ISSUE NO. 9

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 The Proposal Notice Section contains state agencies' proposed new, amended, or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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

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

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BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 2.59.1716 pertaining to recovery of the costs in bringing an administrative action; ARM 2.59.1741 pertaining to treatment of initial license applications submitted near year-end; and ARM 2.59.1753 pertaining to abandonment of initial license applications, all related to mortgage licensees	))))))))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On June 15, 2015, the Department of Administration proposes to amend the above-stated rules.

2. The Department of Administration will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Administration no later than 5:00 p.m. on June 4, 2015, to advise us of the nature of the accommodation that you need. Please contact Wayne Johnston, Division of Banking and Financial Institutions, P.O. Box 200546, Helena, Montana 59620-0546; telephone (406) 841-2918; TDD (406) 444-1421; facsimile (406) 841-2930; or e-mail to banking@mt.gov.

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

2.59.1716 COSTS IN BRINGING THE ADMINISTRATIVE ACTION

(1) Costs in bringing the administrative action as used in 32-9-133, MCA, ~~shall~~ include:

~~(a) examiner time charges;~~

~~(b) department legal counsel time charges;~~

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

(b)~~(d)~~ court reporter ~~costs~~ fees;

(c)~~(e)~~ transcription ~~fees~~ cost as provided under 2-4-614, MCA;

(d)~~(f) document~~ exhibit preparation ~~fees~~ cost if the exhibit was admitted into evidence at the hearing;

(e)~~(g) other hearing costs~~ deposition cost if the deposition was used at the hearing;

(f)~~(h) costs of subpoenaing documents~~ fees, if any, for service of subpoenas;

(g)~~(i) any other cost incurred by the department in bringing the action~~ witness fees and mileage for the department's lay/fact witnesses; and

~~(j) travel costs.~~

(h) mileage for the department's expert witness if the expert appears personally and testifies at the hearing.

(2) Nothing in this rule limits the department's authority under 32-9-130, MCA, to charge for a special examination performed before a department decision to initiate a contested case under the Montana Administrative Procedure Act and upon which the decision is based in whole or in part. The manner of calculating the charge for a special examination is the same as for a regularly scheduled compliance examination under 32-9-130(7), MCA.

AUTH: 32-9-130, MCA
IMP: 32-9-133, MCA

STATEMENT OF REASONABLE NECESSITY: One of the remedies available to the department under 32-9-133(2)(b), MCA, in a contested case under the Montana Administrative Procedure Act, is issuance of an order requiring reimbursement of the department's costs in bringing the administrative action. Section 2-4-104, MCA, states that rules regarding witness fees and mileage are the same in administrative contested cases as in civil actions in district court. Witness fees and mileage allowed in civil actions in district court are governed by 26-2-501 and 2-18-503, MCA, respectively. The costs that may be recovered by the prevailing party in a civil action in district court are listed in 25-10-201, MCA. Certain cost recoveries have been limited by court decisions. *See, Thayer v. Hicks*, 243 Mont. 138, 793 P.2d 784 (1990). The costs included in this rule are adapted from 25-10-201, MCA, as limited by case law, and to the extent that certain costs in 25-10-201, MCA, are ever incurred in an administrative contested case.

Section (1)(a) "examiner time charges" for a department examiner acting in the capacity of a lay/fact witness in a contested case proceeding is deleted to make the rule consistent with 25-10-201 and 26-2-501, MCA. The amendment to (1)(b) deletes "department legal counsel time charges" as a cost of bringing an administrative action to make the rule consistent with the American Rule "which provides that, absent statutory or contractual authority, attorney fees will not be awarded to the prevailing party in a lawsuit." *City of Helena v. Svee,* 2014 MT 311, ¶ 18, 377 Mont. 158, 339 P.3d 32. The cost of a hearing transcript, in (1)(c) revised, was retained in the rule but clarified by reference to 2-4-614(2), MCA. These amendments are also appropriate so as not to discourage persons from exercising their right to an administrative hearing. The addition of (2) is necessary to clarify the relationship between 32-9-133(2)(b) and 32-9-130(7)(b), MCA.

2.59.1741 PROCEDURES FOR DETERMINING FINANCIAL RESPONSIBILITY (1) through (4) remain the same.

~~(5) Applications must be deemed withdrawn or abandoned if the applicant fails to provide the information requested by the department within 60 days of notification to the applicant by the department of deficiencies in the application or December 31, whichever comes first.~~

AUTH: 32-9-130, MCA
IMP: 32-9-113, 32-9-117, 32-9-120, MCA

STATEMENT OF REASONABLE NECESSITY: Section (5) is being deleted because it unnecessarily covers the same subject matter as does ARM 2.59.1753. The deletion of (5) and the amendment of ARM 2.59.1753 in this proposal notice are intended to clarify the abandonment issue included in 32-9-120(2), MCA, and ARM 2.59.1741 and 2.59.1753.

2.59.1753 ~~APPLICATION DEEMED ABANDONED~~ APPLICATIONS FOR INITIAL LICENSE NEAR YEAR-END; WHEN APPLICATION FOR INITIAL LICENSE MAY BE DEEMED ABANDONED (1) An application for initial license submitted to the department through NMLS during the period of November 1 through December 31 is deemed an application for licensure for the next calendar year unless the following conditions are met:

(a) the applicant requests expedited processing of the application and issuance of a license for the remainder of the calendar year in which the application is submitted;

(b) the application is complete and contains no deficiencies; and

(c) the department has sufficient time and staff resources to accommodate the applicant's request during the period November 1 through December 31, which coincides with the renewal period for current licensees. Current licensees' renewal applications are given administrative priority over applications for initial licensure.

(2) All licenses expire on December 31 regardless of issuance date. A person whose license has expired may not engage in the activities for which the license was issued. Reinstatement of an expired license is governed by ARM 2.59.1731.

(3)~~(1)~~ An application for initial license may be ~~is~~ deemed abandoned if the applicant fails to provide the documents or information requested by the department within 60 days of notification to the applicant of the deficiencies ~~to applicant by the department or December 31, whichever comes first~~.

(a) If the 60-day period following notification of deficiencies has not elapsed by December 31, the application is deemed an application for the next calendar year and will be processed without submission of a new application and fee.

(b) Except as provided in (4), the application may be deemed abandoned if the requested documents or information have not been provided within the remainder of the 60-day period in the new year.

(4) The department may grant a 30-day extension of the 60-day period included in (3) if requested by the applicant in writing before the lapse of the 60-day period and if the department determines that the applicant is diligently attempting to obtain the documents or information, or that the applicant has produced satisfactory evidence that the documents or information do not exist.

(a) When the 30-day extension period expires, the application is deemed abandoned if the applicant has not produced the documents or information or satisfactory evidence that the documents or information do not exist.

(b) The licensing process may be started anew with the submission of a new license application and fee.

(5) The 60-day period for providing documents or information requested by the department and any 30-day extension granted by the department under (3) and

(4) are applicable only to persons applying for initial licensure. These time periods do not apply to renewal applicants.

AUTH: 32-9-120, 32-9-130, MCA
IMP: 32-9-120, 32-9-134, MCA

STATEMENT OF REASONABLE NECESSITY: The department believes that clarifying the issue of license application abandonment and streamlining the licensing function are in the public interest to assure acceptable turnaround time for the processing of license applications and continued delivery of superior service to industry applicants and the public they serve. In addition, a need exists to include in rule the priority of license renewals over applications for initial licensure at year-end when department staff members are busy processing renewals. Persons whose licenses expire on December 31 cannot continue to perform their job functions until the licenses are reinstated. That circumstance affects employers and the continuity of services to their customers. Applications for initial licensure are generally more time-consuming to process than are renewal applications and can create a bottleneck during the renewal period of November 1 through December 31.

Sections (3) and (4) are only applicable to persons applying for initial licensure and not to renewal applicants because 32-9-134(3), MCA, states any license not renewed by December 31 expires, and ARM 2.59.1731 includes the requirements, procedure, and time period for reinstatement of expired licenses.

The department believes the rule amendments fairly balance the interests of new license applicants and renewing licensees. The amendments are also necessary because the department has an obligation to promptly identify abandoned applications and an obligation to use department resources to maintain the integrity of the NMLS database by devoting those resources to applicants who are responsive and diligent concerning their pending license applications.

An amendment is needed to add an authority citation because 32-9-120, MCA, provides authority only for rulemaking concerning the issue of application abandonment. The amendments address a slightly broader spectrum of related issues not limited to abandonment. The addition of 32-9-134, MCA, as an implemented citation is necessary because provisions in this rule distinguish abandonment of initial applications and expiration, reinstatement, and termination of licenses.

4. Concerned persons may present their data, views, or arguments concerning the proposed action in writing to Lorraine A. Schneider, Legal Counsel, Division of Banking and Financial Institutions, P.O. Box 200546, Helena, Montana 59620-0546; faxed to the office at (406) 841-2930; or e-mailed to banking@mt.gov; and must be received no later than 5:00 p.m., June 11, 2015.

5. If persons who are directly affected by the proposed action wish to express their data, views, or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments to the person listed in 4 above no later than 5:00 p.m., June 11, 2015.

6. If the Division of Banking and Financial Institutions receives requests for a public hearing on the proposed action from either 10 percent or 25, whichever is less, of the persons directly affected by the proposed action; from the appropriate administrative rule review committee of the Legislature; from a governmental subdivision or agency; or from an association having not fewer than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be 230 persons based on the 2,303 existing mortgage licensees.

7. An electronic copy of this proposal notice is available through the department's web site at http://doa.mt.gov/administrativerules. The department strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that if a discrepancy exists between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the department works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

8. The Division of Banking and Financial Institutions maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this division. Persons who wish to have their name added to the mailing list shall make a written request that includes the name, mailing address, and e-mail address of the person to receive notices and specifies that the person wishes to receive notices regarding division rulemaking actions. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written requests may be mailed or delivered to Wayne Johnston, Division of Banking and Financial Institutions, 301 S. Park Ave., Ste. 316, P.O. Box 200546, Helena, Montana 59620-0546; faxed to the office at (406) 841-2930; e-mailed to banking@mt.gov; or may be made by completing a request form at any rules hearing held by the department.

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

10. The department has determined that under 2-4-111, MCA, the proposed rule amendments will not significantly and directly affect small businesses.

By: Sheila Hogan
Sheila Hogan, Director
Department of Administration

By: Michael P. Manion
Michael P. Manion, Rule Reviewer
Department of Administration

Certified to the Secretary of State May 4, 2015.

BEFORE THE DEPARTMENT OF COMMERCE
OF THE STATE OF MONTANA

In the matter of the repeal of ARM 8.99.1001, 8.99.1002, 8.99.1003, and 8.99.1004 pertaining to the implementation of the Montana Indian Language Preservation Pilot Program	)))))	NOTICE OF PROPOSED REPEAL NO PUBLIC HEARING CONTEMPLATED

1. On June 13, 2015, the Department of Commerce proposes to repeal the above-stated rules.

2. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact Department of Commerce no later than 5:00 p.m. on June 1, 2015, to advise us of the nature of the accommodation that you need. Please contact Bonnie Martello, Paralegal, Director's Office, Department of Commerce, 301 South Park Avenue, P.O. Box 200501, Helena, Montana 59620-0501; telephone (406) 841-2596; fax (406) 841-2701; TDD (406) 841-2702; or e-mail bmartello@mt.gov.

3. The department proposes to repeal the following rules:

8.99.1001 PERFORMANCE AND OUTPUT STANDARDS

AUTH: 20-9-537, MCA
IMP: 20-9-537, MCA

8.99.1002 DISTRIBUTION OF $2 MILLION IN MONTANA INDIAN LANGUAGE PRESERVATION PILOT PROGRAM GRANT FUNDS FOR THE 2014-2015 BIENNIUM

AUTH: 20-9-537, MCA
IMP: 20-9-537, MCA

8.99.1003 ACCOUNTING OF FUNDS IN THE MONTANA INDIAN LANGUAGE PRESERVATION PILOT PROGRAM

AUTH: 20-9-537, MCA
IMP: 20-9-537, MCA

8.99.1004 USE OF FUNDS IN THE MONTANA INDIAN LANGUAGE PRESERVATION PILOT PROGRAM

AUTH: 20-9-537, MCA
IMP: 20-9-537, MCA

REASON: In order to more efficaciously administer the Montana Indian Language Preservation Program, each of the four administrative rules attached to 20-9-537, MCA, need to be repealed. These rules are obsolete in that they include old dates and do not reflect the key takeaways from the initial pilot program. House Bill 559 has language that amends 20-9-537, MCA, to include new dates, modified program activities, various partners, and a new appropriation amount. This will allow the department to establish modified program guidelines to generate an accurate and updated contractual agreement with each of the tribal communities that aligns with House Bill 559.

4. Concerned persons may submit their data, views, or arguments in written form or a request for opportunity to submit data, views, or arguments in oral form to: Casey Lozar, Department of Commerce, 301 South Park Avenue, P.O. Box 200505, Helena, Montana, 59620-0505; telephone (406) 841-2821; TDD (406) 841-2731; facsimile (406) 841-2731; or e-mail to clozar@mt.gov, and must be received no later than 5:00 p.m., June 11, 2015.

5. If persons who are directly affected by the proposed action wish to express their data, views, or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments to Bonnie Martello at the above address no later than 5:00 p.m., June 11, 2015.

6. If the agency receives requests for a public hearing on the proposed action from either 10 percent or 25, whichever is less, of the persons directly affected by the proposed action; from the appropriate administrative rule review committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Ten percent of those directly affected has been determined to be one, based on an estimated 8 eligible applicants (each of the 8 tribal nations of Montana) for Montana Indian Language Preservation Program. Notice of the hearing will be published in the Montana Administrative Register.

7. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 4 above or may be made by completing a request form at any rules hearing held by the department.

8. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed

text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

9. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsor, Senator Jonathan Windy Boy, was contacted on May 4, 2015 by e-mail at senatorjwb@gmail.com.

10. With regard to the requirements of 2-4-111, MCA, the department has determined that the repeal of the above-referenced rules will not significantly and directly impact small businesses.

/s/ G. Martin Tuttle
G. MARTIN TUTTLE
Rule Reviewer

/s/ Douglas Mitchell
Douglas Mitchell
Deputy Director
Department of Commerce

Certified to the Secretary of State May 4, 2015.

BEFORE THE FISH AND WILDLIFE COMMISSION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 12.11.501 and the adoption of New Rule I pertaining to recreational use on Silver Lake in Deer Lodge County	)))))	NOTICE OF PROPOSED AMENDMENT AND ADOPTION NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On August 14, 2015, the Fish and Wildlife Commission (commission) proposes to amend and adopt the above-stated rules.

2. The commission will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m. on May 29, 2015, to advise us of the nature of the accommodation that you need. Please contact Jessica Snyder, Department of Fish, Wildlife and Parks, P.O. Box 200701, Helena, Montana, 59620-0701; telephone (406) 444-9785; or e-mail jesssnyder@mt.gov.

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

12.11.501 LIST OF WATER BODIES The following is a list of specific regulations on bodies of water with the reference where the rules regarding those bodies of water are located:

(1) through (96) remain the same.

(97) Silver Lake [NEW RULE I]

(97) through (114) remain the same but are renumbered (98) through (115).

AUTH: 23-1-106, 87-1-301, 87-1-303, MCA
IMP: 23-1-106, 87-1-303, MCA

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

NEW RULE I SILVER LAKE (1) Silver Lake is located in Deer Lodge County.

(2) The water within 100 feet of the intake structure is closed to all boating, sailing, floating, and swimming. The closed water will be identified and delineated by buoys or signs.

AUTH: 87-1-303, MCA
IMP: 87-1-303, MCA

REASON: Butte-Silver Bow County submitted a petition requesting the commission

adopt a rule restricting all watercraft on Silver Lake to a no wake speed and the commission proposed recreational use rules on January 29, 2015. On April 15, 2015, the commission voted to not adopt the rule because it was overly restrictive and unwarranted. The commission is proposing a rule that addresses Butte-Silver Bow County's concerns about safety around the intake structure but allows various recreational uses on the lake. Acquisition, placement, and maintenance of buoys or signs identifying the closed area are the responsibility of Butte-Silver Bow County.

5. Concerned persons may submit their data, views, or arguments concerning the proposed action to Sharon Rose, Fish, Wildlife and Parks, 3201 Spurgin Road, Missoula, MT, 59804; fax 406-542-5529; e-mail shrose@mt.gov, and must be received no later than June 12, 2015.

6. If persons who are directly affected by the proposed actions wish to express their data, views, or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments to Sharon Rose at the above address no later than 5:00 p.m., May 29, 2015.

7. If the agency receives requests for a public hearing on the proposed action from either 10 percent or 25, whichever is less, of the persons directly affected by the proposed action; from the appropriate administrative rule review committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be more than 25 persons based on the number of people who may recreate on Silver Lake in Montana.

8. The department maintains a list of interested persons who wish to receive notice of rulemaking actions proposed by the department or commission. Persons who wish to have their name added to the list shall make written request that includes the name and mailing address of the person to receive the notice and specifies the subject or subjects about which the person wishes to receive notice. Such written request may be mailed or delivered to Fish, Wildlife and Parks, Legal Unit, P.O. Box 200701, 1420 East Sixth Avenue, Helena, MT 59620-0701, or may be made by completing the request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site

may be unavailable during some periods, due to system maintenance or technical problems.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment and adoption of the above-referenced rules will not significantly and directly impact small businesses.

/s/ Dan Vermillion	/s/ William Schenk
Dan Vermillion, Chairman	William Schenk
Fish and Wildlife Commission	Rule Reviewer

Certified to the Secretary of State May 4, 2015.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of NEW RULE I requests for information, the amendment of ARM 24.11.101, 24.11.317, 24.11.511, and 24.11.534, and the repeal of ARM 24.11.901, 24.11.902, 24.11.903, 24.11.904, 24.11.907, 24.11.908, 24.11.909, and 24.11.2231 regarding unemployment insurance	))))))))))	AMENDED NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On June 10, 2015, at 9:00 a.m., the Department of Labor and Industry (department) will hold a public hearing in the Sanders Auditorium of the DPHHS Building at 111 North Sanders Street, Helena, Montana, 59601, to consider the proposed adoption, amendment, and repeal of the above-stated rules.

2. On April 16, 2015, the department published MAR Notice No. 24-11-304 pertaining to the public hearing on the proposed adoption, amendment, and repeal of the above-stated rules at page 357 of the 2015 Montana Administrative Register, Issue Number 7. Due to technical issues the department did not timely send a copy of that notice to interested persons, and therefore this amended notice is being made so that interested persons may be notified as required by law. The substantive text of the proposed amendments, adoptions, and repeals is the same as originally published. The full text of the proposed amendments, adoptions, and repeals is printed below, so that interested persons will not have to refer to the original notice.

3. The department will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Labor and Industry no later than 5:00 p.m. on June 4, 2015, to advise us of the nature of the accommodation that you need. Please contact Rachel Bawden, P.O. Box 8020, Helena, MT 59604-8020; telephone (406) 444-2582; fax (406) 444-2993; Montana Relay Service at 711; or e-mail rbawden@mt.gov.

4. The department proposes to adopt the following rule:

NEW RULE I REQUESTS FOR INFORMATION (1) Persons desiring information concerning the unemployment insurance program and public participation may contact the Unemployment Insurance Division, P.O. Box 8020, Helena, Montana 59604-8020 or visit the division's web site at www.uid.dli.mt.gov.

