ISSUE NO. 1

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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

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SPECIAL NOTICE AND TABLE SECTION

BEFORE THE STATE COMPENSATION INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the proposed adoption of New Rule I pertaining to the construction credit program, amendment of ARM 2.55.320, 2.55.323, 2.55.324, 2.55.325, 2.55.326, 2.55.402, 2.55.403, 2.55.407, 2.55.408, 2.55.409, 2.55.502 pertaining to premium rates, premium modifiers and dividends, and repeal of 2.55.404 and 2.55.405 pertaining to premium modifiers	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION, AMENDMENT AND REPEAL OF RULES

TO: All Concerned Persons

1. On February 3, 2000, the State Fund will hold a public hearing at 2:00 p.m., in Room 201 of the State Compensation Insurance Fund Building, 5 South Last Chance Gulch, Helena, Montana, to consider adopting new Rule I pertaining to the construction industry premium credit program, the amendments to ARM 2.55.320, 2.55.323, 2.55.324, 2.55.325, 2.55.326, 2.55.402, 2.55.403, 2.55.407, 2.55.408, 2.55.409, 2.55.502 pertaining to the State Fund's premium rate making, premium modifiers and the individual loss sensitive dividend plan, and the repeal of 2.55.404 and 2.55.405 pertaining to premium modifiers.

2. The rule proposed to be adopted provides as follows:

RULE I CONSTRUCTION INDUSTRY PREMIUM CREDIT PROGRAM - FY01 (1) The state fund shall each fiscal year offer a program which provides a premium credit to insureds in the construction industry who pay their workers wages equal to or in excess of 1.168 times the state's average weekly wage.

(2) To become eligible for the program, the insured must meet all of the following criteria:

(a) maintain accurate individual employee records of the total hours worked and payroll by class code and make those records available for verification and audit;

(i) If a payroll audit period includes all or a portion of a policy year to which a construction credit applies, the survey period will also be audited to determine the proper credit for the payroll audit period even though the survey period may be more than 3 years prior.

(ii) If the verification or audit reveals hourly records are not available, the insured is disqualified from the program.

(iii) If the insured fails to make the records available within a reasonable period of time after contact, the insured is disqualified from the program.

(iv) If the application of the insured was originally disapproved based on criteria (2)(c) or (2)(d) but otherwise qualified and a subsequent verification or audit results in adjustments which determine the insured actually met those criteria, a credit will be applied retroactively.

(b) apply for the premium credit program and submit the completed and signed application form by the stated due date on the application form;

(c) have paid an average hourly wage equal to or in excess of 1.168 times the state's average weekly wage as published by the department of labor and industry for FY2000; and

(d) have at least 50% of the manual premium during the survey period attributable to one or more of the eligible construction class codes.

(3) The following class codes are the construction codes eligible for the construction industry premium credit program:

3365	5057	5190	5437	5479	5537	6003	6233	7538
3719	5059	5213	5443	5480	5538	6005	6251	7601
3724	5069	5215	5445	5491	5551	6017	6252	7605
3726	5102	5221	5462	5506	5610	6018	6306	7855
5020	5146	5222	5472	5507	5645	6045	6319	8227
5022	5160	5223	5473	5508	5651	6204	6325	9521
5037	5183	5348	5474	5511	5703	6217	6365	9534
5040	5188	5403	5478	5536	5705	6229	6400	9552

(4) The following credit percentages, are to be applied to the manual premium of the insured's construction class codes during the survey period to determine the premium credit factor for policies with effective dates between July 1, 2000 and June 30, 2001 inclusive:

Average Hourly Wage	Credit Percentage
$12.40 or less	0%
12.41 - 13.43	2%
13.44 - 14.46	3%
14.47 - 15.49	4%
15.50 - 16.52	5%
16.53 - 17.55	6%
17.56 - 18.58	8%
18.59 - 19.61	10%
19.62 - 20.64	12%
20.65 - 21.67	14%
21.68 - 22.70	16%
22.71 - 23.73	18%
23.74 - 24.76	20%
24.77 and above	22%

(5) Procedures and processes for the premium credit program are:

(a) The state fund will provide an application form to insureds who are assigned one or more of the construction codes listed in (3);

(b) The insured must sign the application, report total payroll and hours worked by class code (both construction and non-construction) for the survey period and return the form by the stated due date. Following are the only allowed exceptions to reporting total payroll and/or actual hours worked:

(i) The premium portion of overtime wages must be excluded.

(ii) In the absence of specific hourly records for salaried employees, the insured must report total payroll and an assumed 40 hours per week.

(iii) In the absence of specific hourly records for covered corporate officers, or managers of a limited liability company, the insured must report total payroll, subject to the officer minimum and maximum payroll reporting requirements in effect for the survey period, and an assumed 40 hours per week.

(iv) If specific hourly records are maintained for covered corporate officers, or managers of a limited liability company the insured must report those hours and total payroll, subject to the officer minimum and maximum payroll reporting requirements in effect for the survey period.

(v) Covered owners must report an assumed 40 hours per week and payroll (wages) equal to their elected coverage level in effect for the survey period.

(c) The state fund will determine whether the insured meets the criteria, approve or disapprove the application and notify the insured of approval or disapproval;

(i) If approved, the notice will include the premium credit factor.

(ii) If disapproved the notice will specify the reason(s) for disapproval.

(d) The state fund will calculate the premium credit factor of each insured based on the information reported for the survey period. The state fund reserves the right to verify or audit the records of the insured before and/or after the premium credit factor is calculated to verify the information submitted and to adjust the premium credit factor accordingly if necessary;

(e) The premium credit factor will be calculated as follows using the information for the survey period provided by the insured or as adjusted by verification or audit:

(i) The average hourly wage will be calculated for each of the construction and non-construction class codes by dividing payroll by the number of hours worked.

(ii) The manual premium will be calculated for each construction and non-construction class code by multiplying the payroll, divided by 100, times the manual class code rate in effect for the insured during the survey period. If the survey period used is after July 1, 2000, rates in effect for July 1, 1999 through June 30, 2000 shall be used.

(iii) The manual premium for each construction class code will be multiplied by the appropriate credit percentage to determine the construction credit dollar amount and these amounts will be totaled for the survey period.

(iv) The total of the construction credit dollar amounts will be divided by total manual premium and the result will be

subtracted from 1.0000 to arrive at the premium credit factor.

(6) The following definitions apply to the construction industry premium credit program:

(a) "Policy year" means the period beginning on the effective date of the policy and ending on the expiration date of the policy.

(b) "Premium credit factor" means the factor as calculated in (5)(e). This factor will be applied to the insured's total standard premium for that policy year.

(c) "Survey period" means the third calendar quarter, July 1 through September 30, preceding the policy year to which the premium credit factor will apply. If the insured did not engage in operations for the complete usual survey period (July 1 through September 30), then the last complete quarter prior to the policy effective date shall be used or if there was no complete quarter of operations prior to the policy effective date, the first complete quarter after the policy effective date shall be used.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Secs. 39-71-2211, 39-71-2311, 39-71-2316, and 39-71-2330, MCA.

RATIONALE: The State Fund is proposing a new construction credit rule for fiscal year 2001 and subsequent fiscal years to incorporate Senate Bill 396 passed in the 1999 legislative session and State Fund program changes. The start of fiscal year 2001 is July 1, 2000. The existing construction credit rule, ARM 2.55.327, must remain in effect to address fiscal years prior to 2001. The State Fund has outstanding policies and issues that will be governed by the existing rule. However, the changes needed to the rule are too extensive to make them in the existing rule. The new rule will avoid confusion between the existing requirements of the construction credit program and the requirements for fiscal year 2001 and subsequent fiscal years.

Subsections (1) and (2) of the proposed rule provide that the starting point for the construction credit table is 1.168 times the Montana average weekly wage as reported by the department of labor and industry. This conforms the rule to the amendment of section 39-71-2211(2), MCA, made in Chapter 131, 1999 Montana Session Laws (SB 396). The table in subsection (4)(a) reflects changes in the state's average weekly wage as determined by the department of labor and industry, effective July 1, 1999. The State Fund's program changes have been made possible by a new computer system brought on line in June, 1999, and are designed to bring the construction credit program more in line with National Council on Compensation Insurance rules. The program changes include eliminating the waiting period for participation in the program, providing variable survey periods, and offering staggered policy effective dates.

The state fund has considered the fiscal impact of the new rule, as required by section 2-4-302(1), MCA. Some individual

policyholders in FY01 may experience lower premiums under the construction credit program, while others may experience higher premiums. However, the overall fiscal impact for the state fund is neutral. It is unknown at this time what policyholders will qualify for the program or what their credits will be, if any.

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

2.55.320 METHOD FOR ASSIGNMENT OF CLASSIFICATIONS OF EMPLOYMENTS

(1) and (2) remain the same.

(3) The state fund staff shall assign its insureds to classifications contained in the classifications section of the State Compensation Insurance Fund Policy Services Underwriting Manual issued July 1, ~~1993~~ 1997, and assign new or changed classifications as approved by the board. That section of the manual is hereby incorporated by reference. Copies of the classification section of the manual may be obtained from the Underwriting Department of the State Fund, 5 South Last Chance Gulch, Helena, Montana 59601.

AUTH: Sec. 39-71-2315 and 39-71-2315, MCA;
IMP: Sec. 39-71-2311 and 29-71-2316, MCA.

RATIONALE: The amendment of this rule is reasonably necessary to reference the latest published edition of the state fund's Policy Services Underwriting Manual.

2.55.323 OVERALL RATE LEVEL ADJUSTMENT (1) In order to determine the premium rate to be charged to ~~an insured covered by the state fund for the following fiscal~~ each insured's policy year that begins on or after the next July 1, the state fund actuary shall recommend the projected overall rate level adjustment for the fiscal year of the state fund. The projected overall rate level adjustment must be sufficient to cover:

(a) the value of claims, as determined by actuarial analysis, expected to be incurred as a direct result of covered accidents during the following fiscal year of the state fund;

(b) operational and administrative expenses, claims adjustment expense related to covered claims, and other expenses required to operate the state fund for the fiscal year; and

(c) an amount sufficient to maintain appropriate contingency reserves and policyholder surplus.

(2) Remains the same.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2311, 39-71-2316 and 39-71-2330, MCA.

2.55.324 PREMIUM RATESETTING

(1) through (4) remain the same.

(5) The state fund may, with concurrence of the state fund board of directors, adopt and implement ~~interim premium rate changes. The interim adjustment of the premium rates for classifications may be either experience based for the remainder~~

~~of the fiscal year as set forth in ARM 2.55.321 through 2.55.324(1) or the same percentage increase or decrease may be applied to each classification's rate. If the interim rate adjustment is experience-based, the immediately preceding fiscal year may be excluded in the review of total incurred losses and total payroll as per ARM 2.55.321. In an interim rate adjustment, the board may also use the exact experience utilized to set the rate for the fiscal year as in ARM 2.55.321.~~ changes to previously adopted rates. These changes may be based on, but are not limited to, statutory or other legal changes in benefits or costs, or revisions in actuarial indications. These rate changes shall be effective on a date and in such manner as determined by the board of directors, and shall apply to each policy for the remainder of the policy year to which the previously adopted rates apply, and for new and renewal policies.

(6) and (7) remain the same.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA.
IMP: Sec. 39-71-2211, 39-71-2311, 39-71-2316 and 39-71-2330, MCA.

2.55.325 VARIABLE PRICING WITHIN A CLASSIFICATION

(1) The state fund staff in consultation with the actuary and with approval of the board shall implement variable pricing categories within individual classifications based upon annual premium threshold, and the insured's most recent policy effective date, incurred loss ratio and qualification for experience modification. An analysis shall be conducted annually, and will result in placement of insureds into a pricing category applicable to ~~for the~~ policies with new or renewal effective dates in the next fiscal year.

(2) The annual analysis will include a determination of each insured's most recent policy effective date; earned premium for the most recent complete ~~fiscal~~ policy year; incurred loss ratio, including any prior associated policies of up to three of the most recent complete ~~fiscal~~ policy years and qualification for experience modification in the next ~~fiscal~~ policy year. The annual analysis will also include a variable pricing stabilization review.

(3) "Variable pricing stabilization review" means an annual analysis of total earned premium, state fund administrative and operating expenses, adequate reserve requirements and other relevant factors, to establish a premium threshold and loss ratio thresholds so as to reward employers with a good safety record and penalize employers with a poor safety record. Any adjustment in the preferred category shall be offset by an adjustment in the equitable category so as to assist the state fund to be neither more nor less than self-supporting.

(4) Insureds will be placed in one of the following three pricing categories established under this rule:

(a) For placement in the preferred category with the lowest premium rate, all of the following must apply:

(i) the insured's most recent policy effective date is

prior to the beginning of most recent complete fiscal year;

(ii) the insured's premium in the most recent complete ~~fiscal~~ policy year is more than the threshold determined by a variable pricing stabilization review;

(iii) the insured's incurred loss ratio for up to three of the most recent complete ~~fiscal~~ policy years places the insured in the lowest rated variable pricing category as determined by a variable pricing, stabilization review; and

(iv) the insured is not qualified for experience modification in the next ~~fiscal~~ policy year.

(b) For placement in the select category with the middle premium rate, any one of the following must apply:

(i) the insured's most recent policy effective date is subsequent to the beginning of the most recent complete fiscal year; or

(ii) the insured's premium in the most recent complete ~~fiscal~~ policy year is less than the threshold determined by a variable pricing stabilization review; or

(iii) the insured will qualify for experience modification in the next ~~fiscal~~ policy year; or

(iv) the insured's most recent policy effective date is prior to the beginning of the most recent complete fiscal year~~,~~ and all of the following apply:

(A) the insured's premium in the most recent complete ~~fiscal~~ policy year is more than the threshold determined by a variable pricing stabilization review;

(B) the insured's incurred loss ratio for up to three of the most recent complete ~~fiscal~~ policy years is average as determined by a variable pricing stabilization review; and

(C) the insured is not qualified for experience modification in the next ~~fiscal~~ policy year.

(c) For placement in the equitable category with the highest premium rate, all of the following must apply:

(i) the insured's most recent policy effective date is prior to the beginning of the most recent complete fiscal year;

(ii) the insured's premium in the most recent complete ~~fiscal~~ policy year is more than the threshold determined by a variable pricing stabilization review;

(iii) the insured's incurred loss ratio for up to three of the most recent complete ~~fiscal~~ policy years places the insured in the highest rated variable pricing category as determined by a variable pricing stabilization review; and

(iv) the insured is not qualified for experience modification in the next ~~fiscal~~ policy year.

(5) Notwithstanding (1) through (4), the state fund may at any time place an insured in a pricing category with a higher or lower premium rate based upon consideration of other relevant factors including, but not limited to:

(a) timeliness of the insured's payroll reporting and premium payment history;

(b) an insured's prior policy was canceled for nonsubmission of payroll reports, nonpayment of premium, nonpayment of policy charge, failure to pay increased deposit when required, failure to reimburse the state fund for expended

medical deductible amounts, failure to cooperate in an audit or material misrepresentation;

(c) the prior insolvency of the insured or any of the insured's principals;

(d) determination that the insured is an increased risk pursuant to a state fund evaluation;

(e) the insured qualifies for the safety incentive or loss prevention program but refuses or fails to adequately implement or maintain a loss control program;

(f) the work is primarily performed at locations other than the insured's principal job site or place of business and the insured does not have control over the job site or place of business;

(g) the insured has a history of preventable losses;

(h) the insured or any of its principals have a prior history with any insurer where the most recent experience modification reflects a factor of greater than 1.00;

(i) timeliness of the insured's history of submitting a first report of injury to the state fund;

(j) an employer's history and experience with any other insurer;

(k) new business without workers' compensation experience history;

(l) the most recent complete ~~fiscal~~ policy year premium is below a threshold determined by the board of directors and the insured will not qualify for experience modification during the next ~~fiscal~~ policy year.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2311, 39-71-2316, 39-71-2330, and 39-71-2341, MCA.

2.55.326 MINIMUM ~~YEARLY~~ LOSS BASED PREMIUM (1) The state fund, subject to the approval of the state fund board of directors, may establish each fiscal year and charge a minimum ~~yearly~~ loss based premium to a policy with an effective date between July 1 and June 30 inclusive, in order to cover the risk of loss for coverage of small employers.

(2) The ~~M~~minimum ~~yearly~~ loss based premium may be derived by establishing a minimum yearly payroll. The minimum ~~yearly~~ loss based premium shall be determined by multiplying the minimum yearly payroll by the rate of the governing classification of the policy. The board may adopt an amount that the minimum ~~yearly~~ loss based premium may not be below, and may adopt an amount that the minimum ~~yearly~~ loss based premium may not exceed.

(3) Minimum ~~yearly~~ loss based premium may be established as a flat dollar amount.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2311 and 39-71-2316, MCA.

