system that will allow land classification offices to scan narrative legal descriptions directly from survey documents into the property assessment data base. So as not to defeat the labor and timesaving benefits of this new system, the Department has decided to retain the requirement, but, at the request of the surveying community, has clarified what constitutes a legal description for purposes of the rule. The Department has also exempted from the requirement surveys which neither create nor retrace the boundaries of entire parcels. (This response applies to the similar requirement for subdivision plats.)

Proposed Amendments to 8.94.3003 - Subdivision Plats

COMMENT NO. 14: The requirement that a subdivision plat show the widths of streets, alleys, avenues, road, and highways "if ascertainable" should be limited to information that is reflected in the pubic record.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendments.

COMMENT NO. 15: The requirement that a subdivision plat contain the owner's certificate of dedication of streets, parks or playgrounds, and other public improvements should extend to easements to be dedicated to the public.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendments.

COMMENT NO. 16: State highway access permits are sometimes referred to as "encroachment" permits. The requirement that subdivision plats presented for filing be accompanied by state highway access permits should refer to "encroachment" permits as well.

RESPONSE: The Department concurs and has incorporated this suggestion into the final amendments.

BY:

Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY:

Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000.

BEFORE THE BOARD OF INVESTMENTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of ARM 8.97.1101, 8.97.1201, 8.97.1202, 8.97.1301, 8.97.1502 and 8.97.2102, the repeal of 8.97.1302 through 8.97.1307, 8.97.1401 through 8.97.1416, 8.97.1501, 8.97.1503 through 8.97.1505 and 8.97.1603 and the adoption of rules pertaining to the board of investments	NOTICE OF AMENDMENT, REPEAL AND ADOPTION

TO: All Concerned Persons

1. On December 2, 1999, the Board of Investments published a notice of the proposed amendment, repeal and adoption of the above stated rules pertaining to the Board of Investments, at page 2682 of the 1999 Montana Administrative Register, issue number 23.

2. On January 4, 2000, a public hearing was held in Helena concerning the proposed rule changes. No oral and written comments were offered at that time by any members of the public. No written comments were received prior to the closing date of January 12, 2000.

3. The Department has amended the above stated rules as proposed except for the following correction:

"8.97.2102 GENERAL REQUIREMENTS OF THE ENVIRONMENTAL REVIEW PROCESS (1) Section 75-1-201, MCA, requires state agencies to integrate use of the natural and social sciences and the environmental design arts in planning and in decision-making, and to prepare an environmental impact statement (EIS) on each proposal for projects, programs, legislation, and other major actions of state government specifically affecting the quality of the human environment. In order to determine the level of environmental review for each proposed action that is necessary to comply with 75-1-201, MCA, the agency shall apply the following criteria:

(a) through (g) will remain as proposed."

Auth: Sec. 2-3-103, 2-4-201, MCA; IMP, Sec. 2-3-103, 75-1-201, MCA

4. The Department has repealed the above stated rules as proposed.

5. The Department has adopted the 3 new rules exactly as proposed. The new rules are numbered as follows:

8.97.2103 (NEW RULE I) AUTHORIZED LOAN TYPES

8.97.2104 (NEW RULE II) AUTHORIZED APPLICANTS

8.97.2105 (NEW RULE III) LOAN PROGRAM POLICIES

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000.

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
AND THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.4.101 pertaining to incorporation by reference of the Attorney General's Model Rules	NOTICE OF AMENDMENT (PROCEDURAL)

TO: All Concerned Persons

1. On October 7, 1999, the Board of Environmental Review published notice of the proposed amendment of ARM 17.4.101 pertaining to incorporation by reference of the Attorney General's Model Rules at page 2173 of the 1999 Montana Administrative Register, Issue No. 19.

2. The Department and Board have amended ARM 17.4.101 as proposed.

3. No comments or testimony were received.

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

DEPARTMENT OF ENVIRONMENTAL QUALITY

by: *Mark A. Simonich*
MARK A. SIMONICH, Director

Reviewed by:

John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.24.101, 17.24.102, 17.24.118, 17.24.123, 17.24.128, 17.24.137, 17.24.140, 17.24.141, 17.24.144, 17.24.150, 17.24.158, 17.24.184 through 17.24.189 pertaining to the metal mines reclamation act	NOTICE OF AMENDMENT (METAL MINES)

TO: All Concerned Persons

1. On October 7, 1999, the Board of Environmental Review published notice of the proposed amendment of ARM 17.24.101, 17.24.102, 17.24.118, 17.24.123, 17.24.128, 17.24.137, 17.24.140, 17.24.141, 17.24.144, 17.24.150, 17.24.158, 17.24.184 through 17.24.189 pertaining to the metal mines reclamation act at page 2178 of the 1999 Montana Administrative Register, Issue No. 19.

2. The Board has amended ARM 17.24.101, 17.24.102, 17.24.118, 17.24.123, 17.24.128, 17.24.137, 17.24.140, 17.24.141, 17.24.144, 17.24.150, 17.24.158, 17.24.184 through 17.24.188 as proposed.

3. The Board has amended 17.24.189 as proposed with the following change:

17.24.189 SMALL MINER METAL LEACHING SOLVENT OR REAGENT PROCESSING FACILITIES PERFORMANCE STANDARDS AND BONDING

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

(3) Bonding for cyanide or other metal leaching solvent or reagent-processing facilities must cover the actual cost of reclamation to the department and the additional estimated cost to the department which may arise from management, operation, and maintenance of the site upon temporary or ~~permament~~ permanent insolvency or abandonment, until full bond liquidation can be effected. Bonds must be reviewed and, if necessary, adjusted at least once every 5 years, tied to either the rate of inflation based on the consumer price index, a change in activities, or both as appropriate.

(4) remains the same.

AUTH: 82-4-321, MCA
IMP: 82-4-305, 82-4-335, MCA

The change was made to correct a misspelling in the initial notice.

4. No comments or testimony were received.

BOARD OF ENVIRONMENTAL REVIEW

by: *Joe Gerbase*
JOE GERBASE, Chairperson

Reviewed by:

John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State January 31, 2000.

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

In the matter of the repeal of ARM 11.5.201, 11.5.203, 11.5.205, 11.5.206, 11.5.209 and 11.5.210 pertaining to protective services for the developmentally disabled	))))))	NOTICE OF REPEAL

TO: All Interested Persons

1. On December 16, 1999, the Department of Public Health and Human Services published notice of the proposed repeal of the above-stated rules at page 2834 of the 1999 Montana Administrative Register, issue number 24.

2. The Department has repealed rules 11.5.201, 11.5.203, 11.5.205, 11.5.206, 11.5.209 and 11.5.210 as proposed.

3. No comments or testimony were received.

Dawn Sliva
Rule Reviewer

Carmie Thompson
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the transfer of ARM 46.12.101, 46.12.102, 46.12.3001 through 46.12.3004, 46.12.3201 through 46.12.3208, 46.12.3210, 46.12.3211, 46.12.3214, 46.12.3216, 46.12.3220, 46.12.3224, 46.12.3228, 46.12.3401 through 46.12.3404, 46.12.3601 through 46.12.3604, 46.12.3801 through 46.12.3805, 46.12.3808, 46.12.4001 through 46.12.4014 pertaining to medicaid eligibility	)	NOTICE OF TRANSFER

TO: All Interested Persons

1. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, medicaid eligibility is transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services. In order to implement that legislation, the above-stated rules are transferred to the Department of Public Health and Human Services ARM Title 37, Chapter 82.