AUTH: 39-51-302, 39-51-603, MCA

IMP: 39-51-301, 39-51-303, 39-51-603, MCA

REASON: The department is proposing this new rule to clearly set forth the mailing address and web address of the unemployment insurance division to facilitate general information requests.

5. The department proposes to amend the following rules, new matter underlined, deleted matter interlined:

24.11.101 DIVISION ORGANIZATION--LOCATION (1) and (2) remain the same.

(3) The address and contact numbers for the department's main office in Helena are as follows:

Unemployment Insurance Division
Montana Department of Labor and Industry
1315 East Lockey Street
P.O. Box 8020
Helena, MT 59604-8020
Telephone: (406) 444-3555
Fax: (406) 444-~~1394~~ 2993
~~TTY/TTD: (406) 444-0532~~ Montana Relay Service at 711
e-mail: contact links are included on the unemployment insurance web page at: http://uid.dli.mt.gov~~/uid/contact.asp~~

(4) remains the same.

(5) The Unemployment Insurance Internet Application for filing a benefit claim (UI4U) is at: http://ui4u.mt.gov.

(6) The unemployment insurance web portal for registering, filing, and paying employer taxes is at: http://uieservices.mt.gov.

AUTH: 2-4-201, 39-51-302, MCA
IMP: 2-4-201, 39-51-301, MCA

REASON: The department is amending (3) to provide the current street address, telephone, facsimile, and e-mail contact information for the unemployment insurance division. The department is amending (5) and adding (6) to set forth the separate web portals for filing benefits claims and for employers to utilize for unemployment insurance tax purposes.

24.11.317 NOTICE OF HEARINGS (1) through (4) remain the same.

(5) The advance notice requirements in (2) and (3) do not apply to rescheduled hearings or rescheduled prehearing conferences.

AUTH: 39-51-301, 39-51-302, MCA
IMP: 39-51-1109, 39-51-2407, MCA

REASON: The department is adding (5) to clarify that unemployment hearings may be rescheduled after the issuance of the initial ten- or twenty-day notice. By

necessity, notice to parties participating in a rescheduled hearing or prehearing conference may be a shorter period of time.

24.11.511 SCOPE AND PURPOSE--MODEL LANGUAGE (1) ARM ~~24.11.511, 24.11.513,~~ 24.11.515, 24.11.516, 24.11.517, 24.11.518, 24.11.521, 24.11.523, 24.11.525, 24.11.531, and 24.11.534 govern the department's procedures relative to its administrative cooperation with other states adopting similar rules or regulations to implement the interstate benefit payment plan, to which the department is signatory, to provide for the payment of benefits to interstate claimants. In the interest of promoting uniformity of interpretation and consistency of application between Montana and the other states, the department has adopted, with minor modifications, the model rule language promulgated by the interstate conference of employment security agencies. The duties and responsibilities imposed by this subchapter are binding only on the state of Montana in its role as an agent state or as a liable state.

AUTH: 39-51-301, 39-51-302, MCA
IMP: 39-51-504, MCA

REASON: The department determined it is reasonably necessary to delete reference to ARM 24.11.513, which was repealed in 2014. Additionally, the department is eliminating the rule's internal reference to itself, as this is unnecessary and potentially confusing to the reader.

24.11.534 EXTENSION OF INTERSTATE BENEFIT PAYMENT PLAN TO INCLUDE CLAIMS TAKEN IN AND FOR CANADA (1) ARM 24.11.511, ~~24.11.513,~~ 24.11.515, 24.11.516, 24.11.517, 24.11.518, 24.11.521, 24.11.523, 24.11.525, and 24.11.531~~, and 24.11.534~~ shall apply in all their provisions to claims taken in and for Canada.

AUTH: 39-51-301, 39-51-302, MCA
IMP: 39-51-504, MCA

REASON: The department determined it is reasonably necessary to delete reference to ARM 24.11.513, which was repealed in 2014. Additionally, the department is eliminating the rule's internal reference to itself, as this is unnecessary and potentially confusing to the reader.

6. The department proposes to repeal the following rules:

24.11.901 STATISTICAL MANUALS AND INFORMATION located at ARM page 24-683.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: The department no longer publishes a document entitled Montana Employment and Labor Force. Therefore, this rule is no longer necessary.

24.11.902 SUGGESTIONS FOR OPERATIONAL AND PROCEDURAL CHANGES--COMPLAINTS located at ARM page 24-683.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: The department now manages the unemployment insurance program from the central office of the division in Helena, rather than out of Montana's local job service centers. Because questions, comments, and suggestions are now directed to the central division office, this rule is no longer necessary.

24.11.903 INFORMATIONAL BULLETINS located at ARM page 24-683.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: The department determined that this rule is no longer necessary since the department uses a variety of means to distribute information on the unemployment insurance program to claimants, employers, and the general public. The department customarily issues press releases related to labor statistics and special programs, such as those that provide for extended benefits. Employers are informed about changes in law, rule, or procedure by web site postings, direct mailing, and the addition of informational inserts in departmental communications.

24.11.904 RESPONSE TO INQUIRIES AND SUGGESTIONS located at ARM page 24-683.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: The department is repealing this rule because 72 hours may be an unrealistic time frame for the agency to respond to requests for public information. The department responds to all information requests as soon as possible and always within a reasonable period of time, and has determined this rule is unnecessary.

24.11.907 MEETINGS WITH OFFICE MANAGERS, SUPERVISORS, DEPUTY ADMINISTRATORS, AND OTHER OFFICIALS located at ARM page 24-683.1.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: All state agencies are required to comply with the public participation provisions of the Montana Administrative Procedure Act. At all times, the public is invited and encouraged to participate in the rulemaking process and departmental meetings of significant public interest. Therefore, the department determined this rule is unnecessary and is proposing its repeal.

24.11.908 COPIES OF STATUTES AND REGULATIONS located at ARM page 24-683.1.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: The department determined it is reasonably necessary to repeal this unnecessary rule as the unemployment insurance statutes and rules are readily available on the department web site, the Montana Secretary of State's web site, and various other electronic formats. The department customarily provides copies of all pertinent statutes and rules to claimants and employers with every notice of departmental action regarding the adjudication of claims. As well, the department provides copies of the unemployment insurance statutes and rules to the public upon request, at no cost.

24.11.909 POLICIES AND OBJECTIVES located at ARM page 24-683.2.

AUTH: 2-4-103, MCA
IMP: 2-4-103, MCA

REASON: All state agencies are required to comply with the public participation provisions of the Montana Administrative Procedure Act. The public is always invited and encouraged to participate in the rulemaking process and departmental meetings of significant public interest. Therefore, the department determined this rule is unnecessary and is proposing its repeal.

24.11.2231 BENEFIT OVERPAYMENTS--CREDITING EMPLOYER ACCOUNTS located at ARM page 24-724.

AUTH: 39-51-301, 39-51-302, MCA
IMP: 39-51-1110, MCA

REASON: The department determined this rule is unnecessary and redundant as it merely references the general rule regarding the crediting of employer accounts.

7. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Rachel Bawden, P.O. Box 8020, Helena, MT 59604-8020; telephone (406) 444-2582; fax (406) 444-2993; Montana Relay Service at 711; or e-mail rbawden@mt.gov., and must be received no later than 5:00 p.m., June 17, 2015.

8. The department's Office of Administrative Hearings has been designated to preside over and conduct this hearing.

9. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request, which includes the name and e-mail or mailing address of the person to receive notices, and specifies the particular subject matter or matters regarding which the person wishes to receive notices. Such written request may be mailed or delivered to the Department of Labor and Industry, attention: Mark Cadwallader, 1327 Lockey Avenue, P.O. Box 1728, Helena, Montana 59624-1728, faxed to the department at (406) 444-1394, e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency

10. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

11. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

12. With regard to the requirements of 2-4-111, MCA, the department has determined that the adoption, amendment, and repeal of the above-referenced rules will not significantly and directly impact small businesses.

/s/ MARK CADWALLADER
Mark Cadwallader
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015.

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

In the matter of the amendment of ARM 24.159.1010 standards related to intravenous (IV) therapy, and the adoption of NEW RULES I through IV related to nurse licensure compact	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On June 5, 2015, at 1:00 p.m., a public hearing will be held in the Small Conference Room, 301 South Park Avenue, 4th Floor, Helena, Montana, to consider the proposed amendment and adoption of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Nursing (board) no later than 5:00 p.m., on May 29, 2015, to advise us of the nature of the accommodation that you need. Please contact Cynthia Gustafson, Board of Nursing, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2380; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; or nurse@mt.gov (board's e-mail).

3. GENERAL REASONABLE NECESSITY: The 2015 Montana Legislature enacted House Bill 147, an act adopting the nurse licensure compact (Compact). The bill was signed by the governor February 27, 2015, and the Compact will become effective on October 1, 2015. Article VIII of the Compact requires the board to adopt uniform rules developed by the Compact administrators, and the board is proposing New Rules I through IV to comply with that requirement. The board is proposing these new rules to further implement the Compact legislation and to be consistent with other states that are Compact parties. Where additional specific bases for a proposed action exist, the board will identify those reasons immediately following that rule.

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

24.159.1010 STANDARDS RELATED TO INTRAVENOUS (IV) THERAPY

(1) through (2)(i) remain the same.

(j) initiate and administer IV medications and fluids ~~that are commercially prepared or mixed and properly labeled by a registered nurse, pharmacist, physician, podiatrist, APRN, or dentist, in accordance with ARM 24.174.511~~ with the exception of the medications specifically prohibited in ARM 24.159.1011;

(k) through (3) remain the same.

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

REASON: The board is amending this rule to address ongoing confusion regarding LPN scope of practice relative to intravenous (IV) therapy. In October 2011, the board amended ARM 24.159.1011 to remove "mix unit dose IV medication solutions" from those IV therapy procedures that LPNs are prohibited from performing. The board intended for the amendment to clarify for LPNs their ability to mix IV medications.

However, the board has continued to receive questions because (2)(j) of this rule seems to limit LPNs to mixing only those IV medications and fluids that are commercially prepared or mixed and properly labeled by another health care professional. The board is now amending (2)(j) to clarify that LPNs can mix and administer IV medications not otherwise specifically prohibited by ARM 24.159.1011.

5. The proposed new rules provide as follows:

NEW RULE I DEFINITIONS (1) For the purpose of the Compact:

(a) "Board" means the Montana Board of Nursing.

(b) "Information system" means the coordinated licensure information system.

(c) "Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.

(d) "Public" means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc.

AUTH: Chapter 65, Laws of 2015, MCA
IMP: Chapter 65, Laws of 2015, MCA

NEW RULE II ISSUANCE OF A LICENSE BY A COMPACT STATE

(1) For the purposes of this Compact:

(a) No applicant for initial licensure will be issued a compact license granting a multistate privilege to practice, unless the applicant first obtains a passing score on the applicable NCLEX examination or any predecessor examination used for licensure.

(b) A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include, but is not limited to:

(i) driver's license with a home address;

(ii) voter registration card displaying a home address;

(iii) federal income tax return declaring the primary state of residence;

(iv) Military Form No. 2058 - state of legal residence certificate; or

(v) W2 form U.S. Government or any bureau, division, or agency thereof indicating the declared state of residence.

(c) A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued.

(d) A license issued by a party state is valid for practice in all other party states, unless clearly designated as valid only in the state which issued the license.

(e) When the board issues a license authorizing practice only in Montana and not authorizing practice in other party states, the license shall be clearly marked with words indicating that it is valid only in Montana as the state of issuance.

(f) A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 90 days.

(g) The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the 90-day period in (f) shall be stayed until resolution of the pending investigation.

(h) The former home state license shall no longer be valid upon the issuance of a new home state license.

(i) If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten business days, and the former home state may take action in accordance with that state's laws and rules.

AUTH: Chapter 65, Laws of 2015, MCA
IMP: Chapter 65, Laws of 2015, MCA

NEW RULE III LIMITATIONS ON MULTISTATE LICENSURE PRIVILEGE - DISCIPLINE (1) Home state boards shall include in all licensure disciplinary orders and/or agreements that limit practice and/or require monitoring the requirement that the licensee subject to said order and/or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order and/or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state boards.

(2) An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued.

AUTH: Chapter 65, Laws of 2015, MCA
IMP: Chapter 65, Laws of 2015, MCA

NEW RULE IV INFORMATION SYSTEM (1) Levels of access:

(a) The public shall have access to nurse licensure information limited to:

(i) the licensee's name;

(ii) jurisdiction(s) of licensure;

(iii) licensure expiration date(s);

(iv) licensure classification(s) and status(es);

(v) public emergency and final disciplinary actions, as defined by contributing state authority; and

(vi) the status of multistate licensure privileges.

(b) Nonparty state boards shall have access to all information system data except current significant investigative information and other information as limited by contributing party state authority.

(c) Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state authority.

(2) The licensee may request in writing to the home state board to review the data relating to the licensee in the information system. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and within ten business days correct inaccurate data to the information system.

(3) The board shall report to the information system within ten business days:

(a) disciplinary action, agreement, or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority);

(b) dismissal of complaint; and

(c) changes in status of disciplinary action or licensure encumbrance.

(4) Current significant investigative information shall be deleted from the information system within ten business days upon report of disciplinary action, agreement, or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.

(5) Changes to licensure information in the information system shall be completed within ten business days upon notification by a board.

AUTH: Chapter 65, Laws of 2015, MCA
IMP: Chapter 65, Laws of 2015, MCA

6. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Nursing, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to nurse@mt.gov, and must be received no later than 5:00 p.m., June 12, 2015.

7. An electronic copy of this notice of public hearing is available at www.nurse.mt.gov (department and board's web site). The department strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the department strives to keep its web site

accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

8. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Nursing, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; faxed to the office at (406) 841-2305; e-mailed to nurse@mt.gov; or made by completing a request form at any rules hearing held by the agency.

9. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsor was contacted on April 15, 2015, by electronic mail.

10. With regard to the requirements of 2-4-111, MCA, the board has determined that the amendment of ARM 24.159.1010 will not significantly and directly impact small businesses.

With regard to the requirements of 2-4-111, MCA, the board has determined that the adoption of NEW RULES I through IV will not significantly and directly impact small businesses.

Documentation of the board's above-stated determinations is available upon request to the Board of Nursing, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to nurse@mt.gov.

11. Cynthia Gustafson, executive officer, has been designated to preside over and conduct this hearing.

BOARD OF NURSING
HEATHER O'HARA, RN, PRESIDENT

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015

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

In the matter of the amendment of ARM 24.171.502 outfitter qualifications	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On June 8, 2015, at 2:00 p.m., a public hearing will be held in the Large Conference Room, 301 South Park Avenue, 4th Floor, Helena, Montana, to consider the proposed amendment of the above-stated rule.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Outfitters (board) no later than 5:00 p.m., on May 29, 2015, to advise us of the nature of the accommodation that you need. Please contact Steve Gallus, Board of Outfitters, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2370; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; or dlibsdout@mt.gov (board's e-mail).

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

24.171.502 OUTFITTER QUALIFICATIONS (1) An applicant for an outfitter license shall have the qualifications to provide all services and use all equipment necessary to provide the functions of an outfitter that the license will authorize the applicant to provide. In addition, the applicant shall have:

(a) for a fishing outfitter applicant applying on or after January 1, 2016:

(i) a minimum of three years and 120 days of verified experience as a licensed guide working for a licensed outfitter in this state, guiding clients and using methods for pursuing fish; or

(ii) a minimum of three years and 120 days of verified experience as a licensed outfitter in another state guiding clients and using methods for pursuing fish, subject to approval by the board; or

(b) for all other applicants:

~~(a)~~ (i) 100 days of verified experience as a licensed guide working for a licensed outfitter in this state, guiding clients in pursuing the types of game and using methods for which licensure is sought by the applicant ~~(hunting or fishing)~~; or

~~(b)~~ (ii) 100 days of verified experience as a licensed outfitter in another state guiding clients in pursuing the types of game and using the methods for which licensure is sought by the applicant ~~(hunting or fishing)~~, subject to approval by the board.~~; and~~

~~(c) the qualifications to provide all services and use all equipment necessary to provide the functions of an outfitter that the license will authorize the outfitter to provide.~~

(2) through (4) remain the same.

AUTH: 37-1-131, 37-47-201, MCA
IMP: 37-47-201, 37-47-302, 37-47-304, 37-47-307, 37-47-308, MCA

REASON: Unlike hunting guides, fishing guides are quite capable of accumulating the currently required number of experience days to become a licensed outfitter within a single calendar year. Some reasons not unique to fishing guides include the growing demand for outfitter services and the availability of multiple experience waivers. However, fishing guides also have a much longer season to acquire experience compared to the general hunting season.

The board notes that the in-field experience requirement is the sole one-time objective qualifier of a fishing outfitter applicant's practical knowledge and capability regarding equipment handling, river and waterbody conditions, associated hazards, and fishing techniques in order to provide and supervise licensed guides in providing quality fishing services while protecting the public health, safety, and welfare. Therefore, to promote an improved competence in the profession, it is reasonably necessary to amend the experience requirement for outfitter qualification with fishing endorsement to reflect the historical approach and intent of multi-season, multi-year experience required as a licensed guide before graduating to a licensed outfitter.

Requiring multiple seasons of experience will allow guides to develop more maturity over time and ensure more experience working with clients and engaging with other members of the public in the field. Guides with more in-field experience under the mentoring of outfitters are expected to develop a greater capacity for working well with others, especially as public resources fall under increased pressure, and those guides will be better prepared to assume the added responsibilities placed upon outfitters. The board finds that increased experience in the field with clients will result in more skilled and knowledgeable guides and will lead to improved experiences for their clients and the members of the general public in the field.

In addition, the board finds this rule amendment an implementation of its "policy, intent, and purpose," according ARM 24.171.101(2), to "provide quality regulatory functions and services to the profession it regulates and the public in order to promote, maintain, and preserve an ever-improving high degree of competence in the profession, satisfaction in the public, and an everlasting environment in which the profession operates."

4. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Outfitters, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to dlibsdout@mt.gov, and must be received no later than 5:00 p.m., June 12, 2015.

5. An electronic copy of this notice of public hearing is available at www.outfitter.mt.gov (department and board's web site). The department strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

6. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Outfitters, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; faxed to the office at (406) 841-2305; e-mailed to dlibsdout@mt.gov; or made by completing a request form at any rules hearing held by the agency.

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

8. With regard to the requirements of 2-4-111, MCA, the board has determined that the amendment of ARM 24.171.502 will not significantly and directly impact small businesses.

Documentation of the board's above-stated determination is available upon request to the Board of Outfitters, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to dlibsdout@mt.gov.

9. Tyler Moss, attorney, has been designated to preside over and conduct this hearing.

BOARD OF OUTFITTERS
ROBIN CUNNINGHAM, CHAIRPERSON

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015

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

In the matter of the amendment of ARM 24.174.503 administration of vaccines, 24.174.1412 additions, deletions, and rescheduling of dangerous drugs, and the repeal of ARM 24.174.1420 through 24.174.1424 related to scheduling of dangerous drugs	)))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On June 23, 2015, at 1:00 p.m., a public hearing will be held in the Large Conference Room, 301 South Park Avenue, 4th Floor, Helena, Montana, to consider the proposed amendment and repeal of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Pharmacy (board) no later than 5:00 p.m., on June 16, 2015, to advise us of the nature of the accommodation that you need. Please contact Marcie Bough, Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2371; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2344; or dlibsdpha@mt.gov (board's e-mail).