2.55.402 MEDICAL DEDUCTIBLE (1) The state fund offers an annual (fiscal year July 1 through June 30) medical deductible

plan for policies with effective dates between each July 1 and June 30 inclusive, in increments of $500, $1,000, $1,500, $2,000 and $2,500 per claim. This plan allows qualified employers to reimburse the state fund for a selected deductible amount of the medical costs of each claim in exchange for a premium discount.

(2) To qualify for the plan for the next ~~fiscal~~ policy year, an employer must:

(a) file an endorsement form, provided by the state fund prior to the beginning of the next ~~fiscal~~ policy year;

(b) have estimated annual premium for the next policy year which equals or exceeds the chosen deductible amount; and

(c) demonstrate the ability to promptly pay the deductible amounts by not having a poor premium payment history with the state fund.

(3) Remains the same.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-434, 39-71-2311, and 39-71-2316, MCA.

2.55.403 VOLUME DISCOUNT (1) The state fund may establish each fiscal year for ~~provide to~~ insureds covered by the state fund a ~~fiscal year~~ percentage reduction of premium for policies with effective dates between each July 1 and June 30 inclusive, based on premium volume.

(2) The state fund may provide a group volume discount to a group ~~certified by the department of labor and industry~~ as provided by 39-71-433, MCA.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-433, 39-71-2311, 39-71-2316 and 39-71-2330, MCA.

2.55.407 OPTIONAL DEDUCTIBLE PLANS (1) through (3) remain the same.

(4) The employer may be disqualified or terminated at any time from participation in a plan because of a poor payment history with the state fund; as a result of a credit investigation, or review of relevant financial information which demonstrates the employer is not sufficiently financially stable to be responsible for the payment of the reasonably anticipated deductible amounts. As a condition of approval or continuation in a plan, the state fund may require security including, but not limited to, surety bond, cash deposit or guarantee sufficient to meet the reasonably anticipated obligations of the employer for the ~~fiscal~~ policy year.

(5) Remains the same.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2316, 39-71-435 and 39-71-2330, MCA.

2.55.408 RETROSPECTIVE RATING PLANS

(1) through (3) remain the same.

(4) The employer, group, or group member may be disqualified from participation in a plan because of a poor payment history

with the state fund, as a result of a credit investigation or review of relevant financial information which demonstrates the employer, group, or group member is not sufficiently financially stable to be responsible for the payment of any retrospective rating adjustment. As a condition of approval the state fund may require security including, but not limited to, surety bond, cash deposit or guarantee sufficient to meet the reasonably anticipated obligations of the employer for the ~~fiscal~~ policy year.

(5) Remains the same.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2316, 39-71-2330 and 39-71-2341, MCA.

2.55.409 POLICY CHARGE (1) The state fund may assess a policy charge on all policies in effect during a fiscal year. The amount of the charge shall be determined annually by the board for the future fiscal year, and may be in addition to any other charge, ~~or~~ premium or loss based premium.

(2) The policy charge is included in the total minimum premium charged if the policy charge plus premium is less than the total minimum premium established by the board for the fiscal year.

(3) The policy charge includes, but is not limited to, expense components for issuing, maintaining and servicing policies, which are common to all policies regardless of premium size.

(4) The state fund may cancel the employer's policy for failure to pay a policy charge.

AUTH: Sec. 39-71-2315 and 39-71-2316, MCA;
IMP: Sec. 39-71-2311 and 39-71-2316, MCA.

RATIONALE: The State Fund implemented a new computer system in June, 1999. The amendments to ARM 2.55.323, 2.55.324, 2.55.325, 2.55.326, 2.55.402, 2.55.403, 2.55.407 and 2.55.408 are needed to accommodate the State Fund's ability with its new computer system to begin offering staggered policy effective dates to its insured employers. The amendments are technical in nature. Presently, all State Fund policyholders have a policy year of July 1 to June 30, which matches the State Fund's fiscal year. With staggered policy effective dates, a policyholder's policy year may be different than the State Fund's fiscal year. The proposed amendment of ARM 2.55.324(5) also clarifies the ability of the State Fund to adopt interim rate changes and how these changes apply to all State Fund policies, regardless of policy effective dates when circumstances such as statutory or other legal changes or actuarial revisions occur.

The amendment of subsection (2) in ARM 2.55.403 is reasonably necessary to conform the rule to 39-71-433, MCA. Effective July 1, 1997, 39-71-433, MCA was amended to no longer require that a group be certified by the department of labor and industry.

The amendments of ARM 2.55.326 and 2.55.409, after providing for

staggered policy effective dates in 2.55.326, have language added to clarify that the minimum premium is loss based, and that total minimum premium includes a loss based portion and a policy charge. The State Fund recently conducted an internal review of its rules, and found that these technical changes will clarify the nature of minimum premium and total minimum premium.

2.55.502 INDIVIDUAL LOSS SENSITIVE DIVIDEND DISTRIBUTION PLAN (1) through (8) remain the same.

(9) The state fund has a security interest in all dividends to secure payment to the state fund of any and all amounts owed to the state fund by the policyholder, regardless of the policy years in relation to which the policyholder owes the state fund, or to which the state fund declares a dividend.

AUTH: Sec. 39-71-2315 and 29-71-2323, MCA;
IMP: Sec. 39-71-2323, MCA.

RATIONALE: The State Fund declared a dividend for the first time in December, 1998, which was paid to policyholders in January, 1999. Depending on its financial condition, the State Fund intends to pay dividends in the future. During the State Fund's recent internal review of its rules, and based on its experience with the declaration and payment of the dividend described above, the State Fund determined that it should clarify its position with respect to the payment of dividends to policyholders who owe a debt to the State Fund. The amendment of ARM 2.55.502 is reasonably necessary to assure that the state fund has a security interest in dividends to secure payment of debts owed the State Fund. Without this security interest, the State Fund may be in the position of paying a dividend to a person who owes the State Fund money.

4. The Montana state fund proposes to repeal ARM 2.55.404 (authority sections 39-71-2315 and 2316, MCA, implementing sections 39-71-2316 and 2341, MCA) and 2.55.405 (authority sections 39-71-2315 and 2316, MCA, implementing sections 39-71-2316, 2330 and 2341, MCA), located at pages 2-3754 to 2-3755, Administrative Rules of Montana. The reason for the proposed repeal is that the statute under which these rules were adopted was amended in Chapter 407, 1999 Montana Session Laws to eliminate an additional pricing level with a higher rate for employers who do not satisfactorily implement safety programs, and to eliminate the State Fund's authority to assess an additional 20% surcharge on high-loss employers. Therefore, the rules are obsolete and no longer needed.

5. The Montana state fund makes reasonable accommodations for persons with disabilities who wish to participate in this public hearing. Persons needing accommodations must contact the Montana State Fund, Attn: Wendi Waterman, PO Box 4759, Helena, MT 59604; telephone (406) 444-6480; TDD (406) 444-5971; fax (406) 444-6555, no later than 5:00 p.m., January 27, 2000, to advise as to the nature of the accommodation needed and to allow

adequate time to make arrangements.

6. 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 Montana State Fund attorney Nancy Butler, Legal Department, State Compensation Insurance Fund, 5 South Last Chance Gulch, P.O. Box 4759, Helena, Montana 59604-4759, or by electronic mail address nbutler@state.mt.us, and must be received no later than 5:00 p.m. February 11, 2000.

7. The Montana State Fund Legal Department has been designated to preside over and conduct the hearing.

8. The State Fund 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 State Fund administrative rules. Such written request may be mailed or delivered to Ms. Wendi Waterman, Montana State Fund, PO Box 4759, Helena, MT 59601, telephone (406) 444-6480, faxed to the office at (406) 444-6555, or may be made by completing a request form at any rules hearing held by the State Fund.

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

Nancy Butler, General Counsel
Rule Reviewer

Jim Brouelette
Chairman of the Board

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Certified to the Secretary of State January 3, 2000.

BEFORE THE MONTANA HERITAGE
PRESERVATION AND DEVELOPMENT COMMISSION

In the matter of the adoption of Rules I through VII, pertaining to the acquisition of real and personal property	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF RULES

TO: All Concerned Persons

1. On February 25, 2000 at 9:00 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 of the above stated rules.

The Montana Heritage Preservation and Development Commission will make reasonable accommodation 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 Commission no later than 5:00 p.m., February 18, 2000, to advise us of the nature of the accommodation. Please contact Karlee Smith, Montana Heritage and Preservation Development Commission, P.O. Box 201204, Helena, MT 59620-1204; telephone (406) 841-4014; Facsimile (406) 841-4004.

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

RULE I. DEFINITIONS The following definitions shall be used in these rules, unless context clearly indicates otherwise.

(1) "Acquisition" means the purchase by the commission, or any other conveyance, transfer, assignment, gift or devise to the commission of a fee title interest in property. The term acquisition does not include property that is on loan from a person or entity.

(2) "Commission" means the Montana heritage and preservation development commission as created by 22-3-1002, MCA.

(3) "Fee title interest" means a fee simple or lesser estate or interest.

(4) "Property" means real and personal property, unless otherwise specifically indicated.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE II. ACQUISITION PROCEDURE (1) With respect to each acquisition, the commission must consider:

(a) whether the property represents the state's culture and history;

(b) whether the property can become self-supporting;

(c) whether the property can contribute to the economic

and social enrichment of the state;

(d) whether the property lends itself to programs to interpret Montana history;

(e) whether the acquisition will create significant social and economic impacts to affected local governments and the state; and

(f) other matters that the commission considers necessary and appropriate.

(2) With respect to the proposed acquisition of real property, public notice and the opportunity for hearing will be given in the geographical area of the proposed acquisition. The notice will be published twice, with at least 6 days separating publication.

(a) Publication must be in a newspaper meeting the following qualifications, except if no newspaper meets these qualifications, publication must be made in a qualified newspaper in an adjacent county. If there is no qualified newspaper in an adjacent county, publication must be made by posting the notice in three public places in the county where the property to be considered for acquisition is located, as designated by resolution of the commission. The newspaper must be:

(i) of general paid circulation with a second-class mailing permit;

(ii) published at least once a week; and

(iii) published in the county where the property to be considered for acquisition is located.

(b) The first publication must be no more than 21 days prior to the hearing and the last no less than 3 days prior to the hearing. The published notice must contain:

(i) the date, time, and place of the hearing;

(ii) a brief statement and description of the property considered for acquisition; and

(iii) the address and telephone number of the person who may be contacted for further information on the hearing or the property.

(3) After notice has been given, the public hearing will be held in the general geographic area where the property considered for acquisition is located. At the hearing, the public and officials from affected local governments and the state shall be given the opportunity to make written and verbal comments on the proposed acquisition.

(4) The assessment of properties for acquisition will be based upon consideration of the criteria listed in these rules and, where applicable, consideration of comments from affected local government officials, recommendations from professional historians, and comments from the public at large.

(5) The commission shall make the final decision as to whether or not to acquire personal property. With respect to the acquisition of real property, the commission shall make the final decision of whether or not to recommend the acquisition to the board of land commissioners.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE III. UNCONDITIONAL CONVEYANCE (1) It is preferred that all acquisitions are conveyed, sold, granted or devised unconditionally to the commission. The commission may, nonetheless, in its discretion, decide to make an acquisition which has reasonable conditions.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE IV. HISTORIC AND CULTURAL CONSIDERATIONS (1) In assessing whether the property represents the state's culture and history, and whether the property lends itself to programs to interpret Montana history, the commission shall consider the quality of the significance of the property in Montana history including, but not limited to, the property's authenticity and integrity of location, design, setting, materials, and workmanship; its age; and its aesthetic or historic sense of place or period of time. The commission shall also consider whether the property:

(a) is associated with events that have made a significant contribution to Montana history and prehistory;

(b) is associated with the lives of a person or persons who were significant in Montana history;

(c) embodies distinctive characteristics of a type, period, or method of construction representing an event, way of life, groups of persons, or trends in Montana history; or

(d) has yielded or is likely to yield information important to Montana history or prehistory.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE V. THE PROPERTY AS SELF-SUPPORTING (1) In assessing whether the property is self-supporting, the commission shall consider:

(a) the location of the property and its proximity to population centers, to other areas of historical and popular interest, and to standard tourist routes;

(b) the difficulty or ease in access to the property;

(c) the likelihood of individual, corporate or other financial support;

(d) the estimated cost of restoration, rehabilitation or maintenance of the property;

(e) the degree of popular and educational interest in the property; and

(f) the current and projected revenues and expenses associated with the property.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE VI. EDUCATIONAL RESOURCE (1) The commission shall consider whether the property is an educational resource for the study and interpretation of Montana history.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

RULE VII. NON-HISTORIC PROPERTIES (1) These rules do not apply to non-historic properties or property interests sold, leased, granted or otherwise transferred or conveyed to the commission. Property excluded from the procedures in these rules includes real or personal property that is used in the administration and management of historic properties including, but not limited to, office space and equipment, recently constructed buildings for the housing and display of artifacts, and other property purchased or constructed by the commission which does not fall within the type of properties described in 22-3-1001, MCA.

AUTH: Sec. 22-3-1003, MCA
IMP: Sec. 22-3-1003, MCA

3. These new rules are being proposed in order to implement § 22-3-1003(5), MCA which requires the Commission to adopt rules establishing a policy for making acquisitions of property described in § 22-3-1001, MCA. Although the statutes allow the Commission to purchase both real and personal property, it is the Commission's belief that these rules apply for the most part to the purchase of real property and the personal property associated with or connected to real property. For this reason, the public notice and hearing procedure in proposed Rule II apply only to the purchases of real property. Discussions are currently being held with the Montana Historical Society concerning the care and maintenance of personal property and artifacts.

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 Karlee Smith, Montana Heritage and Preservation Development Commission, P.O.Box 201204, Helena, Montana, 59620-1204 and must be received by the Commission by 5:00 p.m. on March 3, 2000.

5. Elizabeth L. Griffing, attorney, Jamison Law Firm, Power Block Building, Level 4, Helena, MT 59601 has been designated to preside over and conduct the hearing.

6. The Montana Heritage and Preservation Development Commission maintains a list of interested persons who wish to receive notice of rulemaking actions. Persons who wish to have their names added to the list shall make a written request that includes the name and mailing address of the person to receive notices. This written request may be sent to the Montana Heritage and Preservation Development Commission, P.O. Box 201204, Helena, MT 59620-1204.

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

MONTANA HERITAGE PRESERVATION
AND DEVELOPMENT COMMISSION

By: Jeffrey Tiberi
Jeffrey Tiberi, Executive Director

By: Elizabeth L. Griffing
Elizabeth L. Griffing
Rules Reviewer

Certified to the Secretary of State on January 3, 2000.

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

In the matter of proposed adoption of new rules pertaining to the importation of bait leeches.	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On March 10, 2000, the Montana Fish, Wildlife and Parks Commission (commission) proposes to adopt the following new rules, regarding the importation of bait leeches into Montana.

2. The commission 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 department no later than 5:00 p.m. on February 10, 2000, to advise us of the nature of the accommodation that you need. Please contact Karen Zackheim, Department of Fish, Wildlife and Parks, PO Box 200701, Helena, MT 59620; (406) 444-3301; FAX (406)444-4952.

3. The proposed rules provide as follows:

"RULE I SOURCE PERMIT REQUIRED FOR IMPORTATION OF BAIT LEECHES (1) Bait leeches originating from sources outside the boundaries of the state of Montana may not be imported into the state unless the department approves the source of the bait leeches.

(2) Commercial bait dealers wanting to ship bait leeches into Montana for use as fish bait, including sales to commercial bait dealers in Montana, shall submit a completed application for approval to the department on forms provided for this purpose.

(a) The application must include information about the source of bait leeches, documentation that leeches are not collected from areas known to contain zebra mussels, and certification that the requirements in [Rule II] for importation of bait leeches into Montana will be met.

(b) The department may permit any source that is determined to be in compliance with the requirements of this rule. Additional information may be requested from the dealer to evaluate the application if necessary.

(3) The department shall keep a list of permitted bait leech sources. The list of approved bait leech sources shall be provided to persons wishing to import bait leeches.

(4) A bait dealer shall remain on the approved list and may sell leeches in Montana unless the dealer is removed from the approved list by the department, or unless the dealer

requests to have his or her name removed from the list.

(a) A dealer may be removed from the approved list at any time it is determined that the dealer has not complied with the requirements of [Rules I, II or III], zebra mussels are discovered in the watershed from which the leeches were collected, or it is determined that importation of leeches from this source poses a threat to existing fisheries, native wildlife and plants, or to agricultural production.

(5) The department may deny any request for a source permit to ship bait leeches into Montana if the department determines that the source applying for the permit may pose a threat of harm to existing fisheries, native wildlife and plants, or to agricultural production."

