Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 100—Office of Quality Schools

PROPOSED AMENDMENT

5 CSR 20-100.210 Persistently Dangerous Schools. The State Board of Education is amending the purpose, amending sections (2) and (4), and deleting sections (5) and (6).

PURPOSE: This amendment aligns with the provisions of the Every Student Succeeds Act and removes the list of violent criminal offenses which are detailed within section 160.261, RSMo. In addition, the amendment deletes language that is no longer mandatory in the Every Student Succeeds Act.

*PURPOSE: This rule will be used in Missouri to establish state compliance with the federal requirement set forth in the [No Child Left Behind Act of 2001] **Every Student Succeeds Act of 2015**, and to determine if any Missouri public elementary and secondary schools are "persistently dangerous."*

(2) A Missouri public elementary or secondary school is persistently dangerous if the following conditions exist:

(A) In each of three (3) consecutive years:

1. The school has a federal and/or state gun-free schools violation; or

2. A violent criminal offense as set forth *[below]* **in section 160.261, RSMo** is committed on school property which includes**,** but is not limited to**,** school buses or school activities; and

(B) In any two (2) years within the three**-** (3-)*[-]* year period listed above, the school experienced expulsions by local board action, for drug, alcohol, weapons**,** or violence that exceed one (1) of the following rates:

1. More than five (5) expulsions per year for a school of less than two hundred fifty (250) students;

2. More than ten (10) expulsions per year for a school of more than two hundred fifty (250) students but less than one thousand (1,000) students; or

3. More than fifteen (15) expulsions per year for a school of more than one thousand (1,000) students.

(4) For the purpose of determining a persistently dangerous school, a "violent criminal offense" shall be any offense that would require school administrators to, as soon as reasonably practical, notify the appropriate law enforcement agency pursuant to section 160.261, RSMo. Violent criminal offenses shall be reported by the school district to the Department of Elementary and Secondary Education (DESE) through Core Data. *[Violent criminal offenses are as follows:*

(A) Murder 1st Degree under section 565.020, RSMo;
(B) Murder 2nd Degree under section 565.021, RSMo;
(C) Kidnapping under section 565.110, RSMo;
(D) Assault 1st Degree under section 565.050, RSMo;
(E) Forcible Rape under section 566.030, RSMo;
(F) Forcible Sodomy under section 566.060, RSMo;
(G) Burglary 1st Degree under section 569.160, RSMo;
(H) Burglary 2nd Degree under section 569.170, RSMo;
(I) Robbery 1st Degree under section 569.020, RSMo;
(J) Distribution of Drugs under section 195.211, RSMo;
(K) Distribution of Drugs to a Minor under section 195.212, RSMo;
(L) Arson 1st Degree under section 569.040, RSMo;
(M) Voluntary Manslaughter under section 565.023, RSMo;
(N) Involuntary Manslaughter under section 565.024, RSMo;
(O) Assault 2nd Degree under section 565.060, RSMo;
(P) Sexual Assault under section 566.040, RSMo;
(Q) Felonious Restraint under section 565.120, RSMo;
(R) Property Damage 1st Degree under section 569.100, RSMo;
(S) Possession of a Weapon under Chapter 571, RSMo;
(T) Child Molestation 1st Degree under section 566.067, RSMo;
(U) Deviate Sexual Assault under section 566.070, RSMo;
(V) Sexual Misconduct Involving a Child under section 566.083, RSMo; and/or
(W) Sexual Abuse under section 566.100, RSMo.]

[(5) For the purpose of determining when a student has been a victim of a violent criminal offense eligible to transfer to a safe school in the district, a violent criminal offense includes:

(A) Kidnapping under section 565.110, RSMo;
(B) Assault 1st Degree under section 565.050, RSMo;
(C) Forcible Rape under section 566.030, RSMo;
(D) Forcible Sodomy under section 566.060, RSMo;
(E) Burglary 1st Degree under section 569.160, RSMo.
(F) Robbery 1st Degree under section 569.020, RSMo;
(G) Arson 1st Degree under section 569.040, RSMo;
(H) Assault 2nd Degree under section 565.060, RSMo;
(I) Sexual Assault under section 566.040, RSMo;
(J) Felonious Restraint under section 565.120, RSMo;
(K) Property Damage 1st Degree under section 569.100, RSMo;
(L) Child Molestation 1st Degree under section 566.067, RSMo;
(M) Deviate Sexual Assault under section 566.070, RSMo;
(N) Sexual Misconduct Involving a Child under section 566.083, RSMo; and/or
(O) Sexual Abuse under section 566.100, RSMo.

(6) A Missouri public elementary or secondary school shall receive technical assistance from DESE staff which includes but may not be limited to a site visit to work with building and district staff to prepare and implement a plan to prevent the building from meeting the criteria for a second year if it has:
(A) In any one (1) year:
1. A federal or state gun-free schools violation; or
2. A violent criminal offense, as set forth above, on school property; or
(B) In any one (1) year, expulsions by local board action for drugs, alcohol, weapons or violence that exceed one (1) of the following rates:
1. More than five (5) expulsions for schools of less than two hundred fifty (250) students;
2. More than ten (10) expulsions for schools of more than two hundred fifty (250) students, but less than one thousand (1,000) students; or
3. More than fifteen (15) expulsions per year for a school of more than one thousand (1,000) students.]

*AUTHORITY: sections 160.261, [RSMo Supp. 2001,] 161.092, [RSMo Supp. 2002] and 167.171, RSMo [2000] **2016**. This rule previously filed as 5 CSR 50-355.100. Original rule filed Jan. 14, 2003, effective Aug. 30, 2003. Moved to 5 CSR 20-100.210, effective Aug. 16, 2011. Amended: Filed June 29, 2017.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500).

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, ATTN: School Improvement, Office of Quality Schools, PO Box 480, Jefferson City, MO 65102-0480, or by email to msip@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 300—Office of Special Education

PROPOSED RESCISSION

5 CSR 20-300.150 Administrative Policies of the State Schools for Severely Disabled Regarding Approved Private Agencies. This rule established that the State Schools for the Severely Handicapped, State Department of Elementary and Secondary Education, was authorized to contract for educational services for children who could not be adequately served in the State Schools for Severely Handicapped. The rule set forth certain policies which would aid the development of administrative cooperation and program continuity.

PURPOSE: This rule is being rescinded as it is no longer consistent with least restrictive environment as outlined in the Individuals with Disabilities Education Act (IDEA).

AUTHORITY: section 162.735, RSMo 1986. This rule previously filed as 5 CSR 70-760.070. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. Amended: Filed June 4, 1979, effective Sept. 14, 1979. Amended: Filed July 23, 1993, effective Jan. 31, 1994. Moved to 5 CSR 20-300.150, effective Aug. 16, 2011. Rescinded: Filed June 29, 2017.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Elementary and Secondary Education, Attn: Stephen Barr, Assistant Commissioner, Office of Special Education, PO Box 480, Jefferson City, MO 65102-0480 or email specialeducation@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 2—Income Maintenance

PROPOSED AMENDMENT

13 CSR 40-2.030 Definitions Relating to Real and Personal Property. The division is amending sections (7)–(10) and (12) and renumbering thereafter.

PURPOSE: This amendment provides for updates to the asset limits that define the real and personal property considered in determining eligibility for assistance and how the value of that property is determined.

