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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

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

In the matter of the repeal of ARM 16.24.901 through 16.24.905 pertaining to state plans for maternal and child health (MCH), ARM 16.38.1501 pertaining to lab services and ARM 16.48.101 through 16.48.103 pertaining to Montana health care authority	))))))))	NOTICE OF PROPOSED REPEAL NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On April 7, 2001, the Department of Public Health and Human Services proposes to repeal the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on March 19, 2001, 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 The rules ARM 16.24.901 through 16.24.905 and 16.38.1501 as proposed to be repealed are on pages 16-1181 through 16-1183 and 16-1875 of the Administrative Rules of Montana.

AUTH: Sec. 50-1-202, MCA
IMP: Sec. 50-1-202, MCA

The rules ARM 16.48.101 through 16.48.103 as proposed to be repealed are on page 16-4911 of the Administrative Rules of Montana.

AUTH: Sec. 50-4-401, MCA
IMP: Sec. 50-4-401, MCA

3. Rules 16.24.901 through 16.24.905 and 16.38.1501 need to be repealed because they adopt state plans for maternal and child health, family planning, and laboratories in response to federal requirements dating back to 1972 that no longer exist. The maternal and child health and family planning state plans were originally adopted to meet requirements of Title V of the federal Social Security Act and the Public Health Service Act upon which receipt of federal funding depended. Currently, those programs have to submit an application to the sources of federal funding for the programs that reflects a wide range of

planning, the application is changed with regularity, and there is no contemporary requirement to adopt the requirement for receipt of federal funds from the former Department of Health, Education, and Welfare. The requirement for a state plan no longer exists. In addition, there is no clear authority in state statute for the adoption of such state plan rules. Finally, ARM 16.48.101 through 16.48.103, adopted by the Montana Health Care Authority to implement health planning statutes, need to be repealed because the statutes in question have been repealed and the Authority no longer exists.

4. Interested persons may submit their data, views or arguments concerning the proposed action in writing to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than 5:00 p.m. on April 5, 2001. Data, views or arguments may also be submitted by facsimile (406) 444-9744 or by electronic mail via the Internet to dphhslegal@state.mt.us. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments to 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 April 5, 2001.

6. If the Department of Public Health and Human Services receives requests for a public hearing on any of the proposed actions from either 10% or 25, whichever is less, of those who are directly affected by the proposed action, from the Administrative Rule Review Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date and a notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected by each of the proposed rule repeals has been determined in each case to be zero because, since there is no underlying legal authority for any of the rules in question, no one is impacted by either their existence or their deletion.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

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

In the matter of the adoption of rules I through XII pertaining to quality assurance for managed care plans	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Interested Persons

1. On March 28, 2001, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on March 23, 2001 to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; Email dphhslegal@state.mt.us.

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

RULE I PURPOSE (1) The purpose of these rules is to implement the quality assurance provisions of the Montana Managed Care Plan Network Adequacy and Quality Assurance Act specified in Title 33, chapter 36, part 3, MCA. These rules establish mechanisms for the department to evaluate quality assurance activities of health carriers providing managed care plans in Montana.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-102, MCA

RULE II DEFINITIONS The following definitions, in addition to those contained in 33-36-103, MCA, apply to this subchapter:

(1) "HEDIS" means health plan employer data and information set, a standardized set of performance measures used by the national committee for quality assurance to assess quality in managed care plans' health delivery systems.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105, MCA

RULE III WRITTEN QUALITY ASSURANCE PLAN (1) The health carrier shall implement a written quality assurance plan that is evaluated annually and updated as necessary. The plan must be submitted to the department by October 1 of each year. The plan must describe:

(a) the plan's mission, goals, and objectives;

(b) the plan's organizational structure and the job titles of the personnel responsible for quality assurance;

(c) the scope of the quality assurance plan's activities, including:

(i) specific diagnoses, conditions, or treatments targeted for review to improve health care services and health outcomes;

(ii) mechanisms to evaluate enrollees' health and health care services in relation to current medical research, knowledge, standards, and practices;

(iii) communication processes by which the findings generated by the quality assurance program are communicated to providers and consumers to improve the health of enrollees; and

(iv) mechanisms to evaluate the service performance of the health carrier and primary care physicians.

(2) The written quality assurance plan must be signed by the health carrier's corporate officer certifying that the plan meets the department's requirements.

(3) The department and each health carrier will meet annually to review and approve the written quality assurance plans and their outcomes.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-302, MCA

RULE IV QUALITY ASSURANCE STRUCTURE (1) The health carrier shall appoint, prior to commencing operation, a medical physician licensed to practice in the state of Montana to advise, oversee, and actively participate in the implementation and operation of the quality assurance program.

(2) The health carrier may delegate quality assurance activities. The health carrier shall retain responsibility for the performance of all delegated activities and shall develop and implement review and reporting requirements to assure that the delegated entity performs all delegated quality assurance activities.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-302, MCA

RULE V COMPONENTS OF QUALITY ASSURANCE ACTIVITIES

(1) Annually, the health carrier shall evaluate its quality assurance activities by using the following HEDIS year 2001 measures:

(a) childhood immunization;

(b) breast cancer screening;

(c) cervical cancer screening;

(d) comprehensive diabetes care; and

(e) HEDIS/consumer assessment of health plan studies (CAHPS) adult survey.

(2) The health carrier shall record organizational components that affect accessibility, availability, comprehensiveness, and continuity of care, including:

(a) referrals;

(b) case management;

(c) discharge planning;

(d) appointment scheduling and waiting periods for all types of health care services;

(e) second opinions, as applicable;

(f) prior authorizations, as applicable;

(g) prior reimbursement arrangements; and

(h) other systems, procedures, or administrative requirements used by the health carrier that affect the delivery of care.

(3) The health carrier may meet the requirements in (2) of this rule by submitting information to the department regarding network adequacy as specified in ARM 37.108.201, et seq., as long as the information is consistent with what is required in (2) of this rule.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-302, MCA

RULE VI QUALITY IMPROVEMENT (1) By October 1 of each year, the health carrier shall provide documentation on its quality improvement activities. Such documentation must include the health carrier's identification of quality assurance problems and opportunities for improving care through:

(a) ongoing monitoring of process, structure, and outcomes of patient care or clinical performance;

(b) evaluation of the data collected from ongoing monitoring activities to identify problems in patient care or clinical performance using criteria developed and applied by health care professionals;

(c) measurable objectives for each improvement action within the reporting year, including the degree of expected change in persons or situations;

(d) time frames for quality improvement action; and

(e) persons responsible for implementing quality improvement action.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-303, MCA

RULE VII CLINICAL FOCUSED STUDY (1) The health carrier shall conduct a focused study relevant to the quality of its services for enrollee care. The health carrier must document the clinical focused study and submit it to the department by October 1 of each year.