AUTH: 87-5-704, MCA
IMP: 87-5-711, MCA

"RULE II IMPORTATION OF BAIT LEECHES - REQUIREMENTS

(1) Bait leeches which have been obtained from a source approved by the department may be imported into Montana under the following conditions:

(a) leeches must be held in clean well water at the place of collection for a minimum of two days (48 hours) prior to being shipped into Montana;

(b) leeches must be shipped into the state in well water;

(c) authorized bait dealers must notify the department of each shipment of leeches sent to Montana. Notification will be made in writing prior to, or at the same time of shipment to Montana. The notification shall be sent to the following address: Montana Department of Fish, Wildlife and Parks, 4801 Giant Springs Road, Great Falls, Montana 59405.

(2) The party receiving the imported leeches in Montana must comply with the following conditions:

(a) leeches must be washed in clean water upon arrival in the state; and

(b) all water in which leeches are shipped must be disinfected with chlorine prior to disposal."

AUTH: 87-5-704, MCA
IMP: 87-5-713, MCA

"RULE III SHIPMENT INSPECTIONS (1) The department may inspect shipments of imported bait leeches at mutually convenient times and locations prior to removing leeches from shipping containers.

(2) The department may order the shipment of bait leeches removed from the state or destroyed in a manner that will not contaminate any state waters when:

(a) unwanted aquatic pests, including zebra mussels, fish pathogens, or parasites are found in the shipment;

(b) bait leeches in the shipment have visible symptoms of infectious disease or parasitic infection;

(c) the shipment is not from a source authorized by the department;

(d) zebra mussels have been found in drainages from which the bait leeches were taken; or

(e) false information was provided in the permit application."

AUTH: 87-5-704, MCA
IMP: 87-5-713, MCA

4. Rules I, II and III are reasonably necessary to protect the native wildlife, plant species, and agricultural production of Montana, while allowing for the importation of bait leeches. Section 87-5-711, MCA prohibits the importing of any wildlife into Montana for introduction or transplantation unless the commission determines, based upon scientific investigation and after public hearing, that the importation poses no threat of harm to native wildlife, plants, or agricultural production. This statute also authorizes the commission to assess whether the transplantation or introduction of a species has significant public benefits. Bait leeches are commonly being imported into Montana at the present time. The bait leeches being imported come from several sources in North Dakota, Minnesota, and Wisconsin. While the commission is not concerned about bait leeches themselves having a detrimental effect on native wildlife, plants, or agricultural production, there is a serious concern for what might be transported with them - zebra mussels and other pathogens or infectious diseases. Zebra mussels are small (less than 5 cm long at maturation) and can be difficult to detect. They may easily be spread with water used to transport other aquatic animals.

Zebra mussels can have serious impacts when introduced into new waters. This aquatic pest was first accidentally introduced into the Great Lakes in 1986 and soon became established in the upper Mississippi drainage. The zebra mussel quickly colonizes new areas and rapidly achieves high densities. Zebra mussels are now found in 21 states and two Canadian provinces. They readily attach themselves to any available surface including freshwater mussels, screens, pipes, chains, etc. Power plant intake lines have been clogged by zebra mussels, causing temporary suspension of operations. Infestations have caused temporary power outages and difficulty in obtaining water for power plant cooling and waste removal operations. When a thick layer of zebra mussels covers a metallic surface, it can cause anoxia, reduced pH, and accelerated corrosion rates. Zebra mussel infestations have been costly and are expected to reach $5 billion in the United States by the year 2000.

Importation of fish, leeches, or other aquatic animals from the upper Mississippi drainage states should only be allowed after a determination is made that zebra mussels are not present in the waters these animals originate from. Therefore, it is necessary to have a procedure in place requiring permitting and certification of sources free of undesirable aquatic pests, and possible inspection of shipments and shipment media. These

precautions are needed to insure that there will be no threat to Montana's native wildlife, plants, or agricultural production.

5. Concerned persons may submit their data, views or arguments, either orally or in writing, to Karen Zackheim, Department of Fish, Wildlife and Parks, P.O. Box 200701, Helena, Montana 59620-0701, no later than February 14, 2000.

6. If a person who is directly affected by the proposed adoption wishes to express his or her data, views and arguments orally or in writing at a public hearing, he or she must make written request for a hearing and submit this request along with any written comments to Karen Zackheim, Department of Fish, Wildlife and Parks, P.O. Box 200701, Helena, Montana 59620-0701, no later than February 14, 2000.

7. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the administrative rule review committee of the legislature; from a governmental agency or subdivision; or from any 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 and mailed to all interested persons. Ten percent of those persons most directly affected has been determined to be in excess of 25 persons based on the fact that while the exact number of bait dealers in the state of Montana is unknown, it is reasonable to assume that the number is greater than 250.

8. The Department of Fish, Wildlife and Parks maintains a list of persons interested in both department and commission rulemaking proceedings. Any person wishing to be on the list must make a written request to the department, providing name, address and description of the subject or subjects of interest. Direct the request to Montana Fish, Wildlife and Parks, Legal Unit, PO Box 200701, Helena, MT 59620-0701.

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

By:

S.F. Meyer
Commission Chairman

John F. Lynch
Rule Review

Certified to the Secretary of State on January 3, 2000.

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

In the matter of the proposed adoption of 9 new rules related to the workers' compensation administrative assessment	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF NINE NEW RULES

TO: All Concerned Persons

1. On February 3, 2000, at 10:30 a.m., a public hearing will be held in the first floor conference room, Room No. 104 of the Walt Sullivan Building (Dept. of Labor building), 1327 Lockey, Helena, Montana, to consider the adoption of rules related to the workers' compensation administrative assessment.

2. The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 4:00 p.m., January 26, 2000, to advise us of the nature of the accommodation that you need. Please contact the Employment Relations Division, Attn: Ms. Linda Wilson, P.O. Box 8011, Helena, MT 59604-8011; telephone (406) 444-6531; TTD (406) 444-5549; fax (406) 444-4140. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Ms. Wilson.

3. The Department of Labor and Industry proposes to adopt new rules as follows:

NEW RULE I DEFINITIONS Unless the context clearly otherwise indicates, the following definitions apply to [NEW RULES II through IX]:

(1) "Advisory organization" means the workers' compensation premium rate advisory organization designated pursuant to 33-16-1023, MCA.

(2) "Assessment" means the workers' compensation administrative assessment as provided for by 39-71-201, MCA. It does not include the assessment for the subsequent injury fund or the assessment for the industrial accident rehabilitation account.

(3) "Department" means the department of labor and industry.

(4) "IARA" means the industrial accident rehabilitation account provided for by 39-71-1104, MCA.

(5) "Insurance" and "self-insurance" mean the insurance coverage that is required to be carried by an employer pursuant to the Workers' Compensation and Occupational Disease Acts (Title 39, chapters 71 and 72, MCA).

(6) "Insured" means an employer that obtains insurance via:

(a) Plan No. 1 self-insurance;
(b) a Plan No. 1 self-insured group;
(c) a Plan No. 2 private insurance carrier; or
(d) the Plan No. 3 insurer, the state fund.

(7) "Insurer" means a Plan No. 1 self-insured employer, (including a Plan No. 1 self-insured group of employers), a Plan No. 2 private insurance carrier authorized to insure employers, or the Plan No. 3 insurer, the state fund, and has the same meaning as provided for by 39-71-116, MCA. The term does not include the uninsured employers' fund as provided for by 39-71-503, MCA, or the subsequent injury fund as provided for by 39-71-901, MCA.

(8) "New fund claim" means a claim covered under Plan No. 3, the state fund, where the claim arises from an injury or occupational disease that occurred on or after July 1, 1990.

(9) "Plan No. 1 employer" means any individual employer that is self-insured, and any group of individual employers that have joined together for self-insurance purposes.

(10) "Old fund claim" means a claim covered under Plan No. 3, the state fund, where the claim arose from an injury or occupational disease that occurred before July 1, 1990.

(11) "SIF" means the subsequent injury fund as provided for by 39-71-901, MCA.

(12) "Year" means a calendar year.

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-915, 39-71-1004, and 39-71-2352, MCA

NEW RULE II CALCULATION OF AMOUNT OF INSURER'S ASSESSMENT

(1) The assessment on each insurer is calculated on the total amount of compensation benefits paid each year by the insurer for Montana claims, as specified in (2) and, except as provided in (6), the total amount of medical benefits paid each year by the insurer for Montana claims, as specified in (3).

(2) Compensation benefits paid include (but are not necessarily limited to) payments for:

(a) permanent total disability;
(b) permanent partial disability;
(c) temporary total disability;
(d) temporary partial disability;
(e) lump sum or bi-weekly payments of settlements of future benefits;
(f) rehabilitation benefits (biweekly compensation paid to claimants);
(g) burial benefits;
(h) death benefits;
(i) disfigurement payments;
(j) compensation benefits in subsequent injury fund cases, to the extent paid by the insurer;
(k) disputed settlement amounts paid pursuant to 39-71-741, MCA;
(l) compensation benefits paid pursuant to 39-71-608, MCA; and
(m) disputed settlement amounts paid pursuant to 39-72-405, MCA.

(3) Medical benefits paid include (but are not necessarily limited to) payments for:

(a) medical expenses, including hospital, chiropractic, diagnostic expenses, and physical and occupational therapy;

(b) prescription drugs;

(c) prosthetics;

(d) other durable medical goods;

(e) dental care;

(f) domiciliary care;

(g) medical benefits paid pursuant to 39-71-610, MCA;

(h) medical benefits paid pursuant to 39-71-615, MCA; and

(i) hearing loss.

(4) With respect to medical expenses, the amount actually paid by the insurer, rather than the amount billed by the provider, is the basis for computation of benefits paid.

(5) Benefits paid include any amount paid by the insurer or the employer, irrespective of any deductible paid by the employer. Co-payments actually made by the claimant are not considered to be "benefits paid" for the purposes of this rule.

(6) Each insurer must report the compensation paid and the medical expenses paid in the preceding year by not later than March 1 of each year. The department will then multiply, by the statutory rate of 3%, the total compensation paid and total medical expenses paid, up to an aggregate total of $200,000 per claim, to calculate the amount of that insurer's assessment.

(a) The Plan No. 3 insurer, the state fund, must identify each claim as an old fund claim or a new fund claim. The department will separately calculate the amount of the assessment attributable to old fund claims and the assessment attributable to new fund claims.

(7) The minimum amount of assessment for an insurer is $500.00, regardless of the amount of benefits paid or length of time that the insurer has been authorized to act as an insurer in Montana.

(8) The following costs or expenses of administering a claim are not included in the calculation of the assessment:

(a) rehabilitation services provided by a licensed rehabilitation provider or the department of public health and human services;

(b) rehabilitation expenses, such as books and tuition, or auxiliary rehabilitation benefits, such as relocation expenses;

(c) administrative costs for the processing of claims, such as the costs of investigating or adjusting the claim;

(d) independent medical examinations requested by the insurer, where the purpose of the examination(s) is not for the diagnosis or treatment of the claimant's condition; and

(e) various other miscellaneous costs that do not constitute a compensation benefit or medical benefit provided to the claimant.

(9) In the event an insurer submits an amended report identifying compensation paid and medical expenses paid, following the timely filing of the report as required by (6), the department will compare the amended report with the initial report. The department reserves the right to recalculate the

amount of assessment owed by the insurer if the difference in the amount of the assessment owed appears to the department to be substantial. The department also reserves the right to disregard de minimus changes where the cost of recalculating and re-billing the insurer for the difference in the amount of the assessment outweighs the amount of the difference in the original amount and recalculated amount of the assessment.

(10) From time to time, the department may publish technical bulletins regarding what constitutes a reportable "compensation benefit or medical benefit provided to the claimant" as that phrase is used in this rule. Insurers that have questions regarding what is reportable under this rule are encouraged to contact the department's employment relations division, workers' compensation regulation bureau for clarification.

(11) Insurers shall keep adequate records of what benefit payments, if any, are not included in the amount of loss paid for each claim. The department may inspect those records from time to time as it deems appropriate.

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-203, and 39-71-209, MCA

NEW RULE III BILLING FOR AND PAYMENT OF THE ASSESSMENT

(1) Once the amount of the assessment for each insurer is calculated pursuant to [NEW RULE II], the department will deduct any outstanding credits the insurer may have to arrive at the final amount that the department will bill to that insurer.

(2) Each insurer must pay the department not less than half of the amount assessed and billed by the department by not later than July 1 of the current year, and pay the remaining balance by not later than December 31 of that year. Alternatively, the insurer may pay the entire amount of the assessment billing in a single payment by not later than July 1 of that year.

(3) The obligation to pay the assessment rests solely upon the insurer, despite the fact that an insurer may pass along the cost of the assessment to its insureds. The fact that the insurer might not timely collect from its insureds the full amount of the assessment does not excuse the insurer from paying the assessment.

(4) As provided by 39-71-201, MCA, an insurer that does not timely pay the assessment is subject to a fine of $100.00 plus 12% interest on the unpaid balance.

(5) Failure to timely pay the assessment may jeopardize an insurer's authority to continue to act as a workers' compensation insurer in Montana.

(a) Pursuant to 39-71-408, MCA, failure to timely pay the assessment results in the department obtaining statutory first lien rights in the property of the insurer.

(b) The department reserves the right to notify other appropriate regulatory agencies, insurance advisory organizations, guaranty funds and similar bodies, or the public that the insurer is delinquent in its payment of the assessment.

AUTH: 39-71-203, MCA

IMP: 39-71-201 and 39-71-408, MCA

NEW RULE IV COMPUTATION OF PREMIUM SURCHARGE RATE FOR PLAN NO. 2 AND NO. 3 (1) The department will compute the premium surcharge rate in the manner provided by statute for the Plan No. 2 insurers. In addition to consulting with the advisory organization, the department may, in its discretion, consult with insurers regarding any factors that may affect the computation of the insurer's premium surcharge rate. The premium surcharge rate will apply to all Plan No. 2 insurers.

(2) The department will compute the premium surcharge rate in the manner provided by statute for the Plan No. 3 state fund. Pursuant to 39-71-2352, MCA, old fund claims can not be paid using premiums collected on wages paid on or after July 1, 1990. Accordingly, the premium surcharge rate for Plan No. 3, the state fund, will be calculated only with regards to the portion of the assessment attributable to new fund claims. In addition to consulting with the advisory organization, the department may, in its discretion, consult with the insurer regarding any factors that may affect the computation of the insurer's premium surcharge rate.

(3) Each Plan No. 2 insurer and the Plan No. 3 state fund is responsible for correctly identifying the amount of the authorized premium surcharge that the insurer is to collect from each of its insured employers. Because the insurer, not the department, calculates the amount of premium due from the employer, disputes between the insurer and the insured regarding the amount of the premium surcharge are not disputes over which the department has jurisdiction.

(4) Each Plan No. 2 insurer and the Plan No. 3 state fund shall maintain reasonable records showing the total amount of premium surcharge billed to its insureds and the total amount of premium surcharge actually collected. The department may inspect those records from time to time as it deems appropriate.
AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-203, and 39-71-2352, MCA

NEW RULE V COLLECTION AND DISBURSEMENT OF PREMIUM SURCHARGE BY PLAN NO. 2 AND NO. 3 (1) The department finds that the intent of the legislature in amending the manner in which the assessment is funded was to increase fairness and equity in the way the regulatory and similar functions of the workers' compensation system were paid for by insurers and employers. The department further finds that the intent of the legislature in amending the manner for funding the assessment was not intended to create a windfall for some insurers at the expense of other insurers, or to inadvertently create competitive advantages for some insurers and disadvantages for other insurers, except by reason of sound and efficient business practices.

(2) The premium surcharge for the assessment which is collected by insurers is not considered to be an insurance premium paid to the insurer, and is not the property of the insurer which collects that surcharge. The department finds

that the legislature intended that the premium surcharge be a way of providing insurers with a means of paying for the assessment, without the insurers having to build the cost of the assessment into the insurance premium rates. Accordingly, the premium surcharge collected by an insurer must be segregated from premium or other income collected by the insurer. The amount, if any, of premium surcharge collected (and any interest thereon) which exceeds the amount of assessment owed by the insurer must be held by the insurer in trust on behalf of insured employers subject to the premium surcharges.

(3) The disposition of the premium surcharge held in trust by insurers is a matter that rests solely with the legislature. Until such time as the legislature provides for manner of disposition of those funds, neither the insurers or the department have the legal right to the beneficial use of those premium surcharge amounts held in trust.