(7) In those programs applying the OAA, PTD criteria, in GR cases, and in Aid to Families with Dependent Children (AFDC) cases, in certain instances as defined in sections (8)—*[(12)]***(13)** of this rule, the property will be considered as a resource which the applicant or recipient can and should use in meeting his/her needs and will not be eligible for public assistance. *(Original rule filed Feb. 6, 1975, effective Feb. 16, 1975.)* The eligibility factor of property as an available resource applies under the OAA criteria to an applicant, recipient**,** and spouse. In AFDC cases, the policy applies to a child and to a parent(s) or, as allowed by federal law or regulation, to stepparents or, if included in the grant, a needy nonparent caretaker relative or legal guardian with whom the child is living. In cases receiving GR, the policy applies to an applicant or recipient and spouse and children in the home under the age of twenty-one (21). If the GR applicant or recipient is under age twenty-one (21), it applies to his/her parent(s) in the home. In programs applying the PTD criteria, the

policy applies to the applicant or recipient and spouse. *(Original rule filed Nov. 3, 1950, effective Nov. 13, 1950. Amended: Oct. 20, 1967, effective Oct. 30, 1967. Amended: July 8, 1969, effective July 18, 1969. Amended: Feb. 6, 1975, effective Feb. 16, 1975.)*

(8) When an applicant or recipient of programs applying the OAA, PTD**, or Aid to the Blind (AB)** criteria *[or GR]*, or the spouse with whom s/he lives *[or, when the GR applicant or recipient is under age twenty-one (21), the parent(s) with whom s/he lives,]* owns real property which is not furnishing shelter for him/her**,** *[and]* its current market value *[is one thousand dollars ($1000) or more if owned by a single person or more than two thousand dollars ($2000) if owned by a married person living with spouse, it shall be considered as a resource and the claimant will not be eligible for assistance on the basis of need; provided, all of the following criteria which apply are met (the value of an equity in a life estate and of burial lots shall be excluded from this computation). In GR cases involving two (2) or more persons eligible for GR, the limitation will be more than two thousand dollars ($2000).]* **shall be considered an available asset and subject to the limits of section (12) of this regulation. When an applicant or recipient of programs applying the OAA, PTD, or AB criteria is under age eighteen (18) and the parent(s) with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value shall be considered an available asset and subject to the limits of section (12) of this regulation. For GR, when an applicant or recipient or the spouse with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value shall be considered an available asset and subject to the limits of section (13) of this regulation. When an applicant or recipient of GR is under age twenty-one (21) and the parent(s) with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value shall be considered an available asset and subject to the limits of section (13) of this regulation. In programs applying the OAA, PTD, AB criteria, or GR, the claimant will not be eligible for assistance on the basis of need; provided, all of the following criteria which apply are met (the value of an equity in a life estate and of burial lots shall be excluded from this computation).** For AFDC cases, the limitation will be one thousand dollars ($1000), except that burial lots must be excluded from this computation. If the value of real property *[is less than the amounts stated previously,]* **does not exceed the asset limits of section (12) or (13) of the rule,** it shall be counted as a part of the combination of available resources in determining eligibility*[, as stated in section (12) of this rule]*.

(9) A single individual applying for or receiving assistance in programs applying the OAA or PTD criteria who owns insurance (over and above the first one thousand five hundred dollars ($1500) in face value) with a cash or loan value of one thousand dollars ($1000) or more **through June 30, 2017,** will not be considered eligible for assistance on the basis of available resources. **Effective July 1, 2017, the cash or loan value in excess of the one thousand five hundred dollars ($1500) shall be considered an available asset and subject to the limits of section (12) of this regulation.** A husband or wife living together may own insurance (over and above the first one thousand five hundred dollars ($1500) each in face value) in any combination with a total cash or loan value up to and including two thousand dollars ($2000) **through June 30, 2017**. **Effective July 1, 2017, the cash or loan value in excess of the one thousand five hundred dollars ($1500) for each spouse shall be considered an available asset and subject to the limits of section (12) of this regulation.** In GR cases, the one thousand five hundred dollar ($1500) face value exemption will apply to each person included in the GR case. When the claimant has deposited money with an individual, firm**,** or corporation as an advance payment for a funeral and the payment is safeguarded by burial insurance, trust fund or joint bank account, the amount of money over one thousand five hundred dollars ($1500) deposited under such a plan will be considered a resource in the same manner as the cash or loan value of life insurance policies, if the contract is revocable. If the burial/funeral contract is irrevocable, the entire amount of money deposited will be excluded from available resources. If the claimant has both life insurance and prepaid burial (revocable or irrevocable), the one thousand five hundred dollar ($1500) exemption will apply to either or to any combination. The face value of an irrevocable burial contract will always be counted toward the one thousand five hundred dollar ($1500) exemption. If the cash or loan value of insurance is less than the amounts stated in this section, it shall be counted as part of the combination of available resources in determining eligibility as stated in section (12) **for OAA or PTD, or in section (13) for GR** of this rule. An individual applying for or receiving assistance in programs applying the OAA or PTD criteria may designate separately identifiable funds as set aside for burial for the individual or spouse up to a maximum of one thousand five hundred dollars ($1500). The amount of one thousand five hundred dollars ($1500) shall be reduced by—1) the total face value of insurance policies on the life of the individual or spouse which are owned by him/her or his/her spouse, the cash surrender value of which has been excluded in determining eligibility on available resources as provided in this section and in section (12) **for OAA or PTD, or in section (13) for GR** of this rule and 2) the value of any burial/funeral contract on the life of the individual or spouse. When this fund has been designated and all or a portion is excluded in determining available resources eligibility as provided in this section and in section (12) **for OAA or PTD, or section (13) for GR** of this rule, the interest or appreciation to the excluded portion of this fund (if left to accumulate) also shall be excluded in determining available resources eligibility, starting with interest or appreciation accrued on or after the beginning date of Medicaid eligibility. In AFDC cases, there shall be disregarded any prearranged funeral or burial contract, or any two (2) or more contracts, which provides for the payment of one thousand five hundred dollars ($1500) or less per family member. The face value of an irrevocable burial contract will always be counted toward the one thousand five hundred dollar ($1500) exemption. In AFDC cases, any family who owns revocable prepaid burials (over and above the first one thousand five hundred dollars ($1500) in equity value) or insurance with cash surrender value over one thousand dollars ($1000) will not be eligible for assistance. If the cash surrender value of revocable prepaid burials (over and above the first one thousand five hundred dollars ($1500) in equity value) or insurance is one thousand dollars ($1000) or less, it shall be counted as a part of the combination of available resources in determining eligibility as stated in section *[(12)]* **(13)** of this rule. *(Original rule filed Jan. 1, 1952, effective Jan. 10, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970. Amended: Dec. 22, 1972, effective Jan. 1, 1973.)*

(10) In programs applying the OAA, PTD**, or AB** criteria**,** and GR cases, salable personal property, such as livestock, farm surplus, jewelry (except wedding and engagement rings owned by claimant or spouse), machinery, automobiles and trucks, and the like, shall be considered as an available resource when the following criteria are present:

(A) In programs applying the OAA, PTD**, or AB** criteria**,** and GR cases, the equity based on current market value is one thousand dollars ($1000) or more, or more than two thousand dollars ($2000) in the case of a married person living with spouse. In GR cases involving two (2) or more persons eligible for GR, the limitation is more than two thousand dollars ($2000)**. Effective July 1, 2017, the equity value for programs applying the OAA, PTD, or AB criteria shall be considered an available asset and subject to the limits of section (12) of this rule**;

(C) Household furnishings shall not be considered as available

resources unless they are not being used by the applicant, in which case *[the limits of one thousand dollar ($1000) value will apply]* **they are subject to the limitations in section (12) for OAA, PTD, or AB criteria, and section (13) for GR**; *[and]*

(D) Effective July 1, 2017, in programs applying the OAA, PTD, or AB criteria, the first five thousand dollars ($5000) of medical savings accounts and independent living accounts shall be limited to deposits of earned income and earnings on that income while the individual is a participant; and

*[(D)]***(E)** If the value of the personal property is less than the amounts stated in subsections (10)(A)—*[(C)]***(D)**, it shall be counted as a part of the combination of available resources in determining eligibility as stated in section (12) **for OAA, PTD, or AB, or section (13) for GR** of this rule. *(Original rule filed Jan. 11, 1952, effective Jan. 21, 1952. Amended: Dec. 3, 1952, effective Dec. 13, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970. Amended: Dec. 22, 1972, effective Jan. 1, 1973.)*

(12) *[In programs applying the OAA, PTD criteria and GR cases, a]***A**ny combination of available resources—real property, personal property, cash or securities, or cash surrender or loan value of life insurance (including money deposited in revocable prepaid burials)*[, the combined value of which is one thousand dollars ($1000) or more, will result in ineligibility for a single person. For a married person living with spouse, any combination of available resources which exceeds a value of two thousand dollars ($2000) will result in ineligibility for both persons.]* **shall be considered in regards to the asset limits set below. The following asset limits apply to every MHABD program, except Blind Pension, the Breast and Cervical Cancer Treatment program, and the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs:**

(A) This subsection identifies the asset limits for MHABD before July 1, 2017.

