

Volume 44, Number 11
Pages 1489–1656
June 3, 2019

SALUS POPULI SUPREMA LEX ESTO

“The welfare of the people shall be the supreme law.”



JOHN R. ASHCROFT
SECRETARY OF STATE

MISSOURI
REGISTER

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The *Missouri Register* is published semi-monthly by

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ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are available on the Internet. The Register address is www.sos.mo.gov/adrules/moreg/moreg and the CSR is www.sos.mo.gov/adrules/csr/csr. These websites contain rulemakings and regulations as they appear in the paper copies of the Registers and CSR. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

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February 1, 2019 February 15, 2019	March 1, 2019 March 15, 2019	March 31, 2019 March 31, 2019	April 30, 2019 April 30, 2019
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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at www.sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	<i>Code of State Regulations</i>	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and Register on the Internet

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The *Code* address is www.sos.mo.gov/adrules/csr/csr

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These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2016. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 2—Income Tax**

EMERGENCY AMENDMENT

12 CSR 10-2.015 Employers' Withholding of Tax. The department is amending sections (1)–(8), (10)–(27), (29), and (30).

PURPOSE: The amendment modifies the calculation for determining the amount of withholding and clarifies the instructions to employers.

*EMERGENCY STATEMENT: This emergency amendment informs employers of the amount of withholding and clarifies instructions to employers as to withholding in response to changes effective for tax year 2019. These changes require immediate implementation to allow employers to most accurately withhold Missouri income tax from their employees. As a result, the Missouri Department of Revenue finds a compelling governmental interest which requires this emergency action. A proposed amendment that covers the same material, is also published in this issue of the *Missouri Register*. The scope is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri* and *United States Constitutions*. The Department of Revenue believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed Tuesday, April 16, 2019, becomes effective Friday, April 26, 2019, and expires Tuesday, February 5, 2020.*

(1) General Information. The Missouri general assembly in 1972 enacted Senate Bill 549, a new Missouri income tax law. This law adopts many provisions and terms of the *Internal Revenue Code*. Its withholding provisions are applicable to wages paid after December 31, 1972. The "Missouri Employer's Tax Guide" and this rule are designed to assist employers in withholding Missouri income tax from wages paid from sources in Missouri. An employer may generally follow the provisions of the Internal Revenue Service (IRS) [publication titled "Employer's Tax Guide"] **Publication 15 (Circular E), Employer's Tax Guide** relating to withholding income tax. An employer already assigned a Missouri [withholding] tax identification number will not need to obtain a new one. If a business is discontinued, transferred, or sold, the employer must file [an *Employer's Withholding*] a Final Report, Form [MO-941F] **5633**, to close the employer's withholding account. If the business of another employer is acquired, do not use the number assigned to that business; a new number must be obtained.

(2) Employers. An employer is any person, firm, corporation, association, fiduciary of any kind, or other type of organization for whom an individual performs service as an employee, unless the person or organization for whom the individual performs service does not have control of the payment of compensation for the service[,] (section 143.191, RSMo). The term employer means the person, including all government agencies, who controls the payment of the compensation. An employer required to withhold Missouri income tax is personally liable for the tax. Any amount of tax actually deducted and withheld by an employer is a special fund in trust for the director of revenue (section 143.241, RSMo). An employee does not have a right of action against the employer in respect to any money deducted and withheld from his [//] or her wages if it is paid over to the director of revenue in good faith compliance with the Missouri Income Tax Law.

(3) Registration of Employers. Every employer must register with the Missouri Department of Revenue by completing the Missouri Tax Registration Application, Form DOR-2643. A permanent registration number will be assigned. A new application is required, and a new Missouri tax identification number will be assigned, when any change in ownership or ownership type occurs. An employer who receives a new identification number as a result of a change in ownership type[,] must file [an *Employer's Withholding*] a Final Report, Form [MO-941F] **5633**, to close the old account. These numbers are not transferable and should be referred to in all reports and correspondence concerning withholding.

(4) Employer With More Than One (1) Payroll Unit—Complex Employer. If a consolidated report and remittance of the tax withheld cannot be made by the employer because of the complexity of the organization, branch offices, or divisions may be designated as withholding agents. These agents can perform the actual withholding and remitting. However, regardless of any internal arrangements which may be established by the complex employer, the legal responsibility and liability under the law still rests with the home office. If the complex employer has designated withholding agents, and the agents wish to claim the compensation deduction, only one (1) agent will be entitled to the full deduction and the remaining agents will be entitled to one-half of one percent (1/2%) deduction of income taxes withheld if the returns are filed timely.

(5) Seasonal. If [your business] an employer is only open for several months out of the year, [you] the employer may register as a seasonal employer.

(6) Employees. The term employee for Missouri withholding purposes has the same meaning as it has for federal withholding [(see "Employer's Tax Guide," Circular E, published by the IRS)] as

set forth in Publication 15, (Circular E), Employer's Tax Guide. This definition is the same for Missouri residents and nonresidents.

(7) Wages. The term wages for Missouri withholding purposes has the same meaning as it has for federal withholding [(see "Employer's Tax Guide," Circular E, published by the IRS)] as set forth in Publication 15, (Circular E), Employer's Tax Guide. Wages include all pay given to an employee for services performed. The pay may be in cash or in other forms. It includes salaries, vacation allowances, bonuses, and commissions, regardless of how measured or paid.

(8) Interstate Transportation Employees.