AUTH: 39-71-203, MCA
IMP: 39-71-201 and 39-71-203, MCA

NEW RULE VI THE SUBSEQUENT INJURY FUND ASSESSMENTS FOR YEARS BEGINNING ON OR AFTER JULY 1, 2000 (1) Beginning on July 1, 2000, the SIF assessment is calculated based on the same compensation benefit and medical benefit amounts as are reported pursuant to [NEW RULE II]. The department will then assess each insurer in accordance with 39-71-915, MCA, and bill accordingly. For Plan No. 3, the state fund, the department will separately identify the SIF assessment that is attributable to old fund claims and the SIF assessment that is attributable to new fund claims.

(2) Pursuant to statute, payment of the SIF assessment billing must be made semiannually on June 30 and December 31 of each year. However, for the convenience of insurers, an insurer may tender to the department the full amount of the SIF assessment billing on June 30 of the year. In such a case, the department will hold the not-yet-due balance in trust and apply it to the amount that is due from the insurer on December 31. However, if an insurer chooses to tender the full amount of the SIF assessment on June 30, none of the interest or investment income that may accrue on the not-yet-due balance held by the department will inure to the benefit of the insurer.

(3) The obligation to pay the SIF assessment rests solely upon the insurer, despite the fact that an insurer may pass along the cost of the SIF assessment to its insureds. The fact that the insurer might not timely collect from its insureds the full amount of the SIF assessment does not excuse the insurer from paying the SIF assessment.

(4) Each Plan No. 2 insurer and the Plan No. 3 state fund must determine the amount of the SIF premium surcharge that each of its own insured employers must pay. The SIF premium surcharge must be computed in the manner required by statute. Pursuant to 39-71-2352, MCA, old fund claims can not be paid using premiums collected on wages paid on or after July 1, 1990. Accordingly, the SIF premium surcharge rate for Plan No. 3, the state fund, will be calculated only with regards to the portion

of the SIF assessment attributable to new fund claims.

(a) Because the department does not set the level of SIF premium surcharge billed to the insured, disputes between an insurer and its insured over the computation or amount of the SIF premium surcharge are not disputes over which the department has jurisdiction.

(b) If such a dispute arises, the insurer shall provide for an informal dispute resolution process between itself and the insured before canceling an insured's insurance, if the sole reason for the pending cancellation is the insured's failure to pay the SIF premium surcharge. The informal dispute resolution process is intended to provide a non-adversarial, pre-cancellation forum for the insured to question the basis for the calculation of the insured's SIF premium surcharge and for the insurer to correct any errors that may be discovered during the process. The insurer must provide specific notice to the insured and the department that:

(i) the insured employer has not paid the SIF premium surcharge;

(ii) the workers' compensation insurance covering the insured employer will be canceled unless surcharge is timely paid or the amount of the surcharge is reduced by the insurer following an informal dispute resolution process; and

(iii) what the insured employer must do to invoke the informal dispute resolution process.

(5) Each Plan No. 2 insurer and the Plan No. 3 state fund shall maintain reasonable records showing the total amount of SIF premium surcharge billed to each of its insureds and the total amount of SIF premium surcharge actually collected. The department may inspect those records from time to time as it deems appropriate.

AUTH: 39-71-203, MCA
IMP: 39-71-915, MCA

NEW RULE VII COLLECTION AND DISBURSEMENT OF SIF PREMIUM SURCHARGE BY PLAN NO. 2 AND NO. 3 (1) The department finds that the intent of the legislature in amending the manner in which the SIF assessment is funded was to increase fairness and equity in the way the regulatory and similar functions of the workers' compensation system were paid for by insurers and employers. The department further finds that the intent of the legislature in amending the manner for funding the SIF assessment was not intended to create a windfall for some insurers at the expense of other insurers, or to inadvertently create competitive advantages for some insurers and disadvantages for other insurers, except by reason of sound and efficient business practices.

(2) The premium surcharge for the SIF assessment which is collected by insurers is not considered to be insurance premium paid to the insurer, and is not the property of the insurer which collects that surcharge. The department finds that the legislature intended that the SIF premium surcharge be a way of providing insurers with a means of paying for the SIF assessment, without the insurers having to build the cost of the

SIF assessment into the insurance premium rates. Accordingly, the SIF premium surcharge collected by an insurer must be segregated from premium or other income collected by the insurer. The amount, if any, of SIF premium surcharge collected (and any interest thereon) which exceeds the amount of SIF assessment owed by the insurer must be held by the insurer in trust on behalf of insured employers subject to the premium surcharges.

(3) The disposition of the SIF premium surcharge held in trust by insurers is a matter that rests solely with the legislature. Until such time as the legislature provides for manner of disposition of those funds, neither the insurers or the department have the legal right to the beneficial use of those SIF premium surcharge amounts held in trust.

AUTH: 39-71-203, MCA
IMP: 39-71-203 and 39-71-915, MCA

NEW RULE VIII INDUSTRIAL ACCIDENT REHABILITATION ACCOUNT ASSESSMENT (1) The IARA assessment upon each insurer is calculated on the total amount of compensation paid each year by the insurer for Montana claims. For the purpose of this rule, the phrase "compensation paid" means the same as provided by [NEW RULE II (2)].

(2) The department will set the percentage rate of the IARA assessment at a level that is projected to produce adequate revenue to maintain each plan's account balance at approximately 105% of the prior year's expenditures or 1% of compensation paid, whichever is lower.

(3) All insurers operating in the same plan will be assessed the same percentage rate, regardless of whether or not that particular insurer requested funds pursuant to 39-71-1003, MCA. Because the IARA assessments paid by each of the three compensation plans are segregated by plan, the department may assess Plan No. 1 insurers at a different rate than Plan No. 2 insurers or Plan No. 3, the state fund.

(4) The IARA assessment may be billed at the same time as the administrative assessment, the SIF assessment, or separately. Payment of the IARA assessment is due within 30 days of the date of the IARA assessment billing.

AUTH: 39-71-203, MCA
IMP: 39-71-1004, MCA

NEW RULE IX FAILURE OF INSURER TO TIMELY REPORT PAID LOSSES--DEPARTMENT ESTIMATE OF PAID LOSSES--RECALCULATION OF ASSESSMENT AND PREMIUM SURCHARGE (1) In the event an insurer fails to timely report its paid losses for the previous year by the following March 1, the department will estimate the insurer's paid losses. The estimate will be 200% of the insurer's most recently reported annual paid losses, or at a rate that would result in the assessment being $1000.00, whichever is higher. The department may also use that estimate as the basis for the SIF and IARA assessment as well. The estimate is intentionally designed to produce a rate sufficiently high as to:

(a) provide an additional incentive for insurers to timely file their reports;

(b) help maintain fair competition among insurers and between plans so that any unfair competitive advantage that might be gained by an insurer's non-timely reporting is nullified; and

(c) ensure that the department's ability to carry out its statutory duties is not impaired due to delay in the receipt of adequate assessment payments due from the non-timely reporting insurer.

(2) The estimate will be used to bill the insurer for the assessments and may also be used to compute the percentage rate of premium surcharges for the insurer by March 31, as required by statute. The department may, in its sole discretion, consult with the advisory organization, in order to judge whether the estimated premium surcharge percentage rate will generate adequate revenue to cover the likely actual amounts the insurer will owe for the assessments. The insurer is responsible for making the July 1 payment for half of the total estimated assessment billing.

(3) The department will re-calculate the assessments after the insurer reports its paid losses. The department will then give the insurer whatever credit may be due if the July 1 payment of the estimated assessments exceeds the amount due following the re-calculation. Any interest or investment income actually earned on the amount overpaid will accrue to the insurer's credit as a prepayment of the next year's assessments. The department may also re-calculate the percentage rate of the premium surcharges in light of the actual amount of the assessments and the probable collection of the premium surcharges. In the event that the insurer over-collects premium surcharge, it must hold that excess in trust as provided by rule.

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-915, and 39-71-1004, MCA

REASON: There is reasonable necessity to adopt the proposed rules so as to implement the funding mechanisms for the various workers' compensation functions as provided by Chapter 377, Laws of 1999 (Senate Bill 117). There is reasonable necessity to adopt the rules so that insurers can be ready to timely report paid losses and the Department can timely make the various assessments according to the statutory time table. There is reasonable necessity to adopt NEW RULE V and VII in order that insurers which end up collecting premium surcharge from insured employers that exceeds the amount of that insurer's assessment do not reap windfall profits that were unintended by the Legislature. The Department recognizes that such over-collection would not be due to any unseemly business practices of an insurer, but would result from the mechanical application of the statutory methodology regarding how the surcharge is to be applied. In addition, there is reasonable necessity to adopt NEW RULE IX in order for the Department to have in place a way of estimating and collecting the amount of the various

assessments due from an insurer, in the event an insurer fails to timely and properly report paid losses.

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:

Keith Messmer, Bureau Chief
Workers' Compensation Regulations Bureau
Employment Relations Division
Department of Labor and Industry
P.O. Box 8011
Helena, Montana 59604-8011

and must be received by not later than 5:00 p.m., February 10, 2000.

5. An electronic copy of this Notice of Public Hearing is generally available through the Department's site on the World Wide Web at http://dli.state.mt.us/calendar.htm, under the Calendar of Events, Administrative Rule Hearings section. The Department strives to make the electronic copy of this Notice of Public Hearing conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. Because the Department is continually updating the design and features of its website, the Department reserves the right to change the location of the electronic copy of this Notice to elsewhere within the Department's website. In the event of such a change of location, the Department will endeavor to provide appropriate links from the Calendar of Events section of the website to the new location of this Notice of Public Hearing and other current rule-making documents. At the present time, the Department does not yet have the capability of accepting comments on the proposed rules via the Internet or e-mail.

6. The Hearings Bureau of the Centralized Services Division of the Department has been designated to preside over and conduct the hearing.

7. The Department 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 any subject matter over which the Department has rulemaking authority. Such written request may be mailed or delivered to Mark Cadwallader, Office of Legal Services, Department of Labor and Industry, P.O. Box 1728, Helena, MT 59624-1728; telephone (406) 444-4493; TTY (406) 444-0532; FAX (406) 444-1394, 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.

9. The Department proposes to make the new rules effective as soon as feasible. The Department reserves the right to adopt only portions of the rules, or to adopt some or all of the rules at a later date.

/s/ KEVIN BRAUN
Kevin Braun
Rule Reviewer

/s/ PATRICIA HAFFEY
Patricia Haffey, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: January 3, 2000.

BEFORE THE DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 36.12.102, 36.12.103, 36.12.202, 36.12.501, 36.12.502, 36.12.503, 36.12.1202, 36.12.1209, and 36.12.1210 pertaining to the water rights bureau	)	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On February 14, 2000, the Department of Natural Resources and Conservation proposes to amend ARM 36.12.102, 36.12.103, 36.12.202, 36.12.501, 36.12.502, 36.12.503, 36.12.1202, 36.12.1209 and 36.12.1210 pertaining to the Water Rights Bureau.

2. The agency 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 agency no later than 5:00 p.m. on January 27, 2000, to advise us of the nature of the accommodation that you need. 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.

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

36.12.102 FORMS (1) through (1)(p) remain the same.

(q) Form No. 608 "Water Right ~~Transfer Certificate~~ Ownership Update";

(r) Form No. 608A "Addendum to Water Right ~~Transfer Certificate~~ Ownership Update Form for Apportioned Water Right";

(s) through (v) remain the same.

(w) Form No. 615 "Water ~~Use Guidelines~~ Conversion Table";

(x) remains the same.

(y) Form No. 617 "~~Notice of~~ Project Completion ~~of~~ Notice for Permitted Water Development";

(z) Form No. 618 "~~Notice of~~ Project Completion ~~of~~ Notice for Change of a Water Right ~~Change~~;

(aa) through (ai) remain the same.

(aj) Form No. 630 "Petition ~~to the Department of Natural Resources and Conservation~~ for Controlled Groundwater Area to the Department of Natural Resources and Conservation";

(ak) Form No. 631 "Petition ~~to the Department of Natural Resources and Conservation to Adopt Rules to Reject Permit Applications, or Modify or Condition Permits Issued in~~ for

Closure of a Highly Appropriated ~~Water~~ Basin ~~or Subbasin~~";

(al) and (am) remain the same.

AUTH: 85-2-113, MCA
IMP: 85-2-113, MCA

36.12.103 APPLICATION AND SPECIAL FEES (1) A fee, if required, shall be paid at the time the permit, change, notice of completion, extension of time request, temporary change renewal, ~~transfer certificate~~ ownership update, exempt water right, or petition application (hereafter singularly or collectively referred to as application) is filed with the department. The department will not process any application without the proper filing fee. Failure to submit the proper permit or change application fee within 30 days after notice shall result in a determination that the application is not in good faith, ~~and~~ does not show a bona fide intent, and ~~the application~~ it shall be terminated. ~~A fee paid on a~~An application fee is a one-time filing and processing fee paid at the time of ~~making the~~ application, and the fee will not be ~~returned~~ refunded once the application has been filed with the department, except as noted below. If an applicant withdraws an application, he shall be entitled to a refund, or, if an applicant inadvertently files the wrong form, the applicant may apply the fee paid to the correct form for his purpose and pay the difference due or be entitled to a refund, if overpayment is made. However, no refund ~~upon withdrawal or no exchanges of fees from one form to another or a refund, if otherwise justified,~~ will be made in any case even if otherwise justified once the newspaper publication of the application has been initiated, or substantial direct processing costs have been accrued in making the application correct and complete prior to publication or department waiver of publication. When an application needs to be republished due to an applicant's error or request for republication, the applicant shall pay the direct cost of the new republication. The fees cover direct costs for newspaper publication, individual notices, issuance of certificates of water right on perfected permits, hearing costs, computer processing, and other miscellaneous direct costs connected with the permit process.

(a) through (f) remain the same.

(g) For a Water Right ~~Transfer Certificate~~ Ownership Update, Form No. 608, there shall be a fee of $25 plus~~,~~ $5 for each water right transferred after the first water right, not to exceed a maximum of $50.

(h) For each Addendum to Water Right ~~Transfer Certificate~~ Ownership Update Form for Apportioned Water Right, Form No. 608A, there shall be an additional fee of $50, up to a maximum of $200.

(i) through (k) remain the same.

(l) For a Petition ~~to the Department of Natural Resources and Conservation~~ for Controlled Groundwater Area to the Department of Natural Resources and Conservation, Form No. 630,

there shall be a fee of $200 for filing this petition form, plus the petitioner shall also pay reasonable costs of giving notice, holding the hearing, conducting investigations, and making records pursuant to 85-2-506 and 85-2-507, MCA, except the cost of salaries of the department personnel.

(m) For a Petition ~~to the Department of Natural Resources and Conservation to Adopt Rules to Reject Permit Applications, or Modify or Condition Permits Issued in~~ for Closure of a Highly Appropriated ~~Water~~ Basin ~~or Subbasin~~, Form No. 631, there shall be a fee of $200 for filing this petition form, plus the petitioners shall also pay reasonable costs of giving notice, holding the hearing, conducting investigations, and making records pursuant to 85-2-319, MCA, except the cost of salaries of the department personnel.

(n) through (2)(b) remain the same.

(2)(c) Form No. 617, ~~Notice of~~ Project Completion ~~of~~ Notice for Permitted Water Development.

(d) Form No. 618, ~~Notice of~~ Project Completion ~~of~~ Notice for Change of ~~Appropriation~~ a Water Right.

(3) remains the same.

AUTH: 85-2-113, MCA
IMP: 85-2-113, 85-2-312, MCA

36.12.202 DEFINITIONS As used in these rules, the following definitions apply:

(1) and (2) remain the same.

~~(3) "Board" means the board of natural resources and conservation.~~

(4) through (19) remain the same but will be renumbered (3) through (18).

AUTH: 2-4-201~~(2)~~ and 85-2-113~~(2)~~, MCA
IMP: 2-4-201~~(2)~~ and 85-2-113~~(2)~~, MCA

36.12.501 DEFINITIONS In addition to the definitions in 85-2-102, MCA the following definitions apply to these rules:

(1) through (3) remain the same.

(4) "~~Notice of~~ Project completion due date" means the date on the permit, change authorization or an authorized extension when the ~~notice of~~ project completion notice is to be received by the department. The postmark on the envelope, if the notice is mailed, must be on or before the ~~notice of~~ project completion due date.

AUTH: 85-2-312~~(3)~~, MCA
IMP: 85-2-312~~(3)~~, 85-2-312, MCA

36.12.502 FILING AN APPLICATION FOR EXTENSION OF TIME

(1) When an appropriator cannot complete the project under a permit or change authorization by the ~~notice of~~ project completion due date specified, an application for extension of time may be filed. The application must be postmarked ~~at least 30 days or more prior to the~~ by the project completion due date.

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

(c) ~~notice of~~ project completion due date;

(d) and (e) remain the same.

(3) An application postmarked ~~less than 30 days prior to the notice of~~ after the project completion due date is void.