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

24.174.503 ADMINISTRATION OF VACCINES BY PHARMACISTS (1) ~~In order to administer or prescribe vaccinations, a pharmacist must have a collaborative practice agreement with a practitioner authorized to prescribe drugs, or in the case of a public health emergency, a directive from the state medical officer of the Montana Department of Public Health and Human Services.~~ An immunization-certified pharmacist may prescribe and administer those immunizations listed in 37-7-105, MCA, without a collaborative practice agreement in place, as required by the statute.

~~(2) A pharmacist may administer vaccines to persons 18 years of age or older and administer influenza vaccine to persons 12 years of age or older provided that:~~

~~(a) the pharmacist has successfully completed a course of training approved by the Centers for Disease Control and Prevention (CDC), a provider accredited by the Accreditation Counsel on Pharmacy Education (ACPE), or other authority approved by the board;~~

~~(b) the pharmacist holds a current basic cardiopulmonary resuscitation certification issued by the American Heart Association, the American Red Cross, or other recognized provider, and documentation is on file at the practice site;~~

~~(c) the pharmacist and the pharmacist intern must provide a copy of the immunization certificate and CPR certification to the board for initial specialty recognition;~~

~~(d) the vaccines are administered in accordance with an established protocol that includes site-specific emergency measures; and~~

~~(e) the pharmacist has either a current copy of or online access to the most recent edition of the CDC reference "Epidemiology and Prevention of Vaccine-Preventable Diseases."~~

(2) An immunization-certified pharmacist must have a collaborative practice agreement with a practitioner authorized to prescribe drugs to administer immunizations not listed in 37-7-105, MCA, to persons 18 years of age or older; or, in the case of a public health emergency, a directive from the State Medical Officer of the Montana Department of Public Health and Human Services.

(3) An immunization-certified pharmacist, as defined in 37-7-105(3)(a), MCA, shall:

(a) provide a copy of the immunization certificate and current basic cardiopulmonary resuscitation (CPR) certification to the board for initial endorsement on license; and

(b) maintain documentation of immunization endorsement and current CPR certification on file at the practice site.

(4) In order to administer immunizations, with or without a collaborative practice agreement, an immunization-certified pharmacist must:

(a) administer vaccinations in accordance with established protocol that includes site-specific emergency measures;

(b) have access to a current edition of the United States Centers for Disease Control and Prevention (CDC) reference "Epidemiology and Prevention of Vaccine-Preventable Diseases";

~~(3) The pharmacist must give~~

(c) provide a copy of the most current vaccine information statement (VIS) to the patient or the patient's legal representative, ~~for those vaccines which have them, and counsel the patient accordingly.~~ as required by 37-7-105(2)(b), MCA;

~~(4) The pharmacist must~~

(d) maintain the following:

(i) written policies and procedures for the types of immunizations administered;

(ii) specific description of the procedures, methods, and decision criteria to follow for administering the immunization;

(iii) a detailed description of the procedures and patient activities to follow in the course of administering immunizations;

(iv) training for staff procedures and record keeping requirements; and

(v) disposal of used or contaminated supplies~~.~~;

(e) ensure that the individual immunized is assessed for contraindications to immunization, as required by 37-7-105(2)(a), MCA;

~~(5) The pharmacist must~~

(f) report any significant adverse events to the primary care provider if one is identified by the patient, and to the Vaccine Adverse Events Reporting System (VAERS), if applicable~~.~~, as required by 37-7-105(2)(c), MCA; and

~~(6) A pharmacist administering any vaccine shall~~

(g) maintain the following information in the patient's medical records for a period of at least ~~three~~ seven years, as required by 37-7-105(2)(d), MCA, which shall be considered confidential information:

(a) through (g) remain the same, but are renumbered (i) through (vii).

~~(7)~~ (5) The authority of a pharmacist to administer immunizations may not be delegated~~,~~; however, ~~an immunization-certified~~ a pharmacy intern may immunize under the direct supervision of ~~a~~ an immunization-certified pharmacist or other healthcare provider qualified in vaccine administration and deemed appropriate by the preceptor upon meeting the immunization-certified requirements listed in 37-7-105, MCA, and this rule.

~~(8) In order to maintain specialty recognition, an immunization certified pharmacist must maintain a current CPR certification.~~

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

AUTH: 37-7-201, MCA
IMP: 37-7-101, 37-7-105, 37-7-201, MCA

REASON: The board determined it is reasonably necessary to amend this rule to reflect statutory authority for immunization-certified pharmacists to prescribe and administer certain immunizations. In 2013, the Montana Legislature amended 37-7-105, MCA, to establish standards that allow pharmacists to prescribe and administer certain immunizations without a collaborative practice agreement.

Although the current rule only addresses immunizations prescribed or administered with a collaborative practice agreement, both the statute and rule require the pharmacist to be immunization-certified. The board determined it is reasonably necessary to amend this rule to further implement the legislative changes and clarify the standards that apply to this practice, regardless of whether a collaborative practice agreement exists. The board notes that collaborative practice agreements are still defined and regulated by ARM 24.174.524.

24.174.1412 ADDITIONS, DELETIONS, AND RESCHEDULING OF DANGEROUS DRUGS (1) ~~The Board of Pharmacy adopts the most current schedule of dangerous drugs as defined in 21 CFR 1308, et. seq. April 1, 2009. Copies are available from the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, MT 59620-0513.~~ In addition to those dangerous drugs scheduled in 50-32-222, 50-32-224, 50-32-226, 50-32-229, and 50-32-232, MCA, the board adds the following to dangerous drug schedules after considering federal regulations and/or the criteria enumerated in Title 50, chapter 32, part 2, MCA:

(a) Schedule I:

(i) none at this time;

(b) Schedule II:

(i) none at this time;

(c) Schedule III:

(i) methasterone;
(ii) perampanel; and
(iii) prostanozol;
(d) Schedule IV:
(i) tramadol;
(ii) alfaxalone;
(iii) suvorexant; and
(iv) lorcaserin;
(e) Schedule V:
(i) ezogabine.

(2) The board deletes the following dangerous drugs from the schedules in 50-32-222, 50-32-224, 50-32-226, 50-32-229, and 50-32-232, MCA, after considering federal regulations and/or the criteria enumerated in Title 50, chapter 32, part 2, MCA:

(a) Schedule I:
(i) none at this time;
(b) Schedule II:
(i) naloxegol;
(c) Schedule III:
(i) 50-32-226(4)(c) and (d), MCA (hydrocodone combination products);
(d) Schedule IV:
(i) none at this time;
(e) Schedule V:
(i) none at this time.

(3) After considering federal regulations and/or the criteria enumerated in Title 50, chapter 32, part 2, MCA, the board reschedules the following dangerous drugs from those scheduled in 50-32-222, 50-32-224, 50-32-226, 50-32-229, and 50-32-232, MCA:

(a) Schedule I:
(i) none at this time;
(b) Schedule II:
(i) none at this time;
(c) Schedule III:
(i) none at this time;
(d) Schedule IV:
(i) modafinil;
(e) Schedule V:
(i) none at this time.

AUTH: 50-32-103, 50-32-203, MCA
IMP: 50-32-103, 50-32-202, 50-32-203, 50-32-209, 50-32-222, 50-32-223, 50-32-224, 50-32-225, 50-32-226, 50-32-228, 50-32-229, 50-32-231, 50-32-232, MCA

REASON: The board determined it is reasonably necessary to amend this rule to clarify Montana scheduling requirements for dangerous drugs (controlled substances Schedules I-V). Currently, dangerous drugs are scheduled by the U.S. Drug

Enforcement Administration (DEA) in the Code of Federal Registrations (CFR), by the Montana Legislature in statute (Title 50, chapter 32, MCA), and also by the board in administrative rule (ARM Title 24, chapter 174).

Because dangerous drugs are scheduled by three different government entities and published in three different sources, it may not always be clear to licensees, practitioners, law enforcement, and the public what constitutes the current schedule(s) of dangerous drugs. These proposed rule revisions streamline and clarify the scheduling of dangerous drugs in Montana by adding, deleting, or rescheduling only those dangerous drugs in administrative rule that are updated from statute.

Furthermore, 50-32-203, MCA, requires the board to "similarly control" a drug that is scheduled, rescheduled, or deleted from schedule under federal law through rulemaking. While the board may also hold a public hearing to consider alternatives to federal law, the board is amending this rule to "similarly control" the dangerous drugs which the DEA has recently added, deleted, or rescheduled.

To that end, the DEA added methasterone (schedule III), perampanel (schedule III), prostanozol (schedule III), tramadol (schedule IV), alfaxalone (schedule IV), suvorexant (schedule IV), lorcaserin (schedule IV), and ezogabine (schedule V) to schedule under federal law between 2012 and 2015, and the board is now updating the Montana schedule to include these drugs.

Hydrocodone is a schedule II dangerous drug under Montana and federal law. In August 2014, the DEA deleted hydrocodone combination products from schedule III under federal law; therefore, single ingredient hydrocodone and any hydrocodone combination product are schedule II dangerous drugs. Hydrocodone combination products are currently scheduled in Montana under schedule III at 50-32-226(4)(c) and (d), MCA. Therefore, the board is amending (2)(c)(i) to align Montana with federal law in scheduling single-ingredient hydrocodone and any hydrocodone combination product under schedule II.

In January 2015, the DEA deleted naloxegol (schedule II) from schedule under federal law by excluding it from the list of opiates under schedule II. Therefore, the board is now similarly deleting naloxegol from schedule II under Montana law by excluding it from the list of opiates under 50-32-224, MCA.

Modafinil is listed as a schedule IV dangerous drug under federal law. While the drug is also listed in schedule IV under Montana law, it is incorrectly spelled. Therefore, the board is correcting this error by rescheduling the drug under its correct name.

4. The rules proposed to be repealed are as follows:

24.174.1420 SCHEDULE I DANGEROUS DRUGS found at ARM page 24-19847.

AUTH: 50-32-103, MCA
IMP: 50-32-103, MCA

REASON: The board determined it is reasonably necessary to clarify Montana scheduling requirements for dangerous drugs, accomplished by listing only those

drugs in administrative rule that update statute. The board concluded that it is no longer necessary to duplicate schedules I-V in administrative rule and statute and is repealing ARM 24.174.1420 through 24.174.1424 accordingly.

24.174.1421 SCHEDULE II DANGEROUS DRUGS found at ARM page 24-19855.

AUTH: 50-32-103, MCA
IMP: 50-32-103, MCA

24.174.1422 SCHEDULE III DANGEROUS DRUGS found at ARM page 24-19858.

AUTH: 50-32-103, MCA
IMP: 50-32-103, MCA

24.174.1423 SCHEDULE IV DANGEROUS DRUGS found at ARM page 24-19865.

AUTH: 50-32-103, MCA
IMP: 50-32-103, MCA

24.174.1424 SCHEDULE V DANGEROUS DRUGS found at ARM page 24-19868.

AUTH: 50-32-103, MCA
IMP: 50-32-103, MCA

5. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2344, or e-mail to dlibsdpha@mt.gov, and must be received no later than 5:00 p.m., June 30, 2015.

6. An electronic copy of this notice of public hearing is available at www.pharmacy.mt.gov (department and board's web site). The department strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

7. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; faxed to the office at (406) 841-2344; e-mailed to dlibsdpha@mt.gov; or made by completing a request form at any rules hearing held by the agency.

8. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsor was contacted on July 11, 2013, by telephone.

9. With regard to the requirements of 2-4-111, MCA, the board has determined that the amendment of ARM 24.174.503 and 24.174.1412 will not significantly and directly impact small businesses.

With regard to the requirements of 2-4-111, MCA, the board has determined that the repeal of ARM 24.174.1420 through 24.174.1424 will not significantly and directly impact small businesses.

Documentation of the board's above-stated determinations is available upon request to the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2344, or e-mail to dlibsdpha@mt.gov.

10. Kevin Maki, attorney, has been designated to preside over and conduct this hearing.

BOARD OF PHARMACY
STARLA BLANK, RPh
PRESIDENT

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015

BEFORE THE BOARD OF PHYSICAL THERAPY EXAMINERS
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.177.501 examinations, 24.177.507 licensure of out-of-state applicants, the adoption of NEW RULE I dry needling, and the repeal of ARM 24.177.2101 renewals and 24.177.2401 complaint procedure	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT, ADOPTION, AND REPEAL

TO: All Concerned Persons

1. On June 8, 2015, at 9:00 a.m., a public hearing will be held in the Large Conference Room, 301 South Park Avenue, 4th Floor, Helena, Montana, to consider the proposed amendment, adoption, and repeal of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Physical Therapy Examiners (board) no later than 5:00 p.m., on May 29, 2015, to advise us of the nature of the accommodation that you need. Please contact Linda Grief, Board of Physical Therapy Examiners, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2395; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; or dlibsdptp@mt.gov (board's e-mail).

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

24.177.501 EXAMINATIONS (1) through (4) remain the same.

(a) application fee; and

(b) copy of their certificate of graduation or transcripts from a board-approved physical therapy school or physical therapist assistant curriculum~~;~~.

~~(c) verification of physical therapy or physical therapist assistant instruction and graduation; and~~

~~(d) recent photograph of the applicant.~~

(5) and (6) remain the same.

AUTH: 37-1-131, 37-11-201, MCA
IMP: 37-1-131, 37-1-304, 37-11-303, 37-11-304, MCA

REASON: The board is amending this rule and ARM 24.177.507 since the board determined that it is redundant and unnecessary to require graduation verifications and a recent applicant photograph. Universities and colleges typically charge an extra fee for completing the verification form, which adds to initial licensure costs.

The national examination service requires photo identification to sit for the exam, and a copy of that photo is included on the exam scores sent to the states, as requested by an applicant. The amendments will make obtaining a license more affordable and less restrictive for applicants than current requirements.

Implementation citations are being amended to accurately reflect all statutes implemented through the rule.

24.177.507 LICENSURE OF OUT-OF-STATE APPLICANTS (1) through (2)(b) remain the same.

~~(c) verification of graduation from a board-approved physical therapy school or physical therapist assistant curriculum;~~

~~(d) recent photograph of the applicant within the last six months;~~

(e) and (f) remain the same but are renumbered (c) and (d).

(3) remains the same.

AUTH: 37-1-131, 37-11-201, MCA
IMP: 37-1-131, 37-1-304, 37-11-307, MCA

4. The proposed new rule provides as follows:

NEW RULE I DRY NEEDLING (1) Dry needling is a manual therapy technique that uses a filiform needle as a mechanical device to treat conditions within the scope of physical therapy practice.

(a) It is based upon Western medical concepts, requires a physical therapy examination and diagnosis, and treats specific anatomic entities.

(b) Dry needling does not include the stimulation of auricular or distal acupuncture points or acupuncture meridians.

(2) Licensed physical therapists performing dry needling must be able to demonstrate they have received training in dry needling that meets the standards of continuing education as set forth by the board's continuing education rules.

(a) Dry needling courses must include, but not be limited to, training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients.

(b) Initial training in dry needling must include hands-on training, written examination, and practical examination.

(3) A licensed physical therapist must perform dry needling in a manner consistent with generally acceptable standards of practice, including clean needling techniques, relevant standards of the Centers for Disease Control and Prevention, and Occupational Safety and Health Administration blood borne pathogen standards as per 29 CFR 1910.1030, et. seq.

(4) Dry needling may only be performed by a licensed physical therapist and may not be delegated to a physical therapist assistant.

(5) The physical therapist performing dry needling must be able to provide written documentation, upon request by the board, which substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action.

(6) No physical therapist shall advertise or in any way hold themselves out as an acupuncturist, unless that physical therapist is a licensed acupuncturist under the provisions of Title 37, chapter 13, MCA.

AUTH: 37-1-131, 37-11-201, MCA
IMP: 37-1-131, 37-11-101, 37-11-104, MCA

REASON: The board is proposing to adopt this new rule to provide guidance on the practice of dry needling within the scope of physical therapy. The scope of practice of physical therapists is broad and includes the use of mechanical devices, such as filiform needles, to treat physical disability, bodily malfunction, pain, and injury. The Federation of State Boards of Physical Therapy (FSBPT) reports that research supports the use of dry needling to improve pain, reduce muscle tension, and facilitate speedier rehabilitation.

Dry needling is being incorporated into physical therapy curricula nationally and has been determined to be within the scope of physical therapy practice in Alabama, Arkansas, Colorado, Georgia, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Nebraska, Nevada, New Mexico, New Hampshire, New Jersey, North Dakota, Ohio, South Carolina, Texas, Utah, Virginia, Wisconsin, Wyoming, and the District of Columbia. Pennsylvania and Arizona do not preclude a physical therapist from performing dry needling. For over 20 years, dry needling has been an accepted part of physical therapy practice internationally. Australia, Belgium, Canada, Chile, Denmark, Ireland, the Netherlands, New Zealand, Norway, South Africa, Spain, and the United Kingdom allow physical therapists to perform dry needling.

The board formed a joint committee with the Board of Medical Examiners (BME) to investigate the safety, efficacy, educational standards, and uses of dry needling in physical therapy and the overlap with the practice of acupuncture, which is under the jurisdiction of BME. Acupuncturists and the Montana Association of Acupuncture and Oriental Medicine oppose dry needling within the scope of physical therapy practice. The BME determined they have no authority over physical therapists or their scope of practice.

As medical technology evolves, scopes of practice and training for many health professionals, including physicians, physical therapists, and acupuncturists who all use needles, naturally shift and sometimes overlap. The training for and application of dry needling in physical therapy, not the use of a needle, distinguishes dry needling from acupuncture. Acupuncture meridians and auricular or distal acupuncture points are not part of dry needling.

The board is proposing this new rule now because physical therapists in Montana are incorporating dry needling into their practices. Public safety is the foremost concern of the board. This new rule establishes criteria for the inclusion of dry needling within the scope of physical therapy, ensures that physical therapists practicing dry needling meet demonstrable educational, training, and safety standards, and sets consequences for failing to meet those standards.

5. The rules proposed to be repealed provide as follows:

24.177.2101 RENEWALS found at ARM page 24-20189

AUTH: 37-1-131, 37-11-201, MCA
IMP: 37-1-141, MCA

REASON: The board is repealing this unnecessary rule, because the department administers a standardized renewal process for all professional and occupational licensure boards, and this rule merely references the department rules on renewals.

24.177.2401 COMPLAINT PROCEDURE found at ARM page 24-20225

AUTH: 37-11-201, MCA
IMP: 37-1-308, 37-1-309, MCA

REASON: The board is repealing this unnecessary rule, because the complaint procedure is adequately addressed in statute and should not be unnecessarily repeated in rule per the Montana Administrative Procedure Act.

6. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Physical Therapy Examiners, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to dlibsdptp@mt.gov, and must be received no later than 5:00 p.m., June 12, 2015.

7. An electronic copy of this notice of public hearing is available at www.pt.mt.gov (department and board's web site). The department strives to make the electronic copy of this notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

8. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Physical Therapy Examiners, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; faxed to the office at (406) 841-

2305; e-mailed to dlibsdptp@mt.gov; or made by completing a request form at any rules hearing held by the agency.

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

10. With regard to the requirements of 2-4-111, MCA, the board has determined that the amendment of ARM 24.177.501 and 24.177.507 will not significantly and directly impact small businesses.