(2) The health carrier shall select topics for the focused study that are justified based on any of the following considerations:

(a) areas of high volume;
(b) areas of high risk;
(c) areas where problems are expected or where they have occurred in the past;
(d) areas that can be corrected or where prevention may have an impact;
(e) areas that have potential adverse health outcomes; and
(f) areas where enrollee complaints have occurred.
(3) The health carrier shall document the study methodology employed, including:
(a) the focused study question;
(b) the sample selection;
(c) data collection;
(d) evaluation criteria; and
(e) measurement techniques.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-303, MCA

RULE VIII ENROLLEE COMPLAINT SYSTEM (1) The health carrier shall have an internal complaint system for enrollees that complies with the requirements of 33-31-303, MCA, and ARM 6.6.2509(4).
(2) The health carrier shall conduct ongoing evaluations of all enrollee complaints, including complaints filed with participating providers. Ongoing evaluations must be conducted in accordance with [Rule VI]. The data on complaints must be reported and evaluated by the health carrier at least quarterly.
(3) Evaluation methods must permit the health carrier to track specific complaints, assess trends, and establish that corrective action is implemented and effective in improving the identified problem(s).
(4) The health carrier shall document and monitor the effectiveness of its evaluation of the enrollee complaint system and communicate it to the involved providers, enrollees, and the department upon request. The information is subject to the confidentiality requirements provided in 33-36-305, MCA.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-303, MCA

RULE IX RECORDING CONSUMER SATISFACTION (1) The health carrier shall record consumer components that identify enrollees' perceptions on the quality of the health plan's services, including:
(a) enrollee satisfaction surveys; and
(b) enrollee complaints, including:
(i) the health carrier's resolution of the complaints through its internal procedures;
(ii) independent peer reviewers' decision pursuant to 33-37-103, et seq., MCA, and ARM 37.108.301, et seq.;
(iii) arbitration decisions; and
(iv) court decisions.
(2) The health carrier shall submit documentation of its

handling of consumer satisfaction to the department by October 1 of each year.

(3) The health carrier may meet the requirements in (1)(a) of this rule regarding enrollee satisfaction surveys by submitting to the department the information required for network adequacy as specified in ARM 37.108.201, et seq., as long as the information is consistent with what is required in (1)(a) of this rule.

(4) The identities of enrollees involved in recording consumer satisfaction are subject to the confidentiality requirements provided in 33-36-305, MCA.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-303, MCA

RULE X DISCLOSURE REQUIREMENTS OF QUALITY ASSURANCE PROGRAM (1) The health carrier shall clearly disclose enrollee rights and responsibilities relating to quality assurance activities, and make information available to the department, providers, and the public about its quality assurance activities while assuring the confidentiality of enrollees pursuant to 33-36-305, MCA.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-304, MCA

RULE XI CORRECTIVE ACTION (1) The department may recommend corrective action to the health carrier in the event that the health carrier fails to comply with this subchapter.

(2) If a health carrier fails to implement adequate corrective action, the department will provide the commissioner of insurance with documentation of the health carrier's inadequacy.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-401, MCA

RULE XII INFORMAL RECONSIDERATION OF DEPARTMENT DECISION

(1) If a health carrier is aggrieved by a decision by the department pursuant to Title 33, chapter 36, part 3, MCA, and these rules, the health carrier may request an informal reconsideration of the department action as provided in ARM 37.5.311.

(2) The informal reconsideration includes:

(a) written notice to the health carrier of the department action and the findings upon which it was based, if not otherwise already provided;

(b) the health carrier's written refutation of the department's findings, which must be received by the department within 15 days after mailing of the department's notice under (2)(a); and

(c) the department's written determination modifying, affirming or reversing its decision.

(3) Any informal reconsideration under this rule is not

subject to the provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, MCA.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-401, MCA

3. In devising these proposed rules, the department reviewed managed care quality assurance rules and programs in Minnesota, Utah, Texas, Colorado, and Oklahoma. These states' rules and programs were chosen because of their rural nature and location in the midwest and west. These proposed rules for Montana contain provisions from these other states' rules, particularly those from Minnesota, a state which has had the most experience in evaluating managed care quality assurance activities.

The department also met with representatives of the Montana Commissioner of Insurance, health carriers offering managed care plans in Montana, consumer protection groups, hospital administrators, and various health associations in task force meetings held on December 14, 1999 and April 28, 2000. The department met with a smaller work group of health carriers and a representative from the Commissioner of Insurance on May 16, 2000, June 19, 2000, and January 11, 2001. The purpose of the small group meetings was to devise definite standards for proposed [Rule V].

[Rule I] is necessary to define the purpose of the rules and link them to their statutory counterpart found in Title 33, chapter 36, part 3, MCA. Other options for this rule were not considered, as it was found to be a clarifying measure for the public when reading the ensuing rules.

[Rule II] is necessary to define Health Plan Employer Data and Information Set (HEDIS), a standardized set of performance measures developed and maintained by the National Committee for Quality Assurance. [Rule II]'s definition is needed when reading proposed [Rule V], where the department proposes to use HEDIS in its analysis of quality assurance activities. Other options for this rule were not considered because it was felt to be vital when reading proposed [Rule V].

[Rule III] provides details of what is needed for a written quality assurance plan, which is required pursuant to 33-36-302, MCA. This rule provides uniform standards so that the department can systematically evaluate the different health carriers' written plans. When devising [Rule III], the department reviewed the other states' rules and adopted the substance found in Minnesota's version. The department felt Minnesota's rules provided the best and most complete information that the department wanted to see in written quality assurance plans. Minnesota's was also the most readable.

[Rule IV] is necessary to clearly define the structure of an effective and responsive quality assurance program. Subsection (1) of this rule, appointing a licensed medical physician to oversee quality assurance activities, is important in assuring that a qualified health professional is using competent medical judgment in overseeing a quality assurance program. Options considered included dropping the requirement that the medical director be licensed to practice medicine in Montana. Members in the December 14, 1999 task force meeting elected to have the state licensing requirement. Another option considered was to not have a medical physician's oversight, which the department rejected. The department felt that having no physician oversight may result in judgements being made by non-medical professionals, which could potentially lead to poor quality of services for consumers.

Subsection (2) of [Rule IV] allows health carriers to delegate quality assurance activities to another entity as long as the health carriers retain ultimate responsibility for the quality assurance activities. The department found that other states, including Minnesota, Colorado, and Oklahoma, used this rule's approach, and the department found that having the delegation option would be easier for health carriers conducting quality assurance activities. In doing so, the department chose to have the health carrier ultimately responsible for the delegated quality assurance activities, for which members in the department's task force meetings agreed to. The department felt that not having health carriers responsible for delegated activities may lead to poor delivery of health care to consumers.

[Rule V] is designed to establish HEDIS quality performance measures in the rules. HEDIS is the most widely used set of performance measures in the nation for assessing and improving the quality of manage care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance, an independent, non-profit organization that is used nationwide by government insurance programs (such as Medicaid and Medicare) and private health carriers. HEDIS measures are used to assess and report on quality assurance activities of offered managed care plans.

HEDIS was selected for [Rule V] because of the statutory mandate found in 33-36-105(2), MCA, which provides: "Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards [HEDIS]. The department shall select and adopt only standards appropriate for quality assurance in Montana."

The department considered many options in developing the HEDIS requirement in [Rule V]. One option was to spell out the HEDIS measures that the department found important to Montana consumers. However, that option was rejected by members of the task force because: HEDIS measures change on a yearly basis;

HEDIS measures are subjectively implemented based on the consumer population and services offered for each individual health carrier; and one carrier's HEDIS measurements may not be able to be compared to another's. After much work and negotiating in the department's task force meetings on May 16, 2000, June 19, 2000, and January 11, 2001, a consensus was reached to have health carriers abide by five HEDIS 2001 measures, and those measures were agreed upon by the health carrier representatives. Successive measures that may be implemented every year by HEDIS will result in amending changes to [Rule V] to reflect those new measures. Again, the department will meet with representatives of the health carriers to reach agreed-upon measurers.

Subsection (2) of [Rule V] is needed to provide criteria in assessing a managed care plan's accessibility, availability, comprehensiveness, and continuity of healthcare. Such criteria are vital in assessing potential barriers to good health care. The department reviewed other states' rules on this subject, and elected to use Minnesota's version because it provided the best detail in assessing access to care. Some members of the task force pointed out that the requirements in (2) are contained in the department's Managed Care Network Adequacy rules in ARM Title 37, chapter 108, subchapter 2. However, to provide a well-rounded sense of what quality assurance activities should be, of which enrollee access to care is part of, the department elected to retain (2), and added (5). Subsection (3) allows health carriers to submit the same information for the network adequacy rules, as long as the information is consistent with the requirements in (2).