AUTH: 85-2-312~~(3)~~, MCA
IMP: 85-2-312~~(3)~~, MCA

36.12.503 ACTION ON THE APPLICATION (1) remains the same.

(2) When the department determines the applicant has proceeded with diligence and has established that the reasons stated in the application justify an extension based on a consideration of the cost and magnitude of the project, the engineering and physical features encountered during development of the project, and the time reasonably necessary for the project, an extension shall be granted. The extension of time must state the new ~~notice of~~ project completion due date and any conditions to ensure completion.

(3) remains the same.

AUTH: 85-2-312~~(3)~~, MCA
IMP: 85-2-312~~(3)~~ and 85-2-314, MCA

36.12.1202 DEFINITIONS As used in these rules, the following definitions apply:

(1) through (20) remain the same.

(21) "~~Notice of~~ Project completion" means Form No. 617, ~~Notice of~~ Project Completion ~~of~~ Notice for Permitted Water Development or Form No. 618, Project Completion Notice for Change of a Water Right, filed by permittee after completion of the groundwater well or spring and beneficial use of the water granted under a provisional permit or changes granted under an authorization to change.

(22) through (31) remain the same.

AUTH: 85-20-401, MCA
IMP: 85-20-401, MCA

36.12.1209 PERMIT CONDITIONS (1) and (1)(a) remain the same.

(b) The deadline to complete this permit and file a ~~Notice of~~ Project Completion ~~of~~ Notice for Permitted Water Development (Form No. 617) is December 31, (specify year).

(i) For type "A" permit applications, the ~~notice of~~ project completion notice must be filed 60 days after completion of the appropriation. If you cannot meet the deadline above, the permittee shall contact the Bozeman water resources regional office for a new deadline.

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

(g) Upon a change in ownership of all or any portion of this permit, the parties to the transfer shall file with the department a Water Right ~~Transfer Certificate~~ Ownership Update, Form No.608, pursuant to 85-2-424, MCA.

(2) remains the same.

AUTH: 85-20-401, MCA
IMP: 85-20-401, MCA

36.12.1210 FILING OF ~~NOTICE OF~~ PROJECT COMPLETION NOTICE

(1) Permittee shall file a ~~notice of~~ project completion notice on Form No. 617 with the department pursuant to state law and Article IV of the Compact.

(2) remains the same.

AUTH: 85-20-401, MCA
IMP: 85-20-401, MCA

4. These rule amendments are being proposed to make the department's rules consistent with statutory changes, changes in water right forms and because the board of natural resources and conservation no longer exists.

5. Concerned persons may submit their data, views or arguments concerning the proposed amendments in writing to Nancy Andersen, Department of Natural Resources and Conservation, P.O. Box 201601, Helena, MT 59620-1601. Any comments must be received no later than February 10, 2000.

6. If persons who are directly affected by the proposed amendments wish to express their data, views and arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments they have to Nancy Andersen, Department of Natural Resources and Conservation, P.O. Box 201601, Helena, MT 59620-1601. A written request for hearing must be received no later than February 10, 2000.

7. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendments; from the appropriate administrative rule review committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 20,000 persons based on the number of water claims filed in Montana.

8. The department 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 conservation districts and resource development, forestry, oil and gas conservation, trust land management, water resources or combination thereof. Such written request may be mailed or delivered to the Department of Natural Resources and Conservation, 1625 11th Avenue, P.O. Box 201601, Helena, MT 59620-1601, faxed to the office at (406) 444-2684, or may be made by completing a request form at any rules hearing held by

the agency.

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

DEPARTMENT OF NATURAL
RESOURCES AND CONSERVATION

By: ARTHUR R. CLINCH
Director

DONALD D. MACINTYRE
Rule Reviewer

Certified to the Secretary of State January 3, 2000.

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

In the matter of the repeal of ARM 46.9.301, 46.9.302, 46.9.303, 46.9.304, 46.9.305 and 46.9.310 pertaining to grants-in-aid to counties and the transfer of rules 46.9.601, 46.9.602, 46.9.603, 46.9.604, 46.9.605, 46.9.606, 46.9.607, 46.9.608 and 46.9.611 pertaining to community services block grants	)	NOTICE OF PROPOSED REPEAL AND TRANSFER NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On February 12, 2000, the Department of Public Health and Human Services proposes to repeal and transfer 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 February 3, 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 46.9.301, 46.9.303, 46.9.304, 46.9.305 and 46.9.310 as proposed to be repealed are on pages 46-717 through 46-724 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-207, 53-2-321 and 53-2-323, MCA

3. The rule 46.9.302 as proposed to be repealed is on page 46-717 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-207, 53-2-321, 53-2-323 and 53-2-803, MCA

4. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, the economic assistance organization and auxiliary programs are transferred from the Department of Social and Rehabilitation Services to the Department of Public Health and Human Services. In order to implement that legislation, rules 46.9.601 through 46.9.608 and 46.9.611 are transferred to the Department of Public Health and Human Services ARM Title 37, Chapter 2.

5. The Department of Public Health and Human Services has determined that the transferred rules will be numbered as follows:

OLD	NEW	
46.9.601	37.2.901	Purpose
46.9.602	37.2.902	Definitions
46.9.603	37.2.906	Contractor Plan
46.9.604	37.2.907	Contractor Plan Assurances and Content
46.9.605	37.2.908	Contractor Plan Approval, Disapproval, Amendments
46.9.606	37.2.915	Contractor Allotments
46.9.607	37.2.916	Release of Allotments
46.9.608	37.2.920	Reports
46.9.611	37.2.925	Termination or Reduction of Allotment

6. The Department is repealing rules 46.9.301, 46.9.302, 46.9.303, 46.9.304, 46.9.305 and 46.9.310 because the grant-in-aid to counties program no longer exists and the rules are no longer necessary.

The transfer of rules pertaining to community services block grants 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.

7. 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 January 10, 2000.

8. 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 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 directly affected has been determined to be 1 based on the 10 Human Resource Development Councils affected by rules covering grants-in-aid to counties and community services block grants.

Dawn Sliva
Rule Reviewer

Laurie Ekanger
Director, Public Health and Human Services

Certified to the Secretary of State January 3, 2000.

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

In the matter of the amendment of ARM 46.12.521, 46.12.4801, 46.12.4804, 46.12.4805, 46.12.4806, 46.12.4810, 46.12.4813, 46.12.4814, 46.12.4817, 46.12.4821, 46.12.4825, 46.12.4827, 46.12.5002, 46.12.5003, 46.12.5004, 46.12.5007, and 46.12.5010 pertaining to the Montana medicaid passport to health program	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On February 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 amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on January 26, 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 amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

46.12.521 PODIATRY SERVICES, REQUIREMENTS (1) and (2) remain the same.

~~(3) Coverage for routine podiatric care, other than debridement of nails, is limited to one visit every 60 days.~~

~~(4) Coverage for orthotic services is limited to one visit every 24 months.~~

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

46.12.4801 HEALTH MAINTENANCE ORGANIZATIONS: DEFINITIONS (1) remains the same.

(2) "Basic medicaid" means the program of medicaid services for adults receiving medical assistance through the FAIM program who are 21 years and older and not pregnant. Basic medicaid excludes coverage for dental services, most durable

medical equipment and supplies, eye examinations, eyeglasses, hearing aids, audiology services, and personal care services.

(2) and (3) remain the same but are renumbered (3) and (4).

(5) "Complaint" means an informal, verbal communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate or lack of appropriate action by the HMO or any of its providers.

(4) through (8) remain the same but are renumbered (6) through (10).

~~(9)~~ (11) "Emergency ~~care~~ service" means, as defined at ARM 46.12.102, inpatient and outpatient hospital services that are necessary ~~to prevent the death or serious impairment of the health of a recipient~~ to treat an emergency medical condition.

~~(10) "Emergency room screens" means a medical screening examination within the capability of the emergency facility to determine whether an emergency medical condition exists or active labor is occurring.~~

(12) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(11) and (12) remain the same but are renumbered (13) and (14).

(15) "Exempt" means medicaid recipients who are not ineligible for managed care and who can prove it would be a hardship to participate in a managed care program. The department has the discretion to determine hardship and to place time limits on all exemptions on a case by case basis.

(16) "Families achieving independence in Montana (FAIM)" is a comprehensive welfare reform package. Participation in FAIM affects medicaid coverage for able-bodied adults 21 years and older. FAIM participants who are 21 years and older and not pregnant:

(a) are only eligible for basic medicaid;

(b) are required to enroll in an HMO if one is available in their area. If there is no HMO available, they must enroll in the passport to health program. If there is neither a passport to health program nor an HMO available, recipients stay on regular fee-for-service medicaid.

(13) remains the same but is renumbered (17).

(18) "Full medicaid" means the full scope of medicaid benefits as defined in ARM 46.12.501.

~~(14)~~ (19) "Grievance" ~~means an incident, complaint or concern of an enrolled recipient~~ means a formal, written communication which an enrollee or their authorized representative presents regarding what the enrollee or their authorized representative perceives to be an inappropriate

action or lack of appropriate action by the HMO or its providers.

(15) remains the same but is renumbered (20).

(21) "Ineligible" means medicaid recipients who are not allowed by the department to be under managed care and who must stay on regular medicaid. The following categories of recipients are ineligible:

(a) recipients with a spend down (medically needy);

(b) recipients living in a nursing home or institutional setting;

(c) recipients receiving medicaid for less than 3 months;

(d) recipients on the medicaid restricted card program;

(e) recipients who have medicare;

(f) recipients who live in an area without medicaid managed care;

(g) recipients in the medicaid eligibility subgroup of subsidized adoption;

(h) recipients whose eligibility period is only retroactive;

(i) recipients who cannot find a primary care provider who is willing to provide case management;

(j) recipients who are receiving medicaid home and community services for persons who are aged or disabled; and

(k) recipients who reside in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program.

(16) and (17) remain the same but are renumbered (22) and (23).

~~(18)~~ (24) "Primary care provider" means a physician including ~~obstetricians and gynecologists~~ an obstetrician and/or gynecologist, ~~a certified nurse practitioner, a certified nurse midwife,~~ advanced practice registered nurse, a physician's assistant, a federally qualified health center or rural health clinic with a contract to serve an HMO's enrollees that has been designated by an enrollee as the provider through whom the enrollee obtains health care benefits provided by the HMO. A primary care provider attends to an enrollee's routine medical care, supervises and coordinates all of the enrollee's health care, determines the need for and initiates all referrals, determines the provider of medical services and determines the medical necessity of the medical services to be performed. Obstetrician or gynecologist means a physician who is board eligible or board certified by the American board of obstetrics and gynecology.

(19) through (25) remain the same but are renumbered (25) through (31).

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

46.12.4804 HEALTH MAINTENANCE ORGANIZATIONS: RECIPIENT ELIGIBILITY (1) A recipient in any one of the following categories is eligible to enroll with an HMO contracting with the department:

(a) ~~an AFDC or AFDC related~~ a FAIM or family-related

recipient required by ARM 46.12.5003 to participate in a primary care case management program; or

(b) ~~beginning October 1, 1997,~~ an SSI recipient or SSI-related recipient required by ARM 46.12.5003 to participate in a primary care case management program.

(2) A recipient~~, exempt from required participation~~ who is ineligible to participate in a primary care case management program ~~as provided in ARM 46.12.5003(2)(a) through (m),~~ is not eligible to enroll with an HMO contracting with the department.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

46.12.4805 HEALTH MAINTENANCE ORGANIZATIONS: ENROLLMENT (1) through (11) remain the same.

~~(12) The total number of enrollees and Part A and Part B medicare beneficiaries with a non federally qualified HMO may not exceed 75% of the HMO's total enrollment, as provided in 42 CFR 434.26(a), unless the HMO is the subject of one of the exceptions provided at 42 CFR 434.26(b). The department hereby adopts and incorporates by reference 42 CFR 434.26, dated October 1996. A copy of the incorporated provision may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

46.12.4806 HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT (1) through (3)(b) remain the same.

(4) An HMO, based on good cause, may request that the department disenroll a recipient. The request with the basis for the request must be in writing.

(a) remains the same.

(b) An enrollee may be terminated from medical assistance for good cause if the enrollee:

(i) and (ii) remain the same.

~~(iii) has moved outside of the enrollment area of the HMO;~~

(iv) through (vi) remain the same but are renumbered (iii) through (v).

(5) and (6) remain the same.

(7) The department will disenroll an enrollee from an HMO if:

(a) remains the same.

(b) the enrollee becomes ineligible for medicaid~~.~~ ; or

(c) the enrollee moves outside the HMO's enrollment area.

(8) and (9) remain the same.

~~(10) Prior to October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the department will retroactively disenroll a newborn enrollee if the newborn enrollee is determined retroactively SSI eligible within 4 months of birth.~~

~~(11)~~ (10) A person participating in the FAIM project who is required to enroll in an HMO under ARM 46.12.4605 is considered to have good cause to disenroll if the person:

(a) remains the same.

(b) meets one of the conditions for exemption from or is ineligible for the passport to health program as defined in ARM 46.12.5003; or

(c) is under treatment by a physician or mid-level practitioner who is not affiliated with a medicaid HMO and ~~both~~ the patient, ~~and~~ provider, and department believe that a disruption of the patient/provider relationship may adversely affect treatment or cause unnecessary hardship to the patient~~; provided that good cause to disenroll for this reason shall exist only until the end of treatment or until the provider contracts with an HMO, whichever first occurs, and in no event for more than 4 months~~.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

46.12.4810 HEALTH MAINTENANCE ORGANIZATIONS: COVERED SERVICES (1) An HMO must provide the following services ~~except that the HMO is not required to provide any of the service components specified in (2)~~:

(a) through (e) remain the same.

(f) early periodic screening, diagnosis and treatment services for individuals under the age of 21 (EPSDT) as defined at ARM 46.12.514, ~~and~~ 46.12.515, 46.12.516, 46.12.570 and 46.12.571;

(g) through (j) remain the same.

(k) chiropractor services as defined at ARM ~~46.12.516(1)(b)~~ 46.12.516(2)(b);

(l) remains the same.

(m) nutrition services as defined at ARM ~~46.12.516(1)(a)~~ 46.12.516(2)(a);

(n) through (t) remain the same.

(u) private duty nursing services as defined at ARM ~~46.12.565 and 46.12.566~~ 46.12.516(2)(f);

(v) remains the same.

(w) respiratory therapy services as defined at ARM ~~46.12.516(1)(d)~~ 46.12.516(2)(d);

(x) through (z) remain the same.

(aa) remains the same.

(ab) prescription drugs supplied by a participating provider or a provider with a family planning and/or public health clinic;

(ac) durable medical equipment limited to diabetic supplies, oxygen, prosthetics, ostomy or incontinence supplies and only if supplied by a participating provider or a provider with a family planning and/or public health clinic;

(ad) optometric/ophthalmic services for medical conditions of the eye.

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

~~otherwise:~~

~~(a) nursing facility services as defined at ARM 46.12.1201 et seq.;~~

~~(b) institutions for mental disease services;~~

~~(c) audiology services as defined at ARM 46.12.535 et seq.;~~

~~(3)~~ (2) An enrolled recipient may obtain the following covered services through self-referral to a participating or nonparticipating provider and the HMO must reimburse the provider of a service to which the enrollee may self-refer:

(a) through (c) remain the same.

(d) ~~services for an urgent condition or~~ emergency service.

(4) and (5) remain the same but are renumbered (3) and (4).

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-111, 53-6-113 and 53-6-116, MCA

46.12.4813 HEALTH MAINTENANCE ORGANIZATIONS: CONTRACTS FOR SERVICES (1) and (2) remain the same.

(3) A contract for the provision of services through an HMO must meet the requirements of 42 CFR part 434. The department hereby adopts and incorporates by reference 42 CFR part 434, dated October ~~1996~~ 1998. A copy of the incorporated provisions may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

(c) provide for disclosure of ownership and subcontractor relationship~~.~~; and

(d) owners, directors, officers, or partners of the HMO must certify that they meet federal nondebarment requirements.

(8) through (12) remain the same.

(13) The department or an HMO may terminate the contract without cause ~~by giving 120 days written notice to the other party.~~ after giving written notice at least 120 days prior to the effective date of termination, except if the termination is a result of a change in funding, in which case the HMO may terminate the contract upon 60 days written notice.

(14) remains the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-115 and 53-6-116, MCA

46.12.4814 HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES (1) An HMO may impose the following requirements in the provision of services:

(a) remains the same.

(b) the preauthorization for services and use of network providers other than emergency services, family planning, immunizations and blood lead testing at a public health clinic, obstetrical, gynecological, and maternity services;

(c) remains the same.

(d) denial of payment to a provider for services provided to an enrollee if the participation requirements in this ~~section~~

rule are not met by the enrollee~~.~~ ; or

(e) if a recipient is mandated into an HMO and chooses to go to an FQHC that is not on the provider panel, approval for services is not required, but the recipient must inform the HMO before receiving services.