2. The Department of Public Health and Human Services has determined that the transferred rules will be numbered as follows:

OLD	NEW	
46.12.101	37.82.101	Medical Assistance, Purpose
46.12.102	37.82.102	Medical Assistance, Definitions
46.12.3001	37.82.201	Application
46.12.3002	37.82.204	Determination of Eligibility
46.12.3003	37.82.205	Redetermination of Eligibility
46.12.3004	37.82.206	Furnishing Assistance
46.12.3201	37.82.401	Citizenship and Alienage
46.12.3202	37.82.402	Residency
46.12.3203	37.82.406	Applicant's Choice of Category
46.12.3204	37.82.407	Limitation on the Financial Responsibility of Relatives
46.12.3205	37.82.415	Application For Other Benefits
46.12.3206	37.82.416	Assignment of Rights to Benefits, Cooperation with Child Support Enforcement Requirements

OLD	NEW	
46.12.3207	37.82.417	Transfer of Resources
46.12.3208	37.82.418	Bona Fide Effort to Sell Non-Home Real Property
46.12.3210	37.82.422	Conditional Medical Assistance, Definitions
46.12.3211	37.82.423	Conditional Medical Assistance, Eligibility
46.12.3214	37.82.424	Health Plan Premium Payments
46.12.3216	37.82.430	COBRA Continuation Beneficiaries, Application and Eligibility for Medicaid
46.12.3220	37.82.431	Medicaid Estate Recoveries, Waiver of Recovery Based Upon Undue Hardship
46.12.3224	37.82.436	Medicaid Real Property Lien, Waiver of Lien Recovery Based Upon Undue Hardship
46.12.3228	37.82.438	Medicaid Real Property Lien, Release of Lien After Recipient's Return Home
46.12.3401	37.82.701	Groups Covered, Non-Institutionalized FAIM Financial Assistance Related Families and Children
46.12.3402	37.82.702	Non-Financial Requirements, Non-Institutionalized FAIM Financial Assistance Related Families and Children
46.12.3403	37.82.703	Financial Requirements, Non-Institutionalized FAIM Financial Assistance Related Families and Children
46.12.3404	37.82.704	Three Month Retroactive Coverage, Non-Institutionalized FAIM Financial Assistance Related Families and Children
46.12.3601	37.82.901	Groups Covered, Non-Institutionalized SSI-Related Individuals and Couples
46.12.3602	37.82.902	Non-Financial Requirements, Non-Institutionalized SSI-Related Individuals and Couples
46.12.3603	37.82.903	Financial Requirements, Non-Institutionalized SSI-Related Individuals and Couples
46.12.3604	37.82.904	Three Month Retroactive Coverage, Non-Institutionalized SSI-Related Individuals and Couples
46.12.3801	37.82.1101	Individuals Covered, Non-Institutionalized Medically Needy
46.12.3802	37.82.1102	Non-Financial Requirements, Non-Institutionalized Medically Needy
46.12.3803	37.82.1106	Medically Needy Income Standards
46.12.3804	37.82.1107	Income Eligibility, Non-Institutionalized Medically Needy
46.12.3805	37.82.1110	Resource Standards, Non-Institutionalized Medically Needy

OLD	NEW	
46.12.3808	37.82.1111	Three Month Retroactive Coverage, Non-Institutionalized Medically Needy
46.12.4001	37.82.1301	Definitions Relating to Institutional Status
46.12.4002	37.82.1305	Groups Covered, AFDC-Related Institutionalized Individuals
46.12.4003	37.82.1306	Groups Covered, SSI-Related Institutionalized Individuals
46.12.4004	37.82.1310	Non-Financial Requirements, AFDC-Related Institutionalized Individuals
46.12.4005	37.82.1311	Non-Financial Requirements, SSI-Related Institutionalized Individuals
46.12.4006	37.82.1312	Financial Requirements, AFDC-Related Institutionalized Individuals
46.12.4007	37.82.1313	Financial Requirements, SSI-Related Institutionalized Individuals
46.12.4008	37.82.1320	Post-Eligibility Application of Patient Income to Cost of Care
46.12.4009	37.82.1321	Prohibited Coverage
46.12.4010	37.82.1330	Institutionalized Spouse, Definitions
46.12.4011	37.82.1331	Institutionalized Spouse, Resource Assessments
46.12.4012	37.82.1336	Institutionalized Spouse, Resource Eligibility Determination
46.12.4013	37.82.1337	Institutionalized Spouse, Receipt of Additional Resources
46.12.4014	37.82.1338	Institutionalized Spouse, Transfer of Resource to Community Spouse

3. The transfer of rules is necessary because this program was transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services by the 1995 legislature by Chapter 546, Laws of Montana 1995.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the transfer of ARM 46.12.202, 46.12.204, 46.12.301 through 46.12.304, 46.12.306, 46.12.308, 46.12.309, 46.12.401 through 46.12.407, 46.12.501 through 46.12.502A pertaining to general medicaid services	)	NOTICE OF TRANSFER

TO: All Interested Persons

1. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, general medicaid services is transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services. In order to implement that legislation, the above-stated rules are transferred to the Department of Public Health and Human Services ARM Title 37, Chapter 85.

2. The Department of Public Health and Human Services has determined that the transferred rules will be numbered as follows:

OLD	NEW	
46.12.202	37.85.201	Selection of Provider
46.12.204	37.85.204	Recipient Requirements, Copayments
46.12.501	37.85.206	Services Provided
46.12.502	37.85.207	Services Not Provided by the Medicaid Program
46.12.502A	37.85.212	Resource Based Relative Value Scale (RBRVS) Reimbursement for Specified Provider Types
46.12.301	37.85.401	Provider Participation
46.12.302	37.85.402	Provider Enrollment and Agreements
46.12.303	37.85.406	Billing, Reimbursement, Claims Processing, and Payment
46.12.304	37.85.407	Third Party Liability
46.12.306	37.85.410	Determination of Medical Necessity
46.12.308	37.85.414	Maintenance of Records and Auditing
46.12.309	37.85.415	Medical Assistance Medicaid Payment
46.12.401	37.85.501	Grounds for Sanctioning
46.12.402	37.85.502	Sanctions
46.12.403	37.85.505	Factors Governing Imposition of Sanction
46.12.404	37.85.506	Scope of Sanction
46.12.405	37.85.507	Notice of Sanction
46.12.406	37.85.511	Provider Education
46.12.407	37.85.512	Notice of Adverse Action

3. The transfer of rules is necessary because this program was transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services by the 1995 legislature by Chapter 546, Laws of Montana 1995.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the transfer of ARM 46.12.503 through 46.12.508, 46.12.514 through 46.12.517, 46.12.520 through 46.12.522, 46.12.525A, 46.12.526A, 46.12.527A, 46.12.528, 46.12.533, 46.12.534, 46.12.538, 46.12.540 through 46.12.542, 46.12.570 through 46.12.573, 46.12.575 through 46.12.577, 46.12.583 through 46.12.585, 46.12.601, 46.12.602, 46.12.605, 46.12.606, 46.12.701A through 46.12.703, 46.12.706, 46.12.708 through 46.12.710, 46.12.801, 46.12.802, 46.12.805, 46.12.806, 46.12.901, 46.12.902, 46.12.905, 46.12.911, 46.12.912, 46.12.915, 46.12.1001, 46.12.1002, 46.12.1005, 46.12.1011, 46.12.1012, 46.12.1015, 46.12.1021, 46.12.1022, 46.12.1025, 46.12.1501, 46.12.1503, 46.12.1505, 46.12.1708, 46.12.1712, 46.12.1713, 46.12.1718 through 46.12.1720, 46.12.1725, 46.12.1726, 46.12.1901 through 46.12.1903, 46.12.1915 through 46.12.1918, 46.12.1920 through 46.12.1924B, 46.12.1935, 46.12.1936, 46.12.1937, 46.12.1939 through 46.12.1944B, 46.12.1956, 46.12.1959 through 46.12.1962, 46.12.1966, 46.12.1969 through 46.12.1972, 46.12.2001 through 46.12.2003, 46.12.2010, 46.12.2011, 46.12.2013, 46.12.2101, 46.12.2102, 46.12.4801, 46.12.4804 through 46.12.4806, 46.12.4810, 46.12.4813,	NOTICE OF TRANSFER

46.12.4814, 46.12.4816,)
46.12.4817, 46.12.4821,)
46.12.4825 through)
46.12.4828, 46.12.5001)
through 46.12.5004,)
46.12.5007, 46.12.5010 and)
46.12.5011 pertaining to)
medicaid services - primary)
care)

TO: All Interested Persons

1. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, medicaid services - primary care is transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services. In order to implement that legislation, the above-stated rules are transferred to the Department of Public Health and Human Services ARM Title 37, Chapter 86.