With regard to the requirements of 2-4-111, MCA, the board has determined that the adoption of NEW RULE I will not significantly and directly impact small businesses.

With regard to the requirements of 2-4-111, MCA, the board has determined that the repeal of ARM 24.177.2101 and 24.177.2401 will not significantly and directly impact small businesses.

Documentation of the board's above-stated determinations is available upon request to the Board of Physical Therapy Examiners, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or e-mail to dlibsdptp@mt.gov.

11. Mark Jette, attorney, has been designated to preside over and conduct this hearing.

BOARD OF PHYSICAL THERAPY EXAMINERS
BRIAN MILLER, PRESIDING OFFICER

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015

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

In the matter of the amendment of ARM 37.40.1026, 37.40.1135, 37.85.104, and 37.85.105 pertaining to the revision of fee schedules for Medicaid provider rates	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On June 3, 2015, at 1:30 p.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on May 27, 2015, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

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

37.40.1026 AGENCY-BASED AND SELF-DIRECTED COMMUNITY FIRST CHOICE SERVICES: REIMBURSEMENT (1) through (5) remain the same.

(6) ~~The agency-based and self-directed CFCS fee schedules are effective July 1, 2014. Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov and may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59620-2951.~~ Reimbursement fees for agency-based and self-directed CFCS are stated in the department's fee schedule adopted at ARM 37.85.105(4).

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

37.40.1135 AGENCY-BASED AND SELF-DIRECTED PERSONAL ASSISTANCE SERVICES: REIMBURSEMENT (1) through (5) remain the same.

(6) ~~The agency-based and self-directed PAS fee schedules are effective July 1, 2014. Copies of the department's current fee schedules are posted at~~

~~http://medicaidprovider.hhs.mt.gov and may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59620-2951.~~ Reimbursement fees for agency-based and self-directed PAS are stated in the department's fee schedule adopted at ARM 37.85.105(4).

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

37.85.104 EFFECTIVE DATES OF PROVIDER FEE SCHEDULES FOR MONTANA NON-MEDICAID SERVICES (1) The department adopts and incorporates by reference the fee schedule for the following programs within the Addictive and Mental Disorders Division and Developmental Services Division on the dates stated:

(a) Mental health services plan provider reimbursement, as provided in ARM 37.89.125, is effective ~~July 1, 2014~~ July 1, 2015.

(b) 72-hour presumptive eligibility for adult-crisis stabilization services reimbursement for services, as provided in ARM 37.89.523, is effective ~~July 1, 2014~~ July 1, 2015.

(c) Youth respite services reimbursement for services as provided in ARM 37.87.2233, is effective ~~July 1, 2014~~ July 1, 2015.

(2) Copies of the department's current fee schedules are posted at ~~http://medicaidprovider.hhs.mt.gov~~ http://medicaidprovider.mt.gov and may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59620-2951. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered service ~~is~~ are published in the chapter or subchapter of this title regarding that service.

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

37.85.105 EFFECTIVE DATES, CONVERSION FACTORS, POLICY ADJUSTERS, AND COST-TO-CHARGE RATIOS OF MONTANA MEDICAID PROVIDER FEE SCHEDULES (1) The Montana Medicaid Program establishes provider reimbursement rates for medically necessary, covered services based on the estimated demand for services and the legislative appropriation and federal matching funds. Provider reimbursement rates are stated in fee schedules for covered services applicable to the identified Medicaid program. New rates are established by revising the identified program's fee schedule and adopting the new fees as of the stated effective date of the schedule. Copies of the department's current fee schedules are posted at ~~http://medicaidprovider.hhs.mt.gov~~ http://medicaidprovider.mt.gov and may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59620-2951. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered service ~~is~~ are published in the chapter

or subchapter of this title regarding that service. The department will make quarterly updates as necessary to the fee schedule noted in this rule to include new procedure codes and applicable rates and removal of terminated procedure codes.

(2) The department adopts and incorporates by reference, the resource-based relative value scale (RBRVS) reimbursement methodology for specific providers as described in ARM 37.85.212 on the date stated.

(a) Resource-based relative value scale (RBRVS) means the version of the Medicare resource-based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at ~~78~~ 79 Federal Register 217, page ~~74230 (December 10, 2013)~~ 67547 (November 13, 2014) effective ~~January 1, 2014~~ January 1, 2015 which is adopted and incorporated by reference. Procedure codes created after ~~January 1, 2014~~ January 1, 2015 will be reimbursed using the relative value units from the Medicare Physician Fee Schedule in place at the time the procedure code is created.

(b) Fee schedules are effective ~~January 1, 2015~~ July 1, 2015. The conversion factor for physician services is ~~$35.86~~ $36.93. The conversion factor for allied services is ~~$24.33~~ $24.93. The conversion factor for mental health services is ~~$23.87~~ $24.55. The conversion factor for anesthesia services is ~~$28.66~~ $29.23.

(c) Policy adjustors are effective ~~January 1, 2015~~ July 1, 2015. The maternity policy adjustor is 112%. The family planning policy adjustor is 105%. The psychological testing for youth policy adjustor is 145%.

(d) The payment-to-charge ratio is effective ~~July 1, 2014~~ July 1, 2015 and is ~~44%~~ 47% of the provider's usual and customary charges.

(e) The specific ~~percents~~ percentages for modifiers adopted by the department ~~is~~ are effective ~~July 1, 2014~~ July 1, 2015.

(f) Psychiatrists receive a 112% provider rate of reimbursement adjustment to the reimbursement of physicians effective ~~July 1, 2014~~ July 1, 2015.

(g) Midlevel practitioners receive a 90% provider rate of reimbursement adjustment to the reimbursement of physicians for those services described in ARM 37.86.205(5)(b) effective ~~July 1, 2014~~ July 1, 2015.

(h) Optometric services receive a 112% provider rate of reimbursement adjustment to the reimbursement for allied services as provided in ARM 37.85.105(2) effective ~~July 1, 2014~~ July 1, 2015.

(i) remains the same.

(3) The department adopts and incorporates by reference, the fee schedule for the following programs within the Health Resources Division, on the date stated.

(a) The inpatient hospital services fee schedule and inpatient hospital base fee schedule rates including:

(i) the APR-DRG fee schedule for inpatient hospitals as provided in ARM 37.86.2907, effective ~~July 1, 2014~~ July 1, 2015; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version ~~31~~ 32 are contained in the APR-DRG Table of Weights and Thresholds effective ~~July 1, 2014~~ July 1, 2015. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective ~~July 1, 2014~~ July 1, 2015.

(b) The outpatient hospital services fee schedules including:

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the Centers for Medicare and Medicaid Services (CMS) in ~~78~~ 79 Federal Register ~~237~~ 217, page ~~74826~~ 66769, November 10, 2014, effective ~~January 1, 2014~~ July 1, 2015, and reviewed annually by CMS as required in 42 CFR 419.5 as updated by the department;

(ii) the conversion factor for outpatient services on or after ~~July 1, 2014~~ July 1, 2015 is ~~$55.53~~ $56.64;

(iii) the Medicaid statewide average outpatient cost-to-charge ratio is 46.3%; and

(iv) remains the same.

(c) The hearing aid services fee schedule, as provided in ARM 37.86.805, is effective ~~January 1, 2015~~ July 1, 2015.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in ~~2014~~ 2015 resulting in a dental conversion factor of ~~$32.53~~ $33.18 and fee schedule is effective ~~July 1, 2014~~ July 1, 2015.

(e) The dental services covered procedures, the Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective ~~July 1, 2014~~ July 1, 2015.

(f) The outpatient drugs reimbursement, dispensing fees range as provided in ARM 37.86.1105(2)(b) is effective ~~July 1, 2014~~ July 1, 2015:

(i) remains the same.

(ii) a minimum of $2.00 and a maximum of ~~$6.65~~ $6.78 for preferred brand-name and generic drugs and generic drugs not identified on the preferred list.

(g) remains the same.

(h) The outpatient drugs reimbursement, vaccine administration fee as provided in ARM 37.86.1105(5), will be $21.32 for the first vaccine and ~~$12.68~~ $13.37 for each additional administered vaccine, effective ~~July 1, 2014~~ July 1, 2015.

(i) and (j) remain the same.

(k) The home infusion therapy services fee schedule, as provided in ARM 37.86.1506, is effective ~~July 1, 2014~~ July 1, 2015.

(l) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, December 2014, which outlines the Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs) as provided in ARM 37.86.1802, effective ~~January 1, 2015~~ July 1, 2015. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective ~~January 1, 2015~~ July 1, 2015.

(m) The early and periodic screening, diagnostic and treatment (EPSDT) services fee schedules for private duty nursing, nutrition, and orientation and mobility specialists as provided in ARM 37.86.2207(2), is effective ~~July 1, 2014~~ July 1, 2015.

(n) The transportation and per diem fee schedule, as provided in ARM 37.86.2405, is effective ~~July 1, 2014~~ July 1, 2015.

(o) The specialized nonemergency medical transportation fee schedule, as provided in ARM 37.86.2505, is effective ~~July 1, 2013~~ July 1, 2015.

(p) The ambulance services fee schedule, as provided in ARM 37.86.2605, is effective ~~July 1, 2014~~ July 1, 2015.

(q) The audiology fee schedule, as provided in ARM 37.86.705, is effective ~~July 1, 2014~~ July 1, 2015.

(r) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM 37.85.610, are effective ~~July 1, 2014~~ July 1, 2015.

(s) The optometric fee schedule provided in ARM 37.86.2005, is effective ~~January 1, 2015~~ July 1, 2015.

(4) The department adopts and incorporates by reference, the fee schedule for the following programs within the Senior and Long Term Care Division on the date stated:

(a) Home and community-based services for elderly and physically disabled persons fee schedule, as provided in ARM 37.40.1421, is effective ~~July 1, 2014~~ July 1, 2015.

(b) Home health services fee schedule, as provided in ARM 37.40.705, is effective ~~July 1, 2014~~ July 1, 2015.

(c) Personal assistance services fee schedule, as provided in ARM ~~37.40.1105~~ 37.40.1135, is effective ~~July 1, 2014~~ July 1, 2015.

(d) Self-directed personal assistance services fee schedule, as provided in ARM ~~37.40.1303~~ 37.40.1135, is effective ~~July 1, 2014~~ July 1, 2015.

(e) Community first choice services fee schedule, as provided in ARM 37.40.1026, is effective July 1, 2015.

(5) The department adopts and incorporates by reference, the fee schedule for the following programs within the Addictive and Mental Disorders Division on the date stated:

(a) Case management services for adults with severe disabling mental illness reimbursement, as provided in ARM 37.86.3515, is effective ~~July 1, 2014~~ July 1, 2015.

(b) Mental health center services for adults reimbursement, as provided in ARM 37.88.907, is effective ~~July 1, 2014~~ July 1, 2015.

(c) Home and community-based services for adults with severe disabling mental illness, reimbursement, as provided in ARM 37.90.408, is effective ~~July 1, 2014~~ July 1, 2015.

(d) Targeted case management services for substance use disorders, reimbursement, as provided in ARM 37.86.4010, is effective ~~July 1, 2014~~ July 1, 2015.

(6) The department adopts and incorporates by reference, the fee schedules for the following programs within the Developmental Services Division, on the date stated~~.~~:

(a) Mental health services for youth, as provided in ARM 37.87.901 in the Medicaid Youth Mental Health Services Fee Schedule, is effective ~~July 1, 2014~~ July 1, 2015.

(b) Mental health services for youth, as provided in ARM 37.87.1313 in the 1915(i) HCBS State Plan Program for Youth with Serious Emotional Disturbance Fee Schedule, is effective ~~July 1, 2014~~ July 1, 2015.

(c) Mental health services for youth, as provided in ARM ~~37.87.1030~~ 37.87.1303 in the 1915(c) HCBS Bridge Waiver for Youth with Serious Emotional Disturbance Fee Schedule, is effective ~~July 1, 2014~~ July 1, 2015.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-402, MCA

4. STATEMENTS OF REASONABLE NECESSITY

Section 53-6-111, MCA, requires the Department of Public Health and Human Services (the department) to establish the Montana Medicaid provider reimbursement rates. The department establishes rates based on the estimated demand for services and the legislative appropriation and federal matching funds. Rates are stated in program fee schedules and rates are changed by revising the fee schedule as of the stated effective date of the schedule. The department adopts fee schedules and fee schedule changes by amending ARM 37.85.104 and 37.85.105.

SUMMARY OF PROPOSED AMENDMENTS TO ARM 37.85.104 AND 37.85.105

These summaries are categorized according to the following divisions: Health Resources Division (HRD), Addictive and Mental Disorders Division (AMDD), Senior and Long Term Care Division (SLTC), and Developmental Services Division (DSD).

Summary of HRD'S Proposed Amendments

Some Montana Medicaid providers' rates are established through the resource-based relative value scale (RBRVS) model. RBRVS is used nationwide by most health plans, including Medicare and Medicaid. The relative value unit component of RBRVS is revised annually by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association. The department amends ARM 37.85.105 annually to adopt current relative value units (RVUs). An RVU is a numerical value assigned to each medical procedure. RVUs are based on physician work, practice expense, and malpractice insurance expenses and express the relative effort and expense expended to provide one procedure compared with another. RVUs are added for new procedures and the RVUs of particular procedures may increase or decrease from year to year.

"Conversion factor" (CF) means a dollar amount by which RVUs are multiplied to establish the RBRVS fee for a service. The department annually calculates conversion factors for physician services, allied services, mental health services, and anesthesia services. These conversion factors are calculated by dividing the Montana Legislature's appropriation for Medicaid member's health care during the upcoming state fiscal year (SFY) by the estimated total units of health care, expressed as total RVUs, to be provided during the upcoming SFY. The resulting quotient is the conversion factor. The RVU for a procedure multiplied by the conversion factor is the fee paid for the procedure. The conversion factor for licensed physicians is set by 53-6-124 through 53-6-127, MCA.

During SFY 2015, the physician services CF was increased by the consumer price index for medical care for the previous year and in SFY 2016, the CF will increase by 3.0%. This is required by 53-6-125, MCA. Other providers receive, in aggregate, the amount appropriated by the 64th Montana State Legislature for provider rate increases.

Summary of Proposed Amendments

HRD has no amendments to ARM 37.85.104. The following describes the proposed amendments that the HRD will make to ARM 37.85.105.

(1) – Amend the provider web site to http://medicaidprovider.mt.gov.

(2)(a) – Amend the citations to the Federal Register to adopt the current RBRVS and RVUs.

(2)(b) – Amend the effective date of the RBRVS fee schedules to July 1, 2015 and the physician services CF from $35.86 to $36.93, the allied services CF from $24.33 to $24.93, the mental health services CF from $23.87 to $24.55, and the anesthesia services CF from $28.66 to $29.23.

(2)(c) – Amend the effective date of the policy adjustors to July 1, 2015; and maintain the policy adjustor percentage for maternity at 112%, family planning at 105%, and psychological testing for youth at 145%.

(2)(d) – Amend the effective date of the payment-to-charge ratio to July 1, 2015; and the payment-to-charge ratio of the providers usual and customary charges from 44% to 47%.

(2)(e) – Amend the effective date for modifiers to July 1, 2015.

(2)(f) – Amend the effective date to July 1, 2015, and maintain the percentage at 112% for the psychiatrists' reimbursement rate.

(2)(g) – Amend the effective date to July 1, 2015, and maintain the percentage at 90% for the mid-level practitioners' reimbursement rate.

(2)(h) – Amend the effective date to July 1, 2015, and maintain the percentage at 112% for optometric services reimbursement rate.

(3)(a)(i) – Amend the effective date to July 1, 2015 for the inpatient hospital fee schedule.

(3)(a)(ii) – Amend the APR-DRG Table of Weights and Thresholds effective date to July 1, 2015, and the APR -DRG grouper version to version 32.

(3)(b)(i) – Adopt the current reference to the RBRVS in the Federal Register and update the effective date to January 1, 2015.

(3)(b)(ii) – Amend the conversion factor for outpatient services from $55.53 to $56.64, and the effective date to July 1, 2015.

(3)(c) – Amend the effective date of the hearing aid services fee schedule to July 1, 2015.

(3)(d) – Amend the Relative Value for Dentists schedule to 2015, the dental conversion factor from $32.53 to $33.18, and the effective date to July 1, 2015.

(3)(e) – Amend the effective date of the dental/denturist provider manual to July 1, 2015.

(3)(f) – Amend the effective date of the outpatient drug reimbursement dispensing fee range to July 1, 2015.

(3)(f)(ii) – Amend the maximum dispensing fee for preferred brand name and generic drugs and generic drugs not identified on the preferred list from $6.65 to $6.78.

(3)(h) - Amend the administration fee for each additional vaccine from $12.68 to $13.37 and the effective date to July 1, 2015.

(3)(k) – Amend the effective date of the home infusion therapy services fee schedule to July 1, 2015.

(3)(l) – Amend the effective date of the reference to the Region D Supplier Manual and the prosthetic devices, durable medical equipment, and medical supplies fee schedule to July 1, 2015. The date that the Region D Supplier Manual was last revised was also added.

(3)(m) – Amend the effective date of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) fee schedule for private duty nursing, nutrition, and orientation and mobility specialists to July 1, 2015.

(3)(n) – Amend the effective date regarding the transportation and per diem fee schedule to July 1, 2015.

(3)(o) – Amend the effective date of the nonemergency medical transportation fee schedule to July 1, 2015.

(3)(p) – Amend the effective date regarding the ambulance services fee schedule to July 1, 2015.

(3)(q) – Amend the effective date for the audiology services fee schedule to July 1, 2015.

(3)(r) – Amend the effective date of the occupational therapists, physical therapists, and speech therapists fee schedule to July 1, 2015.

(3)(s)- Amend the effective date of the optometric fee schedule to July 1, 2015.

Fiscal Impact for Health Resources Division

The proposed amendments will increase the Medicaid budget for SFY 2016 by the amount appropriated by the 64th Montana Legislature for provider rate increases. The number of providers affected by the increase and the fiscal impact for SFY 2016 are:

Provider Type	SFY 2016 Budget Impact	Active Provider Count
Ambulance	$98,021	125
Ambulatory Surgical Center	$2,854	28
Audiology	$1,280	33
Case Mgmt. - Targeted	$7,464	N/A
Dental	$835,110	423
Denturist	$35,671	18
EPSDT	$8,044	N/A
Hearing Aid	$3,828	26
Home Infusion Therapy	$16,991	17
Inpatient Hospital	$1,940,497	416
Nonemergency Medical Transportation	$900	6
Nutrition	$165	22
Occupational Therapists	$31,164	86
Optician	$1,505	22
Optometric	$56,428	160
Outpatient Hospital	$1,057,061	406
Pharmacy	$162,998	413
Physical Therapists	$45,108	340
Private Duty Nursing	$94,994	12
Speech Therapists	$31,003	95
Transportation - (First Check)	$62,627	N/A
Transportation - Commercial	$7,032	8
Total	$4,500,745	

Physicians, mid-level practitioners, podiatrists, public health clinics, independent diagnostic testing facilities (IDTF), qualified Medicare beneficiary (QMB) and early

and periodic screening, diagnostic and treatment (EPSDT) chiropractors, laboratory and x-ray services, family planning clinics, and dentists providing medical services comprise the provider types included in the physician services conversion factor. The physician services conversion factor will receive an increase. This increase is determined by the percentage increase to the consumer price index for medical care for the previous year. This is required by 53-6-125, MCA, and will be 3.0%. This amount was appropriated by the legislature.