[Rule VI] establishes how health carriers will identify actual or potential problems of quality care and determine opportunities for improving care. Through problem identification, problem selection, and corrective action, health carriers will be able to systematically monitor the effectiveness of their quality assurance programs. In reviewing other states' rules, the department chose Minnesota's as a model for [Rule VI] because the department felt Minnesota's gave the best detail in adequately performing quality improvement activities. The other states' rules were found to be too general in their approaches. [Rule VI] is needed because an adequate quality assurance program requires quality improvement to adequately address consumers' problems, which in turn will help assist a health carrier to provide better care for consumers.

[Rule VII] is necessary to establish a process which focuses on the kinds of problems or potential problems health carriers encounter. Focused studies allow for more in-depth examination of areas needing improvement. In reviewing other states' rules the department chose Minnesota's as a model for [Rule VII] because they permitted the department to make health carriers accountable for the quality of services they provide. The

alternative, not using focused studies at all, was rejected because the studies provide the best method for identifying and solving health care service problems.

[Rule VIII] regarding enrollee complaint systems is necessary to meet the primary obligation of quality assurance: Providing the best quality of care possible for consumers. By establishing a formal complaint system, [Rule VIII] defines the roles of enrollees, health carriers and the department in monitoring quality health care.

[Rule VIII] references 33-31-303, MCA, and ARM 6.6.2509, which are the Montana insurance commissioners' statute and rule regarding complaint systems in health maintenance organizations. Health maintenance organizations may consist of managed care organizations. The department felt it best to have managed care plans follow the insurance commissioner's statute and rules rather than have different, and perhaps contradictory, requirements.

Also, in drafting [Rule VIII], the department used Minnesota's model regarding enrollee complaint systems because it provided the greatest detail, which in turn will assist the department in evaluating grievance systems.

Some task force members questioned the need for [Rule VIII], saying that the department's Managed Care Network Adequacy rules found in ARM Title 37, chapter 108, subchapter 2, already provide an enrollee satisfaction procedure. ARM 37.108.207(1)(c) provides that a health carrier's access plan regarding the network of its health care providers contain: "[T]he health carrier's process for monitoring on a periodic basis the need for and satisfaction with health care services of the enrolled population and ensuring on an ongoing basis, the sufficiency of the network to meet those needs and, at a minimum, the health carrier's methods for complying with each of the standards set forth in ARM 37.108.240". ARM 37.108.240 provides that the health carrier must establish methods for periodically assessing the sufficiency of the network, and that the following be included in this assessment as they pertain to enrollee satisfaction: "...(d) enrollee satisfaction with billing and record keeping; ...(f) enrollee satisfaction with educational materials available to them; (g) enrollee satisfaction with 24-hour access to medical advice and services; (h) enrollee satisfaction with the referral process..."

The department felt that the network adequacy provisions in ARM 37.108.207(1)(c) and 37.108.240 pertained mostly to enrollee access to care within a health carrier's network of health providers, and they did not emphasize the quality of health care for enrollees. The department further felt that having an enrollee complaint system in the quality assurance rules was needed because it was part and parcel of a well-rounded quality assurance program. The department, therefore, elected to leave

[Rule VIII].

Without [Rule VIII], the department and health carriers would be failing to use one of the most effective tools available to improve the quality of health care services. The department would not be fulfilling its statutory obligation to protect consumer rights if it did not evaluate enrollee complaints on an ongoing basis.

[Rule IX] is an extension of the previous rule whereby a formal procedure is established to record consumer complaints and satisfaction with health care services. This rule is necessary because it identifies enrollees' perceptions on the quality of services, which is the essence of an effective quality assurance program. This rule also takes into consideration all avenues of resolving consumer grievances: Internal procedures within a health carrier, independent peer review decisions, arbitration decisions, and court decisions.

Without [Rule IX], it would be extremely difficult to determine if health carriers are providing the quality of health care that their consumers may expect. Not having methods to determine consumer perceptions may lead to continuous problems in the health carriers' managed care plans, which in turn may lead to substandard health care.

[Rule X] establishes requirements for disclosure of quality assurance activities. This rule is necessary because it makes health carriers accountable for their quality assurance activities, and provides needed information to consumers. In drafting this rule, the department relied on Oklahoma's disclosure requirement because the department found it contained the best substance in protecting consumer rights.

[Rules XI and XII] provide a method for the department to enforce these rules. [Rule XI] allows health carriers to enter into corrective actions with the department before any reporting to the Montana commissioner of insurance, as provided in 33-36-401, MCA. [Rule XII] provides an opportunity for informal reconsideration whenever a health carrier is not satisfied with the department's enforcement of these rules and Title 33, chapter 36, part 3, MCA, of the Montana Managed Care Plan Network Adequacy and Quality Assurance Act.

The actions contained in [Rule XI] are mandated by 33-36-401(1), MCA, which provides:

> If the department determines that a health carrier has not complied with this chapter or the rules implementing this chapter, the department may recommend corrective action to the health carrier.

No other alternatives were considered for [Rule XI] because of the statutory mandate provided in 33-36-401, MCA.

For [Rule XII], the department opted to create an informal reconsideration of any department decision, as allowed under ARM 37.5.311. ARM 37.5.311(1)(c) provided that the informal reconsideration provisions apply to cases "as otherwise provided in department rule." Ultimate enforcement authority exists with the commissioner of insurance under 33-36-401(3), MCA, which provides:

> The commissioner may take any of the following enforcement actions to require a health carrier to comply with this chapter or the rules implementing this chapter:
> (a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or
> (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3, MCA.

No alternatives were considered for [Rule XII] because of the commissioner's authority under 33-36-401(3), MCA.

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 April 5, 2001. 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.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

**BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA**

In the matter of the adoption of a rule pertaining to the administration of the 2001 Federal Community Development Block Grant Program	)))))	NOTICE OF ADOPTION OF RULE I (8.94.3717) PERTAINING TO THE ADMINISTRATION OF THE 2001 FEDERAL COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

TO: All Concerned Persons

1. On December 21, 2000, the Local Government Assistance Division published a notice of the proposed adoption of the above-stated rule at page 3493, 2000 Montana Administrative Register, issue number 24. The hearing was held on January 11, 2001.

2. The Division has adopted Rule I (8.94.3717) exactly as proposed.

3. The Division has received comments. The comments received and the Division responses are as follows:

COMMENT NO. 1: The department has proposed to continue its past policy in the ranking of applications for housing and public facilities planning grants awarding up to 50 additional points to local governments which are applying for a planning grant for the first time. This practice fails to recognize that when a county applies on behalf of an unincorporated community, only that community, not the entire county, is benefited by the proposed planning activity. Consequently, the policy unfairly penalizes other areas of the county.

RESPONSE: The department agrees and will modify its ranking criteria to give the 50 point ranking priority if the county has never applied for a planning grant for the unincorporated community in question.

COMMENT NO. 2: In addition to loans to businesses, the department has proposed the same eligible activities as under the 2000 program. This includes grants for employee training, technical assistance to the network of microbusiness development corporations, and the State Small Business Innovation Research (SBIR) Program, and the technical assistance for projects that have a statewide economic development impact. Commentators were generally favorable toward this proposal, however, two commentors expressed concern that the use of CDBG economic development funds for so many purposes would substantially reduce the amount of money that will be available for direct loans to companies.

RESPONSE: The department has proposed to spend $130,000 on technical assistance activities. This is a small portion of the $2.6 million allocated to economic development activities in 2001. Because job-training grants are an eligible activity in addition to business loans, funding is awarded on a first come, first served basis in response to the demand from communities across the state.