1. A household that is applying for or receiving MHABD on the basis of being over age sixty-five (65) or permanently and totally disabled does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of one thousand dollars ($1,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of two thousand dollars ($2,000) or more.

2. A household that is applying for or receiving MHABD on the basis of being blind does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of two thousand dollars ($2,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of four thousand dollars ($4,000) or more;

(B) Effective July 1, 2017, a household is not eligible for MHABD, regardless of whether eligibility is determined based on age, blindness, or permanent and total disability, if it has countable assets at or in excess of the following limits:

Dates Effective	One- (1-) person Household	Two- (2-) person Household
July 1, 2017 – June 30, 2018	$2,000	$4,000
July 1, 2018 – June 30, 2019	$3,000	$6,000
July 1, 2019 – June 30, 2020	$4,000	$8,000
July 1, 2020 – June 30, 2021	$5,000	$10,000

(C) Effective July 1, 2021 (Fiscal Year 2022), the asset limit identified in section (5) of this rule shall increase every July thereafter at the same rate as the increase in the cost-of-living percentage of the Consumer Price Index for All Urban Consumers (CPI-U), or its successor, as determined by the U.S. Department of Labor. The asset limit shall be rounded to the nearest five cents (5¢).

1. The percentage increase shall be based on changes in the CPI-U between July of two (2) years prior to the year in which the current fiscal year begins, and July of the immediately preceding year.

A. Example: To determine the asset limit for Fiscal Year 2022 (FY22), the department shall measure the increase in the CPI-U between July 2019 and July 2020. If the CPI-U increased by one percent (1%) during that period, the asset limit for FY22 shall also increase by one percent (1%); and

(D) Notwithstanding the provisions of this section, a person is not eligible for QMB or SLMB if the person's household has countable assets in excess of the maximum resource level applied for the applicable year under 42 U.S.C. section 1395w-114(a)(3)(D), pursuant to 42 U.S.C. section 1396d(p)(1)(C).

(13) In GR cases, any combination of one thousand dollars ($1000) or more for the applicant or recipient of GR would make that person ineligible (except that a husband and wife or two (2) or more persons in the household eligible for GR could have up to two thousand dollars ($2000) together). In AFDC cases, any combination of more than one thousand dollars ($1000) would make the family ineligible. *(Original rule filed Jan. 11, 1952, effective Jan. 21, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970.)*

*[(13)]***(14)** Notwithstanding the previously mentioned eligibility requirements with respect to resources, the following will apply to individuals meeting the definition of institutionalized spouses who begin a period of continuous institutionalization on or after September 30, 1989:

(A) As used in this section, the definitions for the following terms shall apply:

1. Assessment shall mean a determination by the FSD of the total equity value of available resources (as stated in sections (6)-*[(12)]***(13)**) owned by the institutionalized spouse, the community spouse, or both, which may be requested at the beginning of a period of continuous institutionalization expected to last at least thirty (30) days or more;

2. Community spouse shall mean the husband or wife of an institutionalized spouse who does not reside in a medical hospital or a Medicaid-certified bed in a nursing facility (NF) and, if the institutionalized spouse is one who meets the definition in subparagraph *[(13)]***(14)**(A)3.C., the community spouse may not be one who meets those criteria;

3. Institutionalized spouse shall mean a claimant who resides in—

A. A medical hospital;

B. A Medicaid-certified bed in an NF, with an expected stay of at least thirty (30) days; or

C. His/her own home and is assessed by the Division of Disability and Senior Services as needing both an NF level-of-care as defined in 19 CSR 30-81.030 and home- and community-based waiver services and is assessed to need these services for at least thirty (30) days, and is married to a person who meets the definition of a community spouse in paragraph *[(13)]***(14)**(A)2.; and

4. Period of continuous institutionalization shall mean a stay in a medical hospital or Medicaid-certified bed in an NF or when the Division of Disability and Senior Services determines a need for home- and community-based waiver services which is expected to last thirty (30) days or more; and

(B) The following shall apply with regard to resource eligibility for institutionalized spouses who begin a period of continuous institutionalization on or after September 30, 1989:

1. When an individual meets the criteria in subparagraph *[(13)]***(14)**(A)3.C., his/her gross monthly income shall be compared to one thousand twelve dollars ($1,012). If his/her gross monthly income is equal to or less than one thousand twelve dollars ($1,012),

the FSD shall complete an assessment of assets as defined in paragraph *[(13)]***(14)**(B)2. When his/her gross monthly income is greater than one thousand twelve dollars ($1,012), s/he is not eligible for an assessment of assets as defined in paragraph *[(13)]***(14)**(B)2. The one thousand twelve dollar ($1,012) income limit shall be increased each year effective January 1 in accordance with the Social Security cost-of-living adjustment (COLA), beginning in 2006;

2. At the beginning of the first period of continuous institutionalization, the institutionalized spouse, the community spouse**,** or a representative acting on behalf of either may request an assessment by the FSD of total equity in available resources owned by either or both in the month in which the period of institutionalization began or, in the case of an institutionalized spouse who meets the definition in subparagraph *[(13)]***(14)**(A)3.C. and who met that definition prior to January 1, 1993, January 1993 shall be substituted for the month in which the period of institutionalization began;

3. From this total, the FSD shall compute the spousal share, which shall be the greater of—1) twelve thousand dollars ($12,000) or 2) one-half (1/2) of the total, not to exceed sixty thousand dollars ($60,000). The twelve thousand dollar ($12,000) minimum and the sixty thousand dollar ($60,000) maximum shall be increased each January in accordance with the increase in the Consumer Price Index, beginning in 1990;

4. In determining initial Medicaid eligibility for the institutionalized spouse in this continuous period of institutionalization, the FSD again shall determine the total equity in available resources owned by the institutionalized spouse, the community spouse, or both, at the time of Medicaid request. From this total, the FSD shall deduct the amount of the spousal share as computed in paragraphs *[(13)]***(14)**(B)2. and 3. If the remainder is equal to or less than the appropriate resource maximum for a single person, the institutionalized individual, to the extent the individual expresses intent to transfer any excess resources to the community spouse, shall be initially eligible for Medicaid on the factor of available resources. Eligibility for Medicaid for individuals described in subparagraph *[(13)]***(14)**(A)3.C. who become resource eligible using the assessment described in paragraph *[(13)]***(14)**(B)2. cannot begin prior to the date the individual actually receives home- and community-based waiver services;

5. Any such individual who is determined initially eligible for Medicaid must transfer any resources above the appropriate resource maximum which are held in the individual's name to the community spouse within ninety (90) days of notification of initial eligibility, unless good cause exists;

6. If good cause does not exist, the FSD shall consider any resources held in the name of the institutionalized spouse, including any jointly-owned resources, in determining continued Medicaid eligibility, effective ninety (90) days after notification of initial eligibility;

7. After the determination of initial eligibility for the institutionalized spouse, no resources of the community spouse not jointly owned with the institutionalized spouse shall be considered available to the institutionalized spouse in Medicaid determinations in that continuous period of institutionalization;

8. If either spouse establishes in a fair hearing that the spousal share (in relation to the amount of income generated by that amount) is inadequate to raise the community spouse's own income to the amount determined in 13 CSR 40-2.200(5)(A), the spousal share may be adjusted to an amount adequate to provide the additional income. At the fair hearing the maximum amount of the institutionalized spouse's income that may be made available to the community spouse under 42 U.S.C.1396r-5(d), shall be considered the community spouse's own income; and

9. If a court has entered an order against an institutionalized spouse for the support of the community spouse, the amount of the order shall be substituted for the spousal share.

*AUTHORITY: sections [207.020, RSMo 2000] **207.022 and 660.017, RSMo 2016**. Filing dates for original rules are shown in the text of the rule. This version filed March 24, 1976. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. Amended: Filed June 20, 2017.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions $72,836,001 in Fiscal Year 2018 and the following for subsequent fiscal years– FY19: $146,832,345; FY20: $170,131,940; FY21: $187,814,828; FY22: $198,611,006 to the MO HealthNet Division.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Social Services
Division Title: Family Support Division (FSD)
Chapter Title: Income Maintenance

Rule Number and Title:	13 CSR 40-2.030 Definitions Relating to Real and Personal Property
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Family Support Division	**$0**
MO HealthNet Division	**$72,836,001 (FY18)**

III. WORKSHEET

Section 208.010 states that in fiscal year 2018 the resource limit for MHD blind claimants, MHD aged claimants, and MHD permanent and total disability claimants will increase to $2,000 for a single person and $4,000 for a couple. The following years the resource limits will increase by $1,000 for a single person and $2,000 for a couple until the sum of the resources reaches the amount of $5,000 for a single person and $10,000 for a couple in fiscal year 2021. Beginning in fiscal year 2022 and in each successive year, the division shall modify the resource limits to reflect any increases in cost-of-living, with the amount of the resource limit rounded to the nearest five cents.