2. The Department of Public Health and Human Services has determined that the transferred rules will be numbered as follows:

OLD	NEW	
46.12.2001	37.86.101	Physician Services, Definitions
46.12.2002	37.86.104	Physician Services, Requirements
46.12.2003	37.86.105	Physician Services, Reimbursement/ General Requirements and Modifiers
46.12.2010	37.86.201	Mid-level Practitioner Services, Requirements
46.12.2011	37.86.202	Mid-level Practitioner Services, Definitions
46.12.2013	37.86.205	Mid-level Practitioner Services, Requirements and Reimbursement
46.12.520	37.86.501	Podiatry Services, Definitions
46.12.521	37.86.505	Podiatry Services, Requirements
46.12.522	37.86.506	Podiatry Services, Reimbursement
46.12.525A	37.86.601	Therapy Services, Definitions
46.12.526A	37.86.605	Therapy Services, Provider Requirements
46.12.527A	37.86.606	Therapy Services, Service Requirements and Restrictions
46.12.528	37.86.610	Therapies, Reimbursement
46.12.533	37.86.701	Audiology Services, Provider Requirements
46.12.534	37.86.702	Audiology Services, Service Requirements and Restrictions
46.12.538	37.86.705	Audiology Services, Reimbursement
46.12.540	37.86.801	Hearing Aid Services, Definitions
46.12.541	37.86.802	Hearing Aid Services, Requirements And Limitations
46.12.542	37.86.805	Hearing Aid Services, Reimbursement
46.12.601	37.86.1001	Dental Services, Definitions

OLD	NEW	
46.12.602	37.86.1002	Dental Services, Requirements
46.12.605	37.86.1005	Dental Services, Reimbursement
46.12.606	37.86.1006	Dental Services, Covered Procedures
46.12.701A	37.86.1101	Outpatient Drugs, Definitions
46.12.702	37.86.1102	Outpatient Drugs, Requirements
46.12.703	37.86.1105	Outpatient Drugs, Reimbursement
46.12.570	37.86.1401	Clinic Services, Definitions
46.12.571	37.86.1402	Clinic Services, Requirements
46.12.572	37.86.1405	Clinic Services, Covered Procedures
46.12.573	37.86.1406	Clinic Services, Reimbursement
46.12.706	37.86.1501	Home Infusion Therapy Services, Definitions
46.12.708	37.86.1502	Home Infusion Therapy Services, Provider Requirements
46.12.709	37.86.1505	Home Infusion Therapy Services, Requirements
46.12.710	37.86.1506	Home Infusion Therapy Services, Reimbursement
46.12.575	37.86.1701	Family Planning Services
46.12.576	37.86.1705	Family Planning Services, Requirements
46.12.577	37.86.1706	Family Planning Services, Reimbursement
46.12.801	37.86.1801	Prosthetic Devices, Durable Medical Equipment~~,~~ and Medical Supplies, Definitions
46.12.802	37.86.1802	Prosthetic Devices, Durable Medical Equipment~~,~~ and Medical Supplies, General Requirements
46.12.805	37.86.1806	Prosthetic Devices, Durable Medical Equipment~~,~~ and Medical Supplies, Reimbursement Requirements
46.12.806	37.86.1807	Prosthetic Devices, Durable Medical Equipment~~,~~ and Medical Supplies, Fee Schedule
46.12.901	37.86.2001	Optometric Services, Definitions
46.12.902	37.86.2002	Optometric Services, Requirements
46.12.905	37.86.2005	Optometric Services, Reimbursement
46.12.911	37.86.2101	Eyeglasses, Definitions
46.12.912	37.86.2102	Eyeglasses, Services, Requirements and Restrictions
46.12.915	37.86.2105	Eyeglasses, Reimbursement
46.12.514	37.86.2201	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), Purpose, Eligibility and Scope
46.12.515	37.86.2205	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), Required Screening and Preventive Services
46.12.516	37.86.2206	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), Medical and Other Services

OLD	NEW	
46.12.517	37.86.2207	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT), Reimbursement
46.12.1001	37.86.2401	Transportation and Per Diem, Definitions
46.12.1002	37.86.2402	Transportation and Per Diem, Requirements
46.12.1005	37.86.2405	Transportation and Per Diem, Reimbursement
46.12.1011	37.86.2501	Specialized Nonemergency Medical Transportation, Definitions
46.12.1012	37.86.2502	Specialized Nonemergency Medical Transportation, Requirements
46.12.1015	37.86.2505	Specialized Nonemergency Medical Transportation, Reimbursement
46.12.1021	37.86.2601	Ambulance Services, Definitions
46.12.1022	37.86.2602	Ambulance Services, Requirements
46.12.1025	37.86.2605	Ambulance Services, Reimbursement
46.12.503	37.86.2901	Inpatient Hospital Services, Definitions
46.12.504	37.86.2902	Inpatient Hospital Services, Requirements
46.12.505	37.86.2905	Inpatient Hospital Services, Reimbursement
46.12.506	37.86.3001	Outpatient Hospital Services, Definitions
46.12.507	37.86.3002	Outpatient Hospital Services, Scope and Requirements
46.12.508	37.86.3005	Outpatient Hospital Services, Reimbursement
46.12.2101	37.86.3201	Nonhospital Laboratory and Radiology (X-Ray) Services, Requirements
46.12.2102	37.86.3205	Nonhospital Laboratory and Radiology (X-Ray) Services, Reimbursement
46.12.1903	37.86.3301	Case Management Services, General Definitions
46.12.1901	37.86.3305	Case Management Services, General Provisions
46.12.1902	37.86.3306	Case Management Services, General Eligibility
46.12.1916	37.86.3401	Case Management Services for High Risk Pregnant Women, Definitions
46.12.1915	37.86.3402	Case Management Services for High Risk Pregnant Women, Eligibility
46.12.1917	37.86.3405	Case Management Services for High Risk Pregnant Women, Coverage
46.12.1918	37.86.3410	Case Management Services for High Risk Pregnant Women, Provider Requirements
46.12.1920	37.86.3415	Case Management Services for High Risk Pregnant Women, Reimbursement

OLD	NEW	
46.12.1922	37.86.3501	Case Management Services for Adults with Severe Disabling Mental Illness, Definitions
46.12.1921	37.86.3502	Case Management Services for Adults with Severe Disabling Mental Illness, Eligibility
46.12.1923	37.86.3505	Case Management Services for Adults with Severe Disabling Mental Illness, Service Coverage
46.12.1924	37.86.3506	Case Management Services for Adults with Severe Disabling Mental Illness, Service Requirements
46.12.1924A	37.86.3507	Case Management Services for Adults with Severe Disabling Mental Illness, Provider Requirements
46.12.1924B	37.86.3515	Case Management Services for Adults with Severe Disabling Mental Illness, Reimbursement
46.12.1935	37.86.3601	Case Management Services for Persons Age 16 and Over with Developmental Disabilities, Definitions
46.12.1936	37.86.3602	Case Management Services for Persons Age 16 and Over with Developmental Disabilities, Eligibility
46.12.1937	37.86.3605	Case Management Services for Persons Age 16 and Over with Developmental Disabilities, Coverage
46.12.1939	37.86.3606	Case Management Services for Persons with Developmental Disabilities, Provider Requirements
46.12.1940	37.86.3607	Case Management Services for Persons with Developmental Disabilities, Reimbursement
46.12.1942	37.86.3701	Case Management Services for Youth with Serious Emotional Disturbance, Definitions
46.12.1941	37.86.3702	Case Management Services for Youth with Serious Emotional Disturbance, Eligibility
46.12.1943	37.86.3705	Case Management Services for Youth with Serious Emotional Disturbance, Service Coverage
46.12.1944	37.86.3706	Case Management Services for Youth with Serious Emotional Disturbance, Service Requirements
46.12.1944A	37.86.3707	Case Management Services for Youth with Serious Emotional Disturbance, Provider Requirements