COMMENT NO. 3: The department has proposed to adopt two limitations on the use of CDBG grant dollars to train workers. The first of these is that the training may not extend for more than one year. The second is that upon completion of training the participating employees must be compensated at a minimum rate of $11.00 per hour in salary and benefits. This compensation requirement represents a $3.85 increase from the $7.15 per hour package required by the current program guidelines. Although commentors generally favored this proposal, some thought it was excessive for the more rural and sparsely populated communities in the state and would prevent these communities from attracting new businesses to their areas. One commentor proposed adopting wage rates that are tied to prevailing wages in the area in which the project is to be located. Another commentor thought the required wage was not high enough.

RESPONSE: The following language, already contained in the guidelines, gives the department the discretion to approve compensation at rates lower than $11.00 per hour in low wage areas where this rate might be excessive:

"The definition of what constitutes adequate benefits is subject to evaluation by Montana Department of Commerce. The department may consider projects that involve lower compensation packages only in situations where there is a significant positive impact overall on the local economy and strong community support is documented."

The department believes that this language gives it the ability to grant wage exceptions in appropriate cases. Although the application may require slightly more paperwork to document a justification for a lower wage rate, the department does not intend to adopt regional wage rates as part of the criteria for application. Because the department reviews applications on a case-by-case basis, the additional effort required to calculate regional wage rates could not be justified. Additionally, nearly all applicants will be able to meet the $11.00 per hour compensation requirement which is the same as the private average annual wage rate used by the Montana Board of Investments in its job creation programs.

COMMENT NO. 4: The department has proposed to authorize revolving loan funds (RLFs) to use up to $250,000 for loans to individual businesses that were affected by last summer's wildfires. Commentors generally endorsed this proposal but

requested clarification as to its scope and a description of the criteria the department would use in implementing it. One commentor suggested methods by which the department might most effectively distribute the funds to RLFs.

RESPONSE: The department has identified the dollar amount of business losses attributable to and the location and the type of businesses affected by the summer wildfires. The department will use this information to assist businesses that for a variety of reasons have been unable to obtain financial assistance from FEMA or SBA. The intent of the department's proposal is to provide a pool of funds to be administered at the local level with minimal restrictions. At the time of the public hearing, the department had not yet developed application criteria for these fire impact funds, but it has now done so. The department will distribute $1.25 million to the five regional lending entities whose service areas were most heavily affected by the fires.

COMMENT NO. 5: Three eastern counties requested that the department reinstate multi-project revolving loan funds (RLFs) as an eligible activity.

RESPONSE: At one time the department did fund multi-project RLFs in the hope that this arrangement would provide administrative relief to local government grantees. However, in 1999, the department stopped funding multi-project RLFs because they failed to provide the intended relief and these grants were burdensome for the department to administer and made it difficult for the department to meet HUD's requirement for the timely disbursal of funds.

COMMENT NO. 6: The department proposed to maintain its loan interest rate at 8%. All but one of the commentors thought this rate should be reduced to be more attractive. Several commentors observed that the banks can currently match the CDBG interest rate and that the job creation component and other restrictions on the use of CDBG loans outweigh the advantage of a slightly lower interest rate of the program's loans. Companies tend to use familiar loan products. If the interest rate is too high, there is a disincentive to access the CDBG program.

RESPONSE: The department's reason for proposing to maintain the 8% rate was to offset the higher risk of program loans and to provide a higher rate of return to local RLFs. However, the department agrees with these comments and will reduce the interest rate on its loans to 6.5%. This reduction is warranted by the fact that, since the proposed guidelines were first distributed for comment, the prime rate has dropped, and further reductions are expected. In addition, the lower rate is more in line with the 6.6% interest rate for the Montana Board of Investments' loan participation program.

LOCAL GOVERNMENT ASSISTANCE DIVISION

By: /s/ Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

By: /s/ Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 26, 2001

**BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA**

In the matter of the amendment of ARM 10.16.3346 and 10.16.3514, pertaining to special education	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On January 25, 2001, the Office of Public Instruction published notice of the proposed amendment of ARM 10.16.3346 and 10.16.3514, pertaining to special education, at page 148 of the 2001 Montana Administrative Register, Issue Number 2.

2. One comment was received from Pat Gum, Director of Special Education, Billings Public Schools, who commented in support of the change to ARM 10.16.3346.

3. The agency has amended ARM 10.16.3346 and 10.16.3514, as proposed.

By: /s/ Linda McCulloch
Linda McCulloch
Superintendent
Office of Public Instruction

/s/ Jeffrey A. Weldon
Jeffrey A. Weldon
Rule Reviewer
Office of Public Instruction

Certified to the Secretary of State February 26, 2001.

**BEFORE THE OFFICE OF THE WORKERS' COMPENSATION JUDGE
OF THE STATE OF MONTANA**

In the matter of the amendment of procedural rule	)))	NOTICE OF AMENDMENT OF ARM 24.5.317

TO: All Concerned Persons

1. On January 25, 2001, the Workers' Compensation Judge published notice of the proposed amendment and adoption of the above-stated rule at page 153A, 2001 Montana Administrative Register, Issue Number 2.

2. The Office of the Workers' Compensation Judge has amended ARM 24.5.317 exactly as proposed.

3. No comments or testimony were received.

By: /s/ Mike McCarter
Mike McCarter, Judge
Workers' Compensation Court

/s/ Jay Dufrechou
Jay Dufrechou, Rule Reviewer

Certified to the Secretary of State February 26, 2001.

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

In the matter of the transfer of ARM 16.24.101 through 16.24.111 pertaining to children's special health services program, ARM 16.24.201, 16.24.202, 16.24.205 through 16.24.207, 16.24.209 through 16.24.211, 16.24.213, 16.24.215 pertaining to infant screening tests and eye treatment program, ARM 16.24.1001 pertaining to block grant funds program, ARM 16.24.801 through 16.24.806 pertaining to documentation and studies of abortions and ARM 16.25.101 through 16.25.104 pertaining to family planning program deficiencies	)	NOTICE OF TRANSFER

TO: All Interested Persons

1. Pursuant to Chapter 546, Laws of Montana 1995, effective July 1, 1995, the children's special health services program, the infant screening tests and eye treatment program and the block grant funds program are transferred from the Department of Health and Environmental Sciences to the Department of Public Health and Human Services ARM Title 37, Chapter 57.

The documentation and studies of abortions program is transferred from the Department of Health and Environmental Sciences to the Department of Public Health and Human Services ARM Title 37, Chapter 21.

The family planning program deficiencies program is transferred from the Department of Health and Environmental Sciences to the Department of Public Health and Human Services ARM Title 37, Chapter 19.

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

OLD	NEW	
16.24.101	37.57.101	Purpose of Rules
16.24.102	37.57.105	General Requirements for CSHS Assistance
16.24.103	37.57.102	Definitions
16.24.104	37.57.106	Applicant Eligibility
16.24.105	37.57.110	CSHS Services
16.24.106	37.57.117	CSHS Provider Requirements
16.24.107	37.57.111	Payment Limits and Requirements
16.24.108	37.57.109	Application Procedure
16.24.109	37.57.112	Informal Reconsideration Procedure
16.24.110	37.57.118	Program Records
16.24.111	37.57.125	Advisory Committee
16.24.201	37.57.301	Definitions
16.24.202	37.57.320	Responsibilities of Registrar of Birth: Administrator of Hospital
16.24.205	37.57.304	Premature Infants: In-Hospital
16.24.206	37.57.305	Non-Premature Infants: In-Hospital
16.24.207	37.57.306	Transfer of Newborn Infant
16.24.209	37.57.307	Infant Born Outside of Hospital or Institution
16.24.210	37.57.315	Exchange Transfusion; When Specimen Taken
16.24.211	37.57.316	Positive or Suspicious Test
16.24.213	37.57.321	State Laboratory: Responsibility for Tests
16.24.215	37.57.308	Newborn Eye Treatment
16.24.1001	37.57.1001	Maternal and Child Health Block Grant: Standards for Receipt of Funds
16.24.801	37.21.101	Definitions