FSD:

The FSD determined there would be a total of 10,005 new cases for MHABD program(s) through FY 2022 if the resource limits are increased as proposed.

The FSD arrived at 10,005 new cases in this manner:

In SFY 2015, the FSD rejected (due to excess resources) 5,449 MO HealthNet (MHN) applications. Of these rejected applications, 4,221 were rejected for all FSD MO HealthNet programs. The remaining 1,228 (5,449-4,221) cases were eligible for Qualified Medicare Beneficiary (QMB)/Specified Low Income Medicare Beneficiary (SLMB), which have higher resource limits and are included in the QMB/SLMB population below. The FSD estimates that in FY 2018, 901 of the 4,221 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased to $2,000 for individuals and $4,000 for a couple as proposed.

Using the same methodology, the incremental increases for FY 2019-FY2022 are:

FY 2019: 442 of the 4,221 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased to $3,000 for individuals and $6,000 for a couple as proposed.

FY 2020: 300 of the 4,221 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased to $4,000 for individuals and $8,000 for a couple as proposed.

FY 2021: 212 of the 4,221 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased to $5,000 for individuals and $10,000 for a couple as proposed.

FY 2022: In FY 14, the COLA was a 1.7% increase. In FY 15 there was not a COLA increase, however for the purpose of estimating, the FSD assumes future increases will be the same as FY 14. 25 of the 4,221 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased by the COLA percentage to $5,085 for individuals and $10,170 for a couple as proposed.

Total new MHN Cases from Rejections:

FY 2018: 901

FY 2019: 442

FY 2020: 300

FY 2021: 212

FY 2022: 25

Total: 1,880

In the first six months of SFY 2015, 373 or approximated 50% of applications rejected for all programs were eventually approved after they spent their assets down below the applicable resource limit. 272 became eligible within 1 month of rejection, 33 cases became eligible within 2 months of rejection, 25 cases became eligible within 3 months of rejection, 16 cases became eligible within 4 months of rejection, 15 cases became eligible within 5 months of rejection, and 12 cases became eligible within 6 months of rejection. Therefore, 451 of the 901 rejected applicants would become eligible incrementally during the first 6 months of FY 2018. The remaining 50% remained ineligible for resources, other reasons, or did not reapply.

Using the same methodology, the incremental increases for FY 2019-FY 2022 are:

FY 2019: 221 of the 442 rejected applications would become eligible incrementally during the first six months of FY 2019.

FY 2020: 150 of the 300 rejected applications would become eligible incrementally during the first six months of FY 2020.

FY 2021: 106 of the 212 rejected applications would become eligible incrementally during the first six months of FY 2021.

FY 2022: 13 of the 25 rejected applications would become eligible incrementally during the first six months of FY 2022.

If the resource limit is increased incrementally in SFY 2018 to SFY 2022 to $5,085 for single individuals or $10,170 for couples, FSD expects the above trend will continue and approximately 50% of the rejected applications will ultimately be approved within similar timeframes.

In SFY 2015, the FSD closed 918 MO HealthNet for the Aged, Blind, and Disabled (MHABD) cases due to resources. Of these closed cases, 8 were not eligible for other MHN programs. The remaining 910 (918-8) were eligible for QMB/SLMB and are included in the QMB/SLMB population below. The FSD estimates in FY 2018, 3 of the 8 cases closed and not eligible for other MHN programs would be eligible if the resource limit was increased to $2,000 for individuals and $4,000 for couples as proposed.

Using the same methodology, the incremental increases for FY 2019-FY 2022 are:

FY 2019: 2 of the 8 cases closed and not eligible for other MHN programs would be eligible if the resource limit was increased to $3,000 for individuals and $6,000 for a couple as proposed.

FY 2020: 0 of the 8 cases closed and not eligible for other MHN programs would be eligible if the resource limit was increased to $4,000 for individuals and $8,000 for a couple as proposed.

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Total new MHN cases from Closures:

FY 2018: 3

FY 2019: 2

FY 2020: 0

FY 2021: 0

FY 2022: 0

Total: 5

The FSD would also see an increase in MHN eligibles from the QMB/SLMB population. In SFY 2015, there was an average of 4,605 QMB persons. Of these, 4,366 live alone and 239 live with a spouse. Of those living alone, 805 would be eligible in SFY 2018 if the resource limit was increased to $2,000 for individuals and $4,000 for a couple as proposed. Of those living with a spouse, 59 would be eligible.

Using the same methodology, the incremental increases for FY 2019-FY 2022 are:

FY 2019: Of those living alone, 418 would be eligible in SFY 2019 if the resource limit was increased to $3,000 for individuals and $6,000 for a couple as proposed. Of those living with a spouse, 35 would be eligible.

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FY 2021: Of those living alone, 141 would be eligible in SFY 2021 if the resource limit was increased to $5,000 for individuals and $10,000 for a couple as proposed. Of those living with a spouse, 6 would be eligible.

FY 2022: Of those living alone, 18 would be eligible in SFY 2021 if the resource limit was increased to $5,085 for individuals and $10,170 for a couple as

proposed. Of those living with a spouse, 0 would be eligible. Total new MHN cases from QMB:

FY 2018: 805+59= 864

FY 2019: 418+35= 453

FY 2020: 248+16=264

FY 2021: 141+6=147

FY 2022: 18+0=18

Total: 1,746

In SFY15, there was an average of 11,523 SLMB persons. Of these, 9,635 live alone and 1,888 live with a spouse. Of those living alone, 951 would be eligible in SFY 2018 if the resource limit was increased to $2,000 for individuals and $4,000 for a couple as proposed. Of those living with a spouse, 191 would be eligible.

Using the same methodology, the incremental increases for FY 2019- FY 2022 are:

FY 2019: Of those living alone, 463 would be eligible in SFY 2019 if the resource limit was increased to $3,000 for individuals and $6,000 for a couple as proposed. Of those living with a spouse, 115 would be eligible.

FY 2020: Of those living alone, 330 would be eligible in SFY 2020 if the resource limit was increased to $4,000 for individuals and $8,000 for a couple as proposed. Of those living with a spouse, 64 would be eligible.

FY 2021: Of those living alone, 191 would be eligible in SFY 2021 if the resource limit was increased to $5,000 for individuals and $10,000 for a couple as proposed. Of those living with a spouse, 45 would be eligible.

FY 2022: Of those living alone, 22 would be eligible in SFY 2022 if the resource limit was increased to $5,085 for individuals and $10,170 for a couple as proposed. Of those living with a spouse, 2 would be eligible.

Total new MHN cases from SLMB:

FY 2018: 951+191=1,142

FY 2019: 463+115 =578

FY 2020: 330+~~63~~4 =394

FY 2021: 191+45=236

FY 2022: 22+2 =24

Total: 2,374

The FSD anticipates an increase in applications as a result of the increased resource limits. These applications would come from a previously unknown population who currently chooses not to apply due to the current resource limits. According to U.S. Census Bureau data, 23,960 Missouri individuals, age 19 or above, have a disability. FSD conducted an analysis of the income levels of these individuals and found 7,716 of these individuals have income between 0% and 100% of FPL and 16,243 (7,716+16,243=23,960) of these individuals have income above 100% of FPL. Individuals with income less than 85% of FPL receive full MO HealthNet benefits, with no spend down. For the purpose of this calculation, FSD is using 100% due to Census data parameters. In turn, individuals with income above 100% receive MO Healthnet benefits after meeting a monthly spend down. In FY 14, FSD determined that approximately 35% of individuals in the unknown population had income up to 100% of FPL. Using the same methodology, in FY 15, 35% or 2701 (7,716 *.35) individuals would receive full MO HealthNet benefits. FSD determined that in FY 15, 32% of individuals with income above 100% FPL met their spend down. Using that same methodology, if 32% of the unknown population with income above 100% would meet their spend down, 5,198 (16,243*.32) individuals would receive MHN benefits after meeting spend down, if they applied and were found eligible. FSD concludes that it could be reasonably assumed that 35% of individuals with income below 100% of FPL and 25% of individuals with income above 100% FPL would apply and be eligible for MO HealthNet benefits. FSD would see an increase of 2,701 (7,716*.35) individuals with no spend down and 1,299 (5,198*.25) individuals with a spend down, or a total of 4,000 new MHN cases as a result of the increased resource limits in the first year.