(2) through (4) remain the same.

(5) An HMO must make a reasonable effort to inform enrollees of alternate providers for ~~the~~ noncovered services ~~listed in ARM 46.12.4810(2)~~.

(6) through (8)(a) 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

46.12.4817 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS (1) through (4) remain the same.

~~(5) Prior to October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the department will recoup any capitation payments made to an HMO for a newborn enrollee retroactively disenrolled per ARM 46.12.4806(10).~~

~~(6) Starting October 1, 1997, the date SSI recipients are eligible to enroll with an HMO, the~~

(5) The department will recoup the ~~AFDC based~~ TANF-based capitation payments made for a newborn enrollee retroactively determined SSI eligible within 4 months of life and instead pay the SSI-based capitation rate for each month of enrollment.

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

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

46.12.4821 HEALTH MAINTENANCE ORGANIZATIONS: ACCESS TO SERVICES (1) remains the same.

~~(2) An HMO's medical service delivery sites must:~~

~~(a) be located within the normal service delivery area of the personal residences of enrollees;~~

~~(b) have a sufficient number of participating providers available to adequately provide the medical services contracted for by the site including physicians or providers with relationships with physicians with admitting privileges at one or more participating hospitals;~~

~~(c) meet the applicable standards for participating in the medicaid program; and~~

~~(d) be in compliance with all applicable local, state and federal standards related to the service provided as well as those for fire and safety.~~

~~(3) An HMO must have procedures for the scheduling of appointments for enrollees that are appropriate in relation to the reason for the visit. At a minimum, the time limit on appointments must be those specified below.~~

~~(a) An enrollee with urgent symptoms must be seen within one day of contacting the participating provider.~~

~~(b) Routine visits must be scheduled within 2 to 4 weeks of the date an enrollee requests an appointment with the participating provider.~~

~~(c) Appointments must be scheduled by specific time intervals.~~

(4) remains the same but is renumbered (2).

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

46.12.4825 HEALTH MAINTENANCE ORGANIZATIONS: RECORDS AND CONFIDENTIALITY (1) through (3) remain the same.

~~(4) An HMO and participating providers must maintain the confidentiality of medical record and other confidential information.~~

~~(a) Consent for release must be obtained from an enrolled recipient for release or use of confidential information unless the release or use is authorized by this rule or the provisions of the department of social and rehabilitation services' confidentiality policy.~~

~~(i) The department of social and rehabilitation services' confidentiality policy, adopted October 1, 1988, and published in the Department of Public Health and Human Services Policy Manual ADM 102 is hereby adopted and incorporated by reference. Copies of the policy may be obtained from the Department of Public Health and Human Services, Office of Legal Affairs, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604 4210.~~

~~(b) Confidential information may be used as necessary for administrative purposes or for delivery of medical services.~~

~~(i) Consent for release is not required for the transmission of medical record information to participating providers providing services to the enrollee or to specialty providers who are retained by an HMO to provide services.~~

~~(ii) Consent for release is not required for department staff assisting in the administration of the program, reviewers from the external quality review organization, monitoring authorities from the health care financing administration (HCFA), an HMO itself or other participating providers that require information.~~

~~(iii) Consent for release is not required for the transmission of medical record information to physicians or facilities providing care for an urgent condition or emergency.~~

~~(c) The extent of medical record information to be released in each instance must be determined in accordance with the circumstances of medical necessity and the need for the practitioner or facility to use the information.~~

(4) HMOS, participating providers, and the department are subject to the disclosure requirements of Title 50, chapter 16, MCA, and 33-19-306, MCA.

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

46.12.4827 HEALTH MAINTENANCE ORGANIZATIONS: QUALITY ASSURANCE (1) remains the same.

(2) An internal quality assurance system must meet the requirements of 42 CFR 434.34. The department hereby adopts and incorporates by reference 42 CFR 434.34, dated October ~~1996~~

1998.

(2)(a) 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

46.12.5002 PASSPORT TO HEALTH PROGRAM: DEFINITIONS

(1) through (3) remain the same.

(4) "Emergency service" means, as defined at ARM 46.12.102(5), inpatient and outpatient services that are necessary to treat an emergency medical condition.

(5) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(4) and (5) remain the same but are renumbered (6) and (7).

(8) "Exempt" means medicaid recipients who are not ineligible for managed care who can prove it would be a hardship to participate in a managed care program. The department has the discretion to determine hardship and to place time limits on all exemptions on a case by case basis.

(9) "Ineligible" means medicaid recipients who are not allowed by the department to be under managed care and may stay on regular medicaid. The following categories of recipients are ineligible:

(a) recipients with a spend down (medically needy);

(b) recipients living in a nursing home or institutional setting;

(c) recipients receiving medicaid for less than 3 months;

(d) recipients on the medicaid restricted card program;

(e) recipients who have medicare;

(f) recipients who live in an area without medicaid managed care;

(g) recipients in the medicaid eligibility subgroup of subsidized adoption;

(h) recipients whose eligibility period is only retroactive;

(i) recipients who cannot find a primary care provider who is willing to provide case management;

(j) recipients who are receiving medicaid home and community services for persons who are aged or disabled; and

(k) recipients who reside in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program.

(6) through (11) remain the same but are renumbered (10) through (15).

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

IMP: Sec. 53-6-116, MCA

46.12.5003 PASSPORT TO HEALTH PROGRAM: ELIGIBILITY

(1) The department may require a medicaid recipient in any of the following medicaid eligibility groups to enroll and participate in the passport to health program, unless exempted from or ineligible for participation ~~as provided in (2)~~ as defined by ARM 46.12.5002(8) or (9):

(a) through (c) remain the same.

~~(2) A medicaid recipient is exempt from the program if the recipient:~~

~~(a) is medically needy;~~

~~(b) is in the medicaid eligibility subgroup of subsidized adoption;~~

~~(c) has medicare in addition to medicaid;~~

~~(d) is residing in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR);~~

~~(e) has an eligibility period that is less than 3 months;~~

~~(f) lives in an area that is not covered by the program;~~

~~(g) has an eligibility period that is only retroactive;~~

~~(h) cannot find a primary care provider who is willing to provide case management to the recipient;~~

~~(i) has a private insurance program;~~

~~(j) is in a county in which there are not enough primary care providers to serve the medicaid population required to participate in the program;~~

~~(k) is exempted by the department from participation because of hardship;~~

~~(l) is receiving medicaid home and community services for persons who are aged or disabled;~~

~~(m) is in the medicaid restricted card program; or~~

~~(n) is enrolled in a health maintenance organization (HMO).~~

(2) A medicaid recipient is exempt from or is not allowed to participate in passport to health if the recipient:

(a) is exempted by the department from participation because of hardship; or

(b) is enrolled in a health maintenance organization (HMO).

(3) remains the same.

(4) At the department's discretion, medicaid recipients who are exempted from participation, ~~as provided in (2)(j)~~ as defined in ARM 46.12.5002(9), may elect to enroll in a passport to health program by choosing a primary care provider from a county that the program serves, unless the recipient is ineligible.

(5) and (6) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-6-116 and 53-6-117, MCA

46.12.5004 PASSPORT TO HEALTH PROGRAM: ENROLLMENT IN THE PROGRAM (1) remains the same.

(2) The recipient required to enroll in the program must select a primary care provider within ~~30~~ 45 days of being

notified of the enrollment requirement.

(3) If the recipient does not choose a provider within ~~30~~ 45 days of the notification, the department may designate a primary care provider for the recipient.

(4) remains the same.

(5) An enrollee may once a ~~month~~ quarter choose a new primary care provider.

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

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

46.12.5007 PASSPORT TO HEALTH PROGRAM: SERVICES (1) through (1)(a)(vii) remain the same.

(A) screening services for children as defined in ARM 46.12.515; ~~and~~

(B) remains the same.

(C) respiratory therapy as defined in ARM 46.12.516;

(D) private duty nursing as defined in ARM 46.12.516; and

(E) nutrition services as defined in ARM 46.12.516.

(1)(a)(viii) through (1)(a)(xi) remain the same.

(xii) ~~outpatient~~ physical therapy services as defined in ARM 46.12.525A;

(xiii) occupational therapy services as defined in ARM ~~46.12.545~~ 46.12.525A;

(xiv) speech therapy services as defined in ARM ~~46.12.530~~ 46.12.525A; ~~and~~

(xv) home health services as defined in ARM 46.12.550~~.~~;

(xvi) podiatry services as defined in ARM 46.12.520; and

(xvii) emergency room services for emergent conditions as defined in ARM 46.12.102(5).

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

(iii) family planning services as defined in Social Security Act 1905(a)(4)(c);

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

(vii) ophthalmology services for medical conditions of the eye;

(1)(b)(viii) remains the same.

(ix) testing and treatment for sexually transmitted diseases;

(1)(b)(x) and (1)(b)(xi) remain the same.

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

(2)(a) remains the same.

~~(b) podiatry services as defined in ARM 46.12.520;~~

(2)(c) through (2)(f) remain the same but are renumbered (2)(b) through (2)(e).

~~(g) private duty nursing services as defined in ARM 46.12.565;~~

(2)(h) through (2)(ab) remain the same but are renumbered (2)(f) through (2)(aa).

(ab) hospice as defined in ARM 46.12.1819 and 46.12.1823(g).

(3) and (4) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113, MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-116, MCA

46.12.5010 PASSPORT TO HEALTH PROGRAM: PRIMARY CARE PROVIDERS REQUIREMENTS (1) A primary care provider~~, except for an Indian health clinic,~~ must meet the following requirements:

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

~~(c) be a physician, nurse specialist, physician assistant or clinic; and~~

~~(d)~~ (c) sign ~~an addendum~~ a passport contract for primary care case management ~~to the medicaid enrollment agreement~~.

~~(2) An Indian health clinic, as a primary care provider, must meet the following requirements:~~

~~(a) provide primary care; and~~

~~(b) sign a contract with the program to provide primary care case management.~~

(3) remains the same but is renumbered (2).

~~(4) A physician assistant must have a utilization plan with a physician as required in ARM 8.28.1501, et seq.~~

~~(5) A provider sanctioned under ARM 46.12.402 may be precluded from enrolling in the program or, if already enrolled in the program, may be disenrolled.~~

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

3. The State of Montana operates a number of Medicaid programs to provide medical care for eligible low-income Montanans. The Medicaid programs are intertwined with various other social programs such as Families Achieving Independence in Montana (FAIM), Medicare, Adoption Assistance, and others. Medicaid is governed by various federal laws, including the Balanced Budget Act of 1997, the Waivers provided under Section 1915(b) of the Social Security Act, and the Health Care Financing Administration. The State of Montana receives funding assistance from the federal government to pay, in part, for the Medicaid programs. In order to receive federal funding the State must comply with the federal governing law. The majority of the proposed amendments reflect changes in the federal governing law; the rules must be amended in order to ensure compliance with those federal laws.

ARM 46.12.521

ARM 46.12.521 discusses the requirements for podiatry under the Medicaid program. Currently, podiatry is available to recipients on a self-referral basis, within the limits provided by ARM 46.12.521. However, under the proposed amendment to ARM 46.12.5007, described above, podiatry services will have to be preauthorized by the recipient's primary care provider. Since the primary care provider will now be screening the services to ensure that they are medically necessary and appropriate, subsections (3) and (4) constitute unnecessary restrictions on podiatry services.

The restrictions may impede the primary care providers ability to authorize necessary services, and thus, should be deleted. The proposed amendment is necessary to delete the restrictions on podiatry services and to bring the rule into compliance with ARM 46.12.5007, as proposed to be amended. The amendment will not result in fiscal impact, and will not result in additional costs, benefits, or fees to recipients.

ARM 46.12.4801

ARM 46.12.4801 governs the Health Maintenance Organization (HMO) component of the Medicaid program. It lists the definitions applicable to the HMO component in an attempt to create a common vocabulary and aid understanding. The proposed amendment adds a definition for "Basic Medicaid" and "Full Medicaid". The definitions must be included because under the FAIM Waiver of 1997, adults over 21 who are not pregnant receive "Basic Medicaid" services, as opposed to "Full Medicaid" benefits. It is necessary to amend the rule in order to conform the regulation with the federal waiver governing the FAIM program and to avoid systems problems resulting from inappropriate classification of recipients within the various Medicaid programs. The definitions also provide clarity for the public with respect to what services are available in "Basic Medicaid" and what services are available in "Full Medicaid".

In addition, the proposed amendment adds a definition of "Complaint" and "Grievance" in order to comply with the Balanced Budget Act of 1997. The Balanced Budget Act of 1997 makes a distinction between "Complaint" and "Grievance", each being subject to different resolution procedures. In order to comply with that Act, then, it is necessary to add the proposed definition of "Complaint" and "Grievance" so that the State regulations governing the different resolution procedures can follow the distinction made by federal law. See Subtitle H, Chapter 1, Balanced Budget Act of 1997.

Furthermore, the proposed amendment changes the defined term "Emergency Care", to the term "Emergency Service" in accord with ARM 46.12.102. The amendment also changes the definition of "Emergency Service" to delete old terminology, refering instead to the definition provided by the Balanced Budget Act of 1997, "emergency medical condition". The proposed amendment adds a definition of "Emergency Medical Condition" which complies with the Balanced Budget Act of 1997 and deletes the definition previously provided for "Emergency Room Screens". The amendment is necessary to conform the definitions to other State regulations and to the Balanced Budget Act of 1997 in order to ensure compliance with governing federal law and eliminate confusion with respect to terminology.

The proposed amendment defines the term "Exempt" to include that class of medicaid recipients who are not ineligible for managed care, but who can prove to the Department that participation in managed care would result in hardship. The amendment also

defines the term "Ineligible". The definitions are necessary to clarify the difference between medicaid recipients who are "ineligible" for managed care and those who are "exempt" from managed care. Without the clarification, the Department has experienced difficulty in classifying the different recipients and has experienced problems reporting the different classifications to the Health Care Financing Administration, the federal governing body. As the State has a duty to provide complete, accurate reporting, the proposed amendment is necessary to facilitate accurate classification and reporting of the different Medicaid recipients who do not benefit from managed care.

The proposed amendment adds a definition of "FAIM" to note that adult recipients of FAIM assistance who are not pregnant will be provided "Basic Medicaid" as opposed to "Full Medicaid". The amendment is necessary to comply with the FAIM Waiver of 1997, pursuant to Section 1115 of the Social Security Act, 42 USC 1315.

The definition of "Primary care providers" is amended in order to add advanced practice registered nurses. Section 33-31-102, MCA, governing HMOs, lists advanced practice registered nurses as primary care providers. In order to comport with general insurance law governing HMOs, the proposed amendment is necessary to, likewise, add advanced practice registered nurses as "primary care providers". The amendment adds continuity to the law and alleviates confusion regarding which practitioners are considered primary care providers.

All of the amendments to ARM 46.12.4801 are necessary to comport with other federal and state law. While the Department considered the option of leaving the rule unamended, the Department felt the changes had to be made in order to clarify the definitions in accordance with federal law and to avoid the potential loss of federal financial participation in the various Medicaid programs run by the State. The proposed amendments add, change, or delete definitions. They will not result in fiscal impact, nor will they result in changes to benefits, fees, or costs to recipients.

ARM 46.12.4804

ARM 46.12.4804 discusses eligibility for the HMO component of Medicaid. The proposed amendment deletes outdated references to AFDC as that program was replaced by the FAIM program. The proposed amendment also deletes reference to October 1, 1997, as that date has long passed and the remaining language of the rule has been sufficiently incorporated into the primary care case management program. Therefore, the rule need not make reference to October 1, 1997 any longer. The amendment also clarifies the fact that the rule is discussing ineligibility, not exemption. This is in response to confusion surrounding the different classifications as discussed above. The proposed amendment is necessary to update the rule to appropriately address the FAIM

address the FAIM program and to provide continuity with the definitions added to ARM 46.12.4801. This amendment will not result in fiscal impact, nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.4805

ARM 46.12.4805 regulates enrollment in the HMO component of Medicaid. The proposed amendment deletes subsection (12) in order to comply with the Balanced Budget Act of 1997. The Balanced Budget Act changed the provisions of 42 CFR 434.26 and rendered the deleted section obsolete. Therefore, the proposed amendment is necessary to comport with federal law and protect federal financial participation in the Medicaid programs. The proposed amendment will not result in fiscal impact, nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.4806

ARM 46.12.4806 governs disenrollment in the HMO component of Medicaid. Before the proposed amendment, the rule stated that if a recipient moved outside an enrollment area the move would be cause for termination. Actually, a move outside of the recipient's enrollment area is a cause for disenrollment, not termination. The recipient may still be eligible for services with a different HMO servicing the new area. Therefore, the proposed amendment is necessary to correct the rule. The amendment also deletes subsection 10. That subsection of the rule dealt with changes required by new SSI regulations which caused SSI recipients to be treated differently after October 1, 1997. The effective date of the SSI regulations has long since passed and there is no need to retain subsection (10). In addition, the amendment clarifies that the Department must agree that an enrollee has adequate grounds for disenrollment based on the fact that the enrollee is under treatment by a provider who is not affiliated with the HMO, and thus, enrollment would cause unnecessary hardship. This clarification ensures that voluntary disenrollment is supported by adequate documentation and is not abused. The proposed amendment will not result in fiscal impact, nor will it result in changes in benefits, fees, or costs to recipients.