OLD	NEW	
16.24.802	37.21.104	Certificate of Informed Consent
16.24.803	37.21.110	Facility Report
16.24.804	37.21.111	Pathology Studies
16.24.805	37.21.105	Confidentiality
16.24.806	37.21.115	Disposition of Fetus or Dead Infant
16.25.101	37.19.101	Definitions
16.25.102	37.19.102	Investigation of Complaints
16.25.103	37.19.103	Investigation and Audit Reports: Probationary Status
16.25.104	37.19.104	Family Planning Program Termination Procedures

3. The transfer of these rules is necessary because these programs were transferred from the Department of Health and Environmental Sciences to the Department of Public Health and Human Services by the 1995 legislature by Chapter 546, Laws of Montana 1995.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

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

In the matter of the the amendment of ARM 37.70.601 pertaining to the low income energy assistance program (LIEAP)	)))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On November 9, 2000, the Department of Public Health and Human Services published notice of the proposed amendment of the above-stated rule at page 3118 of the 2000 Montana Administrative Register, issue number 21.

2. The Department has amended the following rule as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

37.70.601 BENEFIT AWARD MATRICES (1) The benefit matrices in (1)(d) and (1)(e) are used to establish the benefit payable to an eligible household for a full winter heating season (October thru April). The benefit varies by household income level, type of primary heating fuel, the type of dwelling (single family unit, multi-family unit, mobile home), the number of bedrooms in the dwelling, and the heating districts in which the household is located, to account for climatic differences across the state.

(a) through (c) remain as proposed.

(d) The following table of base benefit levels takes into account the number of bedrooms in a house, the type of dwelling structure, and the type of fuel used as a primary source of heating:

TABLE OF BENEFIT LEVELS

(i) SINGLE FAMILY

# BEDROOMS	NATURAL GAS	ELECTRIC	PROPANE	FUEL OIL	WOOD	COAL
ONE	~~$ 368~~	~~$ 436~~	~~$ 603~~	~~$ 531~~	~~$306~~	~~$242~~
	474	464	774	538	325	257
TWO	~~536~~	~~634~~	~~877~~	~~772~~	~~444~~	~~352~~
	689	674	1,125	782	472	374
THREE	~~730~~	~~864~~	~~1,195~~	~~1,052~~	~~605~~	~~479~~
	938	919	1,532	1,066	644	510
FOUR	~~1,004~~	~~1,188~~	~~1,644~~	~~1,447~~	~~833~~	~~659~~
	1,291	1,264	2,108	1,466	886	701

(ii) MULTI-FAMILY

# BEDROOMS	NATURAL GAS	ELECTRIC	PROPANE	FUEL OIL	WOOD	COAL
ONE	~~$ 312~~	~~$ 369~~	~~$ 510~~	~~$ 564~~	~~$258~~	~~$204~~
	401	392	654	572	274	217
TWO	~~469~~	~~555~~	~~768~~	~~850~~	~~389~~	~~308~~
	603	591	985	861	413	327
THREE	~~689~~	~~815~~	~~1,127~~	~~1,247~~	~~570~~	~~451~~
	885	867	1,446	1,264	607	480
FOUR	~~805~~	~~952~~	~~1,317~~	~~1,457~~	~~666~~	~~527~~
	1,034	1,012	1,689	1,476	709	561

(iii) MOBILE HOME

# BEDROOMS	NATURAL GAS	ELECTRIC	PROPANE	FUEL OIL	WOOD	COAL
ONE	~~$311~~	~~$367~~	~~$ 508~~	~~$ 469~~	~~$258~~	~~$204~~
	399	391	652	475	274	217
TWO	~~454~~	~~537~~	~~743~~	~~686~~	~~377~~	~~298~~
	584	571	953	695	400	317
THREE	~~602~~	~~712~~	~~985~~	~~909~~	~~499~~	~~395~~
	774	757	1,263	921	531	420
FOUR	~~672~~	~~795~~	~~1,100~~	~~1,014~~	~~557~~	~~441~~
	863	845	1,410	1,028	592	469

(e) remains as proposed.

AUTH: Sec. 53-2-201, MCA
IMP: Sec. 53-2-201, MCA

3. The benefit amounts specified in ARM 37.70.601 as adopted are higher than the amounts shown on the Notice of Public Hearing on Proposed Amendment which was published on page 3118 of the 2000 Montana Administrative Register, issue no. 21, because the Montana's federal LIEAP appropriation has again been increased. This additional funding is intended to offset escalating heating fuel costs. The increased benefit amounts will be applied retroactive to October 1, 2000, the beginning of the current LIEAP heating season, because this will be most advantageous to LIEAP clients and will be easier to administer.

4. No comments or testimony were received.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

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

In the matter of the adoption of the temporary emergency amendment of ARM 37.86.2801, 37.86.2905 and 37.86.3005 pertaining to medicaid reimbursement for inpatient and outpatient hospital services	)))))))	NOTICE OF ADOPTION OF TEMPORARY EMERGENCY RULES

TO: All Interested Persons

1. The Department of Public Health and Human Services is adopting the following temporary emergency rule amendment to prevent imminent harm to the public health, safety and welfare of medicaid recipients who have need of inpatient and outpatient hospital services. Imminent and substantial budget deficits in the Montana Medicaid Hospital Services program for state fiscal year 2001 require the Department to make substantial, immediate adjustments to contain medicaid reimbursement expenditures within appropriations. The emergency rules adjust reimbursement policies to reduce expenditures for services provided at hospital facilities in the state of Montana and within 100 miles of the borders of Montana, remove the capital reimbursement component from the average base price per case, adjust the statewide cost to charge ratio to 56%, conform the DRG grouper to the medicare grouper, and adjust the thresholds so that 7% of the prospective payments will be paid for charges over the cost outlier threshold. In addition, in order to be reimbursed by Montana Medicaid, all out-of-state outpatient hospital services provided to Montana Medicaid patients by facilities more than 100 miles of the nearest border of Montana will require prior authorization. These facilities will also be paid at 61% of billed charges for services that have been deemed medically necessary. The emergency reimbursement reductions were arrived at after informally notifying hospitals and their provider association and accepting comments from them. Without the emergency rule, the Department would be required to reduce rates or limit utilization of other medicaid programs to accommodate the budget deficits caused by hospital services.

Rate reductions would cause marginally profitable providers to withdraw from medicaid participation. This would reduce access to medicaid services in the geographic area served by such providers. Limited access would mean that uninsured low-income Montana Medicaid recipients in rural areas would likely delay or go without treatment for some less serious physical injuries, diseases and disorders. Without timely, adequate and appropriate treatment an imminent risk of harm to the health and safety of these individuals, their families and communities would exist. Regular rulemaking procedures would require at

least 90 days. If cost saving measures were delayed pending regular rulemaking, cuts would have to be greater to realize the same savings total.

Utilization limits would also have an adverse effect on public health. The Department's utilization limits were adopted to meet minimum health industry standards. Reduction of limits would mean that medicaid recipients would be limited to benefits below the level considered by experts to be minimally necessary for good health.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the Department no later than 5:00 p.m. on March 23, 2001, 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 text of the temporary emergency amendment of rules is as follows. Matter to be added is underlined. Matter to be deleted is interlined.

<u>37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL</u>

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

(a) remains the same.

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

(1)(a)(i)(A) and (1)(a)(i)(B) remain the same.

(C) all inpatient <u>and outpatient</u> hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana;

(1)(a)(i)(D) through (1)(f) remain the same.