OLD	NEW	
46.12.1944B	37.86.3715	Case Management Services for Youth with Serious Emotional Disturbance, Reimbursement
46.12.1956	37.86.3801	Case Management Services for Children at Risk of Abuse and Neglect, Definitions
46.12.1959	37.86.3805	Case Management Services for Children at Risk of Abuse and Neglect, Coverage
46.12.1960	37.86.3806	Case Management Services for Children at Risk of Abuse and Neglect, Eligibility
46.12.1961	37.86.3810	Case Management Services for Children at Risk of Abuse or Neglect, Provider Requirements
46.12.1962	37.86.3811	Case Management Services for Children at Risk of Abuse and Neglect, Reimbursement
46.12.1966	37.86.3901	Case Management Services for Children with Special Health Care Needs, Definitions
46.12.1969	37.86.3905	Case Management Services for Children with Special Health Care Needs, Coverage
46.12.1970	37.86.3902	Case Management Services for Children with Special Health Care Needs, Eligibility
46.12.1971	37.86.3906	Case Management Services for Children with Special Health Care Needs, Provider Requirements
46.12.1972	37.86.3910	Case Management Services for Children with Special Health Care Needs, Reimbursement
46.12.1501	37.86.4201	Freestanding Dialysis Clinics for End Stage Renal Disease, Definitions
46.12.1503	37.86.4202	Freestanding Dialysis Clinics for End Stage Renal Disease, Requirements
46.12.1505	37.86.4205	Freestanding Dialysis Clinics for End Stage Renal Disease, Reimbursement
46.12.1708	37.86.4401	Rural Health Clinics and Federally Qualified Health Centers, Definitions
46.12.1712	37.86.4405	Rural Health Clinics and Federally Qualified Health Centers, Provider Participation Requirements
46.12.1713	37.86.4406	Rural Health Clinics and Federally Qualified Health Centers, Service Requirements

OLD	NEW	
46.12.1718	37.86.4407	Rural Health Clinics and Federally Qualified Health Centers, Record Keeping and Reports
46.12.1719	37.86.4412	Rural Health Clinics and Federally Qualified Health Centers, Reimbursement For Certain Provider-Based RHCs
46.12.1720	37.86.4413	Rural Health Clinics and Federally Qualified Health Centers, Reimbursement for Other Provider-Based Entities and for Independent Entities
46.12.1725	37.86.4414	Rural Health Clinics and Federally Qualified Health Centers, Supplemental Payments for Mental Health Services and Health Maintenance Organization (HMO) Services
46.12.1726	37.86.4420	Rural Health Clinics and Federally Qualified Health Centers, Reconciliation and Settlement of Interim Rate Payments
46.12.583	37.86.4701	Organ Transplantation, Definitions
46.12.584	37.86.4705	Organ Transplantation, Requirements
46.12.585	37.86.4706	Organ Transplantation, Reimbursement
46.12.4801	37.86.5001	Health Maintenance Organizations: Definitions
46.12.4804	37.86.5002	Health Maintenance Organizations: Recipient Eligibility
46.12.4805	37.86.5005	Health Maintenance Organizations: Enrollment
46.12.4806	37.86.5006	Health Maintenance Organizations: Disenrollment
46.12.4810	37.86.5007	Health Maintenance Organizations: Covered Services
46.12.4813	37.86.5010	Health Maintenance Organizations: Contracts for Services
46.12.4814	37.86.5011	Health Maintenance Organizations: Provision of Services
46.12.4816	37.86.5013	Health Maintenance Organizations: Reimbursement of Providers
46.12.4817	37.86.5014	Health Maintenance Organizations: Reimbursement of HMOs
46.12.4821	37.86.5020	Health Maintenance Organizations: Access to Services
46.12.4825	37.86.5026	Health Maintenance Organizations: Records and Confidentiality
46.12.4826	37.86.5027	Health Maintenance Organizations: Recipient Education
46.12.4827	37.86.5035	Health Maintenance Organizations: Quality Assurance

OLD	NEW	
46.12.4828	37.86.5036	Health Maintenance Organizations: Third Party
46.12.5001	37.86.5101	Passport to Health Program: Authority
46.12.5002	37.86.5102	Passport to Health Program: Definitions
46.12.5003	37.86.5103	Passport to Health Program: Eligibility
46.12.5004	37.86.5104	Passport to Health Program: Enrollment in the Program
46.12.5007	37.86.5110	Passport to Health Program: Services
46.12.5010	37.86.5111	Passport to Health Program: Primary Care Providers Requirements
46.12.5011	37.86.5112	Passport to Health Program: Reimbursement

3. The transfer of rules is necessary because this program was transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services by the 1995 legislature by Chapter 546, Laws of Montana 1995.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the transfer of ARM 46.12.510 through 46.12.512, 46.12.550 through 46.12.552, 46.12.555, 46.12.557, 46.12.559 through 46.12.559E, 46.12.560 through 46.12.562, 46.12.1102 through 46.12.1106, 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1228, 46.12.1229, 46.12.1231, 46.12.1233 through 46.12.1235, 46.12.1237, 46.12.1240, 46.12.1241, 46.12.1243, 46.12.1245, 46.12.1246, 46.12.1249, 46.12.1251, 46.12.1254, 46.12.1255, 46.12.1258, 46.12.1261, 46.12.1264 through 46.12.1267, 46.12.1301, 46.12.1305, 46.12.1306, 46.12.1308, 46.12.1310, 46.12.1831, 46.12.1833, 46.12.1835 and 46.12.1837 pertaining to senior and long term care services	)	NOTICE OF TRANSFER

TO: All Interested Persons

1. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, senior and long term care services is transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services. In order to implement that legislation, the above-stated rules are transferred to the Department of Public Health and Human Services ARM Title 37, Chapter 40.

2. The Department of Public Health and Human Services has determined that the transferred rules will be numbered as follows:

OLD	NEW	
46.12.1102	37.40.101	Level of Care Determinations
46.12.1103	37.40.105	Skilled Care
46.12.1104	37.40.106	Intermediate Nursing Care
46.12.1105	37.40.110	Services Furnished
46.12.1106	37.40.120	Problem Cases
46.12.1301	37.40.201	Preadmission Screening, Definitions
46.12.1305	37.40.202	Preadmission Screening, General Requirements

46.12.1306	37.40.205	Preadmission Screening, Nursing Facility Services
46.12.1308	37.40.206	Preadmission Screening, Redetermination of Need for Nursing Facility Services
46.12.1310	37.40.207	Preadmission Screening, Qualified Mental Retardation Professional
46.12.1222	37.40.302	Definitions
46.12.1223	37.40.306	Provider Participation and Termination Requirements
46.12.1226	37.40.307	Nursing Facility Reimbursement
46.12.1228	37.40.308	Rate Effective Dates
46.12.1229	37.40.313	Operating Cost Component
46.12.1231	37.40.314	Direct Nursing Personnel Cost Component
46.12.1233	37.40.320	Minimum Data Set Submission, Treatment of Delays in Submission, Incomplete Assessments, and Case Mix Index Calculation
46.12.1234	37.40.321	Correction of Erroneous or Missing Data
46.12.1235	37.40.322	OBRA Cost Reimbursement
46.12.1237	37.40.323	Calculated Property Cost Component
46.12.1240	37.40.324	Grandfathered Property Cost Component
46.12.1241	37.40.325	Change in Provider Defined
46.12.1243	37.40.326	Interim Per Diem Rates for Newly Constructed Facilities and New Providers
46.12.1245	37.40.330	Separately Billable Items
46.12.1246	37.40.331	Items Billable to Residents
46.12.1249	37.40.336	Reimbursement for Intermediate Care Facilities for the Mentally Retarded
46.12.1251	37.40.337	Reimbursement to Out-of-State Facilities
46.12.1254	37.40.338	Bed Hold Payments
46.12.1255	37.40.339	Medicare Hospice Benefit - Reimbursement
46.12.1258	37.40.345	Allowable Costs
46.12.1261	37.40.347	Cost Settlement Procedures
46.12.1264	37.40.351	Third Party Payments and Payment In Full
46.12.1265	37.40.352	Utilization Review and Quality of Care
46.12.1266	37.40.360	Lien and Estate Recovery Funds for One-time Expenditures
46.12.1267	37.40.361	Additional Payments for Direct Care Wage and Benefits Increases
46.12.510	37.40.401	Swing-bed Hospitals, Definitions
46.12.511	37.40.402	Swing-bed Hospitals, Provider Participation Requirements
46.12.512	37.40.405	Swing-bed Hospitals, Special Service Requirements
46.12.550	37.40.701	Home Health Services, Definitions
46.12.551	37.40.702	Home Health Services, Requirements