(A) Rail, Motor and **Motor** Private [*Motor*] Carriers. 49 U.S.C. section 11504, limits state taxation on wages of employees of rail, motor, and **motor** private [*motor*] carriers. Missouri withholding is required on rail, motor, and **motor** private [*motor*] carrier employees whose state of residence is Missouri. Employees of rail carriers and motor carriers who perform regularly assigned duties in more than one (1) state are subject to state income tax only in their state of residency.

(10) Resident of Missouri Employed in Another State. A Missouri resident paying income tax to another state because of employment in that state may file a Withholding Affidavit For Missouri Residents, Form MO W-4C. If the employee does not complete Form MO W-4C, the employer may withhold Missouri taxes on all services performed, regardless of where performed. All income received for services performed in another state not having a state income tax is subject to Missouri withholding. If services are performed partly within and partly without the state, only wages paid for that portion of the services performed within Missouri are subject to Missouri withholding tax, provided that the services performed in the other state are subject to the other state's withholding provisions. If a service is partly within and partly without Missouri and only a portion of an employee's wages is subject to Missouri withholding tax, then the amount of Missouri tax required to be withheld is calculated using a percentage of the amount listed in the withholding tables. The calculation begins by determining the amount that would be withheld if all the wages were subject to Missouri withholding. This amount is then multiplied by a percent, which is determined by dividing the wages subject to Missouri withholding tax by the total federal wages.

(A) Example: A resident employee earns \$1,500 per month[,] and is single [*and claims one allowance*]. The employee performs 40% of his [/] or her services in Kansas. The remaining 60% of the employee's services are performed in Missouri. If the total withholding on all earnings is \$40 per month, the actual withholding for Missouri would be \$24 ($\$40 \times 60\% = \24).

(11) Missouri Employer with Nonresident Employees. If a nonresident employee performs all services outside Missouri, his [/] or her wages are not subject to Missouri withholding. A nonresident employee performing services in more than one (1) state is subject to withholding as outlined in section (9).

(12) Supplemental Wage Payments. If supplemental wages are paid, such as bonuses, commissions, overtime pay, back pay, including retroactive wage increases or reimbursements for nondeductible moving expenses in the same payment with regular wages, [*withhold*] Missouri income tax **shall be withheld** as if the total of the supplemental and regular wages were a single wage payment for the regular payroll period. If supplemental wages are paid in a different payment from regular wages, the method of withholding income tax depends in part on whether income tax is withheld from the employee's regular wages.

(A) If income tax has been withheld from the employee's regular wages, choose either one (1) of the following methods for withholding income tax on the supplemental wages:

1. Method One. Withhold at a flat percentage rate **that is the lower of [six percent (6%)] a) five and four tenths percent (5.4%) or b) the highest individual income tax rate determined under section 143.011, RSMo, for the current tax year of the supplemental wages[, using zero withholding allowances];** or

2. Method Two. Add the supplemental wages to the employee's regular wages paid to the employee within the same calendar year for the payroll period and determine the income tax to be withheld as if the aggregate amount were one (1) payment. Subtract the tax already withheld from the regular wage payment and withhold the remaining tax from the supplemental wage payment.

(B) If income tax has not been withheld from the regular wages (for example, where an employee's withholding exemption exceeds his [/] or her wages), use Method Two described in paragraph (12)(A)2. of this rule. Add the supplemental wages to the regular wages paid within the same calendar year for the payroll period and withhold income tax on the total amount as though the supplemental wages and regular wages were one (1) payment for a regular payroll period.

(13) Tips Treated as Supplemental Wages. Employers must withhold Missouri income tax based upon total tips reported by the employee, **unless the amount of tips received by the employer and remitted to the employee is greater in which case the greater amount shall be withheld. If an employee shares tips, the employer shall withhold only from the employee who actually receives the shared tips. Employers shall [W/]withhold income tax on tips using the same options indicated for withholding on supplemental wage payments.**

(14) Vacation Pay. Vacation pay received by an employee is subject to withholding as though it were a regular wage payment made for the payroll periods during the vacation. If vacation pay is paid in addition to regular wages for the vacation period, the vacation pay is treated as a supplemental wage payment. An employee who is not a resident of Missouri but works in Missouri is subject to withholding on his [/] or her vacation pay.

(15) Lump-Sum and Periodic Distribution. Missouri follows the federal guidelines for lump-sum and periodic distributions. [*If a*]A lump-sum distribution [, *withhold at the rate of six percent (6%)] is withheld at a flat rate that is the lower of a) five and four tenths percent (5.4%) or b) the highest individual income tax rate determined under section 143.011, RSMo, for the current tax year.* If a periodic distribution, follow the computer formula or tax tables.

(16) Determining Proper Amount to Withhold. To determine income tax withholding, take [*the following factors*] into account:

(A) Wages paid during the payroll period, including tips and vacation pay; **and**

(B) [*Marital*] Filing status, [*- T*] as there are separate withholding calculations for single, [*and*] married [*employees*], **and head of household employees. [; and**

(C) *Withholding allowances as indicated on the MO W-4.]*

(17) Exemption for Nontaxable Individuals. Exemption from withholding for an individual is valid only if the employee submits to the employer a completed Form MO W-4 (Employee's Withholding Allowance Certificate), certifying that the employee has no income tax liability from the previous year and expects none for the current year. The employee must file a Form MO W-4 annually if [*s/he*] **the employee** wishes to continue to be exempt.