Provider Type	SFY 2016 Budget Impact	Active Provider Count
Dentists providing medical services	$1,351	423
Independent Diagnostic Testing Facilities	$25,621	23
Laboratory and X-Ray Services	$8,451	150
Midlevel Practitioners	$353,362	2,714
Physician	$1,933,948	10,197
Podiatrist	$16,704	65
Public Health Clinic	$37	44
EPSDT	$16,263	N/A

The proposed rule is estimated to affect 154,734 Medicaid members. In addition, it will impact the provider populations outlined in the tables above.

Summary of Addictive and Mental Disorders Division (AMDD) Proposed Amendments

AMDD is proposing to amend provider fee schedules based on the amount appropriated by the 64th Montana State Legislature for provider rate increases. These increases to the Medicaid and Non-Medicaid budget are effective July 1, 2015. The increase will have a positive impact for providers with mental health centers, mental health waiver, mental health and substance abuse, Mental Health Services Plan, and the 72-Hour Presumptive Crisis Stabilization Program.

ARM 37.85.104

ARM 37.85.104 is for Montana Non-Medicaid Services. The department is proposing to change the effective date in (1)(a) for mental health services plan provider reimbursement and (1)(b) 72-hour presumptive eligibility for adult crisis stabilization services reimbursement from July 1, 2014 to July 1, 2015.

ARM 37.85.105

The department is proposing to change the effective date in (5)(a), (b), and (c) from July 1, 2014 to July 1, 2015 for case management services for adults with severe

disabling mental illness, mental health center services, home and community-based services for adults with severe disabling mental illness and targeted case management services for substance use disorders.

Fiscal Impact

The estimated provider rate increase fiscal impact is:

Service	Fiscal Impact for SFY 2016
Mental Health Centers	$129,687
Targeted Case Management – Substance Abuse	$1,172
Case Management – Adults with Severe Disabling Mental Illness	$68,862
Home and Community Based – Severe Disabling Mental Illness Waiver	$39,546
Total	$239,267

Summary of Senior and Long-Term Care Division's Amendments

The department is proposing to amend ARM 37.40.1026, 37.40.1135, and 37.85.105 to implement the legislatively appropriated provider rate increase effective July 1, 2015 for the Home Health Services Program, Home and Community-based Services (HCBS) Program, and the Community First Choice and Personal Assistance Services Program.

ARM 37.40.1026 and 37.40.1135

In this notice of proposed rulemaking, the fee schedules of two programs, the Community First Choice Program and the Personal Assistance Services Program, are being cross referenced for the first time in ARM 37.85.105. The proposed amendments remove the fee references in these rules and incorporate the fee schedules into the department's Medicaid provider fee rule found at ARM 37.85.105.

The proposed amendments to these rules also describe the method for setting the reimbursement rates for these programs. This is not a change in the method. It is a description of the existing method as required by ARM 37.85.105(1).

ARM 37.85.105

The proposed amendments to ARM 37.85.105 implement the July 1, 2015, provider rate increase appropriated by the 64th Montana Legislature for the Home Health Services Program, Home and Community-based Services (HCBS) Program, and the Community First Choice and Personal Assistance Services Program.

Fiscal Impact

Community First Choice (CFC) and Personal Assistance Program (PAS)

The fiscal impact of the rate changes is estimated to be $1,192,994 for CFC and $16,658 for PAS provider rate increases in total funds. This funding will impact all Medicaid Community First Choice and Personal Assistance Services members and providers who utilize this service.

The anticipated number of members who will receive Personal Assistance Services in FY15 is approximately 200 and the anticipated number of members who will receive Community First Choice services in FY15 is approximately 3,600.

Home Health Services Program

The fee schedule is amended to increase provider rates by $10,823 in total funds appropriated in HB2 (2015). This impacts all Medicaid home health members and home health providers who utilize this service. Approximately 400 members will receive home health services in SFY 2016.

Home and Community-based Services

The fee schedule is amended to increase provider rates by $787,093 in total funds appropriated in HB2 (2015). This impacts all HCBS Medicaid members and providers who utilize this service. Approximately 2,500 Medicaid members will receive HCBS in SFY 16.

Summary of Developmental Services Division's Proposed Amendments

The department is proposing to amend ARM 37.85.104 and 37.85.105 by incorporating by reference the new fee schedules that implement the amount appropriated by the 64th Montana State Legislature for provider rate increases.

Summary of Proposed Amendments - Children's Mental Health Bureau

ARM 37.85.104

The department proposes to amend the rates established in the Medicaid Youth Mental Health Fee Schedule to implement a rate increase in non-Medicaid fees to providers of respite services and update the effective date from July 1, 2014 to July 1, 2015.

ARM 37.85.105

The department proposes to amend the rates established in the Medicaid Youth Mental Health Fee Schedule to implement a rate increase in Medicaid fees to providers and update the effective date from July 1, 2014 to July 1, 2015.

The department proposes to amend rates established in the 1915(i) HCBS State Plan Program for Youth with Serious Emotional Disturbance Fee Schedule to implement a rate increase in Medicaid fees to providers and update the effective date from July 1, 2014 to July 1, 2015.

The department proposes to amend rates established in the Bridge Waiver Schedule to implement rate increases in Medicaid fees to providers and update the effective date from July 1, 2014 to July 1, 2015.

The department is also proposing to correct a typographical error found in (6)(c). The citation to ARM 37.87.1030 is being corrected to ARM 37.87.1303.

Fiscal Impact

The proposed amendments to rates for services provided through the Children's Mental Health Bureau will increase provider rates for Medicaid services by $1,933,594 for FY2016; Comprehensive School and Community Treatment $762,800 for FY2016; and Non-Medicaid Respite $5,800 for FY2016. These are total fund amounts. This funding will impact over 16,000 youth served by children's mental health Medicaid.

5. The department intends to adopt these rule amendments effective July 1, 2015.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., June 11, 2015.

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

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all

concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

/s/ Geralyn Driscoll
Geralyn Driscoll, Esq.
Rule Reviewer

/s/ Mary E. Dalton acting for
Richard H. Opper, Director
Public Health and Human Services

Certified to the Secretary of State May 4, 2015.

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

In the matter of the amendment of ARM 37.40.307, 37.40.337, and 37.40.361 pertaining to nursing facility reimbursement	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On June 3, 2015, at 3:00 p.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on May 27, 2015, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

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

37.40.307 NURSING FACILITY REIMBURSEMENT (1) remains the same.

(2) Effective July 1, 2001, and in subsequent rate years, nursing facilities will be reimbursed using a price-based reimbursement methodology. The rate for each facility will be determined using the operating component defined in (2)(a) and the direct resident care component defined in (2)(b):

(a) through (c) remain the same.

(d) The total payment rate available for the period ~~July 1, 2014~~ July 1, 2015 through ~~June 30, 2015~~ June 30, 2016 will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361.

(3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the Medicaid program in a newly constructed facility will have a rate set at the statewide median price as computed on ~~July 1, 2014~~ July 1, 2015. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider will be set at the previous provider's rate, as if no change in provider had occurred.

(4) through (11) remain the same.

(12) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules, and policies.

All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules.

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

37.40.337 REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) and (2) remain the same.

(3) To receive payments, the out-of-state provider must enroll in the Montana Medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, ~~ACS~~ XEROX, at P.O. Box ~~4286~~ 4936, Helena, MT ~~59604-4286~~ 59604-4936.

(4) and (5) remain the same.

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

37.40.361 DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE REPORTING/ADDITIONAL PAYMENTS INCLUDING LUMP SUM PAYMENTS FOR DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE AND BENEFIT INCREASES (1) Effective for the period ~~July 1, 2014~~ July 1, 2015 and for the six months thereafter, nursing facilities must report to the department actual hourly wage and benefit rates paid for all direct care and ancillary services workers or the lump sum payment amounts for all direct care and ancillary services workers that will receive the benefit of the increased funds. The reported data ~~shall~~ will be used by the department for the purpose of comparing types and rates of payment for comparable services and tracking distribution of direct care wage funds to designated workers.

(2) The department will pay Medicaid certified nursing care facilities located in Montana that submit an approved request to the department a lump sum payment in addition to the amount paid as provided in ARM 37.40.307 and 37.40.311 to their computed Medicaid payment rate to be used only for wage and benefit increases or lump sum payments for direct care or ancillary services workers in nursing facilities.

(a) The department will determine the lump sum payments, twice a year commencing ~~July 1, 2014~~ July 1, 2015, and again in six months from that date as a pro rata share of appropriated funds allocated for increases in direct care and ancillary services workers' wages and benefits or lump sum payments to direct care and ancillary services workers.

(b) To receive the direct care and/or ancillary services workers' lump sum payment, a nursing facility ~~shall~~ must submit for approval a request form to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility to comply with all statutory requirements. The facility ~~shall~~ must submit all of the information required on a form to be developed by the department in order to continue to receive subsequent lump sum payment amounts for the entire rate year. The form for wage and benefit increases will request information including, but not limited to:

(i) through (c)(iv) remain the same.

(d) A facility that does not submit a qualifying request for use of the funds distributed under (2), that includes all of the information requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount ~~shall~~ will not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care and ancillary services workers.

(3) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including, but not limited to, the provisions of ARM 37.40.345, 37.40.346, and 37.85.414.

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

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (the department) is proposing the amendment of ARM 37.40.307, 37.40.337, and 37.40.361 pertaining to implementing Medicaid nursing facility reimbursement for state fiscal year (SFY) 2016.

The 64th Montana Legislature has provided funding to implement an increase in Medicaid provider rates using state and federal funds. $3,013,774 is the amount that equates to the provider rate increase in the Nursing Facility Program. This increase is funded by House Bill 2 (HB2) of the 64th Montana Legislature. The increase is necessary to maintain Medicaid provider rates at a level consistent with efficiency, economy, quality of care, and to assure the continued participation of providers.

These rules continue the methodology for implementing legislative funding for nursing facility reimbursement, including updated estimated patient days, patient contribution amounts, and case mix indices (acuity) into the rate calculation for state fiscal year 2016. Funding will continue to be available to provide for a direct care worker wage increase for nursing facility providers for workers who provide direct care and ancillary services in fiscal year 2016.

New funding has been appropriated to provide for an additional rate increase for wages and benefits to provide up to a 25-cent hourly increase in combined wages and benefits for direct-care workers in fiscal year 2016.

The Legislature continued approval for the use of local county matching funds as a source of additional revenue for nursing facility providers. The intergovernmental fund transfer (IGT) program maintains access to, and the quality of, nursing facility services, and will be available for SFY 2016.

The department will provide rate sheets to all providers in advance of the rule hearing for verification purposes and in order to facilitate comments. These sheets will distribute the funding available in order to meet the department goals for a price-based system of reimbursement and will incorporate legislative appropriated funding levels.

ARM 37.40.307

The department is proposing to amend (2)(d) and (3) by changing the fiscal year to the current fiscal year of 2016.

ARM 37.40.337

The department is proposing to amend the reference to ACS in (3) to XEROX and to update the post office box number.

ARM 37.40.361

The department is proposing to amend (1) and (2)(a) by changing the fiscal year to the current fiscal year of 2016.

Fiscal Impact

The total state and federal funding available for SFY 2016 for rate calculation purposes utilizing the funding in HB2 is currently projected at $143,351,129 which is comprised of $15,704,708 in state special revenue, $34,050,761 in state general funds, and $93,595,660 in federal funds when the provider rate increases are included.

The ongoing funding for lump-sum payments to providers for direct care workers and ancillary staff consists of $1,342,827 of state general funds and $2,638,279 in federal funds for a total appropriation of $3,981,106 for the nursing facility direct care worker wage program.

New funding was provided for direct care worker wages for the purpose of providing a rate increase for wages and related benefits or to provide lump-sum payments to workers who provide direct care and ancillary services in the nursing facility program. The increase will provide up to a 25-cent hourly increase in combined wages and benefits in fiscal year 2016. The total funding provided for this purpose is $1,502,478 with $981,118 coming from federal funds and $521,360 from general fund dollars.

The estimated total funding available for SFY 2016 for nursing facility reimbursement is estimated at approximately $175,879,240 of combined state and federal funds, including $32,528,111 of patient contributions. These numbers do not include at-risk provider funds or direct care wage funding.

Anticipated days for SFY 2016 are 1,018,413 using estimates of caseload adopted by the Montana Legislature.

The estimated total funding impact of the one-time payments to "at-risk" nonstate governmental providers and other nursing facilities not determined to be "at risk," has been appropriated at $19,006,657 in total funds of which $6,737,566 comes from state special revenue funds and approximately $12,269,091 comes from federal funding sources.

Eighty-two nursing facility providers participated in the Medicaid nursing facility payment program and approximately 5,016 recipients received services in nursing facilities under Medicaid.

The analysis of Medicaid nursing facility rates that is annually conducted by Myers and Stauffer, LC shows that in SFY 2014 (report dated 2/3/2015) Montana Medicaid on average is reimbursing 95.65% of the cost of providing nursing facility services. The department considered the impact of the rate changes on efficiency, economy, quality of care, and access to Medicaid services and concluded that the rates are still sufficient to meet the requirements of 42 USC 1396a (a) (30)(A).

5. The department intends to adopt these rule amendments effective July 1, 2015.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., June 11, 2015.

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

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed

text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

/s/ Valerie A. Bashor	/s/ Mary E. Dalton acting for
Valerie A. Bashor, Esq.	Richard H. Opper, Director
Rule Reviewer	Public Health and Human Services

Certified to the Secretary of State May 4, 2015.

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

In the matter of the amendment of ARM 37.34.3005 and 37.86.3607 pertaining to the increase of reimbursement rates and clarification of language in the developmental disabilities manual	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On June 4, 2015, at 11:00 a.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on May 27, 2015, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

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

37.34.3005 REIMBURSEMENT FOR SERVICES OF MEDICAID FUNDED DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROGRAMS (1) remains the same.

(2) The department adopts and incorporates by this reference the rates of reimbursement for the delivery of services and items available through each Home and Community-Based Services Waiver Program as specified in the Montana Developmental Disabilities Program Manual of Service Rates and Procedures of Reimbursement for Home and Community-Based Services (HCBS) 1915c 0208, 1037, and 0667 Waiver Programs, effective ~~July 1, 2014~~ July 1, 2015. A copy of the manual may be obtained through the Department of Public Health and Human Services, Developmental Services Division, Developmental Disabilities Program, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and at ~~http://www.dphhs.mt.gov/dsd/ddp/ddprateinformation.shtml~~ http://dphhs.mt.gov/dsd/developmentaldisabililities/DDPratesinf.

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

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

37.86.3607 CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, REIMBURSEMENT (1) Reimbursement for the delivery by provider entities of Medicaid funded targeted case management services to persons with developmental disabilities is provided as specified in the Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Developmental Disabilities Case Management Services for Persons with Developmental Disabilities Who Are 16 Years of Age or Older or Who Reside in a Children's Community Home, dated ~~July 1, 2014~~ July 1, 2015.

(2) The department adopts and incorporates by this reference the Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Developmental Disabilities Case Management Services for Persons with Developmental Disabilities Who Are 16 Years of Age or Older or Who Reside in a Children's Community Home, dated ~~July 1, 2014~~ July 1, 2015. A copy of the manual may be obtained through the Department of Public Health and Human Services, Developmental Services Division, Developmental Disabilities Program, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and at http://dphhs.mt.gov/dsd/developmentaldisabililities/DDPratesinf.

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (the department) is proposing the amendment of ARM 37.34.3005 and 37.86.3607. These two rules pertain to the reimbursement of services provided to persons who are recipients of developmental disabilities services funded by the state of Montana with Medicaid monies. These proposed amendments are necessary for two reasons: to increase the reimbursement rates to incorporate state fiscal year (SFY) 2016 additional funding appropriated through House Bill 2 (HB2) of the 64th Montana State Legislature; and to implement needed changes in the texts of the two manuals that are incorporated by reference in these rules.

Specifically, the department proposes the following amendments:

ARM 37.34.3005

The purpose of this proposed amendment is to incorporate by reference a new edition of the Montana Developmental Disabilities Program Manual of Service Rates and Procedures of Reimbursement for Home and Community-Based Services (HCBS) 1915c 0208, 1037, and 0667 Waiver Programs dated July 1, 2015. This new edition of the manual includes changes in the rates of reimbursement that are necessitated by additional legislative appropriations for the reimbursement of the Medicaid funded home and community services. The new edition also integrates changes to be in compliance with the plan for the delivery of the Medicaid funded

home and community services approved by the federal Centers for Medicare and Medicaid Services (CMS).

ARM 37.86.3607

The purpose of this proposed amendment is to incorporate into the rule a new edition of the Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Developmental Disabilities Case Management Services for Persons with Developmental Disabilities Who Are 16 Years of Age or Older or Who Reside in a Children's Community Home, to be dated July 1, 2015. The proposed amendments include a change in the rate of reimbursement that is necessitated by additional legislative appropriations for the reimbursement of the Medicaid funded case management services. This proposed change in reimbursement is only applicable to the provision of case management services that are contracted for by the department and is not applicable to the reimbursement of case management services delivered by state employees. The department proposes to incorporate into the rule the web site location for viewing the manual.

Amendments to Manuals

"Montana Developmental Disabilities Program Manual of Service Rates and Procedures of Reimbursement for Home and Community-Based Services (HCBS) 1915c 0208, 1037, and 0667 Waiver Programs, April 2015 Edition"

1. The proposed effective date of the revised manual is July 1, 2015.

2. The proposed maximum payment rates per unit of services for all the categories and subcategories of Table #1 of the manual, Service Reference Information & Clarification, Billable Units, and Reimbursement Rates have been modified to account for the availability of the increased funding appropriated by the 64th Montana State Legislature.

3. Adjustments in payment rates are being made for categories of home and community services that are available as extensions beyond the coverage available for those categories of services as state plan services. These adjustments are necessary to make certain that the extended services are reimbursed at the state plan rates anticipated for July 1, 2015.

4. The hourly units for the Supported Employment – Follow Along services are to be modified to allow hourly units to be used when monthly units are cost prohibitive.

5. Additional details are added to the Homemaker service to clarify that fees can be charged by third parties.

6. Language was added to the Waiver Children's Case Management (WCCM) service to provide clarification that the service is not required to be delivered every

month. But, if the service is provided in a month, then a visual contact must be made for that month within the billed units.

7. Language was added to the Caregiver Training and Support service to provide clarification that the service is not required to be delivered every month. But, if the service is provided in a month, then a visual contact must be made for that month within the billed units.

8. In the past the department allowed providers to impose an administrative fee above the purchase price for the services a home and community participant member receives from the provider. The department has been informed that CMS does not allow for this practice since the participant is charged more than other consumers as a result. Consequently, language referencing administrative fees are to be removed for Adult Foster, Remote Monitoring, Remote Monitoring Equipment, Community Transition Services, Individual Goods and Services, Assisted Living, Transportation, Environmental Modifications, Adaptive Equipment, PERS, Respite, and Live-In Caregiver services categories in both Table #1 of the manual, Service Reference Information and Clarification, Billable Units, and Reimbursement Rates, and Table #2 of the manual, Documentation Expectations By Service and Administrative Rule Reference/Authority.