OLD	NEW	
46.12.552	37.40.705	Home Health Services, Reimbursement
46.12.1819	37.40.801	Hospice, Definitions
46.12.1821	37.40.805	Hospice, Conditions of Participation
46.12.1823	37.40.806	Hospice, Covered Services
46.12.1825	37.40.807	Hospice, Requirements, Plan of Care
46.12.1827	37.40.808	Hospice, Certification of Terminal Illness
46.12.1831	37.40.815	Hospice, Election and Waiver of Other Benefits
46.12.1833	37.40.816	Hospice, Revocation of Election
46.12.1835	37.40.825	Hospice, Change of Hospice
46.12.1837	37.40.830	Hospice, Reimbursement
46.12.560	37.40.901	Home Dialysis for End Stage Renal Disease, Definitions
46.12.561	37.40.902	Home Dialysis for End Stage Renal Disease, Requirements
46.12.562	37.40.905	Home Dialysis for End Stage Renal Disease, Reimbursement
46.12.555	37.40.1101	Personal Care ~~Purpose~~ Services, Services Provided~~,~~ and Limitations
46.12.557	37.40.1105	Personal Care Services, Reimbursement
46.12.559	37.40.1301	Self-Directed Personal Assistance Services, Description and Purpose
46.12.559A	37.40.1302	Self-Directed Personal Assistance Services, Application of General Personal Care Rules
46.12.559B	37.40.1305	Self-Directed Personal Assistance Services, Consumer Requirements
46.12.559C	37.40.1306	Self-Directed Personal Assistance Services, Plan of Care Requirements
46.12.559D	37.40.1307	Self-Directed Personal Assistance Services, Provider Requirements
46.12.559E	37.40.1308	Self-Directed Personal Assistance Services, General Requirements

3. The transfer of rules is necessary because this program was transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services by the 1995 legislature by Chapter 546, Laws of Montana 1995.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

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

In the matter of the amendment of ARM 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1241, 46.12.1243, 46.12.1245, 46.12.1254, 46.12.1255, 46.12.1258, 46.12.1260, 46.12.1264 and 46.12.1268 pertaining to nursing facilities	)	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On December 16, 1999, the Department of Public Health and Human Services published notice of the proposed amendment of the above-stated rules at page 2827 of the 1999 Montana Administrative Register, issue number 24.

2. The Department has amended the rules 46.12.1222, 46.12.1223, 46.12.1226, 46.12.1241, 46.12.1243, 46.12.1245, 46.12.1254, 46.12.1255, 46.12.1258, 46.12.1260, 46.12.1264 and 46.12.1268 as proposed.

3. No comments or testimony were received.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 31, 2000.

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the use of vaginal speculums by RN(s) for specimen collection	))))	NOTICE OF PETITION FOR DECLARATORY RULING

TO: All Concerned Persons:

1. On February 24, 2000 at 10:00 a.m. in the conference room of the Professional and Occupational Licensing Bureau, 111 North Jackson, Arcade Building, Lower Level, Helena, Montana, the Board of Nursing will consider a petition for declaratory ruling on whether RN(s) are allowed to use vaginal speculums for specimen collection.

2. This petition is filed and requested by Vickie Badgely, LPN and member of the Board of Nursing.

3. Petitioner referred to instances of confusion of nursing professionals regarding their scope of practice and whether this is a permissible aspect of their nursing tasks. Petitioner cites 37-8-102(5)(b), MCA.

4. The statute upon which Petitioner requests the declaratory ruling is 37-8-102(5)(b), MCA, which provides:

"37-8-102(5)(b) "Practice of professional nursing" means the performance for compensation of services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as a basis for the nursing process. The nursing process is the assessment, nursing analysis, planning, nursing intervention, and evaluation in the promotion and maintenance of health; the prevention, casefinding, and management of illness, injury, or infirmity; and the restoration of optimum function. The term also includes administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the administration of medications and treatments prescribed by physicians, advanced practice registered nurses, dentists, osteopaths, or podiatrists authorized by state law to prescribe medications and treatments. Each registered nurse is directly accountable and responsible to the consumer for the quality of nursing care rendered. As used in this subsection (5)(b):

(i) "nursing analysis" is the identification of those client problems for which nursing care is indicated and may include referral to medical or community resources;

(ii) "nursing intervention" is the implementation of a plan of nursing care necessary to accomplish defined goals."

5. Petitioner requests the Board of Nursing to declare that the use of vaginal speculums for specimen collection purposes is (or is not) within the scope of practice and tasks for licensed professional nurses for clarification purposes.

6. Petitioner identified the following as other interested persons:

Joan McCracken
InterMountain Planned Parenthood
721 North 29th St.
Billings, MT 59101

Dorothy Bradley
105 W. Main Street
Bozeman, MT 59715

Dr. Mike Spence
Dept. Public Health & Human Services
1400 Broadway
1st Floor, B-wing
Helena, MT 59620

7. Interested persons may submit their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Nursing, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than February 28, 2000.

8. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in the public hearing and need an alternative accessible format of this notice. If you require an accommodation, contact the Department no later than 5:00 p.m. on February 18, 2000, to advise us of the nature of the accommodation that you need. Please contact Jill Caldwell, Acting Board Executive Director, Board of Nursing, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-2071; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-7759.

BOARD OF NURSING
KIM POWELL, CHAIRPERSON

BY:

Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF NURSING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the use of vaginal speculums by RN(s) to obtain forensic evidence from sexual assault victims	)))))	NOTICE OF PETITION FOR DECLARATORY RULING

TO: All Concerned Persons:

1. On February 24, 2000 at 8:00 a.m., in the conference room of the Professional and Occupational Licensing Bureau, 111 North Jackson, Arcade Building, Lower Level, Helena, Montana, the Board of Nursing will consider a petition for declaratory ruling on whether RN(s) are allowed to use vaginal speculums for collection of forensic evidence from sexual assault victims.

2. This petition was filed by Janet Swenson, RN-C, Jean Braden, BSN, APRN, Joan McCracken, MSN, APRN and Lavina Guertin, APRN (Petitioners). Janet Swenson is a retired RN-C. Other listed petitioners are staff members at InterMountain Planned Parenthood, 721 No. 29th Street, Billings, Montana 59101.

3. Petitioners submitted numerous letters supporting this petition from various law enforcement and medical realms - all in the interest of furthering the potential for justice and for easing the emotional trauma of victims. Petitioners cite 37-8-102(5)(b), MCA and state: "Our position on the issue is that the use of a speculum to collect evidence does not constitute a pelvic examination. The purpose of the Sexual Assault Nurse Examiners (SANE) nurse examination is to gather evidence of sexual assault in a manner suitable for use in a court of law. The speculum is essential to the gathering of evidence. The vaginal canal must be examined to document any trauma. The SANE nurses have been trained in assisting a woman through the trauma of rape and the resulting examination with a sense of dignity and support. They are not only trained and committed to gathering the best, most solid evidence, but are trained and willing to provide the expert professional testimony needed to effectively prosecute a case. Nurses have been participating as experts across the country for more than a decade."