(18) Employee Withholding [*Allowance*] Certificate. Each employee is required to file a completed Form MO W-4 [*to determine the number of exemptions to which the employee is entitled*] **that reflects the filing status on his or her income tax return.** The

Form MO W-4 must be used by the employer to determine the amount of Missouri income tax which must be withheld from each paycheck. If an employee has more than one (1) employer, *[s/] he or she may want to [reduce the number of allowances on any MO W-4 that does not pertain to his/her principal employer] withhold an additional amount on Line 2 of Form MO W-4 for his or her principal employer to ensure that the total amount withheld approximates the actual income tax liability.* Failure to *[reduce the MO W-4 allowances] withhold enough from each payroll period* could cause an employee *[to have too little tax withheld and make the employee] to be* subject to underpayment penalties. If an employee expects to have income other than his *[/]* or her wages, *[s/he may request to have additional amounts withheld in addition to the amounts indicated by the allowances claimed on the employee's MO W-4. The additional amount should be included on line 6 of the MO W-4.]* or income from multiple jobs, he or she may request additional amounts be withheld in addition to the standard withholding calculations that are based on the standard deduction for the filing status indicated on the Form MO W-4. The additional amount should be included on Form MO W-4, Line 2. Employees who expect to receive a refund (as a result of itemized deductions, modifications, or tax credits) on their tax returns may direct the employer to only withhold the amount indicated on Form MO W-4, Line 3, in which case the employer will not use the standard calculations for withholding. If the employee does not indicate an amount to be withheld or if the amount indicated is more than is available for the payroll period, the employer will use the standard calculations. Employers are required to submit a copy of each completed Form MO W-4 or an equivalent form for each new employee to the Missouri Department of Revenue within twenty (20) calendar days *[of completion of each form] of hire. "Date of hire" is defined as the date the employee reports to work or the date the employee signs the federal W-4 form, whichever is earlier.* The department will in turn forward the Form MO W-4 to the Division of Child Support Enforcement.

(19) Withholding Tables. Withholding tables prepared by the Missouri Department of Revenue take into account allowable deductions; therefore withholding is based on gross wages before any deductions, such as Federal Insurance Contribution Act (FICA), state unemployment insurance, pension funds, or insurance, etc. In determining the amount of tax to be withheld, the employer should use the table for the correct payroll period—daily, weekly, bi-weekly, semi-monthly, and monthly periods. Any other period would be a miscellaneous pay period. Tables show wage brackets in the two (2) left-hand columns. *[The withholding allowances are shown at the top of each of the remaining columns and correspond to the number of allowances claimed by an employee on the Form MO W-4.]* The filing status is shown at the top of each of the remaining columns.

(20) Percentage *[Formula] Withholding Formula.* A percentage withholding formula has been published by the director of revenue and it may be used on electronic data processing equipment for withholding Missouri income tax. Any other method must be submitted to and approved by the director of revenue. *[The formula is mathematically stated as gross income minus standard deduction, minus personal and dependent exemptions, minus federal income tax withheld equals taxable income. Taxable income multiplied by the rate equals Missouri withholding.]* Missouri withholding is calculated by subtracting the annual standard deduction from the employee's annual gross income and multiplying the result by the applicable tax rate. The formula is illustrated in the "*[Missouri] Employer's Tax Guide (Form 4282).*"

(21) Filing Frequency Requirements. Missouri withholding returns must be filed by the due date as long as an account is maintained with

the Missouri Department of Revenue *[,]* even if there was no payroll for the reporting period. Returns must be filed each reporting period, even though there may not have been any tax withheld. There are four (4) filing frequencies: quarter-monthly, monthly, quarterly, and annually (section 143.221 and 143.225, RSMo). A newly registered employer is initially assigned a filing frequency on the basis of *[his/her] the employer's* estimation of future withholdings. If the assigned filing frequency differs from the filing requirements established by statute, it is the employer's responsibility to immediately notify the Department of Revenue. The time for filing shall be as follows:

(22) Reporting Requirement. Every employer withholding Missouri income tax from employee's wages is required by statute to report and remit the tax to the state of Missouri on the *[Missouri Form MO-941] Employer's Return of Income Taxes Withheld (Form MO-941)*. See regulation 12 CSR 10-2.016 for information on *[filing a Form MO-941P] the requirements for employers* to remit *[required] payments on Quarter-Monthly accounts.*

(A) A separate reporting form must be filed for each reporting period. A personalized booklet of reporting forms detailing the employer's name, address, employer identification number, filing frequency, and due date is provided to each active account. *[The voucher booklet supplied to an employer required to pay on a quarter-monthly basis also includes payment vouchers Form MO-941P, for the four (4) quarter-monthly periods.]* If an employer misplaces, damages, or does not receive the necessary reporting forms, replacement forms should be requested, allowing sufficient time to file a timely return. If a blank form is used, the employer's name, address, and identification number must appear as filed on previous returns and the period for which the remittance is made must be indicated. Failure to receive reporting forms does not relieve the employer of responsibility to report and remit tax withheld. If an employer temporarily ceases to pay wages, a return must be filed for each period indicating that no tax was withheld. Failure to do so will result in the issuance of non-filer notices.