(2) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"), subject to the exceptions and limitations provided in the department's administrative rules. The department hereby adopts and incorporates herein by reference Pub. 15, which is a manual published by the United States department of health and human services, health care financing administration, which provides guidelines and policies

to implement medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) Hospitals located in the state of Montana providing ~~I~~inpatient and outpatient hospital services reimbursement under the retrospective cost-based methodology for a hospital that is identified by the department as a distinct part rehabilitation unit~~,~~ or an isolated hospital ~~or an out-of-state hospital located more than 100 miles outside the state of Montana is~~ are subject to the provisions regarding cost reimbursement and coverage limits and rate of increase ceilings specified in 42 CFR 413.30 through 413.40 (1992), except as otherwise provided in these rules. The department hereby adopts and incorporates herein by reference 42 CFR 413.30 through 413.40 (1992). A copy of 42 CFR 413.30 through 413.40 (1992) may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) through (4) remain the same.

(5) For inpatient hospital services provided on or after July 1, 1993, facilities reimbursed on a retrospective cost basis must submit a cost report in accordance with the applicable subsection below to determine a base year for purposes of applying rate of increase ceilings and settling costs.

(a) remains the same.

(i) Effective March 1, 2001 all out-of-state inpatient and outpatient services for facilities defined in (5)(a) are paid at 61% of billed charges for medically necessary services.

(b) through (8) remain the same.

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

37.86.2905 INPATIENT HOSPITAL SERVICES, REIMBURSEMENT

(1) For inpatient hospital services, the Montana medicaid program will reimburse providers as follows:

(a) through (b) remain the same.

(c) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana will be reimbursed 61% of billed charges for medically necessary services for dates of service beginning March 1, 2001. ~~their actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2801(2). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000 for inpatient and outpatient hospital services provided to Montana medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the department waives retrospective cost~~

~~settlement, the provider's interim payments for the cost report period shall be the provider's final payment for such period.~~

~~(i) Hospitals located more than 100 miles outside the borders of Montana will be reimbursed on an interim basis during each facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If a provider fails or refuses to submit the financial information, including the medicare cost report necessary to determine the cost to charge ratio, the provider's interim rate will be 60% of its usual and customary charges.~~

~~(ii) Hospitals located more than 100 miles outside the borders of Montana must notify the department within 60 days of any change in usual and customary charges that will have a significant impact on the facility cost to charge ratio. A significant impact is a change in the facility cost to charge ratio of 2% or more. The department will adjust reimbursement rates to account for adjusted charges which have a significant impact on the facility cost to charge ratio. The department may adjust interim reimbursement rates to account for such increased or decreased charges.~~

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

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

(a) ~~For recipients admitted on or after July 1, 2000,~~ Prior to October 1st of each year, the department will assign~~s~~ a DRG to each medicaid discharge in accordance with the current medicare grouper program version ~~17.0~~, as developed by 3M health information systems. The assignment of each DRG is based on:

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

(c) The department computes a Montana average base price per case. This average base price per case is ~~$2337.00 including~~ $2075.00 excluding capital expenses, effective for services provided on or after ~~July 1, 2000~~ March 1, 2001.

(d) The relative weight for the assigned DRG is multiplied by the average base price per case to compute the DRG prospective payment rate for that discharge except:

(d)(i) remains the same.

(ii) where there is no weight assigned to a DRG, the DRG will be paid at the statewide cost to charge ratio as defined in ~~(13)~~ (12).

(3) remains the same.

~~(4) The department shall reimburse inpatient DRG hospital~~

~~providers for capital-related costs under a prospective payment methodology. The actual cost per case shall be computed using submitted cost reports for state fiscal year 1998. The prospective payment for capital-related costs for dates of service on or after July 1, 2000 is $262.00. The prospective capital payment amount shall be added to the base DRG amount as proposed in (2)(c).~~

(4) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, 1986. The department hereby adopts and incorporates by reference 42 CFR 412.113, subsections (a) and (b), as amended through October 1, 1986, which set forth medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

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

(ii) All out-of-state hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case is $229.00. Such rate shall be the final capital-related cost with respect to which the department waives retrospective cost settlement in accordance with these rules.

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

(5) through (11)(b)(iii) remain the same.

(12) The medicaid statewide average cost to charge ratio ~~including~~ excluding prospective capital expenses is ~~61%~~ 56% for dates of service on or after March 1, 2001.

(13) The Montana medicaid DRG relative weight values, average length of stay (ALOS), outlier thresholds and stop loss thresholds are contained in the DRG table of weights and thresholds (~~June 2000~~ March 2001 edition). The DRG table of weights and thresholds is published by the department of public health and human services. The department hereby adopts and incorporates by reference the DRG table of weights and thresholds (~~June 2000~~ March 2001 edition). Copies may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(14) through (18) remain the same.

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

37.86.3005 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT

(1) remains the same.

(2) Out-of-state facilities more than 100 miles from the nearest Montana border will be paid at 61% of billed charges for medically necessary services.

~~(2)~~ (3) Except for the services reimbursed as provided in ~~(3)~~ (2) and (4) through ~~(12)~~ (13), all facilities will be reimbursed on a retrospective basis. Allowable costs will be determined in accordance with ARM 37.86.2801(2) and subject to the limitations specified in ARM 37.86.2801(2)(a), (b) and (c). The department may waive retrospective cost settlement for such facilities which have received interim payments totaling less than $100,000.00 for inpatient and outpatient hospital services provided to Montana medicaid recipients in the cost reporting period, unless the provider requests in writing retrospective cost settlement. Where the department waives retrospective cost settlement, the provider's interim payments for the cost report period shall be the provider's final payment for the period.

(a) All facilities will be reimbursed for services subject to ~~(2)~~ (3) on an interim basis during the facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the facility's medicare intermediary or by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If a provider fails or refuses to submit the financial information, including the medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be ~~60%~~ 50% of its usual and customary charges.

~~(3)~~ (4) Except as otherwise specified in these rules, the following outpatient hospital services will be reimbursed under a prospective payment methodology for each service as described in ~~(4)~~ (5) through ~~(12)~~ (13) of this rule.

~~(4)~~ (5) Clinical diagnostic laboratory services will be reimbursed on a fee basis as follows:

(4)(a) through (4)(b) remain the same in text but are renumbered (5)(a) through (5)(b).

(c) For purposes of ~~(4)~~ (5), clinical diagnostic laboratory services include the laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology, Fourth Edition (CPT-4). Certain tests are exempt from the fee schedule. These tests are listed in the HCFA Pub-45, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology specified in ~~(2)~~ (3).

(4)(d) remains the same in text but is renumbered (5)(d).

~~(5)~~ (6) Emergency room and clinic services provided by hospitals that are not isolated hospitals or medical assistance facilities as defined in ARM 37.86.2902(17) and (18) will be

reimbursed on a fee basis for each visit as follows~~.~~:

(5)(a) through (5)(a)(iii) remain the same in text but are renumbered (6)(a) through (6)(a)(iii).

(b) Fees for emergency room and clinic service groups described in ~~(5)~~ (6)(a)(i) through (iii) above for sole community hospitals and non-sole community hospitals are specified in the department's outpatient hospital emergency room fee schedule. The department hereby adopts and incorporates herein by reference the outpatient hospital emergency room fee schedule (June 1998). A copy of the emergency room fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) Except as provided in ~~(5)~~ (6)(c)(i) and (ii), the fee specified in ~~(5)~~ (6)(b) or (d) is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment and other outpatient hospital services.

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

(ii) In addition to the fee specified for each emergency room and clinic service group, medicaid will reimburse providers separately as specified in ~~(4)~~ (5), ~~(8)~~ (9) and ~~(9)~~ (10) for laboratory, imaging and other diagnostic services provided during emergency and clinic visits.