4. The statute upon which Petitioners request the declaratory ruling is 37-8-102(5)(b), MCA, which provides:

"37-8-102(5)(b) "Practice of professional nursing" means the performance for compensation of services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as a basis for the nursing process. The nursing process is the assessment, nursing analysis, planning, nursing intervention, and evaluation in the promotion and maintenance

of health; the prevention, casefinding, and management of illness, injury, or infirmity; and the restoration of optimum function. The term also includes administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the administration of medications and treatments prescribed by physicians, advanced practice registered nurses, dentists, osteopaths, or podiatrists authorized by state law to prescribe medications and treatments. Each registered nurse is directly accountable and responsible to the consumer for the quality of nursing care rendered. As used in this subsection (5)(b):

(i) "nursing analysis" is the identification of those client problems for which nursing care is indicated and may include referral to medical or community resources;

(ii) "nursing intervention" is the implementation of a plan of nursing care necessary to accomplish defined goals."

5. Petitioners request that the Board of Nursing declare that the use of vaginal speculums for forensic evidence collection purposes is within the scope of practice for licensed professional nurses who have completed the SANE education/training program.

6. Petitioners identified the following as other interested persons:

Lavina Guertin
3101 North Daffodil Dr.
Billings, MT 59102

Ellis Kiser
Department of Justice
P.O. Box 201408
Helena, MT 59620

James Mitchell
Student Health Service MSU
P.O. Box 173260
Bozeman, MT 59717-3260

John A. Nordwick
Bozeman Deaconess Hospital
915 Highland Blvd.
Bozeman, MT 59715-6999

John Connor
Department of Justice
P.O. Box 201439
Helena, MT 59620-1439

Julie Long
Department of Justice
Broadway Bldg. 6th F
554 West Broadway
Missoula, MT 59802-4008

Dennis Paxinos
217 North 27th Street
P.O. Box 35025
Billings, MT 59107-5025

Ellen Losch-Rowe
2004 13th St. SW
Great Falls, MT 59404

James Gilson, Dep. Attorney General
ST of NJ Div of Criminal Justice
P.O. Box 085
Trenton, NJ 08625-0085

Jeane Allison
914 13th Ave. South
Great Falls, MT 59405

Detective Rich McLane
Bozeman Police Department
615 South 16th Avenue
Bozeman, MT 59715

Governor Marc Racicot
Office of the Governor
State Capitol
Helena, MT 59620-0801

Neva Oliver
341 North Avenue East
Missoula, MT 59801

Jean Braden
721 North 29th St.
Billings, MT 59101

Detective Dale Brewington
Billings Police Department
P.O. Box 1554
Billings, MT 59101

Marty Lambert
County Attorney
615 South 16th Avenue
Bozeman, MT 59715

Christian Sarver
Student Health Service MSU
P.O. Box 173260
Bozeman, MT 59717-3260

Gloria Edwards
Office of Gallatin County Attorney
615 South 16th Avenue
Bozeman, MT 59715

Nancy Fitch
Student Health Services UM
634 Eddy Avenue
Missoula, MT 59812

Bill Slaughter, Sheriff
Gallatin County Sheriff's Office
615 South 16th
Bozeman, MT 59715

Kathy Bell SANE Coordinator
Police Department
600 Civic Center
Tulsa, OK 74103

Robert McKenzie
Student Health Service, MSU
P.O. Box 173260
Bozeman, MT 59717-3260

7. Interested persons may submit their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Board of Nursing, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than February 28, 2000.

8. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in the public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Department no later than 5:00 p.m. on February 18, 2000, to advise us of the nature of the accommodation that you need. Please contact Jill Caldwell, Acting Board Executive Director, Board of Nursing, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 444-2071; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-7759.

BOARD OF NURSING
KIM POWELL, RN, CHAIRPERSON

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

BEFORE THE BOARD OF RESPIRATORY CARE PRACTITIONERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the interpretation and further delineation of 37-28-102(3)(a) and (b), MCA, and a less broad guideline than that found in ARM 8.59.402(2)	DECLARATORY RULING

On August 25, 1999, at 10:00 a.m., the Board of Respiratory Care Practitioners considered a petition for declaratory ruling on the interpretation and further delineation of 37-28-102(3)(a) and (b), MCA, and a less broad guideline than that found in ARM 8.59.402(2). Hearing was held and written comment and oral testimony was taken. On November 19, 1999 the Board, via conference call, considered the written comments and testimony received and then made a motion to issue this declaratory ruling.

1. The Board has jurisdiction to issue a declaratory ruling on the subject raised in the petition under Sec. 2-4-501, et seq.

2. Petitioner has standing to present the petition for declaratory ruling.

3. That the Petition certified to the Secretary of State on July 12, 1999 and all supporting documents ask questions which are specifically addressed by Sec. 37-28-102(3)(a), 37-28-101, 37-28-102(3)(a)(iii), MCA and ARM 8.59.402. Accordingly the board hereby GRANTS the Petition for Declaratory Ruling and adopts the guidelines as set forth in the Petition.

The comments received and the Board responses are as follows:

Summary of Comments

The Board received a total of fifteen written and testimonial comments supported by demonstrative and written evidence during the hearing held on August 25, 1999.

COMMENT 1: One commentator asked, "Where does the unskilled, unlicensed practice end and the skilled licensed practice begin? And, as a sub-question, what is the driver qualified to answer?

RESPONSE: Unskilled and unlicensed practice are already sufficiently defined in ARM 8.59.402.

COMMENT 2: Another commentator asked, "What is monitoring?"

RESPONSE: Monitoring is already defined in 37-28-102(3)(a), MCA.

COMMENT 3: One commentator asked, "Does the Board of Respiratory Care have authority over truck drivers in the state of Montana?"

RESPONSE: The Board has authority to protect the public from the unqualified practice of respiratory care or unprofessional conduct by qualified practitioners and respiratory care is subject to regulation and control. See 37-28-101, MCA, et seq.

COMMENT 4: Another commentator asked, "Why doesn't the Board just provide guidelines for voluntary compliance of what a truck driver can and can't do?"

RESPONSE: The Board responded that those guidelines are already defined in 37-28-102(3)(a), MCA.

COMMENT 5: Still another commentator asked, "What do you mean by assessment?"

RESPONSE: The Board responded that, "assessment" is defined by 37-28-102(3)(a)(iii), MCA. Formal education is needed in order to have the background education and proof of formal education via the NBRC credential, in order to provide assessment.

COMMENT 6: One commentator asked, "What can't be monitored?"

RESPONSE: The Board again referred to the definition of monitoring at 37-28-102(3)(a), MCA.

COMMENTS 7 and 11: These commentators were very similar and related in their questions and asked, "What is clinical instruction?" and "Is delivery of pamphlets on coping with COPD considered educational?"

RESPONSE: Delivery of printed materials is appropriate. However, absolutely no explanation of that material should be given pursuant to ARM 8.59.402.

COMMENT 8: A commentator asked, "Are there any gray areas of assessment where some symptoms should be reported by delivery personnel?"

RESPONSE: Delivery personnel have a moral obligation to contact the appropriate licensed health care professional if something is inappropriate. The delivery person should

report anything out of the ordinary and leave the assessment to the professional.

COMMENT 9: Another commentator asked, "Who will enforce the ruling of a judge when the line has been crossed?"

RESPONSE: Enforcement is the function of the Board of Respiratory Care Practitioners and judging an issue falls within the complaint process and the procedures within that process. See 37-28-101, MCA.

COMMENT 10: Yet another commentator asked, "The patient can benefit from the delivery person noticing symptoms of low oxygen level and then reporting to the appropriate person. Would that be considered a violation of the no assessment rule?"