ARM 46.12.4810

ARM 46.12.4810 lists the services which are available through the HMO component of Medicaid. Most of the amendments clarify the cites defining particular services as many cites have been repealed or consolidated with other subsections. The proposed amendment deletes subsection (2) as the Department does not feel it is necessary to list the services which an HMO is not required to provide. HMOs are becoming more and more regulated under State law and the Department does not wish to inadvertently contravene any insurance regulation. Furthermore, the Department lists what services the HMO is required to cover. Discretionary services are a contractual matter and the

Department feels it is unnecessary to regulate in that area. Finally, the reference to "urgent condition or emergency" is amended to read "emergency service" in order to comport with the definitions listed in ARM 46.12.4801 and the Balanced Budget Act of 1997. Therefore, the proposed amendment is necessary to clarify the rule, to ensure that appropriate and updated cites are listed, and to provide continuity with federal law. The proposed amendment will not result in fiscal impact, nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.4813

ARM 46.12.4813 regulates contracts with HMOs to provide services for the HMO component of Medicaid. The proposed amendment is necessary to update the reference to 42 CFR part 434. The latest version of that CFR was printed in 1998. The amendment correctly refers to 42 CFR part 434, dated October 1998, as opposed to the 1996 version of the federal regulation. In addition, the federal government recently passed a prohibition forbidding the Department to contract with any provider wherein an owner, director, officer or partner has been debarred from receiving federal funds. Consequently, certification of nondebarment is now required. The proposed amendment is necessary to comport with the federal nondebarment requirement. Finally, the amendment clarifies when a contract with an HMO may be terminated without cause in order to conform the rule with Departmental policy and current HMO contracts. The Department could have retained the rule, but the proposed amendment better complies with current State policy and the unamended rule contravened the language in HMO contracts presently being performed. The amendment will not result in fiscal impact, nor will it result in changes in benefits, fees, or costs to recipients.

ARM 46.12.4814

ARM 46.12.4814 regulates the provision of services through HMOs in the Medicaid programs. The proposed amendment clarifies which services must be preauthorized and which services must be available without preauthorization. This proposed change brings the rule into compliance with the contractual language which the Department uses in its Prime HMO contracts. Furthermore, the Balanced Budget Act of 1997 requires that obstetrical, gynecological and maternity services be available without preauthorization. In addition, the Balanced Budget Act of 1997 requires HMOs to permit a recipient to choose a federally qualified health center (FQHC) to perform services. Preauthorization is not required for services provided by a FQHC under federal law; however, the recipient must inform the HMO of this election before services will be paid. Thus, the proposed amendment is required to comply with federal governing law and to protect federal financial participation in the Medicaid programs. The remaining changes are necessary to correct the cites in the rule and to conform this ARM with the other amendments proposed herein. The amendment will not result in

in fiscal impact, nor will it result in changes in benefits, fees, or costs to recipients.

ARM 46.12.4817

ARM 46.12.4817 governs reimbursement to HMOs for services provided to Medicaid recipients. The proposed amendment deletes obsolete information which was previously included in the rule during a transition period involving SSI regulations. Subsection (5) and the first phrase of subsection (6) are outdated and serve only to confuse. The amendment also changes "AFDC-based" to "TANF-based" as the AFDC program was replaced with the FAIM program, a comprehensive welfare reform program which is funded, in part, by the Temporary Assistance to Needy Families (TANF) block grant. Thus, the proposed amendment is necessary to update and correct the rule and to delete obsolete terms. The proposed amendment will not result in fiscal impact, nor will it result in changes in benefits, fees, or costs to recipients.

ARM 46.12.4821

ARM 46.12.4821 regulates access to services by Medicaid recipients enrolled under the HMO component of the Medicaid program. Subsection (2) of the rule governed provider network adequacy. The 1999 legislature enacted Section 33-36-201 et seq., MCA, to regulate network adequacy and HMO services. Consequently, subsection (2) of ARM 46.12.4821 is no longer necessary. The proposed amendment deletes the network adequacy portion of the rule, in favor of the statutory and regulatory scheme recently enacted. The deletion is necessary in order to prevent conflict with Montana insurance law and to ensure that the obsolete information does not result in confusion with respect to applicable law. The amendment will not result in fiscal impact, nor will it result in changes in benefits, fees, or costs to recipients.

ARM 46.12.4825

ARM 46.12.4825 governs confidentiality of health care information with respect to HMOs providing services to Medicaid recipients. The proposed amendment deletes subsections (4) and (4)(a) and makes reference to the applicable State law governing confidentiality. The unamended rule was outdated. The 1999 legislature enacted 33-19-306, MCA, to govern health care information disclosure by insurance carriers. In addition, Montana law governs health care information disclosure at Title 50, Chapter 16 of the Code. Consequently, the proposed amendment is necessary to delete the outdated reference to confidentiality policy, which may conflict with current Montana law, in favor of the statutory scheme provided by the named cites. Thus, the amendment is necessary to eliminate conflict with State law and provide notice regarding applicable disclosure regulation. The proposed amendment will not result in fiscal impact, nor will it result in changes in benefits,

fees, or costs to recipients.

ARM 46.12.4827

ARM 46.12.4827 governs quality assurance, requiring that HMOs which provide services to Medicaid recipients have an internal quality assurance system in place. The rule incorporates by reference 42 CFR 434.34. The rule currently cites the 1996 version of that CFR. As the Code of Federal Regulations has been updated, the proposed amendment is necessary to update the ARM. The amendment correctly incorporates the 1998 version of 42 CFR 434.34, the latest version published. The amendment will not result in fiscal impact, as it simply updates the rule, nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.5002

ARM 46.12.5002 lists defined terms used in the Passport to Health component of the Medicaid program. The proposed amendment adds definitions for the following terms: "Emergency service"; "Emergency medical condition"; "Exempt"; "Ineligible"; "Primary care case management"; and "Primary care provider". These additional definitions are necessary for the same reasons the proposed amendment to ARM 46.12.4801 adds similar definitions to that rule. The amendment corrects ARM 46.12.5002 to mirror definitions of the same defined terms in other rules and regulations. The amendment is necessary to eliminate conflict between defined terms and confusion with respect to applicable definitions. Furthermore, as mentioned above, the additional defined terms are necessary to comport State law with the Balanced Budget Act of 1997, FAIM Waiver of 1999 pursuant to Section 1915(b) of The Social Security Act, and the Health Care Financing Administration. The amendment adds defined terms only, and therefore, will not result in fiscal impact, nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.5003

ARM 46.12.5003 governs eligibility for the Passport to Health Program component of Medicaid. Currently, the rule discusses Medicaid recipients who are "exempt" from the program. The proposed amendment considers those recipients who are also "ineligible" for the program. The terms "exempt" and "ineligible" were causing confusion. Consequently, the terms are being defined in the proposed amendment to ARM 46.12.5002, above. The amendment to ARM 46.12.5003 is necessary to correct the rule, clarify the status of recipients who are "ineligible" versus "exempt", and to use the defined terms appropriately. This change should correct the difficulties the Department has experienced with classifying those Medicaid recipients who are not participating in Passport to Health. The amendment will alleviate confusion, clarify the rule, and provide notice to recipients regarding their eligibility status. As the amendment is simply a clarification, it will not result in fiscal impact,

nor will it result in changes to benefits, fees, or costs to recipients.

ARM 46.12.5004

ARM 46.12.5004 governs enrollment in the Passport to Health Program component of Medicaid. The rule currently provides enrollees with 30 days to choose a "Primary care provider" and allows the enrollee to choose a new provider once a month. Under the FAIM Waiver of 1999, pursuant to Section 1915(b) of the Social Security Act, recipients are given 45 days to select a "Primary care provider". However, recipients may change providers only once a quarter. The proposed amendment is necessary to correct the rule, bringing it into compliance with the terms of the FAIM Waiver. Though the amendment will impact the timing of certain decisions made by recipients who receive services through the Passport to Health Program, it has no substantive effect on benefits. No fiscal impact will result, and no additional fees or costs will be required of recipients.

ARM 46.12.5007

ARM 46.12.5007 lists the services available to recipients under the Passport to Health Program component of Medicaid. Some of the cites defining particular services have been repealed or consolidated with other sections of the Administrative Rules. Therefore, the proposed amendment is necessary to update and correct the cites defining services. The amendment also adds or reclassifies the following services in the Passport to Health Program: respiratory therapy, private duty nursing, nutrition services, podiatry, hospice, and emergency room services for emergency conditions. The additions are necessary to bring the rule into compliance with the requirements of the Balanced Budget Act of 1997 and the FAIM Waiver of 1999, and to reflect changes in Departmental policy.

All of the services listed in subsection (1) must be obtained through the recipient's primary care provider. Subsection (2) lists those services which need not be accessed through the primary care provider. The amendment reclassifies some services, i.e., podiatry and private duty nursing, to indicate that those services must, indeed, be accessed through the recipient's primary care provider. The primary care provider can better ensure that the services are medically necessary and appropriate. In addition, the amendment adds hospice to subsection (2). Hospice is available without preauthorization from a primary care provider pursuant to the FAIM Waiver of 1999. Thus, the amendment is necessary to correctly differentiate between available services, to update the rule, and to bring the rule into compliance with governing law. Though recipients will now have to access some services which were previously self-referring through their primary care provider, the proposed amendment does not significantly change the available benefits. No significant fiscal impact is expected to result from the proposed amendment and no additional

fees or costs to recipients are likely to occur by reason of the amendment.

ARM 46.12.5010

ARM 46.12.5010 defines the requirements of Primary Care Providers who serve recipients enrolled in the Passport to Health Program component of Medicaid. Some time ago, federal law distinguished between the requirements ordinary primary care providers must meet and the requirements that an Indian health clinic must meet. That distinction has been abolished and the proposed amendment is necessary to delete the obsolete references to Indian health clinic requirements. The amended rule deletes subsection (2), in favor of listing the general applicable requirements together in subsection (1). The proposed amendment also deletes subsections (4) and (5) as the requirements given there are governed by State law and need not be repeated in the rules. The amendment is necessary to update the rule, defer to State law, and to remove the obsolete distinctions involving Indian health clinics. The amendment will not result in fiscal impact, and will not result in additional costs, benefits, or fees to recipients.

The Department estimates that there are approximately 44,000 people receiving Medicaid in the State at any given time. The proposed amendments may impact certain subsections of the population receiving Medicaid, particularly those recipients who are participating in managed care. The exact number of recipients receiving Medicaid through managed care is unknown at this time.

4. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than 5:00 p.m. on February 10, 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 3, 2000.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF ESTABLISHING A NEGOTIATED RULEMAKING COMMITTEE relating to Intangible Personal Property	))))	NOTICE OF NEGOTIATED RULEMAKING

TO: All Concerned Persons

1. The department of revenue intends to establish a negotiated rulemaking committee to negotiate and develop proposed rules relating to intangible personal property in Montana.

2. The department held a hearing addressing a proposed new rule and an amendment to ARM 42.22.105 on December 16, 1999 as stated in MAR Notice No. 42-2-649. Various industry representatives were present at this hearing and many submitted requests for the department to conduct negotiated rulemaking concerning the proposed adoption and amendment to the rules for intangible personal property. Based on these requests, the department has agreed to conduct negotiated rulemaking with the various industries affected by these rules.

3. Interests that are likely to be significantly affected by the proposed rules are: railroad industry, public utility companies, utility cooperatives, telecommunications companies, telephone cooperatives, airline industry, oil pipeline industry, and gas pipeline industry.

4. The individuals proposed to represent the department on the negotiated rulemaking committee are: Gene Walborn, Compliance Valuation Resolution Division; Michael Goodwin, Consultant; and Cleo Anderson, Policy and Performance Management.

5. The department is seeking applications from interested parties to serve on the committee.

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

(a) On January 13, 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 February 14, 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 February 16, 2000. The members selected to serve on the committee must be able to adequately represent the interests of the persons that will be significantly affected by the proposed rules. The committee members will be notified in writing of their selection. Within 5 days from the notification of selection, the committee members will be sent an information packet.

(c) The negotiated rulemaking committee will convene its meeting on February 28 and 29, 2000 to negotiate and develop proposed rules. The committee must have rules developed and ready to file with the secretary of state no later than March 20, 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 February 28 and 29, 2000 meeting will convene at 8:30 a.m. in the Fourth Floor Conference Room, Sam W. Mitchell Building, Helena, Montana. If possible, the committee will begin redrafting the rules at this meeting.

(d) If the negotiated rulemaking committee is successful in achieving a consensus on the proposed rules, the committee will transmit to the department director a report containing the proposed rules. If a consensus cannot be reached on the proposed rules, the committee will transmit to the department director 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 Administrative Register the proposed rules for intangible personal property.

(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 Cleo Anderson, Department of Revenue, P.O. Box 5805, Helena, Montana, 59604-805, no later than February 14, 2000:

(a) The person's name or the nominee'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 a company or industry involved with intangible property, 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. Interested parties may submit their views or comments concerning the proposed negotiated rulemaking process to Cleo Anderson, Department of Revenue, P.O. Box 5805, Helena, Montana, 59604-5805, no later than February 14, 2000.

9. Initially, the department proposes to limit the size of the negotiated rulemaking committee to no more than 10 persons. However, after receipt of comments and applications, the department may determine that a smaller or larger number is necessary to adequately represent the interests of the persons significantly affected by the proposed rules. The selected committee members will represent identified segments of intangible personal property owners and state and local officials. The selected committee members may represent other parties or agencies that have a significant relationship to dealing with intangible personal property.

10. The department will make reasonable accommodations for persons with disabilities who wish to participate on the committee. If you require an accommodation, please advise the department of the nature of the accommodation you need when applying for membership on the committee.

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 15-23-108, MCA. The proposed rules will implement 15-6-218, 15-23-103, 15-23-201, 15-23-202, 15-23-212, 15-23-301, 15-23-303, 15-23-402, 15-23-502, 15-23-602, and 15-23-701, MCA.

Cleo Anderson
CLEO ANDERSON
Rule Reviewer

Mary Bryson
MARY BRYSON
Director of Revenue

Certified to the Secretary of State January 3, 2000.

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the adoption of new Rules I and II, repeal of ARM 2.5.119 and the amendment of ARM 2.5.201, 2.5.202, 2.5.302, 2.5.303, 2.5.401, 2.5.403, 2.5.404, 2.5.405, 2.5.406, 2.5.407, 2.5.501, 2.5.502, 2.5.503, 2.5.505, 2.5.601, 2.5.602, 2.5.603, and 2.5.604 concerning state procurement.	NOTICE OF ADOPTION, REPEAL, AND AMENDMENT OF RULES

TO: All Concerned Persons

1. On October 7, 1999, the Department of Administration published notice of the proposed adoption of new Rules I and II, repeal of ARM 2.5.119, and amendment of ARM 2.5.201, 2.5.202, 2.5.302, 2.5.303, 2.5.401, 2.5.403, 2.5.404, 2.5.405, 2.5.406, 2.5.407, 2.5.501, 2.5.502, 2.5.503, 2.5.505, 2.5.601, 2.5.602, 2.5.603, and 2.5.604 concerning state procurement at page 2124 of the 1999 Montana Administrative Register, Issue Number 19.

2. The Department of Administration repealed ARM 2.5.119, and amended 2.5.303, 2.5.401, 2.5.403, 2.5.404, 2.5.405, 2.5.407, 2.5.501, 2.5.502, 2.5.503, 2.5.505, and 2.5.604 as proposed.

3. The Department will adopt Rule I (2.5.508), but with the following changes:

2.5.508 REQUESTS FOR INFORMATION (1) ~~Agencies may issue requests for information.~~ A request for information, AS DEFINED IN ARM 2.5.201, may be used BY AN AGENCY only to obtain preliminary information about a market or the type of available supply or service, where there is not enough information readily available to write an adequate specification or work statement. A REQUEST FOR INFORMATION MAY NOT BE USED AS A SOURCE SELECTION METHOD TO PROCURE A SUPPLY OR SERVICE.