(B) *[On or before February 28, or with the final return filed at an earlier date, each employer must file a Form MO W-3 (Transmittal of Wage and Tax Statements) and copies of all withholding tax statements, Form W-2/1099R, copy 1, for the year.]* Do not include the fourth quarter or twelfth month return with the Form W-2(s)/1099R(s) and Form MO W-3. The last annual remittance must be sent separately with Form MO-941. **Employers with two hundred fifty (250) or more employees are required to submit these items electronically by the last day of January. Paper filers are required to submit copies of all withholding statements by the last day of February. Paper filings must also be accompanied by a list, preferably an adding machine tape or a computer printout, of the total amount of the income tax withheld as shown on all "Copy 1s" of Form W-2 and Form 1099-R.** Large numbers of forms may be forwarded to the Department of Revenue in packages of convenient size. Each package must be identified with the name and account number of the employer and the packages must be consecutively numbered. Any employee's copies of the Withholding Statement (Form W-2/*[/]* or Form 1099-R) which cannot be delivered to the employee after reasonable effort is exerted, must be kept by the employer for at least four (4) years. The Department of Revenue will accept computer produced magnetic tape records instead of the paper Form W-2/*[/]* or Form 1099-R. The employer must meet tape data specifications which are established by the Department of Revenue. The department follows specifications outlined in Social Security Administration Publication 42-007. Employers must also include the Supplemental record (Code S or Code 1 S).

(C) If an employer *[goes out-of-business] closes* or ceases to pay wages, a Final Report, *[MO-941F] Form 5633* must be filed. This form, which is included in the voucher booklet, is provided to all active accounts.

(23) Time and Place for Filing Returns and Remitting Tax.

(A) All returns and remittances must be filed with the Department of Revenue at the specific address indicated on the form. The dates on which the returns and payments are due are as follows:

1. Quarter-Monthly (see 12 CSR 10-2.016). The quarter-monthly periods are: the first seven (7) days of a calendar month; the eighth to the fifteenth day of a calendar month; the sixteenth to the twenty-second day of a calendar month; and the twenty-third day through the last day of a calendar month. Payments must be *[mailed]* made within three (3) banking days after the end of the quarter-monthly period or received by the Department of Revenue or its designated depository within four (4) banking days after the end of the quarter-monthly period. *[A monthly return (MO-941)]* **Quarter-monthly filers are required to pay by use of an electronic funds payment system established by the department. If quarter-monthly filers are unable to use the electronic funds payment system, alternative electronic payment methods are outlined in the “Employer Tax Guide” Form 4282. An Employer’s Return of Income Taxes Withheld (Form MO-941)** reconciling the quarter-monthly payments and detailing any underpayment of tax is due by the fifteenth day of the following month except for the third month of a quarter in which case the *[MO-941]* **Employer’s Return of Income Taxes Withheld (Form MO-941)** is due the last day of the succeeding month;

2. Monthly. Return and payment must be made by the fifteenth day of the following month except for the third month of a quarter in which case the return is due the last day of the succeeding month;

3. Quarterly. Return and payment must be made on or before the last day of the month following the close of the calendar quarter; and

4. Annually. Return and payment must be made on or before January 31 of the succeeding year.

(B) When the due date falls on a Saturday, Sunday, or legal holiday, the return and payment will be considered timely if made on the next business day (section 143.851, RSMo).

(24) Correcting Mistakes in Reporting or Withholding.

(A) Overpayment. If withholding tax has been over-reported, the employer must file an **Amended Employer’s [Withholding Tax Overpayment Amended Report,] Return of Income Taxes Withheld**, Form *[MO-941X along with]* **Form MO-941, along with** supporting documentation^{1/;}, such as a copy of *[your]* the payroll ledger, records, or W-2s. A claim for credit or refund of an overpayment of withheld tax must be filed by the taxpayer within three (3) years from the time the return was filed or two (2) years from the time the tax was paid, whichever period expires later. If no return was filed by the taxpayer, a claim for credit or refund must be filed within two (2) years from the time the tax was paid. No claim for credit or refund will be allowed after the expiration of the period of limitation prescribed in section 143.801, RSMo.

(B) Underpayment. If withholding tax has been under-reported, the employer must file an **Amended Employer’s [Withholding Tax Underpayment Amended Return,] Return of Income Taxes Withheld** (Form MO-941/U) to report the additional withholding.

(25) Erroneous Withholding. If Missouri tax has been withheld from an employee’s paycheck and the employee is not subject to Missouri tax, it is the employer’s responsibility to complete an **Amended Employer’s [Withholding Tax Overpayment Amended Report,] Return of Income Taxes Withheld** (Form MO-941/X), along with supporting documentation^{1/;}, such as a copy of *[your]* the payroll ledger, records, or W-2s.

(26) Employer Compensation. For every remittance made to the director of revenue, on or before the respective due date for the payment involved, each employer (except the United States, the state of Missouri, and all agencies and political subdivisions of the state of Missouri or the United States government) may deduct and retain as

compensation the following percentages of the total amount of the tax withheld and paid annually: two percent (2%) of the first five thousand dollars (\$5,000) or less; one percent (1%) of the amount in excess of five thousand dollars up to ten thousand dollars (\$5,000–\$10,000); one-half of one percent (1/2%) of the amount collected in excess of ten thousand dollars (\$10,000). The employer is not entitled to any compensation if any payment is not made on or before the due date. Compensation for complex employers is covered in section (4).

(27) Failure to Pay Taxes Withheld—Special Deposits. Any employer who fails to remit income tax withheld, or to file tax returns as required, may be required to deposit the taxes in a special trust account for Missouri (see section 32.052, RSMo). Penalties are provided for failure to make payment. If the director of revenue finds that the collection of taxes required to be deducted and withheld by an employer may be jeopardized by delay, *[s/he or she]* may require the employer to remit the tax or make a return at any time. A lien outstanding with regard to any tax administered by the director shall be a sufficient basis for this action (see section 143.221.4, RSMo). In addition, any officer, director, statutory trustee, or employee of any corporation who has direct control, supervision, or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to section 143.241.2, RSMo.

(29) Records to Be Kept by Employers.