"Montana Developmental Disabilities Program Manual of Service Reimbursement Rates and Procedures for Developmental Disabilities Case Management Services for Persons with Developmental Disabilities Who Are 16 Years of Age or Older or Who Reside in a Children's Community Home"

1. The proposed effective date of the revised manual is July 1, 2015.

2. The proposed reimbursement fee includes the amount appropriated by the 64th Montana State Legislature for provider rate increases.

3. An additional change was necessary to reflect the most current web links where the manual can be accessed.

5. The department intends to adopt these rule amendments effective July 1, 2015.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., June 11, 2015.

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

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

/s/ Cary B. Lund
Cary B. Lund, Esq.
Rule Reviewer

/s/ Richard H. Opper
Richard H. Opper, Director
Public Health and Human Services

Certified to the Secretary of State May 4, 2015.

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

In the matter of the amendment of ARM 37.12.401 and 37.57.301 pertaining to laboratory fees for analysis and newborn screening for severe combined immunodeficiency disease (SCID)	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On June 3, 2015, at 9:00 a.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on May 27, 2015, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

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

37.12.401 LABORATORY FEES FOR ANALYSES (1) Fees for clinical and environmental analyses performed by the laboratory of the ~~Department of Public Health and Human Services~~ department are set to reflect the actual costs of the tests and services provided.

(2) The ~~Department of Public Health and Human Services~~ department will maintain a list of all tests available from the lab and the price of each test. The department adopts and incorporates by reference the Laboratory Test Fee List effective ~~January 1, 2014~~ July 1, 2015, which is available on the web site of the Department of Public Health and Human Services at ~~www.dphhs.mt.gov/publichealth/lab/labfees.shtml~~ http://www.dphhs.mt.gov/portals/85/publichealth/documents/lab/publichealthlabtesting/phlfees2014_1.pdf, and by mail upon request to the lab at the Department of Public Health and Human Services, Public Health and Safety Division, P.O. Box 6489, Helena, MT 59604-6489.

(3) The fee for a specific lab test will be lowered by the ~~Department of Public Health and Human Services~~ department to a level not exceeding the cost to the

department of the test in question whenever a change of analysis method warrants lower fees.

(4) remains the same.

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

37.57.301 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) and (2) remain the same.

(3) "Newborn screening tests" are screening tests, procedures, or both for the following conditions:

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

(vi) tricuspid atresia; ~~and~~

(vii) truncus arteriosus~~.~~; and

(j) Severe combined immunodeficiency disease.

AUTH: 50-19-202, MCA
IMP: 50-19-203, MCA

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (the department) is proposing an amendment to ARM 37.12.401 in order to increase the laboratory fee for newborn screening and to ARM 37.57.301 regarding the required conditions that are screened or tested for in the newborn screening panel. The proposed fee change in ARM 37.12.401 is related to the proposed change in ARM 37.57.301(3), which would add Severe Combined Immunodeficiency Disease (SCID) to the required conditions that are screened or tested for in the newborn screening panel.

SCID is one of the primary conditions that the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services has included in the Recommended Uniform Screening Panel (RUSP) for newborn screening. Essential requirements for inclusion in the RUSP are that the conditions are chosen based on evidence that supports the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. Due to technological and medical advances, newborns with SCID can be screened in a highly effective manner and babies with confirmed SCID can mature and live normal lives.

The department is also proposing to amend the link to the department's web site containing the fees for lab tests. The department recently updated its web site and this change is necessary to ensure the public has access to the most current web site.

ARM 37.12.401

The proposed change to this rule is necessary in order to cover the additional cost of performing the SCID screening test. It is estimated that this will result in an increase of $6.00 to the laboratory fee for screening each baby or cumulative fees of $72,000 annually for the estimated 12,000 babies that are screened each year in the state of Montana.

ARM 37.57.301

The proposed change to this rule is necessary to conform to HRSA's Recommended Uniform Screening Panel for all newborns and to update newborn bloodspot screening to reflect current standards of care for babies born in Montana.

Fiscal Impact

The adoption of the proposed amendment to the administrative rule listed above could have a fiscal impact on the following groups in Montana: newborns and their families, birthing hospitals, birthing centers, and direct entry midwifery services.

There are currently 28 birthing hospitals in Montana. Estimated costs that may be incurred due to adding SCID to the required conditions screened in newborn bloodspot testing include the following:

An additional charge of approximately $6.00 per newborn screen will be added to the cost of the screening panel. In some circumstances, providers may incur this cost.

Other Considerations

The department will provide family education materials.

Impact to babies born in Montana

There are approximately 12,000 babies born in Montana every year. It is possible that hospitals and other providers may in some circumstances bill families for the additional cost associated with performing this screening.

5. The department intends to adopt these rule amendments effective July 1, 2015.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., June 11, 2015.

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

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

/s/ Nicholas Domitrovich
Nicholas Domitrovich, Esq.
Rule Reviewer

/s/ Richard H. Opper
Richard H. Opper, Director
Public Health and Human Services

Certified to the Secretary of State May 4, 2015.

BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
MONTANA STATE AUDITOR

In the matter of the adoption of NEW RULES I through VII pertaining to network adequacy	)))	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On December 24, 2014, the Commissioner of Securities and Insurance, Montana State Auditor, published MAR Notice No. 6-208 pertaining to the public hearing on the proposed adoption of the above-stated rules at page 3017 of the 2014 Montana Administrative Register, Issue Number 24.

2. The department has adopted the above-stated rules, but with the following changes to the original proposal, stricken matter interlined, new matter underlined:

NEW RULE I (ARM 6.6.5901) APPLICABILITY AND IDENTIFICATION OF DIFFERENT LEVELS OF ADEQUACY (1) remains as proposed.

(2) The commissioner may also determine a network to be adequate pursuant to 33-22-1706(4)(a), MCA, and ARM 6.6.5902(1) and (3).

(2) remains as proposed, but is renumbered (3).

(a) The commissioner shall determine whether the payment difference between in- and out-of-network is 25% or less, based on the utilization of actuarial data developed by actuarial experts, such as the information found in the Tillinghast Manual. ~~according to a formula prescribed by the commissioner.~~

(b) Even if the commissioner determines that the insurer utilizes an acceptable payment differential under ~~(2)~~(3), that insurer shall submit the information and follow the requirements set forth in this chapter.

(3) remains as proposed, but is renumbered (4).

(5) ARM 6.6.5902(4)(b) through (f), ARM 6.6.5903(2)(b), ARM 6.6.5905(1)(b), and ARM 6.6.5906(4)(b) do not apply to dental and vision insurers.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE II (ARM 6.6.5902) NETWORK ADEQUACY (1) through (7) remain as proposed.

(8) When providing access to a nonparticipating provider or facility pursuant to ~~(5)~~(6), an insurer is not responsible for amounts that the nonparticipating provider may charge to the patient for a service that is above the reasonable "allowable charge," as determined under 33-15-308, MCA.

(9) through (10) remain as proposed.

(11) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to accept the rate that is negotiated with the insurer as payment in full under that

contract, and the participating provider may not bill the patient for charges above that amount for medically necessary covered services.

(12) remains as proposed.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE III (ARM 6.6.5903) FILING PROVIDER LISTS (1) An insurer shall~~, no later than May 1 of each year,~~ file on the date specified in filing instructions from the commissioner, an electronic report of all participating providers in that insurer's network on a form and in a manner prescribed by the commissioner. If the insurer maintains health plans with different network access, the insurer must file a separate report for each network.

(2) and (3) remain as proposed.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE IV (ARM 6.6.5905) CHOICE OF PRIMARY CARE PHYSICIAN

(1) If an insurer requires a covered person to choose a primary care provider and ties claims payment to that choice or requires a primary care provider referral before seeking specialty provider services, that insurer shall provide the covered person with access to the following:

(a) and (b) remain as proposed.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE V (ARM 6.6.5906) REQUIRED DISCLOSURES REGARDING NETWORK ADEQUACY (1) Each insurer shall have a preferred provider directory on its web site and available in hard copy, if requested. The provider directory must be searchable by specialty, including primary provider designation, county and city or town. The directory must include facilities and must be updated monthly to reflect whether or not the provider is accepting new patients, if that information is available, and any additions or subtractions to the provider list. There must be a separate and clearly designated directory for each health plan type, if more than one network is offered by that insurer. In addition, each insurer shall provide access to a directory of out-of-state participating providers that includes location, provider type, and specialty.

~~(2) The outline of coverage, which is delivered at the point of sale, must contain a prominent disclosure concerning reimbursement of nonpreferred, out-ot-network providers, including the following information:~~

~~(a) a disclosure concerning how the allowable charge is determined;~~

~~(b) a statement that the insurer's reimbursement for out-of-network claims may be less than the full billed charges;~~

~~(c) a disclosure that the covered person may be liable to the nonpreferred provider for amounts not paid by the insurer;~~

~~(d) the amount by which the covered person's cost sharing, including deductibles, coinsurance and copayments, will be increased for out-of-network services; and~~

~~(e) disclosure of all continuity of care provisions applicable to the policy.~~

~~(3) If a new outline of coverage is not delivered at the time of renewal, the insurer shall deliver the information in (2) at renewal in a separate notice.~~

~~(4)~~(2) An insurer shall also include the following information displayed in a prominent manner~~,~~ in the outline of coverage ~~and, as applicable, in the separate notice required in (3)~~:

(a) a description of the process required in ARM 6.6.5902 regarding how patients are provided access to and compensated for medically necessary care if there are no participating providers with the necessary expertise within a reasonable proximity who are able to provide the health care service without unreasonable delay; and

(b) a statement advising that out-of-network emergency room services to treat an emergency medical condition are reimbursed as if obtained in-network, if an in-network emergency room ~~is not~~ cannot be reasonably ~~available~~ reached. That disclosure must include the definition of emergency medical condition provided in applicable federal law.~~; and~~

~~(c) access to a directory of out-of-state participating providers that includes location, provider type, and specialty.~~

~~(5) If an insurer has limitations or restrictions on access to participating providers and facilities based on required authorizations or referrals, the insurer shall prominently disclose the limitations or restrictions in the outline of coverage, the supplemental notice described in (3), and in the front of the policy, certificate, or member contract itself, along with detailed instructions regarding how to obtain the service.~~

(6) remains as proposed, but is renumbered (3).

(a) and (a)(i) remain as proposed.

(ii) in the case of a facility, all covered persons who live in the ~~area~~ city or town that the facility serves.

(b) through (b)(ii) remain as proposed.

~~(7)~~(4) The notice in ~~(6)~~(3)(a) must disclose any applicable continuity of coverage provisions by referring to the section of the policy or certificate that contains ~~contained in the policy or outline of coverage~~ those provisions. ~~This~~ The notice must include a list of available preferred providers in the same geographic area who are the same provider type.

(5) This rule is effective for policies issued or renewed on or after January 1, 2016.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE VI (ARM 6.6.5907) GEOGRAPHIC SERVICES AREAS (1) An insurer may offer health plans with a limited geographic area ~~only~~ to ~~residents of~~ individuals who live or work in that area, as long as the insurer meets the network

adequacy requirements set forth in these rules and provides the commissioner with the following information:

(a) through (2) remain as proposed.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

NEW RULE VII (ARM 6.6.5908) CONTINUITY OF CARE (1) remains as proposed.

(2) If the insured requests it and the treating provider ~~identifies a special circumstance~~ agrees that the insured is in an active course of treatment, the treating provider ~~shall~~ may:

(a) through (c) remain as proposed.

(3) As used in this rule, "~~special circumstance~~ active course of treatment" means a condition which a provider reasonably believes could cause harm to an insured if care by the treating provider is suddenly discontinued, such as pregnancy or an ongoing course of treatment for an episode of cancer or other ~~acute~~ condition for which discontinuing care by the current treating physician may worsen the condition and interfere with anticipated outcomes.~~:~~

(a) In a case involving an active course of treatment ~~a special circumstance~~, an insurer must ensure continuity of care until the later of the following:

(i) and (ii) remain as proposed.

(b) Except in the case of pregnancy, ~~a special circumstance~~ the continuity of care period may not last longer than 90 days, or the next renewal date for that policy, whichever is longer, without insurer consent; and

(c) ~~A special circumstance~~ Continuity of care protections are not required for ~~does not include~~ routine ~~care for a chronic condition or~~ primary and preventive care.

(4) remains as proposed.

(a) the insurer agrees that ~~a condition for which ongoing treatment is being provided is a special circumstance~~ the insured is in an "active course of treatment" as identified by the treating physician; and

(b) the provider contract termination was not "for cause."

(5) remains as proposed.

(6) This rule is effective for policies issued or renewed on or after January 1, 2016.

AUTH: 33-22-1707, MCA
IMP: 33-22-1706, MCA

3. On January 15, 2015, a public hearing was held on the proposed adoption of the above-stated rules in Helena. Comments were received by the January 23, 2015, deadline.

4. The department has thoroughly considered the comments and testimony received. The following comments refer to specific rules which are noted above the comments.

COMMENTS ON NEW RULE I (ARM 6.6.5901) APPLICABILITY AND IDENTIFICATION OF DIFFERENT LEVELS OF ADEQUACY: Eight comments were made in regard to this rule.

COMMENT NO. 1: One commenter states that New Rule I (ARM 6.6.5901) should identify specific requirements of these rules that should not apply to dental insurers, in particular, New Rule II (ARM 6.6.5902(4)(b) through (f)), New Rule III (ARM 6.6.5903(2)(b)), New Rule IV (ARM 6.6.5905(1)(b)) and New Rule V (ARM 6.6.5906(4)(b)).

RESPONSE NO. 1: The department agrees that New Rule I (ARM 6.6.5901(4)(b) through (f)), New Rule Ill (ARM 6.6.5903(2)(b)), New Rule IV (ARM 6.6.5905(1)(b)), and New Rule V (ARM 6.6.5906(4)(b)) should not apply to dental and vision insurers and will make that change.

COMMENT NO. 2: Two commenters state that New Rule I (ARM 6.6.5901(3)) should be more descriptive. It currently states that a network may not be "so inadequate" that it constitutes a misrepresentation under 33-1-502, MCA.

RESPONSE NO. 2: The department has considered this assertion, but believes that the rule language is clear on the issue of disapproval due to misrepresentation. Section 33-1-502, MCA, states that the commissioner may not approve a form (such as a policy containing lower cost-sharing for in-network health care services), if it contains "misleading clauses" that "deceptively affect the risk purported to be assumed in the general coverage of the contract." Therefore, if a disability policy represents to consumers that lower cost sharing and protection from balance billing is available if a network provider is used, but in fact the insurer does not provide reasonable access to "in-network" providers, that policy is misleading and should be disapproved.

COMMENT NO. 3: One commenter expressed concern because there is no payment differential limit that applies if a network is determined to be adequate and therefore not subject to the 25% payment differential in New Rule I (ARM 6.6.5901(2)). This commenter suggests that the commissioner limit the cost-sharing payment differential for plans that have an adequate network, but apply an unreasonably high cost-sharing to out-of-network services.

RESPONSE NO. 3: Section 33-22-1706(4)(a), MCA, states that the 25% payment differential does not apply to health benefit plans that have an adequate network, as determined by the commissioner. This department may not create an administrative rule that conflicts with a statute.

COMMENT NO. 4: One commenter requested clarifications regarding which rules apply to a health benefit plan that meets the provider percentage requirements set forth in 33-22-1706(4)(c), MCA. This commenter requests further clarification on New Rule II (ARM 6.6.5902(3)) which applies specifically to plans that do not meet the threshold percentages in 33-22-1706(4)(c), MCA.

RESPONSE NO. 4: The department believes that the applicability of the rules is sufficiently set forth in the wording of each rule. Certain provisions clearly apply only in certain situations. New Rule I (ARM 6.6.5901(1)) clearly states that in order for a health insurer to be deemed adequate in 33-22-1706(4)(c), MCA, the insurer "must follow the requirements set forth in this chapter." For example, in order for the commissioner to determine that the percentages have been met, the insurer must demonstrate the numbers of providers in the various categories identified in New Rule II (ARM 6.6.5902(4)). The delivery of health care is complex and requires services delivered by a multitude of different provider types. New Rule I (ARM 6.6.5901(1)) identifies that the rules apply to all health insurers, regardless of their network percentages, unless otherwise clearly stated.

New Rule II (ARM 6.6.5902(3)) states there is a general adequacy standard for insurers who do not meet the threshold percentages in all of the categories. This department has been reviewing networks for the past two-and-a-half years and has not yet identified an insurer that has met the threshold percentages in 33-22-1706(4)(c), MCA, for all provider types.

COMMENT NO. 5: One commenter requests clarification that New Rule I (ARM 6.6.5901(2)) (the application of the 25% differential) refers to all health plans that have not met the threshold percentages identified in 33-22-1706(4)(c), MCA.

RESPONSE NO. 5: That is not a correct assumption. The department has clarified this in an amendment to New Rule I (ARM 6.6.5901(2)).

COMMENT NO. 6: One commenter requests that the department identify the formula that will be used by the commissioner to determine the 25% payment differential.

RESPONSE NO. 6: The department has clarified this in an amendment to New Rule I (ARM 6.6.5901(2)(a)).

COMMENT NO. 7: One commenter states that insurers that are subject to the 25% differential should not be subject to the provisions of these rules.

RESPONSE NO. 7: The department disagrees. Consumers are entitled to the protections of these rules, even if the payment differentials are limited to 25%. Furthermore, large parts of this rule relate to adequacy of consumer disclosures. Also, these rules detail how provider networks must be continuously reviewed and updated.

COMMENT NO. 8: One commenter requests that the rule clarify that an insurer that has an adequate network as determined by the commissioner is not subject to the 25% differential in 33-22-1706(4)(b), MCA.

RESPONSE NO. 8: The statute (33-22-1706, MCA) is clear on that point and there is no need for clarification.

COMMENTS ON NEW RULE II (ARM 6.6.5902 NETWORK ADEQUACY): Thirteen comments were made in regard to this rule.

COMMENT NO. 9: Two commenters wrote to specifically express their support for New Rule II (ARM 6.6.5902), particularly sections (3) and (6).

RESPONSE NO. 9: The department appreciates the comments.

COMMENT NO. 10: One commenter requested that further clarification be provided regarding which rules apply to networks with varying degrees of adequacy as described in 33-22-1706(4)(a), (b), and (c), MCA.

RESPONSE NO. 10: Please refer to the responses number 4, 5, and 7 above.

COMMENT NO. 11: One commenter asked what standards will be used for provider to covered person ratios referenced in New Rule II (ARM 6.6.5902(5)) with regard to the reasonable criteria the department "may" use to determine adequacy of choice for each provider type.

RESPONSE NO. 11: The department has concluded that it must avoid stating specific provider ratios and other specific standards involving "minimums" and "maximums" in (5). Montana has very challenging geography and sparse and scattered population density. A provider ratio that may be appropriate for Billings, Montana, is not appropriate for Circle, Montana, or even Kalispell, Montana. Therefore, the department instead chose flexibility and will evaluate these standards on a case-by-case basis that takes into account geographic challenges, population density, and provider availability.

COMMENT NO. 12: One commenter requests that when a consumer is entitled to the protections of New Rule II (ARM 6.6.5902(6)), the rule should require the insurer to apply the "balance-billed" charges referred to in New Rule II (ARM 6.6.5902(8)) (charges that the nonparticipating provider may bill to the consumer, i.e., charges that are in excess of the insurer's "allowable charge") to the insured's in-network "maximum-out-of pocket." This commenter also requests that under New Rule II (ARM 6.6.5902(6)), the insurer be held responsible for balance-billed charges. This commenter has several comments that object to the fact that this rule does not protect consumers from balance billing under New Rule II (ARM 6.6.5902(6)).