RESPONSE: The response here is exactly the same as that for Response to Comment No. 8.

COMMENT 12: One commentator asked, "How are you going to prove that a driver is or is not doing clinical instruction or assessments?"

RESPONSE: Enforcement is the function of the Board and judging an issue falls within the complaint process and the procedures within that process.

COMMENT 13: Another commentator stated, "I think that there should be some defined rules as to what they can and cannot set up."

RESPONSE: Unskilled and unlicensed practice are already defined in ARM 8.59.402 and is further delineated in this Declaratory Ruling.

COMMENT 14: In a letter submitted by Karen Allen, CRT, RPSGT, she stated that, "Home medical equipment personnel should be limited only to the delivery and assembly of equipment based upon the licensed physician's orders. Simulated demonstrations, safety and maintenance of equipment is a licensed and credentialed respiratory therapist's responsibility."

RESPONSE: Definitions and explanations for what respiratory care does and does not include are found in ARM 8.59.402.

COMMENT 15: Ruth Grindinger, RRT stated in her letter "There seems to be very little difference in our minds between 'simulated' demonstration and clinical instruction. We feel that the definition for 'simulated instruction' should be written in terms that the delivery personnel can understand. They need to know where the demonstration ends and clinical

instruction begins."

RESPONSE: The Board stated that that is the purpose of the guidelines found in this Declaratory Ruling and also found in ARM 8.59.402 and 37-28-102(3)(iii), MCA.

DATED this 19th day of November, 1999.

BOARD OF RESPIRATORY CARE
PRACTITIONERS
RICH LUNDY, CHAIRMAN

BY: Annie M. Bartos

ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

BY: Annie M. Bartos

ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, January 31, 2000

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.

Business and Labor Interim Committee:

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

Education Interim Committee:

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

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

- Department of Public Health and Human Services.

Law, Justice, and Indian Affairs Interim Committee:

- Department of Corrections; and
- Department of Justice.

Revenue and Taxation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

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

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

Environmental Quality Council:

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

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

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

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

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

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

Use of the Administrative Rules of Montana (ARM):

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

ACCUMULATIVE TABLE

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

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through September 30, 1999, this table and the table of contents of this issue of the MAR.

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

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

GENERAL PROVISIONS, Title 1

1.2.419 Scheduled Dates for the Montana Administrative Register, p. 2432, 2777
1.3.101 and other rules - Model Rules of Procedure - Amendment of the Sample Forms Attached to the Model Rules, p. 600, 1225

ADMINISTRATION, Department of, Title 2

I Acquiring Services to Operate the State Charitable Giving Campaign, p. 561, 1292
I & II and other rules - State Procurement, p. 2124, 65
2.21.306 and other rule - Disaster Leave for Trained American Red Cross Volunteers, p. 2315
2.21.1423 and other rules - Persons with Disabilities Preference Policy, p. 2312
2.21.3602 and other rules - Veterans' Employment Preference Policy, p. 2304

(Public Employees' Retirement Board)
2.43.403 and other rules - Membership, Service Credit, and Service Purchases in Retirement Systems Administered by the Board - Service Purchases - Social Security Coverage for the Employees of the State and Its Political Subdivisions, p. 932, 1504

2.43.437 Purchase of Military Service by Members of the Retirement Systems Administered by the Public Employees' Retirement Board, p. 2301, 70

(Teachers' Retirement Board)

I and other rules - Teachers' Retirement System - Extra Duty Compensation - Membership of Teacher's Aides and Part-time Employees - Correction of Errors on Contributions and Overpayment, p. 2792

I and other rules - Teachers' Retirement System, p. 1565, 2243, 2837

(State Compensation Insurance Fund)

I and other rules - Construction Credit Program - Premium Rates - Premium Modifiers and Dividends, p. 1

AGRICULTURE, Department of, Title 4

I & II Commodity Research and Market Development Program, p. 113

4.5.202 and other rule - Category 1 and Category 2 Noxious Weeds, p. 2976

4.10.1806 Fees, p. 2672, 182

4.12.3501 and other rules - Grading of Seed Potatoes, p. 677, 1505

(Agriculture Development Council)

4.16.701 Agricultural Marketing Development Program; Purpose, Goals, and Criteria, p. 1458, 1764

STATE AUDITOR, Title 6

I-VII Valuation of Life Insurance Policies, p. 2488, 2839

6.6.302 and other rules - Life Insurance and Annuities Replacement, p. 1575

6.6.1105 Allowable Exclusions and Restrictions, p. 1274, 2246

6.6.1110 Determination of Reasonableness of Benefits in Relation to Premium Charged in Credit Disability and Credit Life Insurance, p. 1717

6.6.4102 Continuing Education Fees, p. 1600, 2247, 183

6.10.126 Unethical Practices, p. 1272, 2245

6.10.131 Foreign Security Exemption, p. 117

(Classification Review Committee)

6.6.8301 Updating References to the NCCI Basic Manual for Workers Compensation and Employers Liability Insurance, 1996 Edition, p. 2139, 2841

COMMERCE, Department of, Title 8

8.2.208 Renewal Dates, p. 1719, 2435

(Board of Alternative Health Care)

8.2.208 and other rules - Renewal Dates - Naturopathic Physician Continuing Education Requirements -

Licensing by Examination - Definitions - Midwives Continuing Education Requirements - Licensure of Out-of-State Applicants - Direct Entry Midwife Protocol Standard List, p. 1460, 2038

8.4.301 Fees, p. 431, 1121

8.4.503 Direct-Entry Midwife Apprenticeship Requirements, p. 1933

(Board of Athletics)

8.8.2806 Fees, p. 433, 1506

(Board of Barbers)

8.10.405 Fee Schedule, p. 435, 2040

(Board of Clinical Laboratory Science Practitioners)

8.13.301 and other rules - Applications for License - Fees - Minimum Standards for Licensure - Continuing Education Requirements, p. 2675

(Board of Cosmetologists)

8.14.814 Fees - Initial, Renewal, Penalty and Refund Fees, p. 439, 2043

(State Electrical Board)

8.18.407 Fee Schedule, p. 441, 1200

(Board of Hearing Aid Dispensers)

8.20.402 Fees, p. 443, 1765

(Board of Landscape Architects)

8.24.409 Fee Schedule, p. 445, 1122

(Board of Medical Examiners)

8.28.420 and other rules - Fee Schedule - Fees, p. 447, 1766

8.28.1501 and other rules - Definitions - Post-Graduate Training Program, p. 2143

8.28.1508 Quality Assurance of Advanced Practice Registered Nurse Practice, p. 22, 1294

(Board of Funeral Service)

8.30.407 Fee Schedule, p. 450, 1201

(Board of Nursing)

8.28.1508 Quality Assurance of Advanced Practice Registered Nurse Practice, p. 22, 1294

8.32.301 and other rules - Nurse Practitioner Practice - Standards Relating to the Licensed Practical Nurse's Role in Intravenous (IV) Therapy - Prohibited IV Therapies, p. 1467

8.32.1409 Prohibited IV Therapies, p. 563, 680, 2437

8.32.1702 and other rules - Nursing Tasks that may be Delegated - General Nursing Tasks that may not be Delegated - Nursing Tasks Related to Gastrostomy Feeding that may be Delegated, p. 2150

(Board of Nursing Home Administrators)
8.34.414 and other rule - Examinations - Fee Schedule, p. 453, 1123

(Board of Optometry)
8.36.417 and other rules - Licensure of Out-of-State Applicants - Approved Programs or Courses - Therapeutic Pharmaceutical Agents - Approved Course and Examination - Approved Drugs, p. 2153, 2760
8.36.804 Approved Drugs, p. 1187