(A) The following records must be retained for all employees:

1. Name, address, Social Security number, and period of employment;

2. Amounts and dates of all wage payments subject to the Missouri withholding tax;

3. Employees’ state income tax withholding *[allowance]* certificate;

4. Employer’s state income tax withholding registration number;

5. Record of quarter-monthly, monthly, quarterly, and annual returns filed including dates and amounts of payments; **and**

6. Records that would assist the Missouri Department of Revenue in auditing the employer’s records *[; and]*.

[7.](B) All records should be kept for at least three (3) years after the date the taxes to which they relate become due, or the date the taxes are paid, whichever is later.

[(B)](C) In addition to the records listed in paragraphs (29)(A)1.–*[7.]6.*, all records of the allocation of working days in the state of Missouri must be retained for all nonresident employees.

(30) Penalties, Interest, and Additions to Tax.

(F) A person who willfully fails to collect, account for, or pay withholding taxes is subject to a penalty equal to the amount not paid to the state, pursuant to section 143.751.4, RSMo. In addition, any officer, director, statutory trustee, or employee of any corporation who has direct control, supervision, or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to section 143.241.1, RSMo.

(G) Penalties for criminal offenses are also provided *[throughout]* in sections 143.911–*[]* to 143.951, RSMo.

AUTHORITY: section 143.961, RSMo [2000] 2016. This rule was previously filed as “Missouri Employer’s Tax Guide” Feb. 20, 1973, effective March 2, 1973. Original rule filed Jan. 29, 1974, effective Feb. 8, 1974. For intervening history, please consult the Code of State Regulations. Emergency amendment filed April 16, 2019, effective April 26, 2019, expires Feb. 5, 2020. A proposed amendment covering this same material is published in this issue of the Missouri Register.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo 2016.

WRIT OF ELECTION

THE STATE OF MISSOURI,

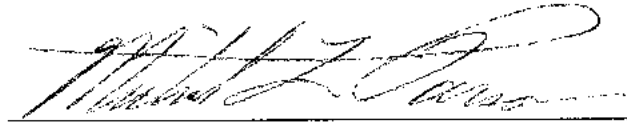
To the Election Authority, that being the Saint Louis County Board of Election Commissioners, State of Missouri, Greetings:

WHEREAS, I have been duly notified pursuant to Section 21.090, RSMo, of the resignation of State Representative Jean Evans, who at the time of her resignation, was a member of the Missouri State House of Representatives of the One Hundredth General Assembly, from the 99th District, comprised of Saint Louis County; and

WHEREAS, as a result of Representative Evans' resignation, a vacancy exists in the membership of the One Hundredth General Assembly from the 99th District.

NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, pursuant to the laws of the State of Missouri, including Article III, Section 14 of the Constitution of the State of Missouri and Sections 21.110 and 115.125, RSMo, do hereby issue this writ of election to fill this vacancy and do hereby direct that you cause the election for this purpose to be held on November 5, 2019, within the limits comprising the 99th District of the Missouri House of Representatives as required by law. Candidates must be selected and filed for office no later than 5:00 p.m. on May 13, 2019. I further direct that you issue your Proclamation or Notice for holding the election in accordance with the provisions of Sections 21.130, 115.125, and 115.127, RSMo, and that you certify the execution of this writ by providing the abstract required by Section 115.507, RSMo.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 22nd day of April, 2019.



MICHAEL L. PARSON
GOVERNOR

ATTEST:



JOHN R. ASHCROFT
SECRETARY OF STATE



WRIT OF ELECTION

THE STATE OF MISSOURI,

To the Election Authority, that being the County Clerk of Barry County, State of Missouri,

To the Election Authority, that being the County Clerk of Lawrence County, State of Missouri,

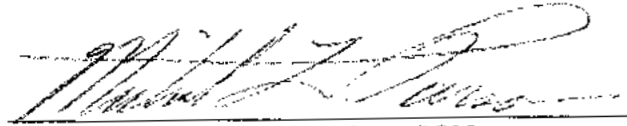
To the Election Authority, that being the County Clerk of Stone County, State of Missouri,

Greetings:

WHEREAS, I have been notified that a vacancy exists in the membership of the Missouri House of Representatives One Hundredth General Assembly from the 158th District, comprised of parts of Barry, Lawrence, and Stone Counties.

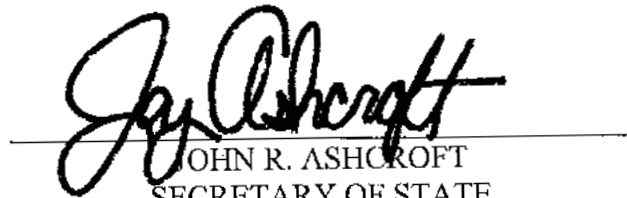
NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, pursuant to the laws of the State of Missouri, including Article III, Section 14 of the Constitution of the State of Missouri and Sections 21.110 and 115.125, RSMo, do hereby issue this writ of election to fill this vacancy and do hereby direct that you cause the election for this purpose to be held on November 5, 2019, within the limits comprising the 158th District of the Missouri House of Representatives as required by law. Candidates must be selected and filed for office no later than 5:00 p.m. on May 13, 2019. I further direct that you issue your Proclamation or Notice for holding the election in accordance with the provisions of Sections 21.130, 115.125, and 115.127, RSMo, and that you certify the execution of this writ by providing the abstract required by Section 115.507, RSMo.

IN WITNESS WHEREOF, I have hercunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 22nd day of April, 2019.