NOTE: The 2014 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) used redesigned measures of health insurance

coverage. The Census Bureau completed more than a decade of research, evaluation, and consultation with outside experts to implement this approach, which is shown to improve the accuracy of health insurance coverage measurement. Due to these changes in the measurement, there has been a significant increase identified in the uninsured disabled population compared to what was reported as 12,886 in the prior year U.S. Census Bureau data.

Total new cases from Unknown Population:

FY 2018: 4,000

Total new cases:

FY 2018:

901 (rejections)

3 (closings)

864 (QMB)

1,142 (SLMB)

4,000 unknown population

Total: 6,910

FY 2019:

442 (rejections)

2 (closings)

453 (QMB)

~~264~~578(SLMB)

Total: 1,475

FY 2020:

300 (rejections)

0 (closings)

264 (QMB)

394 (SLMB)
Total: 958

FY 2021:
212 (rejections)
0 (closings)
147 (QMB)
236 (SLMB)
Total: 595

FY 2022:
25 (rejections)
0 (closings)
18 (QMB)
24 (SLMB)
Total: 67

FY 2018- FY 2022

1,880 (rejections)
5 (closings)
1,746 (QMB)
2,374 (SLMB)
4,000 (unknown population)
10,005 new MHN cases

The FSD assumes existing staff will be able to complete necessary additional work as a result of this proposal.

Therefore, there is no fiscal impact to the Family Support Division.

MHD:

The MO HealthNet Division (MHD) estimates a fiscal impact because of changes to the resource limits for blind, elderly, and disabled persons. Higher cost will result from one group of Medicaid eligible who currently receive limited medical benefits but will receive full Medicaid benefits under this legislation. New eligible are also expected to enter the Medicaid program because of the change in eligibility rules.

FSD estimates 6,910 new cases:

1) 4,904 new cases (901 rejections + 3 closings + 4,000 unknown population)
2) 864 QMB and 1,142 SLMB

An annual cost per person was calculated for persons with disabilities and seniors using FY15 expenditures. Using the annual cost per person, a total cost of $126,705,327 and $7,532,828 was calculated for persons with disabilities and seniors respectively for a total cost of $134,238,155. These figures include MO HealthNet costs for the Department of Mental Health (DMH) and Department of Health and Senior Services (DHSS). With the 864 QMB and 1,142 SLMB eligibles receiving full benefits, the total cost is reduced by the current premium payments for these eligibles ($4,103,112) for a total cost of $72,836,001 in FY18 which was requested in the DSS appropriation bill. This total was calculated based on a gradual phased in approach to increased total enrollment.

The total costs for the new cases based on this same approach are:

FY17: $0
FY18: $72,836,001 (GR $16,069,953 - Other $10,713,301)
FY19: $146,832,345 (GR $32,395,914 – Other $21,597,276)
FY20: $170,131,940 (GR $37,536,551 – Other $25,024,366)
FY21: $187,814,828 (GR $41,437,961 – Other $27,625,307)
FY22: $198,611,006 (GR $43,819,944 – Other $29,213,295)

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 8—MO HealthNet for the Aged, Blind, and Disabled

PROPOSED RULE

13 CSR 40-8.020 Ways of Treating Income and Assets

PURPOSE: This rule defines the asset limits, the ways in which assets are treated, in determining eligibility for MO HealthNet for the Aged, Blind, and Disabled (MHABD), and programs with which MHABD coverage is provided.

(1) Scope. This rule describes the general requirements related to how assets affect eligibility for MHABD. This regulation does not apply to the Blind Pension program pursuant to Chapter 209, RSMo 2016, unless noted otherwise. Any provisions in this rule control over similar provisions in 13 CSR 40-2.030, including, but not limited to, the asset limits defined in that rule.

(2) The division shall treat income and assets in a way that is no more restrictive than the way income and assets are treated for the Supplemental Security Income (SSI) program, with the exception of the asset limits described in section (4) of this rule, and as provided for in the Medicaid State Plan.

(3) In determining eligibility for MHABD, the division shall consider—

(A) Any kind of asset that is owned by a household member, or in the name of someone on behalf of the household member;

(B) Any kind of asset that is owned by a trust or any other entity, but which a household member, or someone acting on behalf of a household member, has the legal power to use for the general benefit of the household; or

(C) Any kind of asset that is owned by a self-settled trust, as defined in, determined by, and subject to the rules of 42 U.S.C. section 1396p(d).

(4) The following asset limits apply to every MHABD program, except Blind Pension, the Breast and Cervical Cancer Treatment program, and the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs:

(A) This subsection identifies the asset limits for MHABD before July 1, 2017.

1. A household that is applying for or receiving MHABD on the basis of being over age sixty-five (65) or permanently and totally disabled does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of one thousand dollars ($1,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of two thousand dollars ($2,000) or more.

2. A household that is applying for or receiving MHABD on the basis of being blind does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of two thousand dollars ($2,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of four thousand dollars ($4,000) or more;

(B) Effective July 1, 2017, a household is not eligible for MHABD, regardless of whether eligibility is determined based on age, blindness, or permanent and total disability, if it has countable assets at or in excess of the following limits:

Dates Effective	One- (1-) person Household	Two- (2-) person Household
July 1, 2017 – June 30, 2018	$2,000	$4,000
July 1, 2018 – June 30, 2019	$3,000	$6,000
July 1, 2019 – June 30, 2020	$4,000	$8,000
July 1, 2020 – June 30, 2021	$5,000	$10,000

(C) Effective July 1, 2021 (Fiscal Year 2022), the asset limit identified in section (4) of this rule shall increase every July thereafter at the same rate as the increase in the cost-of-living percentage of the Consumer Price Index for All Urban Consumers (CPI-U), or its successor, as determined by the U.S. Department of Labor. The asset limit shall be rounded to the nearest five cents (5¢).

1. The percentage increase shall be based on changes in the CPI-U between July of two (2) years prior to the year in which the current fiscal year begins and July of the immediately preceding year.

A. Example: To determine the asset limit for Fiscal Year 2022 (FY22), the department shall measure the increase in the CPI-U between July 2019 and July 2020. If the CPI-U increased by one percent (1%) during that period, the asset limit for FY22 shall also increase by one percent (1%);

(D) Notwithstanding the provisions of this section, a person is not eligible for QMB or SLMB if the person's household has countable assets in excess of the maximum resource level applied for the applicable year under 42 U.S.C. section 1395w-114(a)(3)(D), pursuant to 42 U.S.C. section 1396d(p)(1)(C).

AUTHORITY: sections 207.022 and 660.017, RSMo 2016. Emergency rule filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. Original rule filed June 20, 2017.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $72,836,001 in Fiscal Year 2018 and the following for subsequent fiscal years– FY19: $146,832,345; FY20: $170,131,940; FY21: $187,814,828; FY22: $198,611,006 to the MO HealthNet Division.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

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FISCAL NOTE
PUBLIC COST

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Division Title: Family Support Division (FSD)
Chapter Title:

Rule Number and Title:	13 CSR 40-8.020 Ways of Treating Income and Assets
Type of Rulemaking:	Proposed Rule

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Total new cases:

FY 2018:

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3 (closings)

864 (QMB)

1,142 (SLMB)

4,000 unknown population

Total: 6,910

FY 2019:

442 (rejections)

2 (closings)

453 (QMB)

578 (SLMB)

Total: 1,475

FY 2020:

300 (rejections)

0 (closings)

264 (QMB)

394 (SLMB)
Total: 958

FY 2021:
212 (rejections)
0 (closings)
147 (QMB)
236 (SLMB)
Total: 595

FY 2022:
25 (rejections)
0 (closings)
18 (QMB)
24 (SLMB)
Total: 67

FY 2018- FY 2022

1,880 (rejections)
5 (closings)
1,746 (QMB)
2,374 (SLMB)
4,000 (unknown population)
10,005 new MHN cases

The FSD assumes existing staff will be able to complete necessary additional work as a result of this proposal.