(d) For hospital emergency room and clinic visits determined by the department to be unstable, the fee will be a stop-loss payment. If the provider's net usual and customary emergency room or clinic charges are more than 400% or less than 75% of the fee specified in ~~(5)~~ (6)(b), the visit is unstable and the net charges will be paid at the statewide cost to charge ratio specified in ~~(12)~~ (13). For purposes of the stop-loss provision, the provider's net emergency room or clinic charges are defined as total usual and customary claim charges less charges for laboratory, imaging, other diagnostic and any noncovered services.

(e) Emergency visits as defined in ~~(5)~~ (6)(a)(ii) and other emergency room and clinic visits as defined in ~~(5)~~ (6)(a)(iii) with ICD-9-CM surgical or major diagnostic procedure codes will be grouped into one of the ambulatory surgery day procedure groups described in ~~(10)~~ (11).

(6) through (9)(a) remain the same in text but are renumbered (7) through (10)(a).

~~(10)~~ (11) Ambulatory surgery services provided by hospitals that are not isolated hospitals or medical assistance facilities as defined in ARM 37.86.2902(17) and (18) will be reimbursed on a fee basis. A separate fee will be paid within each day procedure group depending on whether or not the hospital is a sole community hospital as defined in ARM 37.86.2901. Payment for ambulatory surgery services is a fee for each visit determined as follows:

(10)(a) and (10)(b) remain the same in text but are renumbered (11)(a) and (11)(b).

(c) Except as provided in ~~(10)~~ (11)(c)(i) and (ii), the payment specified in ~~(10)~~ (11)(b) or (d) is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment and other outpatient hospital services. For purposes of outpatient hospital ambulatory surgery services, a visit includes all outpatient hospital services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event.

(10)(c)(i) and (10)(c)(ii) remain the same in text but are renumbered (11)(c)(i) and (11)(c)(ii).

(d) For hospital ambulatory surgery services, day procedure groups determined by the department to be unstable will be reimbursed a stop-loss payment. If the provider's net usual and customary charges are more than 400% or less than 75% of the fee specified in ~~(10)~~ (11)(b), the day procedure group is unstable and the net charges will be paid at the statewide cost to charge ratio specified in ~~(11)~~ (13). For purposes of the stop-loss provision, the provider's net ambulatory surgery charges are defined as total usual and customary claim charges less charges for any noncovered services.

(e) If the department's outpatient hospital ambulatory surgery fee schedule described in ~~(10)~~ (11)(b) does not assign a fee for a particular DPG, the DPG will be reimbursed at the statewide average outpatient cost to charge ratio specified in ~~(11)~~ (13).

(f) Ambulatory surgery services for which the primary ICD-9-CM procedure code is not included in the day procedure grouper described in ~~(10)~~ (11)(a) will be reimbursed under the retrospective cost basis as specified in ~~ARM 37.86.3005~~(2).

~~(11)~~ (12) Partial hospitalization services will be reimbursed on a prospective per diem rate basis as follows:

(11)(a) and (11)(b) remain the same in text but are renumbered (12)(a) and (12)(b).

(c) The per diem rates specified in ~~(11)~~ (12)(a) and (b) are bundled prospective per diem rates for full-day programs and half-day programs, as defined in ARM 37.86.3001. The bundled prospective per diem rate includes all outpatient psychiatric and psychological treatments and services, laboratory and imaging services, drugs, biologicals, supplies, equipment, therapies, nurses, social workers, psychologists, licensed professional counselors and other outpatient services, that are part of or incident to the partial hospitalization program, except as provided in ~~(11)~~ (12)(d).

(11)(e) remains the same in text but is renumbered (12)(e).

~~(12)~~ (13) The medicaid outpatient hospital statewide average cost to charge ratio equals ~~.67~~ 56%.

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

3. The temporary emergency amendment will require all hospitals located more than 100 miles outside the borders of the State of Montana (out-of-state hospitals) to obtain prior authorization from the Department's designated review organization for planned outpatient hospital services. Out-of-state hospitals must obtain authorization for emergency services provided to recipients within 48 hours of providing the services to recipients of Montana Medicaid. For out-of-state hospitals, the rate of reimbursement for inpatient and outpatient services will be set at 61%.

For hospitals located in the State of Montana paid under the DRG prospective payment system, the temporary emergency adjustment changes reimbursement for capital related expenses from a prospective payment to a facility specific add-on payment. The cost to charge ratio is therefore adjusted to 56% to reflect the change in the method of reimbursing capital related expenses and the average base price per case is accordingly $2,075.00. The Department has adopted and incorporated by reference the DRG table of weights and thresholds, March 2001 edition. The weights have not been amended but the cost thresholds have been adjusted so that 7% of the prospective payments will be paid for charges over the cost outlier threshold.

Border hospitals, those outside the state but within 100 miles of the nearest Montana border, will be paid the statewide average capital cost per case as an interim capital-related cost payment. The statewide average capital cost per case adopted in these temporary emergency rules is $229.00. This shall be the final capital-related cost with respect to which the Department waives retrospective cost settlement in accordance with these rules.

The temporary emergency amendment to ARM 37.86.2905 reflects the Department's policy to update the DRG grouper every October to coincide with Medicare's policy.

The Department believes the savings of $1.4 million over the last 4 months of FY 2001 resulting from these temporary emergency rules will allow the Department to avoid an immediate rate reduction or reduction of other medicaid services. Hospital services are mandatory medicaid services and 363 hospitals will be adversely affected by these rules. However, any other cost savings would have had to come from medicaid services. The Department rejected the alternative of reducing rates or reducing other medicaid services due to the adverse impact upon the health of 68,000 individuals eligible for Montana Medicaid benefits.

4. The temporary emergency amendments will be effective March 1, 2001.

5. A standard rulemaking procedure will be undertaken by the Department prior to the expiration of the temporary

emergency rule changes.

6. Interested persons may submit their data, views or arguments during the standard rulemaking process. 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 to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, submit by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

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

In the matter of the adoption of the temporary emergency amendment of ARM 37.89.114 pertaining to mental health services plan, covered services	)))))	NOTICE OF ADOPTION OF TEMPORARY EMERGENCY RULE

TO: All Interested Persons

1. The Department of Public Health and Human Services is adopting the following temporary emergency rule amendment to prevent imminent harm to the public health, safety and welfare. Imminent and substantial budget deficits in the Mental Health Services Plan (MHSP) for state fiscal year 2001 require the Department to make immediate adjustments to covered services to contain expenditures within appropriations. The temporary emergency rule targets relatively high cost services that can be eliminated with the least detrimental effect on MHSP members.

Without the emergency rule amendment, the Department would be required to eliminate other services that would likely have a more deleterious effect on the mental health of MHSP members. Regular rulemaking would have taken at least 90 days. If cost saving measures were delayed pending regular rulemaking, cuts would have had to be greater to realize the same total savings accomplished by these rules. Such measures would have left a significant number of mentally ill individuals without treatment. Without adequate and appropriate treatment, mentally ill individuals would have suffered exacerbation of their symptoms and a deterioration in their ability to function within the community, posing an imminent risk of harm to the health and safety of those individuals, as well as to the safety of their families and communities.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on March 23, 2001, 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 text of the temporary emergency amendment of the rule is as follows. Matter to be added is underlined. Matter to be deleted is interlined.

<u>37.89.114 MENTAL HEALTH SERVICES PLAN, COVERED SERVICES</u>

(1) remains the same.