MICHAEL L. PARSON
GOVERNOR

ATTEST:



JOHN R. ASHCROFT
SECRETARY OF STATE



**EXECUTIVE ORDER
19-07**

WHEREAS, the severe weather that began on March 11, 2019, created a condition of distress and hazards to the safety and welfare of the citizens of the State of Missouri beyond the capabilities of some local jurisdictions and other established agencies; and

WHEREAS, Executive Order 19-05 was issued on March 21, 2019, declaring a State of Emergency within the State of Missouri; and

WHEREAS, Executive Order 19-06 was issued on March 28, 2019, authorizing the Director of the Department of Natural Resources to waive or suspend temporarily the operation of statutory or administrative rules or regulations in order to expedite the cleanup and recovery process; and

WHEREAS, several communities in the state continue to clear debris resulting from the severe weather; and

WHEREAS, Executive Order 19-06 expires on April 30, 2019, unless extended in whole or in part.

NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and Laws of the State of Missouri, do hereby extend Executive Order 19-06 through June 30, 2019, for the purpose of continuing cleanup efforts in affected Missouri communities.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 30th day of April, 2019.

Michael L. Parson
Governor

ATTEST:

John R. Ashcroft
Secretary of State

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 symbolology 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 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 14—Limit on Tuition Increases

PROPOSED RULE

6 CSR 10-14.010 Limit on Tuition Increases

PURPOSE: This rule establishes the process by which public institutions of higher education in Missouri will demonstrate compliance, or seek a penalty waiver for noncompliance, with limits on annual tuition increases in accordance with the Higher Education Student Funding Act, sections 173.1000-1003, RSMo.

(1) Definitions.

(A) Academic year means the fall and spring semesters between August 1 and July 31 of one (1) three hundred sixty-five- (365-) day period.

(B) Average tuition means the sum of all included institutions' tuition for the current academic year divided by the number of included institutions. This figure will be determined by adding the tuition of each public four- (4-) year institution and State Technical College, then dividing by the number of included institutions. If any community college has tuition that is equal to or exceeds the aforementioned average tuition, the average tuition shall be recalculated to include that community college's tuition.

(C) Booked tuition means the amount of tuition and required fees an institution records with MDHE as permitted under this rule, but not actually charged during an academic year. Booked tuition is included in an institution's allowable annual increase and the average tuition, but is waived for students in the year that it is initially booked. Booked tuition may be charged in future years without counting further towards an institution's allowable increase when charged.

(D) CBHE means the Coordinating Board for Higher Education.

(E) Commissioner means the Commissioner of Higher Education.

(F) Consumer price index or CPI means the consumer price index for all urban consumers, 1982-1984=100, not seasonally adjusted, as defined and officially recorded by the United States Department of Labor or its successor agency, for December of the current year compared to December of the previous year.

(G) Fee established by the student body of the institution or student approved fee means any fee the amount of which has been approved by a majority of students who vote in a campus-wide election or by a majority of members of an officially recognized student government organization popularly elected by the students of an institution or a campus within a multi-campus system.

(H) FTE means full time equivalent.

(I) Included institution means all institutions that offer four- (4-) year degree programs, State Technical College, and any community college that charges out-of-district Missouri residents tuition that is equal to or exceeds the average tuition.

(J) Institution means an approved public institution of higher education, as defined in section 173.1102, RSMo. An institution that is comprised of more than one (1) campus at which the same level of degree is offered shall constitute one (1) institution for purposes of this rule.

(K) Institutional aid means the aid awarded to the student by the student's institution of higher education only from such institution's funds. It does not include the following: Pell Grants; state awards such as the Missouri higher education academic scholarship program, the A+ schools program, and the access Missouri financial aid program; foundation scholarships; third-party scholarships; employee and dependent fee waivers; and student loans.

(L) MDHE means the Missouri Department of Higher Education.

(M) Mid-year tuition increase means any ongoing increase in tuition that occurs after an institution has submitted its initial notice of tuition change to the MDHE, or any amended notices of tuition change related to the initial notice of tuition change, the duration of which extends beyond the end of the academic year in which it is initially imposed.

(N) Notice of tuition change means written documentation in a format prescribed by MDHE, the accuracy of which is attested by the institution's president or chancellor, indicating the tuition for the current academic year, the tuition for the upcoming academic year, and the percentage change between the two (2).

(O) Net tuition revenue means the net amount of tuition and required fees collected from resident degree-seeking undergraduates reduced by institutional aid only during the fiscal year in which the increase is charged.

(P) Required fees means those fees charged to all full-time undergraduate students and excludes course- and program-specific fees and any student approved fee established after August 27, 2007.

(Q) State appropriations means the state operating appropriation

for the prior year per FTE student for the prior year compared to the state operating appropriation for the current year per FTE student for the prior year.

(R) State operating appropriation means the total dollar amount appropriated by the Missouri Legislature for an institution's core operating appropriation for the fiscal year, exclusive of capital appropriations and any amount withheld by the governor or legislature.

(S) State operating support means the funding actually disbursed from state operating appropriations to approved public institutions and does not include appropriations or disbursement for special initiatives or specific program additions or expansions. To qualify as special initiatives or specific program additions or expansions, it must be separated out in its own line item. Performance funding will be considered as a part of an institution's state operating support regardless of if the legislature decides to appropriate it as a separate line item(s).

(T) Temporary tuition surcharge means any temporary increase in tuition that is assessed in addition to the amount indicated by an institution in its initial notice of tuition change, or in any amended notices of tuition change related to the initial notice of tuition change. The time period during which a temporary tuition surcharge is assessed shall not extend beyond the end of the academic year in which the surcharge is initially imposed.