RESPONSE NO. 12: New Rule II (ARM 6.6.5902(6)) requires the insurer to apply the "in-network" cost-sharing amount to medically necessary specialty care services when the insurer does not have an in-network specialty care provider within a reasonable distance. This protection will result in considerable savings to the consumer. New Rule II (ARM 6.6.5902(8)) clarifies that even if the protections in New Rule II (ARM 6.6.5902(6)) are triggered, the insurer will still pay only the

"allowable charge" for that service. The department does not have the authority to require an insurer to cover whatever charge the nonparticipating provider might bill. The terms of the insurance contract dictate that the insurer will only pay the usual, customary and reasonable charge (the allowable charge). The department may review the allowable charge for reasonableness. The department shares this commenter's concerns about balance-billed charges, but solving it is beyond the scope of these rules.

COMMENT NO. 13: One commenter expresses concern about the provisions in New Rule II (ARM 6.6.5902(9)(b)) that reference the "willingness of providers to contract with the insurer under reasonable terms and conditions" as a factor in determining the number of providers available in a particular area. This commenter states that many times providers have valid reasons that go beyond money for not contracting with insurers, such as objectionable contract language.

RESPONSE NO. 13: This provision is not intended to address contract disputes between two willing parties, but instead is intended to address issues that are easier to identify, such as a provider that routinely refuses to contract with any insurer.

COMMENT NO. 14: One commenter expresses concern about the fact that the list of provider types in New Rule II (ARM 6.6.5902(4)) does not expressly include federally qualified community health centers (FQHC) and Indian health services providers. In addition, this commenter points out the federal requirements placed on qualified health plan (QHP) issuers to include an adequate number of essential community providers (ECPs), including FQHCs and Indian health providers.

RESPONSE NO. 14: The department did not create a separate set of rules for QHP issuers. The department believes that network adequacy should be equally applied to all health insurance issuers in order to maintain a level playing field. New Rule II (ARM 6.6.5902(4)) specifically mentions primary care providers. FQHCs and Indian health providers are primary care providers. The department has specifically included all primary care providers who have also been identified as an ECP in the provider lists the department uses for determining adequacy, as well as in a separate list identifying only ECPs. In this way, the adequacy of ECPs is not subject to a lower 30% federal standard, but rather ECP adequacy is judged by the higher standard that these rules apply to provider adequacy in general.

COMMENT NO. 15: One commenter states New Rule II (ARM 6.6.5902(3)) places too much emphasis on the location of the provider. This commenter views that approach as "antiquated" and believes that other factors are more important, such as cost and quality. This commenter expresses concern for the use of factors such as travel times, wait times, and provider ratios and instead recommends telemedicine and value-based, low-cost networks that may be distant. This commenter stresses the need for flexibility so that insurers can develop low-cost innovative health plans.

RESPONSE NO.15: The department strives to maintain flexibility that will encourage innovation and keep costs down. However, that cannot be accomplished at the expense of ignoring reasonable access to necessary care. If a consumer is forced to travel 200 miles to seek primary health care, it is likely that health care visits will be skipped and necessary preventive care and monitoring of chronic health conditions will not occur. Lack of accessible treatment does not lead to cost savings in the long run. Accessibility of necessary health care services must include a consideration of travel time, geographic barriers, wait times and provider ratios. However, these rules also leave the door open for innovation and value-based network development, as specifically expressed in New Rule II (ARM 6.6.5902(12)).

COMMENT NO. 16: One commenter asked if these rules allow for tiered networks and narrow networks.

RESPONSE NO. 16: Yes, these rules allow for innovative, value-based networks. See response number 15 and the specific reference in New Rule II (ARM 6.6.5902(12)).

COMMENT NO. 17: One commenter expressed concern that the provisions of New Rule II (ARM 6.6.5902(11)), requiring that the participating health care provider accept the insurer's rate negotiated by the insurer as payment in full, may have the unintended consequence of prohibiting the health care provider from seeking payment for other liable third parties.

RESPONSE NO. 17: The department does not necessarily agree that New Rule II (ARM 6.6.5902(11)) results in that consequence, but the commenter suggests a simple language clarification, and the department has amended the rule according to the commenter's suggestion.

COMMENT NO. 18: One commenter requests that New Rule II (ARM 6.6.5902(4)(a)) list specific specialties and subspecialties as identified by the American Board of Medical Specialties and also as identified for QHP issuers in the network adequacy template required by the Center for Consumer Information and Insurance Oversight (CCIIO). This commenter stresses the need for subspecialty identification as well as specialty identification.

RESPONSE NO. 18: The department disagrees with the need for this level of specificity in the rule. In addition, very few "subspecialists" practice medicine in Montana.

COMMENT NO. 19: One commenter suggests that New Rule II (ARM 6.6.5902(5)), which discusses using provider ratios as a criteria, should specifically use the term "full-time equivalent" providers in order to account for providers who may only work part-time or may divide their time between different clinics.

RESPONSE NO. 19: The department agrees that identifying part-time providers may become necessary in some situations; however, it believes that the proposed language of the rule is broad enough to include that consideration when necessary.

COMMENT NO. 20: One commenter asks the department to clarify the meaning of "unreasonable delay" and "sufficient provider choice," as well as the meaning of all terms that use the words "reasonable," "reasonable distance," "reasonable proximity," and sufficiency and adequacy of provider choice.

RESPONSE NO. 20: The commenter is apparently seeking a rule where time and distance standards are mandated for every area of this large state—where "wait times" are defined by a specific number of days and "sufficiency of provider choice" is indicated by a specific number of provider types in each area where a health plan is sold. The department sought input on the content of these rules for many months from the largest major health insurers, from consumers and from all of the large provider groups in the state. The majority of the interested parties consulted did not want administrative rules that are restrictive and contain specific miles and time and distance standards; instead they preferred a rule that allows flexibility, while still protecting the complex health care needs of consumers.

Pursuant to 33-22-1706(4), MCA, the commissioner must determine the adequacy of networks. Every network adequacy review conducted to date has required the commissioner to exercise her discretion when in determining adequacy. No insurer meets the threshold percentage for all health care provider types that are measured. New Rule II (ARM 6.6.5902) sets forth a description of standards that the commissioner considers when exercising her discretion to determine the network adequacy. The use of terms like "reasonable" is necessary, if time and distance standards are to be avoided.

COMMENT NO. 21: One commenter asks again if the provisions of New Rule II (ARM 6.6.5902) apply to insurers who meet the requirements of 33-22-1706(4)(c), MCA.

RESPONSE NO. 21: See Response No. 4. New Rule II (ARM 6.6.5902) applies except for (3).

COMMENTS ON NEW RULE III (ARM 6.6.5903) FILING PROVIDER LISTS: Four comments were made in regard to this rule.

COMMENT NO. 22: Two commenters state that New Rule III (ARM 6.6.5903(2)(a)) requires the insurer to refile their network list if there is an overall decrease of providers, below 5%. One commenter requests that dental insurers be required to file a quarterly report. The second commenter (a health insurer) believes that the 5% trigger is too low.

RESPONSE NO. 22: Because the dental networks in Montana are small, the department understands this concern. However, most of the networks we review

need to grow, so if losses occur, the lists should be re-reviewed. At this time, the department will keep the 5% trigger.

COMMENT NO. 23: One commenter suggests that May 1, 2015, may not be enough time to prepare the network lists for filing. Another commenter requests clarification as to whether the May filing is for the current year or the next plan year. Another commenter requests that these network lists be filed in conjunction with the QHP filings.

RESPONSE NO. 23: This filing date for network lists is largely dictated by the federal filing deadline for QHPs. That date is set forth in the commissioner's filing instructions memorandum and in the federal letter to issuers. Insurers were already advised in March 2015 that they needed to file all their forms, rates, and network lists by May 15, 2015. Because it now appears that the filing dates may change every year, the department has amended the rule to make that date flexible. The filing in May is for the 2016 plan year. That information is contained in the commissioner's filing instructions that are issued every spring. The network lists are reviewed as part of a QHP filing, and also in other types of annual filings, which are required to occur at the same time as QHP filings. This is clarified in the commissioner's filing instructions.

COMMENT NO. 24: One commenter suggests that these rules should not require annual provider lists.

RESPONSE NO. 24: Currently federal law requires annual review of network lists for most types of health plans. In addition, provider lists change considerably from year to year and an annual review at a minimum is necessary to protect consumers. Providers move in and out of the state frequently. Even the master list of providers changes considerably from year to year.

COMMENT NO. 25: One commenter requests that the department add the word "annual" before the word "audit" in New Rule III (ARM 6.6.5903(3)).

RESPONSE NO. 25: The department disagrees with this addition. Some networks may not require even an annual audit. Other networks may require auditing more frequently.

COMMENTS TO NEW RULE IV (ARM 6.6.5905) CHOICE OF PRIMARY CARE PHYSICIAN: Two comments were made in regard to this rule.

COMMENT NO. 26: One commenter asks if any PPO plans actually require a primary care physician (PCP) designation, or if only HMO plans require that.

RESPONSE NO. 26: Every year the department sees new types of innovative benefit plans. Some health plans already require a PCP designation, although do not actually require referrals. Many health plans are incorporating a patient-centered medical home program that may require a PCP designation. The lines between

HMO and other plans are already very blurred and the department expects them to become more so. Therefore, this rule is necessary to protect consumers.

COMMENT NO. 27: One commenter requests that the phrase "access" be added before the term "the following" in New Rule IV (ARM 6.6.5905) so that an insurer may refer to an online directory instead of providing a written list.

RESPONSE NO. 27: The rule and the federal law already require an online directory. The department will amend the rule to allow the information to be delivered online, as long as it is delivered in a manner that clearly identifies PCPs, located in specific cities and towns, and that are accepting new patients.

NEW RULE V (ARM 6.6.5906) REQUIRED DISCLOSURES REGARDING NETWORK ADEQUACY: Six comments were made in regard to this rule.

COMMENT NO. 28: One commenter requests clarification on the geographic scope of the out-of-state provider directory and asks if it is limited to neighboring states.

RESPONSE NO. 28: Out-of-state provider directories for health insurers generally include many different geographic areas, not just those states that are neighboring. Medical needs of patients often take them to specialists located several states away. Dental insurer networks are different. However, the rule is written broadly and is not restrictive as to the geographic location of the providers. Therefore, dental insurers may provide the out-of-state directory that they have available and that is relevant to the dental plans that they are marketing in Montana.

COMMENT NO. 29: One commenter requested that insurers be required to prominently notify consumers of the deficiencies of their networks if the number of certain types of providers is deficient.

RESPONSE NO. 29: The department declines to impose that requirement. If the network is deficient in certain types of providers, the department is working with the insurer to correct that deficiency. Also, consumers are able to search provider directories for certain provider types in their area.

COMMENT NO. 30: One commenter requests that the New Rule V (ARM 6.6.5906(4)(b)) regarding access to out-of-network emergency room services "if an in-network emergency room is not reasonably available" include the circumstance where the patient did not have control over the choice of emergency room; for example, the patient was taken to an emergency room by ambulance.

RESPONSE NO. 30: Section 33-22-1705, MCA, states that if a person receives emergency care and "cannot reasonably reach a preferred provider" that service will be paid as if it were "in-network." In this rule, the department is placing the language of the statute into a consumer disclosure document. However, the department is amending the rule to reflect the exact language of the statute. The language,

"cannot reasonably reach" would cover the circumstance where a patient was transported in an ambulance to an out-of-network emergency room.

COMMENT NO. 31: One commenter suggests that the timeframe for the notice of termination for a provider contract be 90 days instead of 60 days. The commenter states that Medicare Advantage requires 90 days. Also, this commenter wants to ensure that if an insurer terminates a provider contract, those notices should be sent to the provider's physical location address, not the address of the provider's billing company.

RESPONSE NO. 31: The department does not agree with the need to conform to Medicare Advantage rules because it is a different product that is not regulated by the states and not subject to this rule. The provider contract should specify the addresses where notices and other communications should be sent. Health care providers should ensure that the address in the contract is the best location to reach the provider.

COMMENT NO. 32: One commenter requests that the term "monthly" in New Rule V (ARM 6.6.5906(1)) be changed to "within 30 days of the insurer's receipt of information from the provider."

RESPONSE NO. 32: It appears that the requested change would require the insurer to make continuous changes to their directories instead of just making all changes at the same time every month. The department is concerned that the suggested new language makes this requirement more burdensome on other insurers.

COMMENT NO. 33: One commenter states that (2) through (5) in this rule are already contained in the Outline of Coverage requirements in 33-22-244 and 33-22-521, MCA. The commenter then states that the description of allowable charge is already contained in the contract and should be deleted and the continuity of care provisions should be included only in the policy because of its length. The commenter does not want to add anything to the disclosure that is already contained in the contract, specifically the right to continuity of care and the right to have out-of-network services covered as in-network.

This commenter suggests referencing the state definition of emergency services in New Rule V (ARM 6.6.5906) instead of the federal definition.

This commenter also suggests changing the language in New Rule V (ARM 6.6.5906(6)(a)) from "ensure" to "shall make a good faith effort" to notify covered persons when a provider leaves the network. The commenter also wants to change "two years" to one year in (6)(a)(i) and requested clarification on the term "area that the facility serves" in (6)(a)(ii).

This commenter requests that New Rule V (ARM 6.6.5906(7)) be amended to require only a reference to the language in the contract and that the "list of available

in-network providers who are available to see new patients," be reduced to a reference to the existing provider directory.

RESPONSE NO. 33: The department has amended the language in New Rule V (ARM 6.6.5906) to remove any duplication between New Rule V (ARM 6.6.5906) and the provisions of 33-22-244 and 33-22-521, MCA. The notice concerning "the right to continuity of care" was amended by allowing a reference to the section of the policy that contains the language so that the entire provision does not need to be placed in the notice.

The notice concerning out-of-network emergency care is an important right. If the information is buried in policy language, most consumers will not see it. The current outline of coverage statutes contain language that is no longer relevant or necessary or is duplicated in the Summary of Benefits and Coverage (see the Commissioner's Advisory Memorandum on Federal and State Consumer Disclosures dated July 6, 2012). Adding important information about emergency services is not a burden to insurers, and it is a large benefit to consumers.

With regard to the definition emergency services, the state definition is preempted by the federal definition.

Regarding the notice to consumers concerning providers who leave the network, the department believes that the rule provides enough flexibility to imply a good faith effort. It is not appropriate to change two years to one year because many consumers do not see their doctors every year.

The department has also amended New Rule V (ARM 6.6.5906(7)) to accept some of the language suggested by this commenter, such as defining the facility area as the city or town where the facility is located.

COMMENTS TO NEW RULE VI (ARM 6.6.5907) GEOGRAPHIC SERVICES AREAS: One comment was made in regard to this rule.

COMMENT NO. 34: One commenter requested that the rule be changed to strike the term "only" and replace the term "residents of" with "individuals who live, work or reside in."

RESPONSE NO. 34: The department has amended the rule to make this change, except that it did not say both "reside" and "live" because the terms are duplicative.

COMMENTS TO NEW RULE VII (ARM 6.6.5908) CONTINUITY OF CARE: Five comments were made in regard to this rule.

COMMENT NO. 35: This commenter strongly supports the adoption of New Rule VII (ARM 6.6.5908) because it allows patients to continue critical treatment with the same provider when necessary at no additional cost to the patient.

RESPONSE NO. 35: The department agrees.

COMMENT NO. 36: One commenter states that all patients, especially those with chronic conditions, frequently choose their network based on the provider network available to them during the plan selection period. This commenter believes that if a plan terminates a physician from its network without cause, all members should retain access to that physician until the next benefit year when the subscriber has an ability to select a new plan with a provider in the network that meets their needs.

RESPONSE NO. 36: The department believes that this rule balances the need for insurers and providers to manage their businesses and still protect the consumers that are most vulnerable. Opening this protection up to all the insureds in the plan does not achieve that balance.

COMMENT NO. 37: One commenter requests that the commissioner delete "chronic condition" from the list in (3)(c), which states that special circumstances do not include chronic conditions, primary or preventive care. This commenter asserts that excluding "chronic condition" may harm patients if it interrupts continuous care, causing them to suffer unnecessarily.

RESPONSE NO. 37: A special circumstance is defined in part, as an "acute" condition. Upon further consideration, the department agrees that acute vs. chronic, and even "special circumstance" are not the best terms and therefore has made amendments to the rule.

COMMENT NO. 38: One commenter requests that the insured should be able to authorize ("assign") the physician to appeal a decision by the insurer to deny the extension of ongoing treatment at the in-network rate on behalf of the insured under the appeal rights outlined in the contract. The insured will need assistance from the treating physician to complete this appeal process. If the rule is not amended to allow such an assignment, the commenter requests adding additional language that would permit the insured to involve the provider directly.

RESPONSE NO. 38: The physician is not a party to the insurance contract, so the insured must file the appeal. However, once the insured authorizes it, the treating physician may be involved to the extent necessary to make all necessary medical arguments and responses. That is generally the case with most types of appeals. The treating physician usually is an active participant, ready and able to discuss the issues with the insurer's medical director. Therefore, it is not necessary to amend the rule.

COMMENT NO. 39: One commenter recommends limiting any continuity of care period to 90 days, except for pregnancy because that is what is required by current accreditation standards. This commenter goes on to argue that if the rule uses "until the next renewal period," inconsistencies could result in the length of time an individual might have a continuation period—between one month and 11 months.

RESPONSE NO. 39: The department has amended the language to account for the possible inequity relating to the "one month vs. eleven months" comment. However, the department will not limit the continuity of care period to 90 days only. Insurers are already offering a "continuity of care" period for 90 days because it is required by health plan accreditation standards insurers must follow. Ninety days is not enough time in every situation that may arise, as consumers have complained to the department indicating that 90 days is not enough.

COMMENT NO. 40: One commenter questions the department's authority to adopt the rule on continuity of care.

RESPONSE NO. 40: Nearly all of the health plans sold in in 2014 and 2015 are PPO plans that rely heavily on a provider network to deliver the consumer protections required by state and federal law. In fact, many of those protections that limit consumer cost-sharing apply only when the covered person seeks care "in-network." In addition, the cost-sharing differences between in- and out-of-network in these plans has doubled, tripled, or even quadrupled compared to what existed prior to 2014. Also, networks are becoming narrower, "value-based," and more selective. The commissioner has a duty that permeates all parts of Title 33, MCA, to protect insurance consumers. See 33-1-311, MCA. In addition, the commissioner may not approve any policy that "misrepresents" benefits to consumers. See 33-1-502, MCA.

In today's insurance market, consumers may choose plans according to whether or not their physician is included in the insurer's network. This is particularly true if the consumer has an active illness or pregnancy that requires an ongoing course of treatment. When a treating health care provider is terminated from an insurer's network, the covered person has lost a significant part of the value of the health plan they chose. Therefore, in order to protect consumers and give them the benefit of what they contracted for, the rule seeks to lessen the impact of what could be identified as a misrepresentation of the benefits provided under the plan. A limited continuity of care provision is much less drastic than other alternatives, such as limiting network changes to once in a plan year.

GENERAL COMMENTS

COMMENT NO. 41: One commenter stated that the department should wait to adopt these rules until the NAIC Network Adequacy model act is fully amended and adopted.