(2) Covered services include:

(a) evaluation and assessment of psychiatric conditions by licensed and enrolled mental health providers;

~~(b) psychiatric partial hospitalization services;~~

~~(c)~~ (b) residential treatment facility services for children and adolescents who are also covered by the children's health insurance program (CHIP);

~~(d)~~ (c) primary care providers, as defined in ARM 37.86.5001(18), for screening and identifying psychiatric conditions and for medication management;

~~(e)~~ (d) a psychotropic drug formulary, as specified in (6);

~~(f)~~ (e) medication management, including lab services necessary for management of prescribed medications medically necessary with respect to a covered diagnosis;

~~(g)~~ (f) psychological assessments, treatment planning, individual, group and family therapy, and consultations performed by licensed psychologists, licensed clinical social workers, and licensed professional counselors for treatment of specified diagnoses in private practice or in mental health centers;

~~(h)~~ (g) case management services for adults with severe disabling mental illness ~~and for youths with serious emotional disturbance~~;

~~(i)~~ (h) the therapeutic component of therapeutic youth group home care and therapeutic family care services for children and adolescents ~~and for members and medicaid eligible individuals,~~ who are also covered by the children's health insurance program (CHIP). ~~r~~Room and board in therapeutic youth group homes and therapeutic youth family care is covered if the therapeutic component is covered and if funding for room and board is not available from any other source; and

~~(j)~~ (i) mental health center services.

(3) through (11)(a)(ii) remain the same.

AUTH: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113, 53-6-131 and 53-6-706, MCA

IMP: Sec. 41-3-1103, 52-1-103, 53-1-405, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA

3. The temporary emergency amendment will allow the Department to implement essential cost saving measures proposed to the legislature as part of a plan required by 17-7-301, MCA to reduce current fiscal year expenditures in order to obtain a supplemental appropriation request by the Governor's budget office. These changes will eliminate coverage of psychiatric partial hospitalization services for all Mental Health Services Plan (MHSP) members and case management services for MHSP children and adolescents. The temporary emergency amendment would also limit coverage of residential treatment facility services, therapeutic youth group home services and therapeutic family care services to children who are also members of the Children's Health Insurance Plan (CHIP). The services

eliminated are high-cost services for which coverage can be eliminated with the least detrimental effect on MHSP members. The anticipated savings resulting from these rules is $1.3 million annually.

Psychiatric partial hospitalization is a high-cost service that serves a small proportion of MHSP beneficiaries. Alternative services, including day treatment and comprehensive school and community services, are more widely available and provide for better integration in mainstream school and community life. Consequently, the Department is eliminating psychiatric partial hospitalization as an MHSP covered service.

Case management is a relatively high cost service of uneven quality and undemonstrated results. Children are more likely to have other support systems, including family, case workers and educational staff, which can perform much of the linkage work case management is supposed to accomplish. Consequently, the temporary emergency amendment eliminates case management services for MHSP children.

The temporary emergency rule will eliminate coverage of residential treatment facility, therapeutic youth group home and therapeutic family care services for children who are not also enrolled in the CHIP program. The services specified are high-cost services and those for which coverage can be eliminated with the least detrimental effect on children. The services retained as part of the benefits package are those which are most commonly accessed by MHSP children and those which the Department judges to be the most cost effective treatments. The retention of residential treatment center services, therapeutic youth group home services and therapeutic family care services for children who are also enrolled in CHIP adds minimal cost, since 80% of the cost of the services not covered by CHIP will be paid with federal funds. This promotes the Department's policy of covering services for the greatest number of persons at the least cost.

The Department considered a number of other approaches to reduce current expenditures. The primary alternative to achieve the required level of cost reduction would have been to eliminate all services for this group of children. The Department has determined that level of reduction neither necessary nor advisable. Other alternatives would have involved elimination of coverage for other services which would likely have had a more deleterious effect on the mental health of MHSP members. Another alternative, decreased enrollment achieved through reductions in the maximum qualifying family income would have produced equivalent savings by completely eliminating services to now-eligible children.

The Department considered and rejected reductions to adult services or eligibility as an alternative to the reductions adopted in the temporary emergency rule. Reductions to adult

services or adult eligibility under the MHSP sufficient to achieve the same level of cost reduction would likely have resulted in substantial increases in the number of individuals committed to Montana State Hospital, substantially offsetting any benefits to the Department's budget.

4. The temporary emergency amendment will be effective March 1, 2001.

5. A standard rulemaking procedure will be undertaken by the Department prior to the expiration of the temporary emergency rule changes.

6. Interested persons may submit their data, views or arguments during the standard rulemaking process. 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 to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, submit by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@state.mt.us.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 28, 2001.

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

In the matter of the adoption of rules I through XVII and the amendment of ARM 37.86.105, 37.86.2206, 37.86.2207, 37.86.2801, 37.86.3001, 37.86.3005, 37.86.3502, 37.86.3702, 37.88.901, 37.88.905, 37.88.906, 37.88.907, 37.88.1106, 37.88.1116, 46.20.103, 46.20.106, 46.20.114, 46.20.117 and the transfer of Title 46, Chapter 20 pertaining to Mental Health Services	)	CORRECTED NOTICE OF ADOPTION, AMENDMENT AND TRANSFER

TO: All Interested Persons

1. On October 26, 2000, the Department of Public Health and Human Services published notice of the proposed adoption, amendment and transfer of the above-stated rules at page 2889 of the 2000 Montana Administrative Register, issue number 20, and on January 11, 2001 published notice of the adoption, amendment and transfer on page 27 of the 2001 Montana Administrative Register, issue number 1.

2. This corrected notice is being filed to correct a clerical error in ARM 46.20.106 [37.89.106].

3. The rule is corrected as follows:

46.20.106 MENTAL HEALTH SERVICES PLAN, MEMBER ELIGIBILITY

(1) An individual is eligible for covered services under the plan if:

(a) remains the same.

(b) the individual has been denied medicaid eligibility, is ineligible for medicaid by virtue of being a patient in an institution for mental diseases, or has applied for medicaid and the application is pending. An individual who meets medicaid eligibility requirements but does not apply for medicaid is not eligible to receive services under the plan; ~~and~~

~~(c) the individual is under the age of 19 years and the individual is enrolled in or has been denied enrollment in Montana children's health insurance program (CHIP), as established in ARM Title 37, chapter 79. For affected individuals enrolled in the plan on July 31, 2000, this requirement will be effective 60 days following the mailing of written notice by the department to the parent or guardian of record for the individual.~~

(c) the individual is under the age of 19 years and the

individual is enrolled in or has been denied enrollment in Montana children's health insurance program (CHIP), as established in ARM Title 37, chapter 79;

(d) through (6)(d)(iii) remain as proposed.

AUTH: Sec. 41-3-1103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-6-706, MCA
IMP: Sec. 41-3-1103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA

4. At the time the proposed notice of these rule changes was published, the paragraph that was shown as (1)(c) in the proposed notice reflected an emergency amendment to the rule. Please see the emergency amendment notice that was published on page 2105 of the 2000 Montana Administrative Register, issue number 15. However, when the Department adopted the permanent rule change pertaining to the emergency amendment, the text of (1)(c) was altered as proposed on page 2202 of the 2000 Montana Administrative Register, issue number 16. This altered text was adopted as published on page 3177 of the 2000 Montana Administrative Register issue number 21.

When the Department prepared the adoption notice for this transfer and amendment, the Department neglected to reflect the text change that occurred in the other emergency and amendment notices prior to the adoption notice for the transfer and amendment. The Department has published this correction notice to clarify what the actual text is in (1)(c) and apologizes for any confusion that may have resulted from this clerical error.

5. All other rule changes adopted and amended remain the same.

/s/ Dawn Sliva
Rule Reviewer

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

Certified to the Secretary of State February 26, 2001.

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 December 31, 2000. This table includes those rules adopted during the period January 1, 2001 through March 31, 2001 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 December 31, 2000, 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 2000 and 2001 Montana Administrative Registers.

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