Therefore, there is no fiscal impact to the Family Support Division.

MHD:

The MO HealthNet Division (MHD) estimates a fiscal impact because of changes to the resource limits for blind, elderly, and disabled persons. Higher cost will result from one group of Medicaid eligible who currently receive limited medical benefits but will receive full Medicaid benefits under this legislation. New eligible are also expected to enter the Medicaid program because of the change in eligibility rules.

FSD estimates 6,910 new cases:

1) 4,904 new cases (901 rejections + 3 closings + 4,000 unknown population)
2) 864 QMB and 1,142 SLMB

An annual cost per person was calculated for persons with disabilities and seniors using FY15 expenditures. Using the annual cost per person, a total cost of $126,705,327 and $7,532,828 was calculated for persons with disabilities and seniors respectively for a total cost of $134,238,155. These figures include MO HealthNet costs for the Department of Mental Health (DMH) and Department of Health and Senior Services (DHSS). With the 864 QMB and 1,142 SLMB eligibles receiving full benefits, the total cost is reduced by the current premium payments for these eligibles ($4,103,112) for a total cost of $72,836,001 in FY18 which was requested in the DSS appropriation bill. This total was calculated based on a gradual phased in approach to increased total enrollment.

The total costs for the new cases based on this same approach are:

FY17: $0
FY18: $72,836,001 (GR $16,069,953 - Other $10,713,301)
FY19: $146,832,345 (GR $32,395,914 – Other $21,597,276)
FY20: $170,131,940 (GR $37,536,551 – Other $25,024,366)
FY21: $187,814,828 (GR $41,437,961 – Other $27,625,307)
FY22: $198,611,006 (GR $43,819,944 – Other $29,213,295)

IV. ASSUMPTIONS

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending subsections (3)(B) and (15)(B).

PURPOSE: This amendment provides for updates to the calculation of the Direct Medicaid payments made on or after May 1, 2017. Additionally, this amendment provides for the State Fiscal Year (SFY) 2018 trend factor to be applied in determining Federal Reimbursement Allowance (FRA) funded hospital payments for SFY 2018.

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation:

(B) Trend Indices (TI). Trend indices are determined based on the four- (4-) quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill, or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The TI are—

A. SFY 1994—4.6%
B. SFY 1995—4.45%
C. SFY 1996—4.575%
D. SFY 1997—4.05%
E. SFY 1998—3.1%
F. SFY 1999—3.8%
G. SFY 2000—4.0%
H. SFY 2001—4.6%
I. SFY 2002—4.8%
J. SFY 2003—5.0%
K. SFY 2004—6.2%
L. SFY 2005—6.7%
M. SFY 2006—5.7%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%
Q. SFY 2010—3.9%
R. SFY 2011—3.2%—The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid payments, or uninsured payments.
S. SFY 2012—4.0%
T. SFY 2013—4.4%
U. SFY 2014—3.7%
V. SFY 2015—4.3%
W. SFY 2016—2.5%
X. SFY 2017—2.7%
Y. SFY 2018—3.2%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998, rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999, rate shall be trended by 2.4%. The OC of the June 30, 2000, rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with subsection (15)(B).

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment*[;]***.**

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the

second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%), and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by fifty percent (50%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

E. Effective for payments made on or after May 1, 2017, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2017, second prior CY would be 2015) by:

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY; and

(II) The days estimated to shift from FFS to managed care effective May 1, 2017. The estimated managed care days for populations added to managed care beginning May 1, 2017 will be subtracted from the trended FFS days to yield the estimated MO HealthNet patient days.

*[E.]***F.** The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

(I) Effective for dates of service beginning July 1, 2010, the Missouri Specific Trend shall no longer be applied to inflate base period costs.

*[F.]***G.** For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report.

*[G.]***H.** The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance

with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

AUTHORITY: sections ***208.152,*** *208.153,* *and 208.201, RSMo [Supp. 2013, and section 208.152, RSMo Supp. 2015]* ***2016****. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. Amended: Filed June 20, 2017.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately $13.3 million.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier or emailed to ADRULESFEEDBACK.MHD@dss.mo.gov within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimate Cost of Compliance in the Aggregate
Department of Social Services, MO HealthNet Division	**SFY 2018 Impact: Total Cost = $37.1 million; State Share = $13.3 million**

III. WORKSHEET

Estimated Cost for SFY 2018:

Estimated Payments with 3.2% Trend	$1,790,504,990
Estimated Payments without 3.2% Trend	$1,753,398,385
Estimated Impact of 3.2% Trend	$37,106,605
State Share Percentage	35.740%
State Share	$13,261,901

IV. ASSUMPTIONS

The estimated cost is based upon the data in FRA 18-1. The base year for the SFY 2018 payments are the 2014 cost reports, which are adjusted by the applicable trends published in 13 CSR 70-15.010 and the 3.2% trend for SFY 2018, which is the subject of this proposed amendment.

The fiscal impact related to the Direct Medicaid payments is budget neutral.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending subsection (1)(A) and adding section (21).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2018 trend factor to be applied to the inpatient and outpatient adjusted net revenues determined from the Federal Reimbursement Allowance (FRA) fiscal year cost report to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment. Additionally, this amendment establishes the FRA assessment effective July 1, 2017 at a rate of five and seventy hundredths percent (5.70%) of each hospital's inpatient and outpatient adjusted net revenues along with further changes to the FRA assessment if the disproportionate share hospital allotment reductions are implemented during SFY 2018.

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-) month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3 from CMS 2552-96, or Worksheet G-2, Line 28, Column 3 from CMS 2552-10, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6 from CMS 2552-96, or Worksheet C, Part I, Line 45, Column 6 from CMS 2552-10;

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1 from CMS 2552-96, or Worksheet G-2, Line 6, Column 1 from CMS 2552-10;

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.);

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2 from CMS 2552-96, or Worksheet G-2, Line 25, Column 2 from CMS 2552-10;

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7 from CMS 2552-96, or Worksheet C, Part I, Line 95, Column 7 from CMS 2552-10;

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2 from CMS 2552-96, or Worksheet G-2, Line 22, Column 2 from CMS 2552-10;

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59 from CMS 2552-96, or Worksheet C, Part I, Column 7, Line 88 and subsets from CMS 2552-10; and

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24 from CMS 2552-96, or Worksheet G-2, Lines 5, 7, 9, 21, 24, 26, and 27 from CMS 2552-10;

B. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology;

C. "Adjusted Gross Total Charges" (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide "Net Revenue" by "Gross Total Charges"; and

(II) "Adjusted Gross Total Charges" will be multiplied by the result of part (1)(A)13.C.(I) to yield "Adjusted Net Revenue";

D. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1 from CMS 2552-96, or Worksheet G-2, Line 28, Column 1 from CMS 2552-10, of the most recent cost report that is

available for a hospital;

E. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28, Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

F. Total "Adjusted Net Revenue" will be allocated between "Net Inpatient Revenue" and "Net Outpatient Revenue" as follows:

(I) "Gross Inpatient Charges" will be divided by "Gross Total Charges";

(II) "Adjusted Net Revenue" will then be multiplied by the result to yield "Net Inpatient Revenue"; and

(III) The remainder will be allocated to "Net Outpatient Revenue"; and

G. The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2009 = 5.50%
(II) SFY 2009 Missouri Specific Trend = 1.50%
(III) SFY 2010 = 3.90%
(IV) SFY 2010 Missouri Specific Trend = 1.50%
(V) SFY 2011 = 3.20%
(VI) SFY 2012 = 5.33%
(VII) SFY 2013 = 4.4%
(VIII) SFY 2014 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—3.70%
(IX) SFY 2015 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—4.30%
(X) SFY 2016 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—3.90%
(XI) SFY 2017 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—4.10%
(XII) SFY 2018 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—0%

14. Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).

15. Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations, and less income from investments times the trend indices listed in 13 CSR 70-15.010(3)(B).