(U) Tuition means the dollar amount an institution charges each Missouri resident undergraduate student enrolled in thirty (30) credit hours plus the required fees for the academic year. In the community college context, "tuition" means out-of-taxing-district Missouri resident tuition plus the required fees for the academic year.

(2) Limits on Tuition Increases.

(A) Any institution with tuition that is greater than the average tuition shall not increase tuition for the next academic year at a percentage rate that exceeds the percentage increase in the CPI or zero, whichever is greater, plus a percentage of not more than five percent (5%) that would produce an increase in net tuition revenue no greater than the dollar amount by which the state operating support was reduced for the prior fiscal year, if applicable. Booked tuition will count toward an institution's allowable increase and the average tuition in the year it is initially booked.

(B) Any institution with tuition that is less than the average tuition shall not increase tuition for the next academic year in a dollar amount that exceeds the product of either zero or the percentage change in the CPI, whichever is greater, times the average tuition, plus a percentage of not more than five percent (5%) that would produce an increase in net tuition revenue no greater than the dollar amount by which the state operating support was reduced for the prior fiscal year, if applicable. Booked tuition will count toward an institution's allowable increase and the average tuition in the year it is initially booked.

(C) A community college shall be required to abide by the limitations and procedures set forth in this rule only if its tuition is greater than or equal to the average tuition.

(D) Any institution that exceeds the limits set forth in subsection (A) or (B) of this section shall remit five percent (5%) of its state operating appropriation during the fiscal year in which the tuition increase will take place to the state's general revenue fund or request a waiver of the five percent (5%) penalty pursuant to section (4) of this rule.

(3) Notification Procedure.

(A) By December 1 of each year, MDHE will notify all institutions of the average tuition. This notice will also indicate which institutions have higher than average tuition, which institutions have lower than average tuition, and which institutions will be exempt from the requirements of this rule for the upcoming academic year.

(B) By January 31st of each year, MDHE will notify all institutions of the prior year's CPI and their allowable increase.

(C) By July 1 of each year, each institution must submit its notice

of tuition change to the CBHE, via MDHE. If the notice of tuition change is discovered to be inaccurate or becomes inaccurate due to changes in underlying data or assumptions, the institution shall notify MDHE immediately and submit a corrected notice of tuition change as soon as practicable.

(D) Any institution that imposes a mid-year tuition increase and/or temporary tuition surcharge must provide a notice of tuition change reflecting the increase as soon as it is practically possible to do so and will submit to the following:

1. If the mid-year tuition increase and/or temporary tuition surcharge plus the tuition initially indicated in the institution's notice of tuition change exceed the increase permitted by this rule, the institution must abide by the terms of this rule.

2. Because any mid-year tuition increase and/or temporary tuition surcharge will likely be associated with exigent circumstances, the Commissioner and the CBHE recognize that the timeline this rule sets forth for the normal appeals process may be too lengthy for mid-year appeals. The Commissioner and the CBHE will address mid-year appeals in as expeditious a manner as possible, and any institution seeking a waiver under this rule is expected to provide all required information in a like manner. All parties will honor the intent of the timeline this rule sets forth for the normal appeals process, and adequate time for public comment, preparation of responses, consideration of arguments, and deliberation will be afforded.

3. If an institution imposes a mid-year tuition increase, the figure used to calculate the amount the institution may increase tuition the following year will be the amount indicated in the institution's initial notice of tuition change, or in any amended notices of tuition change related to the initial notice of tuition change, plus any mid-year tuition increase.

4. If an institution imposes a temporary tuition surcharge, the figure used to calculate the amount the institution may increase tuition the following year will be the amount indicated in the institution's initial notice of tuition change, or in any amended notices of tuition change related to the initial notice of tuition change, plus any mid-year tuition increase, but shall not include any amount attributable to a temporary tuition surcharge.

(E) Within 15 calendar days of receiving the institution's notice of tuition change, MDHE will notify the institution that its notice of tuition change has been received and whether its tuition increase triggers the penalty described in subsection (2)(D) of this rule.

(4) Penalty Waiver Process.

(A) No later than thirty (30) calendar days after receiving MDHE's notification that the tuition increase triggers the penalty, an institution may submit a request for a waiver of the penalty. The waiver request must set forth each factor the institution contends supports its decision to increase tuition in excess of the limits set forth in this rule.

(B) No later than forty-five (45) calendar days after the institution submits its waiver request, the commissioner will meet with the institution at a time and place agreeable to all parties.

(C) The commissioner may ask an institution to submit additional or clarifying written material to supplement the institution's waiver request before or after the meeting. Such requests from the commissioner may include, among others, information regarding the areas of inquiry listed in section (5) of this rule.

(D) An institution requesting a waiver must provide all information requested by the commissioner in a timely manner.

(E) All written materials, including but not limited to notices of tuition change and waiver requests, submitted to the commissioner in connection with this rule will be considered public information and will be posted on MDHE's website. The MDHE website will specifically advise members of the public that they may submit written comments about any of the posted material to the commissioner at any time before the meeting of the commissioner and the institution requesting a waiver takes place. The commissioner may determine

the weight each comment should be afforded and may consider the comments in determining whether to grant a waiver. Copies of all comments must be provided to the institution requesting a waiver within three calendar days of the date the comment is received.

(F) Unless otherwise agreed, the meeting of the commissioner and the institution requesting a waiver will be led by the commissioner and may include other individuals as requested by the commissioner. The institution will have an opportunity to present its rationale for seeking a waiver and to address any comments received from the public. The commissioner and/or his/her staff will have an opportunity to ask questions of the institution.