~~(2) Pricing information may be requested only with the provision that such information would be submitted voluntarily. The request for information must clearly state that no award will result from the inquiry.~~

AUTH: Sec. 18-4-221, MCA
IMP: Sec. 18-4-221, MCA

4. The Department will adopt Rule II (2.5.509), but with the following changes:

2.5.509 LATE BIDS OR PROPOSALS (1) REGARDLESS OF CAUSE, ~~L~~late bids and proposals will not be accepted AND WILL AUTOMATICALLY BE DISQUALIFIED FROM FURTHER CONSIDERATION. IT SHALL BE THE VENDOR'S SOLE RISK TO ASSURE DELIVERY AT THE SPECIFIED OFFICE BY THE SPECIFIED TIME.

(2) Late bids or proposals will NOT BE OPENED AND MAY be returned ~~unopened~~ to the vendor at the expense of the vendor or destroyed if requested.

AUTH: Sec. 18-4-221, MCA
IMP: Sec. 18-4-221, MCA

5. The Department will adopt 2.5.201, but with the following changes:

2.5.201 DEFINITIONS In these rules, words and terms defined in Title 18, chapter 4, MCA, shall have the same meaning as in the statutes and, unless the context clearly requires otherwise or a different meaning is prescribed for a particular section, the following definitions apply:

(1) through (20) remain the same.

(21) "Request for information" means a document used to informally solicit information about a market or type of available supply or service where there is ~~no~~ NOT ENOUGH information readily available to write an adequate specification or work statement.

(22) through (36) remain the same.

6. The Department will adopt 2.5.202, but with the following changes:

2.5.202 DEPARTMENT OF ADMINISTRATION RESPONSIBILITES (1) through (5)(c) will be adopted as proposed.

(d) mail equipment TO BE USED within a 10-mile radius of the capitol area - approval by the procurement and printing division is required.

(6) through (7) will be adopted as proposed.

7. The Department will adopt 2.5.302, but with the following changes:

2.5.302 REQUISITIONS FROM THE AGENCIES TO THE DIVISION

(1) All agencies must complete the division's ~~electronic~~ requisition form when a state purchase order is required from the division ~~(see ARM 2.5.301)~~. The requisition must be signed or electronically approved by an authorized agency official. Only items of a like nature (items ordinarily procurable from the same vendor) to be billed to one location shall be combined on one requisition. A separate requisition is required for each billing location. The requisition must be accompanied by specifications as described in ARM 2.5.501. Completed requisitions for coarse paper, computer paper, computer software supported by information ~~systems~~ services division, fine paper, forms, flags, fire extinguishers,

janitorial supplies, and office supplies shall be forwarded to the property and supply bureau; requisitions for printing shall be forwarded to publications and graphics bureau. Completed requisitions for supplies and services (not listed above) shall be forwarded to the ~~purchasing~~ state procurement bureau.

(2) through (4) remain the same.

8. The Department will adopt 2.5.406, but with the following changes:

2.5.406 VENDOR PROTEST (1) Except for small purchases or limited solicitations made pursuant to 18-4-305, MCA, a bidder, offeror, or contractor aggrieved in connection with the solicitation, award, or administration of a contract, may protest to the department. Protests involving a solicitation or award must follow the provisions of 18-4-242, MCA. The department MAY EXERCISE ITS DISCRETION WHEN IT DECIDES ~~is responsible for making decisions~~ WHAT IS IN ~~involving~~ the best interest~~s~~ of the state.

(2) through (4) will be adopted as proposed.

9. The Department will adopt 2.5.601, but with the following changes:

2.5.601 COMPETITIVE SEALED BIDS (1) through (4) remain the same.

(5) Upon receipt of a bid or a facsimile transmission of a bid, an employee of the agency other than the procurement officer will cause it to be time-stamped and stored in a secure place until the time and date set for bid opening. In order to be considered timely, ~~the entire~~ A COMPLETE printed bid RESPONSE must be DELIVERED TO THE SPECIFIED DESTINATION by the specified time.

(6) through (15) will be adopted as proposed.

10. The Department will adopt 2.5.602, but with the following changes:

2.5.602 COMPETITIVE SEALED PROPOSAL (1) "Competitive sealed proposal" is a procurement option allowing the award to be based upon an evaluation process using stated criteria ~~or evaluation factors.~~ to ~~facilitate arriving~~ ARRIVE at a contract that will be most advantageous to the state.

(2) through (5) remain the same as proposed.

(6) After the ~~date~~ time established for receipt of proposals, a procurement officer shall open the proposals and inspect the proposals for material not available for public inspection pursuant to 18-4-304 AND 18-4-308, MCA. The procurement officer will remove ~~confidential documents~~ THIS MATERIAL and then make the REMAINDER OF THE proposals available for public inspection. Offerors submitting a proposal containing a claim ~~for~~ TO SHIELD confidential

information pursuant to 18-4-304(4)(a), (b) and (d), MCA, must include a statement that attests to the offeror's acceptance of the legal and financial responsibility for defending the claim. In addition, any claim ~~for~~ TO SHIELD trade secret ~~confidentiality~~ MATERIAL must be made by an offeror's legal counsel using the affidavit FORM prescribed by the division.

(7) through (8)(c) remain the same as proposed.

(d) At the discretion of the procurement officer, one or more offerors may be provided an opportunity to submit a best and final offer if additional information is required in order to reach a final decision. UNLESS THE REQUEST FOR PROPOSALS SO STATES, a ~~A~~ best and final offer may not be requested from the offeror(s) on price alone.

(9) Remains the same.

(10) The evaluation shall be based on the evaluation criteria set forth in the request for proposals. The evaluators shall exercise discretion in assigning points or value to a proposal, which involves a judgmental assessment of the evaluation criteria. ~~The contract will be awarded to the highest scoring proposal offered by a responsive and responsible offeror.~~ THE AWARD MUST BE MADE TO THE RESPONSIVE AND RESPONSIBLE OFFEROR WHOSE PROPOSAL BEST MEETS THE EVALUATION CRITERA.

(11) through (13) will be adopted as proposed.

11. After receiving several comments on the rules, the Department decided to amend several of its proposed changes to the rules. Rule I was amended to further clarify that a "request for information" may not be used as a selection method to procure a certain supply or service. Only the selection methods specified in Title 18, Chapter 4, Part 3, MCA are permitted.

Rule II was amended to provide additional clarification that complete delivery of a timely bid or proposal is the responsibility of the vendor.

ARM 2.5.202(5)(d) is amended to clarify that the requirement for prior approval of mail equipment purchases applies only to mail equipment that will be used within a ten-mile radius of the capitol, not to mail equipment purchased within that area for an outlying office.

ARM 2.5.302(1) was amended to strike out the inserted word "electronic." Since the University System does not use the PeopleSoft system, they would not be able to send an electronic requisition to the division and consequently, they would have been in violation of this rule.

ARM 2.5.406(1) was amended to provide clarity to the sentence.

ARM 2.5.601(5) was amended to provide clarity to the sentence.

ARM 2.5.602(1) was amended to provide clarity to the sentence. Subsection (6) was amended to provide clarity about what documents may be withheld from public inspection. The word "confidential" was removed wherever possible to avoid misinterpretation of the term as opposed to the narrow

exceptions listed in 18-4-304 and 18-4-308, MCA. Subsection (8)(d) was amended to permit best and final offers on price alone if the offeror is aware that this might take place before they submit their offers. If not forewarned, offerors may not be aware that due to the right of the public to inspect most of their proposal documents, their competitors may be aware of the price they are offering. This knowledge could affect how an offeror responds to a best and final offer. Subsection (10) was amended to provide clarity to the sentence and make the ARM language consistent with 18-4-304, MCA.

12. ARM 2.5.603 was not amended as proposed after receiving comments from a state agency that this amendment would pose a hardship for them. Currently, the rule would permit agencies to purchase supplies or services up to $15,000 either on the basis of a low bid or on the basis of quality. Our proposed amendment would have limited this option to only low bid.

13. These rule changes will be effective February 1, 2000.

Dal Smilie
Dal Smilie, Chief Legal Counsel
Rule Reviewer

Lois Menzies
Lois Menzies, Director

Certified to the Secretary of State on December 20, 1999.

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

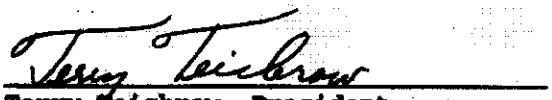
In the matter of amendment of ARM 2.43.437 pertaining to purchase of military service by members of the retirement systems administered by the Public Employees' Retirement Board.	))))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On October 21, 1999, the Public Employees' Retirement Board published notice of proposed amendment of the above stated rule at page 2301 of the 1999 Montana Administrative Register, Issue Number 20.

2. The Board amended the rule as proposed.

3. No comments were received.



Terry Teichrow, President
Public Employees' Retirement Board

Kelly Jenkins, General Counsel and
Rule Reviewer

Dal Smilie, Chief Legal Counsel and
Rule Reviewer

Certified to the Secretary of State on December 15, 1999.

BEFORE THE DIVISION OF BANKING AND FINANCIAL INSTITUTIONS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the adoption of rules pertaining to Deferred Deposit Lending) CORRECTED NOTICE OF ADOPTION

TO: All Concerned Persons

1. On September 9, 1999, the Division of Banking and Financial Institutions published a notice at page 1849 of the 1999 Montana Administrative Register, Issue Number 17, of the proposed adoption of new rules pertaining to Deferred Deposit Lending. On November 4, 1999, the Division of Banking and Financial Institutions published its notice of adoption at page 2570, 1999 Montana Administrative Register, Issue Number 21. In that notice of adoption, the Division adopted the new rules exactly as proposed. The authority and implementing sections remain the same as proposed in the original notice.

2. The reason for the correction is to properly number the new rules. The adoption notice identified the new rule numbers as being 8.80.1101 through 8.80.1106 when in fact the new rule numbers should be 8.80.1201 through 8.80.1206.

3. Replacement pages for the corrected notice of adoption were submitted to the Secretary of State on December 30, 1999.

DEPARTMENT OF COMMERCE
PETER BLOUKE, DIRECTOR

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 3, 2000.

BEFORE THE DEPARTMENT OF ENVIRONMENTAL QUALITY
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 17.40.203 and 17.40.212 pertaining to certification and fees for water and wastewater operators	NOTICE OF ADOPTION (WASTEWATER OPERATORS)

TO: All Concerned Persons

1. On November 18, 1999, the Department of Environmental Quality published notice of the proposed amendment of ARM 17.40.203 and 17.40.212, pertaining to certification and fees for water and wastewater operators, at pages 2596 of the 1999 Montana Administrative Register, Issue No. 22.

2. The Department has amended ARM 17.40.203 and ARM 17.40.212 as proposed.

3. The Department received the following comments; Department responses follow:

COMMENT #1: Instead of raising fees, the Department should change the operator certification fee from an annual to a biannual fee.

RESPONSE: Montana law, as set forth in §§ 37-42-306(3) and 37-42-308(1), MCA, provides that certificates last for a year and must be renewed annually. For this reason, the suggested change has not been made.

COMMENT #2: The Water/Wastewater Certification program should be placed in the Department of Commerce with the other licensing/fee programs.

RESPONSE: Section 37-42-301(1), MCA, places the responsibility for certifying water and wastewater operators on the Department of Environmental Quality, not on the Department of Commerce. For this reason, the suggested change has not been made.

COMMENT #3: Raising the fees would cut down on the number of certified operators because no one would ever take the examination.

RESPONSE: The Department concurs that the increase in application and examination fees may stop some people from taking the examinations. However, the Department is under state and federal requirements to make the operator certification program self-sufficient. Therefore, the Department must raise fees or cut costs. The Water and Wastewater Operators Advisory Council and the Department believe that the Department could not accomplish its objectives with reduced staff or resources, so it must raise fees.

COMMENT #4: Commenters were concerned that the Department was proposing to raise renewal fees.

RESPONSE: Renewal fees are not being raised.

COMMENT #5: The owner/operator of a particular transient system was opposed to the increase in renewal fees.

RESPONSE: Renewal fees are not being raised. Also, because transient systems are not required to have certified operators, the increase in application and examination fees will not affect this system.

DEPARTMENT OF ENVIRONMENTAL QUALITY

by: *Mark A. Simonich*
MARK A. SIMONICH, Director

Reviewed by:

David Rusoff
David Rusoff, Rule Reviewer

Certified to the Secretary of State January 3, 2000.

BEFORE THE DEPARTMENT OF CORRECTIONS
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 20.2.101, pertaining to the department model procedural rules	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On November 18, 1999, the Department of Corrections published notice of the proposed amendment of ARM 20.2.101 concerning the department model procedural rules at page 2600 of the 1999 Montana Administrative Register, Issue Number 22.

2. The agency has amended ARM 20.2.101 as proposed.

AUTH: Sec. 2-4-101, and 2-4-201, MCA
IMP: Sec. 2-4-101, 2-4-201, and 2-4-202, MCA

3. No comments or testimony were received.

DEPARTMENT OF CORRECTIONS

By: Rick Day
Rick Day, ~~Director~~

Lois Adams
Lois Adams, Rule Reviewer

Certified to the Secretary of the State December 20, 1999.

BEFORE THE BOARD OF MILK CONTROL
OF THE STATE OF MONTANA

In the matter of a temporary emergency amendment of a rule as it relates to the economic formula in pricing class I milk at the producer level	NOTICE OF TEMPORARY EMERGENCY AMENDMENT

TO: All Concerned Persons

1. The board believes the following reasons constitute action for a temporary emergency amendment to ARM 32.24.301:

(a) 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, will no longer be available for the February producer pricing of class I milk.

(b) 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.

(c) 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.

(d) That if the board did not act immediately to replace the economic formula for class I producer pricing, the result would have the potential to seriously jeopardize or interfere with the Montana consumer's right to an adequate supply of wholesome class I milk and to otherwise disrupt and injure the milk industry. Such welfare conditions are an imminent peril.

(e) Therefore, as these conditions cannot be averted or remedied any other way, the board intends to adopt the following temporary emergency amendment. The rule as amended will be mailed to all licensed producers, processors and commenting parties and published as a temporary emergency amendment in Issue No. 1 of the 2000 Montana Administrative Register.

2. The milk control bureau 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 milk control bureau no later than 5:00 p.m. on the date set for rulemaking (a standard rulemaking procedure will take place sometime within the next 120 days). Please contact Marlys Mattfeldt, PO Box 202001,

Helena, Montana, 59620-2001; telephone 406-444-2875; TDD 1-800-253-4091; fax 406-444-1432.

3. The temporary emergency amendment is effective January 4, 2000.

4. The text of the temporary emergency amendment is as follows: (text of present rule with matter to be stricken interlined and new matter added, then underlined)

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 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 pursuant to 7 CFR 1000.50(a) through (c) plus a Montana class I location differential of $2.55.

~~(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.~~

(b) When milk does not test 3.5% butterfat, the price per CWT will be adjusted for each .1% the butterfat test moves up or down.

(c) 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 following month.

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

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

5. The rationale for the temporary emergency amendment is as set forth in paragraph 1.

6. A standard rulemaking procedure will be undertaken prior to the expiration of this temporary emergency amendment.

7. Concerned persons are encouraged to submit their

comments during the upcoming standard rulemaking process. If concerned persons wish to be personally notified of that rulemaking process, they should submit their names and addresses to the Milk Control Bureau, 301 N. Roberts Street - Room 236, PO Box 202001, Helena, MT 59620-2001.

8. 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.

9. The business and labor interim committee has been notified of the amendment of this temporary emergency rule.

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

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

By: _____
Bernard A. Jacobs, Rule Reviewer
Livestock Chief Legal Council

Certified to the Secretary of State January 4, 2000.

BEFORE THE BOARD OF MILK CONTROL
OF THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of amendment of ARM 32.24.503 through 32.24.505 and ARM 32.24.511 as they relate to quota and pooling transactions; and adoption of a rule on surplus and excess milk	)	NOTICE OF AMENDMENT AND ADOPTION
	)	DOCKET NO. 1-99

TO: ALL CONCERNED PERSONS:

1. On November 18, 1999, the Montana board of milk control published notice of the proposed amendment of rules 32.24.503 through 32.24.505 and 32.24.511 as they relate to quota and pooling transactions and adoption of a rule regarding surplus and excess milk at page 2602 of the 1999 Montana Administrative Register, Issue No. 22.

2. The board has amended rules 32.24.503 through 32.24.505 and 32.24.511 as proposed; and adopted new rule I (32.24.516) as proposed.

AUTH: 81-23-104, MCA
IMP: 81-23-103, MCA

3. No comments or testimony were received.

DEPARTMENT OF LIVESTOCK

By: Marc Bridges
Marc Bridges, Exec. Officer,
Board of Livestock
Department of Livestock

By: Bernard A. Jacobs
Bernard A. Jacobs, Rule Reviewer
Livestock Chief Legal Counsel

Certified to the Secretary of State January 3, 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.

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