RESPONSE NO. 41: This department is closely following the activity on the amended model law adoption and appreciates the efforts undertaken in that process. However, the Montana Legislature has already adopted a different statutory framework that is reflected in the amendments to 33-22-1706, MCA, and the percentages discussed in the proposed rule. The proposed rule incorporates small parts of the NAIC model language where possible, but adopting the Amended NAIC model act would require a legislative change. The administrative rules could

be changed if the underlying statutes were changed. The next legislative session is in 2017. In the meantime, the department must regulate network adequacy in Montana in a way that meets the requirement of 33-22-1706, MCA, and also meets federal requirements of reasonable access for insurance consumers.

COMMENT NO. 42: One commenter suggests that the new rules exceed the scope of the statutes that implement 33-22-1706, 33-22-244, and 33-22-521, MCA, and insert additional requirements not envisioned by the legislature.

RESPONSE NO. 42: The department disagrees. Section 33-22-1706(4), MCA, gives the commissioner the authority to determine network adequacy. The commissioner is charged with the duty of protecting the insurance consumers in this state (33-1-311, MCA). The detail contained in these rules describes to the public how the commissioner will exercise her discretion in this matter. The financial consequence of receiving health care from an out-of-network physician is significant, and consumers must be protected from that if possible. Therefore, adequate consumer disclosures are imperative.

Calculating percentages of provider types is a complex activity with unpredictable outcomes. An insurer may have 85% of the physicians in the western part of the state, but only 50% in the eastern part of the state. The geographic distances in this state are large. In addition, certain provider types may participate in the network in the consumer's location at the time the policy is purchased, but then leave the network three months later, leaving the consumer with no local options for care during the remaining nine months of the policy term. These administrative rules provide insurers, consumers, and health care providers with detailed information regarding how the commissioner will determine networks to be adequate, while still protecting consumers by ensuring adequate access.

COMMENT NO. 43: One commenter requests an effective date of January 1, 2017, because the rules would require changes to outline of coverage.

RESPONSE NO. 43: The department does not agree that a 2017 effective date is necessary. The department will be reviewing network adequacy for 2016 products during the summer of 2015. Many of these rules describe how that process is conducted and are needed now. The department agrees to apply a January 1, 2016, effective date to New Rule V (ARM 6.6.5906) regarding disclosures and New VII (ARM 6.6.5908) regarding continuity of care. Insurers have more than six months to implement any changes to forms or process to implement those changes. New Rule V (ARM 6.6.5906) has been substantially amended and the additional information in the outline of coverage is minimal.

COMMENT NO. 44: One commenter has requested that "various" terms be further defined, but does not indicate which terms.

RESPONSE NO. 44: Without further identification of terms, the department cannot respond to this comment. However, throughout the responses above, the

department has responded to comments about the definition of "reasonable" and explained why that term is used. The general definition of adequacy is found in New Rule II(3) (ARM 6.6.5902(3)).

COMMENT NO. 45: One commenter asserts that these rules should not apply to insurers who meet the requirements in 33-22-1706(4)(c), MCA, or the 25% differential requirements in 33-22-1706(4)(b), MCA.

RESPONSE NO. 45: The department disagrees. These rules set forth the filing and review process for determining percentages and adequacy and those rules must apply to all insurers. In addition, these rules ensure that consumers are provided with adequate disclosure so that they can choose a network that meets their needs. These rules provide necessary protections when networks change or are insufficient in certain geographic locations. Also, see the responses to comment numbers 7, 40, and 42.

COMMENT NO. 46: One commenter requests that the commissioner reconsider the appropriateness of "narrow" networks in Montana because of the small population in the state and the limited supply of health care providers.

RESPONSE NO. 46: Insurers continually request the flexibility that will allow them to innovate "value-based" networks in order to keep premiums lower. Access to health care necessarily includes affordability. Therefore, the commissioner must keep the door open to innovative network designs that also provide adequate access to medically necessary health care.

COMMENT NO. 47: One commenter asks if a lack of obstetricians and gynecologists in a network may lead to gender discrimination, a violation of 49-2-309, MCA.

RESPONSE NO. 47: A discrimination determination under 49-2-309, MCA, would require a case-by-case review of specific facts and is beyond the scope of these rules.

5. The effective date of New Rules I (6.6.5901), II (6.6.5902), III (6.6.5903), IV (6.6.5905), and VI (6.6.5907) will be May 15, 2015, which is the day after publication of this adoption notice. The effective date of New Rules V (ARM 6.6.5906) and VII (ARM 6.6.5908) will be January 1, 2016. New Rules V (ARM 6.6.5906) and VII (ARM 6.6.5908) will be effective for policies issued or renewed on or after January 1, 2016.

/s/Nick Mazanec
Nick Mazanec
Rule Reviewer

/s/Christina L. Goe
Christina L. Goe
General Counsel

Certified to the Secretary of State May 4, 2015.

BEFORE THE FISH AND WILDLIFE COMMISSION
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 12.11.501 and the adoption of New Rule I pertaining to recreational use on Silver Lake in Deer Lodge County	))))	NOTICE OF DECISION ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On January 29, 2015, the Fish and Wildlife Commission (commission) published MAR Notice No. 12-439 pertaining to the public hearing on the proposed amendment and adoption of the above-stated rules at page 50 of the 2015 Montana Administrative Register, Issue Number 2.

2. A public hearing on the notice of proposed amendment and adoption of the above-stated rules was held on February 26, 2015.

3. The commission did not adopt or amend the rules as proposed. There is minimal boat activity and very little use by personal watercraft or waterskiing on Silver Lake. Anecdotal information indicates recreational boating has rarely occurred. There are no recorded instances of any unsafe boating, complaints of unsafe boating, or reported accidents. Public comment was predominantly opposed to the rule. Concern remains over potential fluctuating water levels, security of the dam and intake infrastructure, and the potential for boaters to accidentally strike the associated equipment. Alternatively, the commission proposes a 100-foot closure to boating, sailing, floating, and swimming around the equipment on the east end of the reservoir. The proposed rule language is published at page 507 of the 2015 Montana Administrative Register, Issue Number 9.

/s/ Dan Vermillion
Dan Vermillion, Chairman
Fish and Wildlife Commission

/s/ William Schenk
William Schenk
Rule Reviewer

Certified to the Secretary of State May 4, 2015.

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

In the matter of the amendment of ARM 24.216.402 fee schedule) NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On March 12, 2015, the Board of Sanitarians (board) published MAR Notice No. 24-216-22 regarding the public hearing on the proposed amendment of the above-stated rule, at page 262 of the 2015 Montana Administrative Register, Issue No. 5.

2. On April 3, 2015, a public hearing was held on the proposed amendment of the above-stated rule in Helena. Several comments were received by the April 10, 2015, deadline.

3. The board has thoroughly considered the comments. A summary of the comments and the board responses are as follows:

ARM 24.216.402 FEE SCHEDULE:

COMMENT 1: Some commenters suggested that the board should balance its budget by enacting cost saving measures.

RESPONSE 1: The board has enacted cost saving measures by minimizing expenses, including holding meetings by teleconference when feasible. The board cannot reduce certain fixed costs. The Economic Affairs Interim Committee (EAIC) will study fees for licensing boards in the interim, and interested parties are urged to communicate during that process.

COMMENT 2: A number of commenters noted the fees for sanitarians and sanitarians-in-training are higher than fees for other professionals who make comparable or higher wages.

RESPONSE 2: The board is required to set fees commensurate with board costs and cannot consider licensee salaries or fees paid by other professionals.

COMMENT 3: Some persons commented that the fees charged for licenses exceed the value of services received by licensees.

RESPONSE 3: The board is directly charged for and pays for the services it receives. However, the board is unable to change this process.

COMMENT 4: Some commenters indicated communication between the board and professionals is poor.

RESPONSE 4: The board understands the commenters' concerns and invites all interested persons and licensees to attend its meetings and access minutes and other information pertaining to board activities.

COMMENT 5: A commenter asserted that several calls to the board office concerning the rule proposal were not returned.

RESPONSE 5: While the comment is beyond the scope of this rule proposal, as board office procedures are not addressed in this notice, the board apologizes for any oversight that may have inadvertently occurred.

COMMENT 6: Several persons asserted that the board does not promptly review and approve applications for licenses and continuing education approval.

RESPONSE 6: The board balances the need to provide services to the public and profession in a timely way, with the need to be efficient and save money, by meeting as infrequently as necessary to conduct the business of the board. This comment is beyond the scope of this rule proposal, in that board application procedures are not addressed in the notice.

COMMENT 7: Some commenters observed that when sanitarian-in-training applications are not approved in a timely way, their employers suffer increased labor costs due to the need for a licensee to accompany the applicant until the application is approved.

RESPONSE 7: This comment is beyond the authority of the board. The board meets less often in an attempt to save money, and tries to group applications and issues in order to increase efficiency.

COMMENT 8: A number of commenters noted many public health agencies do not pay for their employees' license application and renewal fees, and the fees are not affordable for the individual employees who are required to pay them.

RESPONSE 8: Statutorily, the board must set fees commensurate with costs and cannot consider the way other agencies are funded or the source of fees paid by licensees and applicants.

COMMENT 9: Some commenters stated that increasing fees for inactive licensees will result in fewer individuals maintaining inactive licenses and lower revenue for the board.

RESPONSE 9: The board did consider this, but ultimately determined that the proposed fee accurately reflects the cost of processing and maintaining inactive licenses.

COMMENT 10: Several commenters suggested that higher fees will hinder workforce maintenance and development, because qualified persons will seek licensure in other professions, resulting in a smaller and less qualified pool of individuals interested in becoming registered sanitarians.

RESPONSE 10: The board sets fees commensurate with associated board costs as necessary to carry out its duty to protect the public.

COMMENT 11: Some commenters stated that requiring a microbiology course as a prerequisite for licensure increases the expense of becoming licensed as a sanitarian.

RESPONSE 11: This comment is beyond the scope of this rule proposal. The board contends that microbiology is an important aspect of what a registered sanitarian does and is an important part of the curriculum for an environmental health degree.

COMMENT 12: Some commenters observed that Montana licensure fees exceed fees charged by other similar states.

RESPONSE 12: The board must set fees commensurate with costs and cannot consider fees charged by other states when setting its license fees.

COMMENT 13: Several commenters noted that if the board allowed the department to process more license applications and streamlined the approval process for continuing education, the board could meet less often and would save money through these efficiencies.

RESPONSE 13: The continuing education review process does not drive a significant part of expense. The board will continue to review ways to allow the department to process routine applications and continuing education applications. This rulemaking does not provide for or adjust fees related to continuing education.

COMMENT 14: Some commenters stated that the board should use technology to reduce travel costs by having fewer in-person meetings and consider using e-mail to review applications.

RESPONSE 14: Current law does not permit this type of technology and communication, because it interferes with the public's right to participate and know. It also violates statute on necessity of a quorum to conduct official business.

COMMENT 15: Commenters contended the current licensing system is unnecessarily redundant, because it duplicates the work performed by the hiring agency in establishing the applicant's qualifications to act as a registered sanitarian.

RESPONSE 15: This comment is beyond the scope of this rule proposal. Current statute requires sanitarians to be licensed by the board.

COMMENT 16: One commenter requested a breakdown of the board's expenses and an explanation of how the fee increase would address those costs.

RESPONSE 16: Information on the board's budget is discussed at open board meetings and is available to the public upon request.

COMMENT 17: Some commenters alleged that the board did not provide adequate notice regarding the proposed rule amendment, because the rule proposal was not sent to all licensees.

RESPONSE 17: The board sent timely notification to all persons on the interested parties list and posted rule in a timely manner on its web site as required by the Montana Administrative Procedure Act.

COMMENT 18: Some commenters stated the board should set fees on an equitable basis, rather than an equal basis, pursuant to 37-1-101(6), MCA. These commenters contended that, to set fees on an equitable basis, consideration should be given to the earning potential of one profession versus another and the size of the pool of applicants and licensees.

RESPONSE 18: Assessing costs on an equitable basis falls under the broader authority of the department and the board has no authority over the department's interpretation of "equitable." Further, the named statute does not apply to a board setting licensure and renewal fees.

COMMENT 19: Some commenters stated that the department had reason to anticipate the board's budget problems and did not satisfy its duty under 37-1-101(9)(c), MCA, to make recommendations to the appropriate legislative interim committee concerning the board's financial situation.

RESPONSE 19: The department did present a report to the interim committee. The department has been carefully monitoring and reporting the board's budget and financial status, but still concluded that a fee increase is necessary.

COMMENT 20: One commenter observed that increasing fees to achieve a savings equivalent to one year of operating expenses is not reasonable or necessary as the board had stated in the proposal notice.

RESPONSE 20: Common practice for fiscal stability recommends a cash reserve and state law allows reserves exceeding what is recommended. Reserves allow boards to cover unanticipated costs without taking more costly measures to make up deficits. It is common practice and sound fiscal planning allowed by law.

COMMENT 21: A few commenters asserted that delay in approving sanitarian-in-training applications results in lost time and resources for public health

agencies, diminishes employees' self-confidence and enthusiasm, and negatively impacts workplace morale and employee turnover.

RESPONSE 21: This comment is beyond the scope of this rule proposal. The board tries to schedule meetings to reduce costs and balance this interest against the need to provide services to applicants, the public, and the profession.

COMMENT 22: A commenter stated that the proposed fee increase is unreasonably high and an unfair burden for sanitarians.

RESPONSE 22: The board operates in a manner of fees commensurate with costs.

COMMENT 23: A commenter noted that sanitarian licensing fees are already high and will become disproportionately high if the fee increase is adopted.

RESPONSE 23: The board operates in a manner of fees commensurate with costs.

COMMENT 24: Some commenters suggested the board seek other solutions to cut costs and reduce fees, including pursuing a merger with another board or legislative changes to control licensing costs.

RESPONSE 24: The board previously considered this option, surveyed licensees, and found they were opposed to such action. This comment is beyond the scope of this rule proposal, but interested parties are encouraged to follow Senate Bill 390 and provide comments to the EAIC during the interim.

CONTINUING EDUCATION:

COMMENT 25: Numerous commenters stated that when sanitarian continuing education (CE) courses are not approved quickly, and those approved are limited, public agencies that pay for sanitarians to attend training are forced to waste tax dollars on education that is repetitive or not approved.

RESPONSE 25: This comment is beyond the scope of this rule proposal. If a course is germane to the profession, it is generally approved. The board automatically approves CE courses provided by the Department of Public Health and Human Services (DPHHS) and the Department of Environmental Quality (DEQ), as well as other courses offered through other state and federal agencies as provided in ARM 24.216.2102.

COMMENT 26: Several commenters opined that the board's CE course approval system is difficult to understand, results in fewer courses available to expand the capabilities and professionalism of sanitarians, and has a negative effect on public health.

RESPONSE 26: This comment is beyond the scope of this rule proposal; however, the board appreciates the concerns. The board invites all interested parties to consider sending proposals for changing CE to the board for further consideration.

COMMENT 27: Some commenters suggested that the board should give blanket approval for CE provided by other government agencies.

RESPONSE 27: While this comment is beyond the scope of this rule proposal, the board does automatically approve CE courses provided by DPHHS and DEQ, as well as other courses offered through other state and federal agencies as provided in ARM 24.216.2102.

NEHA RECIPROCITY:

COMMENT 28: Numerous commenters stated that the board should determine that a National Environmental Health Association (NEHA) registered environmental health specialist/registered sanitarian is equivalent to the requirements for becoming a registered sanitarian in Montana and allow reciprocity.

RESPONSE 28: This comment is beyond the scope of this rule proposal. The board has reviewed NEHA and its requirements are no longer equivalent to a Bachelor of Science degree in environmental health as required by 37-40-302, MCA.

COMMENT 29: Some commenters contended NEHA reciprocity would make it easier for Montana licensees to obtain licenses elsewhere, and simpler for NEHA-certified sanitarians from other states to obtain a license in Montana.

RESPONSE 29: This comment is beyond the scope of this rule proposal.

COMMENT 30: Several commenters indicated NEHA reciprocity would give the board access to more resources.

RESPONSE 30: This comment is beyond the scope of this rule proposal; however, the board does communicate with NEHA on a regular basis and draw on its resources when needed.

COMMENT 31: Some commenters asserted that NEHA reciprocity should be considered as an alternative to current licensing requirements if the board is unable to reduce costs under the current licensing regime.

RESPONSE 31: This comment is beyond the scope of this rule proposal. Under current law, the requirements of 37-40-302, MCA, exceed NEHA's requirements.

COMMENT 32: Some commenters noted that, because Montana's requirements for registered sanitarians do not match NEHA requirements, those who

wish to have the option of becoming licensed in another state are required to pay the cost of both maintaining Montana registration and NEHA certification.

RESPONSE 32: This comment is beyond the scope of this rule proposal. A Montana license is required to practice as a sanitarian or sanitarian-in-training in Montana. NEHA certification is not required.

COMMENT 33: Multiple commenters observed that NEHA maintains a high standard of professionalism, and several other states having excellent public health programs recognize and accept NEHA certification as satisfying the requirements for licensure.

RESPONSE 33: This comment is beyond the scope of this rule proposal. A license is required and the requirements are set in statute at 37-40-302, MCA. The board cannot set standards based on a comparison of laws in other jurisdictions or the requirements of NEHA.

4. The board has amended ARM 24.216.402 exactly as proposed.

BOARD OF SANITARIANS
JIM ZABROCKI, RS, CHAIRPERSON

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State May 4, 2015

NOTICE OF FUNCTION OF ADMINISTRATIVE RULE REVIEW COMMITTEE

Interim Committees and the Environmental Quality Council

Administrative rule review is a function of interim committees and the Environmental Quality Council (EQC). These interim committees and the EQC have administrative rule review, program evaluation, and monitoring functions for the following executive branch agencies and the entities attached to agencies for administrative purposes.

Economic Affairs Interim Committee:

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

Education and Local Government Interim Committee:

- State Board of Education;
- Board of Public Education;
- Board of Regents of Higher Education; and
- Office of Public Instruction.

Children, Families, Health, and Human Services Interim Committee:

- Department of Public Health and Human Services.

Law and Justice Interim Committee:

- Department of Corrections; and
- Department of Justice.

Energy and Telecommunications Interim Committee:

- Department of Public Service Regulation.

Revenue and Transportation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

State Administration and Veterans' Affairs Interim Committee:

- Department of Administration;
- Department of Military Affairs; and
- Office of the Secretary of State.

Environmental Quality Council:

- Department of Environmental Quality;
- Department of Fish, Wildlife and Parks; and
- Department of Natural Resources and Conservation.

These interim committees and the EQC have the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. They also may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt, amend, or repeal a rule.

The interim committees and the EQC welcome comments and invite members of the public to appear before them or to send written statements in order to bring to their attention any difficulties with the existing or proposed rules. The mailing address is P.O. Box 201706, Helena, MT 59620-1706.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions:

Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR or Register) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the Attorney General (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject

1. Consult ARM Topical Index.
   Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.

Statute

2. Go to cross reference table at end of each number and title which lists MCA section numbers and department corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies that have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 2015. This table includes those rules adopted during the period April 1, 2015, through June 30, 2015, and any proposed rule action that was pending during the past 6-month period. (A notice of adoption must be published within six months of the published notice of the proposed rule.) This table does not include the contents of this issue of the Montana Administrative Register (MAR or Register).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 2015, 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 2015 Montana Administrative Register.

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