(Board of Outfitters)
8.39.501 and other rules - Outfitter Licenses - Qualifications - Examinations - Outfitter Acting as Guide - Renewal - Amendment to Operations Plan - Inactive - Guide or Professional Guide License - Fees for Outfitter Operations Plan - N.C.H.U. - Guide or Professional Guide - Outfitter Records - Safety Provisions - Standards for Outfitters - Guides and Professional Guides - Unprofessional Conduct and Misconduct - Moratorium - Review of New Operations Plan - Proposed Expansion of Net Client Hunting Use Under Existing and New Operations Plans - Sale and Purchase of an Outfitting Operation, p. 2318
8.39.508 and other rules - Licensure--Renewal - Guide or Professional Guide License - Safety Provisions - Standards for Outfitters, Guides and Professional Guides - Unprofessional Conduct and Misconduct, p. 241, 809

(Board of Pharmacy)
8.40.404 Fee Schedule, p. 455, 1124
8.40.608 and other rules - Renewals - Non-compliance - Application for Registration - Wholesale Drug Distributor Licensing, p. 1721, 2438
8.40.702 Definitions, p. 2330

(Board of Professional Engineers and Land Surveyors)
8.48.1105 Fee Schedule, p. 1936

(Board of Private Security Patrol Officers and Investigators)
8.50.437 Fee Schedule, p. 459, 2044

(Board of Psychologists)
8.52.616 Fee Schedule, p. 461, 1125

(Board of Public Accountants)
8.54.410 and other rule - Fee Schedule - Statement of Permit Holders, p. 463, 1203, 1508
8.54.416 and other rules - Licensure of Foreign-Trained Applicants - Credit for Formal Individual Study Programs - Basic Requirement, p. 2332

(Board of Real Estate Appraisers)
8.57.101 and other rule - Board Organization - Continuing Education, p. 1189, 2624

8.57.406 and other rules - Qualifying Education Requirements - Adoption of USPAP by Reference - Regulatory Reviews, p. 2679
8.57.412 Fees, p. 465, 1657

(Board of Realty Regulation)
8.58.415A Continuing Real Estate Education, p. 2337, 184

(Board of Respiratory Care Practitioners)
8.59.402 Definitions, p. 997

(Board of Sanitarians)
8.60.413 Fees, p. 999, 2248

(Board of Speech-Language Pathologists and Audiologists)
8.62.407 and other rules - Qualifications for Probationary License - Fees - Unlicensed Person, p. 1470, 2249

(Board of Veterinary Medicine)
8.64.402 Fee Schedule, p. 467, 1126
8.64.508 and other rule - Unprofessional Conduct - Record-keeping Standards, p. 565, 1509

(Building Codes Division)
8.70.101 and other rules - Building Codes Division, p. 1001, 1885

(Weights and Measures Bureau)
8.77.103 Weights and Measures Bureau - NIST Handbook 44, p. 469, 1295

(Consumer Affairs Division)
I-V Telemarketing Registration and Fraud Prevention Act, p. 120

(Division of Banking and Financial Institutions)
I-VI Deferred Deposit Lending, p. 1849, 2570, 71

(Board of County Printing)
8.91.301 and other rules - County Printing, p. 2339

(Local Government Assistance Division)
I Administration of the 2000 Federal Community Development Block Grant Program, p. 126
I 2000/2001 Treasure State Endowment Program (TSEP), p. 2342, 186
I Administration of the 1999 Treasure State Endowment Program (TSEP), p. 1473, 2761
I Administration of the 1999 Federal Community Development Block Grant Program, p. 3245, 1204, 1511
8.94.3001 and other rules - Monumentation of Surveys - Form, Accuracy, and Descriptive Content of Records Survey, p. 2156

17.40.203 and other rule - Wastewater Operators - Certification - Fees for Water and Wastewater Operators, p. 2596, 72
17.40.203 Wastewater Operator Certification, p. 1494, 1804
17.56.101 and other rule - Underground Storage Tanks - Underground Storage Tank Repairs, p. 1496, 2046
17.56.1001 Underground Storage Tanks - Underground Storage Tanks Fee Schedule, p. 1853, 2858

(Board of Environmental Review)
I and other rules - Public Water Supply - Public Water and Sewage System Requirements, p. 578, 1895
I Water Quality - Temporary Water Quality Standards for Daisy Creek, the Stillwater River, and Fisher Creek, p. 482, 1218
I & II and other rules - Air Quality - Air Quality Transportation - General Conformity Determinations, p. 244, 1216
I-XIV and other rules - Air Quality - Air Quality Compliance Assurance Monitoring - Requirements for Air Quality Operating Permit Content, p. 2725
17.8.101 and other rule - Air Quality - Implementation of Revised Federal Air Quality Standards for Particulate Matter, p. 2750
17.8.102 and other rules - Air Quality - Air Quality Incorporation by Reference Rules, p. 1191, 2250, 2767
17.8.301 and other rules - Air Quality - Maximum Achievable Control Technology (MACT) Approval for Hazardous Air Pollutants, p. 572, 1658
17.8.504 and other rule - Air Quality - Air Quality Permit Application Operation Fees, p. 1612, 2254
17.8.601 and other rules - Air Quality - Open Burning, p. 568, 1660
17.8.705 and other rules - Air Quality - De Minimis Changes that may be made to a Facility without an Application to Revise the Facility's Air Quality Permit, p. 261, 1206
17.8.1201 and other rule - Air Quality - Title V Air Quality Operating Permits, p. 2747
17.24.101 and other rules - Metal Mines - Metal Mines Reclamation Act, p. 2178
17.24.301 and other rules - Coal and Uranium Mining Program Rules for the Industrial and Energy Minerals Bureau, p. 2995, 811
17.24.303 and other rules - Coal and Uranium - Coal and Uranium Mining Organizational Changes, p. 1782, 2768
17.30.105 and other rule - Water Quality - Certification Options - General Prohibitions to Surface Water Quality Standards and Procedures, p. 1608, 2256
17.30.602 and other rules - Water Quality - Trigger Values p. 1603, 2275
17.30.602 and other rules - Water Quality - Montana Surface Water Quality Standards - Nondegradation - Ground Water Pollution Control System, p. 477, 1617, 2257

17.30.705 Water Quality - Nondegredation Requirements for Outstanding Resource Waters, p. 2753
17.30.1341 Water Quality - Permit Requirements of Lagoons, p. 1198, 1661
17.38.215 Public Water Supply - Bacteriological Quality Samples for Public Water Supply Systems, p. 257, 1222

(Department of Environmental Quality and Board of Environmental Review)
17.4.101 Incorporation by Reference of the Attorney General's Model Rules, p. 2173

(Petroleum Tank Release Compensation Board)
17.58.101 and other rules - Procedures and Criteria for Compensation of Petroleum Tank Remedial Costs, p. 1475, 2279
17.58.336 and other rules - Review and Determination of Claims and Charges, p. 682, 1512

TRANSPORTATION, Department of, Title 18

I-IV and other rules - Special Fuel Users Tax, Dealers and LPG Tax, p. 2797, 645, 1298

CORRECTIONS, Department of, Title 20

I-XLIV Operation and Physical Condition of a Private Correctional Facility - Security, Safety, Health, Treatment and Discipline of Persons Confined in a Private Correctional Facility, p. 1276, 1902, 2629
20.2.101 Department Model Procedural Rules, p. 2600, 74

JUSTICE, Department of, Title 23

I and other rules - Insurance Required Prior to the Public Display of Fireworks - Fire Code, p. 2190, 2860
I-IV Permitting the Referral of Department of Justice Debts to the Department of Administration or Other Agency Designated by Law, p. 399, 984
1.3.101 and other rules - Model Rules of Procedure - Amendment of the Sample Forms Attached to the Model Rules, p. 600, 1225
23.14.401 Adding Two Members to the Peace Officers Standards and Training Advisory Council, p. 1734, 2284
23.16.1802 and other rules - Responsible Party for Video Gambling Machine Taxes and Record Keeping, p. 1739, 2048

LABOR AND INDUSTRY, Department of, Title 24

I Payment of Silicosis Benefits, p. 179
I-IX Workers' Compensation Administrative Assessment, p. 22

PUBLIC SERVICE REGULATION, Department of, Title 38