(21) Beginning July 1, 2017, the FRA assessment shall be determined at the rate of five and seventy hundredths percent (5.70%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and seventy hundredths percent (5.70%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(A) If the reduction of disproportionate share hospital allotments for federal fiscal year 2018 is implemented as provided in section 1923(f)(7) of the Social Security Act, the FRA assessment shall be set, effective on the date of such reduction, at the rate of five and fifty hundredths percent (5.50%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and fifty hundredths percent (5.50%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*AUTHORITY: sections 208.201, [and] 208.453, [RSMo Supp. 2013,] and [section] 208.455, RSMo [2000] **2016**. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. Amended: Filed June 20, 2017.*

PUBLIC COST: This proposed amendment will result in FRA Assessment savings to state agencies or political subdivisions of approximately $8 million to $12.8 million.

PRIVATE COST: This proposed amendment will result in FRA Assessment savings to private entities of approximately $41.3 million to $66 million.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier or emailed to ADRULESFEEDBACK.MHD@dss.mo.gov within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Hospitals which provide health care services in Missouri that are owned or controlled by the state, counties, cities, or hospital districts	**Estimated savings for SFY 2018 $8 million to $12.8 million**

III. WORKSHEET

Estimated Assessment at 5.95% for SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues	42	$1,556,594,856	$1,653,078,080	$3,209,672,936
FRA Assessment Rate		5.95%	5.95%	5.95%
Total Assessment without Trend		$92,617,394	$98,358,146	$190,975,540

Estimated Assessment at 5.70% for SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues	42	$1,556,594,856	$1,653,078,080	$3,209,672,936
FRA Assessment Rate		5.70%	5.70%	5.70%
Total Assessment without Trend		$88,725,907	$94,225,451	$182,951,357

Estimated Assessment at 5.70% for three months and 5.50% for nine months of SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Public Facilities Revenues	42	$1,556,594,856	$1,653,078,080	$3,209,672,936
FRA Assessment Rate		5.55%	5.55%	5.55%
Total Assessment without Trend		$86,391,015	$91,745,833	$178,136,848

IV. ASSUMPTIONS

This fiscal note reflects the total assessment using two scenarios as follows: 1) If the FRA Assessment is 5.70% for July 1, 2017 through June 30, 2018, the FRA Assessment to be collected during SFY 2018 is estimated at approximately $183 million which is a savings to the public facilities of approximately $8 million as compared to the FRA Assessment of 5.95% and 2) If the FRA Assessment is 5.70% for July 1, 2017 through September 30, 2017 and then 5.50% for October 1, 2017 through June 30, 2018, the FRA Assessment will result in a further savings of an additional $4.8 million.

The fiscal note is based on establishing the FRA assessment rate as noted above and a trend of 0.0% on inpatient and outpatient revenues effective for dates of service beginning July 1, 2017. The FRA assessment rate levied upon Missouri hospitals' trended, inpatient and outpatient net adjusted revenue in accordance with the Missouri Partnership Plan.

FISCAL NOTE
PRIVATE COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 15 – Hospital Program

Rule Number and Title:	13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
100	**Hospitals**	**Estimated savings for SFY 2018 $41.3 to $66 million**

III. WORKSHEET

Estimated Assessment at 5.95% for SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues	100	$7,904,814,297	$8,592,303,931	$16,497,118,228
FRA Assessment Rate		5.95%	5.95%	5.95%
Total Assessment without Trend		$470,336,451	$511,242,084	$981,578,535

Estimated Assessment at 5.70% for SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues	100	$7,904,814,297	$8,592,303,931	$16,497,118,228
FRA Assessment Rate		5.70%	5.70%	5.70%
Total Assessment without Trend		$450,574,415	$489,761,324	$940,335,739

Estimated Assessment at 5.70% for three months and 5.50% for nine months of SFY 2018:

	No. of Facilities	Inpatient Revenues	Outpatient Revenues	Total
Private Facilities Revenues	100	$7,904,814,297	$8,592,303,931	$16,497,118,228
FRA Assessment Rate		5.55%	5.55%	5.55%
Total Assessment without Trend		$438,717,193	$476,872,868	$915,590,062

IV. ASSUMPTIONS

This fiscal note reflects the total assessment using two scenarios as follows: 1) If the FRA Assessment is 5.70% for July 1, 2017 through June 30, 2018, the FRA Assessment to be collected during SFY 2018 is estimated at approximately $940.3 million which is an FRA Assessment savings to the private facilities of approximately $41.3 million as compared to the FRA Assessment of 5.95% and 2) If the FRA Assessment is 5.70% for July 1, 2017 through September 30, 2017 and then 5.50% for October 1, 2017 through June 30, 2018, the FRA Assessment will result in further savings of an additional $24.7 million.

The fiscal note is based on establishing the FRA assessment rate as noted above and a trend of 0.0% on inpatient and outpatient revenues effective for dates of service beginning July 1, 2017. The FRA assessment rate levied upon Missouri hospitals' trended, inpatient and outpatient net adjusted revenue in accordance with the Missouri Partnership Plan.

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership and Benefits

PROPOSED AMENDMENT

16 CSR 50-2.140 Cost-of-Living Adjustment. The board is amending section (2).

PURPOSE: This amendment revises the cost-of-living adjustment provisions for the plan.

(2) The amount of the COLA increase for a year shall be determined by the board in *[February]* **the first calendar quarter** of each year, based on the excess of the consumer price index for the preceding calendar year over the consumer price index for the calendar year immediately prior thereto. Notwithstanding the preceding sentence, this automatic increase shall not exceed one percent (1%) per year. The total increase in the amount of benefits received pursuant to the provisions of this section shall not exceed fifty percent (50%) of the participant's accrued benefit determined as of his or her most recent separation from service.

*AUTHORITY: section 50.1032, RSMo [Supp. 1999] **2016**. Original rule filed Sept. 29, 2000, effective March 30, 2001. Amended: Filed June 29, 2017.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 20—County Employees' Deferred Compensation Plan

PROPOSED AMENDMENT

16 CSR 50-20.120 Additional Provisions. The board is amending subsection (5)(C) to add a new paragraph 2. and to revise and renumber the current paragraph 2. as paragraph 3.

PURPOSE: This amendment revises the transfer provisions for the plan.

(5) Rollovers to the Plan and transfers shall be in accordance with the following:

(C) Plan-to-Plan Transfers from the Plan.

1. At the direction of the Employer, the Administrator may permit a class of Participants and Beneficiaries to elect to have all or any portion of their Account Balance transferred to another eligible governmental plan within the meaning of section 457(b) of the Code and section 1.457-2(f) of the Income Tax Regulations. A transfer is permitted under this paragraph (5)(C)1. for a Participant only if the Participant has had a Severance from Employment with the Employer and is an employee of the entity that maintains the other eligible governmental plan. Further, a transfer is permitted under this paragraph (5)(C)1. only if the other eligible governmental plan provides for the acceptance of plan-to-plan transfers with respect to the Participants and Beneficiaries and for each Participant and Beneficiary to have an amount deferred under the other plan immediately after the transfer at least equal to the amount transferred.

2. The Administrator may permit a Participant to elect to use all or any portion of his or her Account Balance reflecting amounts deferred by such Participant in a direct trustee-to-trustee transfer to a defined benefit governmental plan in accordance with the following. A transfer may be permitted under this paragraph (5)(C)2. for a Participant if the receiving plan is a defined benefit governmental plan within the meaning of section 414(d) of the Code, the receiving plan permits the purchase of permissive service credit within the meaning of section 415(n)(3)(A) of the Code, and the transfer qualifies as a trustee-to-trustee transfer to purchase permissive service credit within the meaning of section 457(e)(17) of the Code and section 1.457-10(b)(8) of the Income Tax Regulations. The Participant must use the election forms provided by the defined benefit governmental plan or such other forms as may be required by the Administrator that document the exact amount of transfer required to purchase the permissive service credits for such purpose.

*[2.]***3.** Upon the transfer of assets under this subsection (5)(C), the Plan's liability to pay benefits to the Participant or Beneficiary under this Plan shall be discharged to the extent of the amount so transferred for the Participant or Beneficiary. The Administrator may require such documentation from the receiving plan as it deems appropriate or necessary to comply with *[this]* paragraph**s** (5)(C)1. **and (5)(C)2.** (for example, to confirm that the receiving plan is an eligible governmental plan *[under paragraph (5)(C)1.]*, and to assure that the transfer is permitted under the receiving plan) or to effectuate the transfer pursuant to section 1.457-10(b) of the Income Tax Regulations.

*AUTHORITY: section 50.1300, RSMo [2000] **2016**. Original rule filed Nov. 10, 2005, effective May 30, 2006. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 29, 2017.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, 2121 Schotthill Woods Drive, Jefferson City, MO 65101. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2110—Missouri Dental Board
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.001 Definitions. The board is amending section (6).

PURPOSE: This amendment revises the definition of patient of record.

(6) "Patient of record"—one for whom the dentist has obtained a relevant history, performed an examination**,** and evaluated the condition to be treated. **A supervising dentist may delegate to a licensed dental hygienist the collection of relevant and necessary systemic and oral health data prior to the supervising dentist's examination and evaluation. The patient shall be made aware, prior to the collection of any data, that the supervising dentist may not be physically present when that data is collected.**

*AUTHORITY: sections 332.031, 332.091, and 332.311, RSMo [Supp. 1999] **2016**. This rule originally filed as 4 CSR 110-2.001. Original rule filed Jan. 28, 2000, effective Aug. 30, 2000. Moved to 20 CSR 2110-2.001, effective Aug. 28, 2006. Amended: Filed June 26, 2017.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at (573) 751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2233—State Committee of Marital and Family Therapists
Chapter 1—General Rules

PROPOSED AMENDMENT

20 CSR 2233-1.040 Fees. The committee is amending subsection (1)(C).

PURPOSE: This amendment increases the biennial renewal fee.

(1) The following fees are established by the Division of Professional Registration and are payable in the form of a cashier's check, personal check, or money order:

(C) Biennial License Renewal Fee	*[$125.00]* **$250.00**
and in addition—	
1. One day to sixty (1–60) days late (an additional)	$ 75.00
2. Sixty-one (61) days to two (2) years late (an additional)	$100.00

*AUTHORITY: sections 337.712 and 337.727, RSMo [Supp. 2011] **2016**. This rule originally filed as 4 CSR 233-1.040. Original rule filed Dec. 31, 1997, effective July 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 28, 2017, effective Aug. 1, 2017, expires Feb. 22, 2018. Amended: Filed June 28, 2017.*

PUBLIC COST: This proposed amendment will increase revenue for the State Committee of Marital and Family Therapists by twenty-six thousand eight hundred seventy-five dollars ($26,875) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities twenty-six thousand eight hundred seventy-five dollars ($26,875) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with State Committee of Marital and Family Therapists, Loree Kessler, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PUBLIC FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment - 20 CSR 2233-1.040 Fees

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Revenue	
State Committee of Marital and Family Therapists		**$26,875**
	Estimated Biennial Increase in Revenue for the Life of the Rule	**$26,875**

III. WORKSHEET

See Private Entity Fiscal Note

IV. ASSUMPTION

1. The figures reported above are based on FY16 actuals.
2. The committee utilizes a rolling five year financial analysis process to evaluate its fund balance, establish fee structure, and assess budgetary needs. The five year analysis is based on the projected revenue, expenses, and number of licensees. Based on the committee's recent five year analysis, the committee voted on a $125 increase in renewal fees.
3. It is anticipated that the total biennial increase will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2233 - State Committee of Marital and Family Therapists
Chapter 1 - General Rules
Proposed Amendment - 20 CSR 2233-1.040 Fees

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
215	Biennial Renewal Fee (Fee Increase @ $125)	$26,875
	Estimated Biennial Cost of Compliance for the Life of the Rule	**$26,875**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on FY16 actuals.
2. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation and are expected to increase/decrease at the rate projected by the Legislative Oversight Committee.

Note: The committee is statutorily obligated to enforce and administer the provisions of sections 337.700 to 337.739, RSMo. Pursuant to section 337.714, RSMo, the committee shall by rule and regulation set the amount of fees authorized by sections 337.700 to 337.739, RSMo, so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the committee for administering the provisions of sections 337.700 to 337.739, RSMo.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety- (90-) day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 590.020, 590.030, 590.040, and 590.190, RSMo 2016, the director amends a rule as follows:

11 CSR 75-13.010 Classification of Peace Officer Licenses **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 17, 2017 (42 MoReg 431). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 13—Peace Officer Licenses

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 590.030 and 590.190, RSMo 2016, the director amends a rule as follows:

11 CSR 75-13.060 Veteran Peace Officer Point Scale **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 17, 2017 (42 MoReg 432). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 14—Basic Training Centers

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 590.030, 590.040, and 590.190, RSMo 2016, the director amends a rule as follows:

11 CSR 75-14.030 Standard Basic Training Curricula and Objectives **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 17, 2017 (42 MoReg 432). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 590.030.5(1), 590.050, and 590.190, RSMo 2016, the director amends a rule as follows:

11 CSR 75-15.010 Continuing Education Requirement **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 17, 2017 (42 MoReg 432–433). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 75—Peace Officer Standards and Training Program
Chapter 15—Continuing Education

ORDER OF RULEMAKING

By the authority vested in the Department of Public Safety under sections 590.030.5(1), 590.050, and 590.190, RSMo 2016, the director amends a rule as follows:

11 CSR 75-15.020 Minimum Standards for Continuing Education Training **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 17, 2017 (42 MoReg 433). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 4—Wildlife Code: General Provisions

STATEMENT OF ACTUAL COST

3 CSR 10-4.200 Chronic Wasting Disease; Management Zone

The original estimated public cost for this rulemaking was published in the *Missouri Register* on January 15, 2016 (41 MoReg 74–76). Even though the actual cost to state agencies and political subdivisions did not exceed the cost estimate by more than ten percent (10%), the estimated costs deviated from the actual costs sufficiently to warrant explanation for purposes of section 536.200.2, RSMo. As described below, the estimated cost was four hundred ninety-four thousand, one hundred thirty-seven dollars ($494,137); at the end of the first full fiscal year, the actual cost to state agencies and political subdivisions was two hundred ninety-one thousand, seven hundred forty-six dollars ($291,746).

The original estimated cost to public entities included salaries for full-time staff at a cost of one hundred eighty-seven thousand, two hundred eighteen dollars ($187,218). After further review, it is the department's conclusion that labor costs for existing full-time staff should not have been included as an added expense. However, the number of Chronic Wasting Disease (CWD) samples taken during mandatory sampling efforts was underestimated by nine percent (9%), as there were one thousand seven hundred five (1,705) more samples submitted for testing than originally estimated. This resulted in thirty-three thousand, five hundred forty dollars ($33,540) more than originally estimated for testing of CWD samples. Furthermore, the department did not estimate added expense for field supplies and for staff travel expenses that resulted in a cost of fifty-four thousand, six hundred seventy-three dollars ($54,673) and one hundred forty-six thousand, one hundred seventy dollars ($146,170), respectively.

The overall cost for mandatory sampling was five hundred sixty-four thousand, four hundred fifty-three dollars ($564,453), which was seventy thousand, three hundred sixteen dollars ($70,316) or thirteen percent (13%) over the estimated fiscal cost. However, the cost for CWD testing and salaries for hourly technicians is seventy-five percent (75%) federally reimbursable, which was not factored into the original estimate. Making those adjustments, the actual cost for mandatory sampling in FY2017 was two hundred ninety-one thousand, seven hundred forty-six dollars ($291,746), or two hundred two thousand, three hundred ninety-one dollars ($202,391) less than the original estimated cost. The estimated annual costs are expected to be consistent with the actual costs for FY2016; however, the receipt of federal reimbursement in the long-term future is uncertain.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for August 22, 2017. These applications are available for public inspection at the address shown below.

Date Filed
Project Number: Project Name
City (County)
Cost, Description

06/16/2017
#5479 HT: North Kansas City Hospital
North Kansas City (Clay County)
$2,068,000, Replace Robotic Surgery System

07/07/2017
#5462 HT: Capital Region Medical Center
Jefferson City (Cole County)
$3,759,202, Replace Linear Accelerator

07/10/2017
#5494 HT: Poplar Bluff Regional Medical Center
Poplar Bluff (Butler County)
$1,329,077, Replace MRI

#5495 RT: Village Assisted Living
Lee's Summit (Jackson County)
$1,900,000, Renovate/Modernize 31-bed ALF

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by August 10, 2017. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102
For additional information contact Karla Houchins at (573) 751-6700.