(G) The commissioner will notify the institution whether he/she has determined that its tuition increase is sufficiently warranted within twenty (20) calendar days of the meeting or within twenty (20) calendar days after the institution has provided all information requested by the commissioner, whichever is later. If the commissioner finds that the tuition increase is not sufficiently warranted, such notice shall be in writing and shall state the reasons that such increase was deemed not sufficiently warranted. The notice will also inform the institution what percentage, if any, of its state operating appropriation the commissioner recommends the institution be required to remit to the state's general revenue fund.

(H) If the commissioner determines that the tuition increase is not sufficiently warranted, the institution shall have ten (10) calendar days to submit an amended notice of tuition change and the rationale for the tuition rate set forth in the amended notice of tuition change, to agree to increase tuition only at the level permitted by section (2) of this rule, or to maintain its original position. In any case, the institution shall notify the commissioner of its decision in writing within ten (10) calendar days after the commissioner notifies the institution that the initial tuition increase is not sufficiently warranted.

(I) If the institution submits an amended notice of tuition change—

1. The commissioner shall consider the amended notice of tuition change and the rationale for the tuition rate set forth in the amended notice of tuition change and shall meet with the institution if deemed necessary by the commissioner;

2. The commissioner will notify the institution whether he/she has determined that the tuition increase set forth in the amended notice of tuition change is sufficiently warranted within twenty (20) calendar days of the meeting or within twenty (20) calendar days after the institution has provided all information requested by the commissioner, whichever is later;

3. If the commissioner finds that the tuition increase is not sufficiently warranted, such notice shall be in writing and shall state the reasons that such increase was deemed not sufficiently warranted. The notice will also inform the institution what percentage, if any, of its state operating appropriation the commissioner recommends the institution be required to remit to the state's general revenue fund.

4. If the commissioner determines that the tuition increase set forth in the institution's amended notice of tuition change is not sufficiently warranted, the institution shall have ten (10) calendar days within which to either agree to increase tuition only at the level permitted by section (2) of this rule or to maintain the position indicated in its amended notice of tuition change. In either case, the institution shall notify the commissioner of its decision in writing within ten (10) calendar days after the commissioner notifies the institution that the amended tuition increase is not sufficiently warranted.

5. An institution may not submit more than one (1) amended notice of tuition change per academic year unless requested by the commissioner.

(J) If the commissioner determines that the tuition increase is not sufficiently warranted and the institution decides to maintain its original and/or amended position rather than to increase tuition only at the level permitted by section (2) of this rule, the commissioner must notify the CBHE of his/her determination and recommendation as to what percentage of the institution's state operating appropriation the commissioner recommends the institution be required to remit to the state's general revenue fund.

(K) If the commissioner determines that the tuition increase is not sufficiently warranted, the CBHE will determine what, if any, percentage of the institution's state operating appropriation must be remitted to the state's general revenue fund at its next regularly scheduled meeting or at a specially called meeting, by means of a majority vote of all CBHE members present at the meeting, whether present in person or by electronic means; provided, however, that no vote will be made on the matter unless a quorum is established. The institution will have an opportunity to present each factor it believes supports its decision to increase tuition to the CBHE. The CBHE's decision will be binding and final.

(L) If the CBHE votes to impose a penalty, the penalty shall be up to five percent (5%) of the institution's state operating appropriation during the fiscal year in which the tuition increase will take place. The penalty shall be a one- (1-) time penalty only. The institution shall remit the penalty to the state's general revenue fund no more than thirty (30) calendar days after the date the CBHE votes to impose the penalty.

(M) All written material submitted by an institution in connection with this rule shall be submitted in electronic form.

(N) The commissioner, at his/her discretion, may agree to extend any deadline described in this rule.

(O) Throughout his/her tenure, the commissioner will be committed to addressing waiver requests in a timely manner. Failure by the commissioner to meet any deadline described in this rule shall not, however, invalidate the process.

(P) This rule is not intended to inhibit institutions' ability to engage in conversations with the commissioner, MDHE staff, or the CBHE about issues of interest to members of the higher education community, including tuition.

(5) Penalty Waiver Decision Criteria.

(A) The commissioner shall consider all written and verbal information provided by an institution and through public comments in the waiver request process when determining whether the tuition increase is sufficiently warranted. The commissioner may request the institutions to provide information about the number of students enrolled at satellite or branch campuses, in online classes, or in distance education programs at each institution, and the tuition charged for each such type of education. The commissioner may evaluate information outside the institution-provided material to the extent necessary to ensure a fair and complete decision, though any attempt to do so will not relieve the institution of its burden to produce a complete and accurate decision-making record.

(B) The determination of whether an institution's tuition increase is sufficiently warranted will be based on the relationship between state appropriations and the consumer price index. The commissioner may also consider extraordinary circumstances, including but not limited to:

1. Mandatory costs that have increased at a rate that exceeds the CPI, including but not limited to increased costs incurred in connection with the implementation of state or federal mandates or legal requirements;

2. Historical trends in state operating appropriations, tuition policy, and other financial issues and relationships;

3. Costs related to the institution's mission that justify growth in revenues in excess of the CPI;

4. Costs related to initiatives designed to meet specific needs or strategic goals of the state of Missouri that justify growth in revenues in excess of the CPI;

5. The current and/or historical structure of the institution's total budget, including the institution's allocations for faculty and non-faculty salaries, institutional financial aid, student support, research, physical plant maintenance, and other operational activities;

6. Damage, destruction, or deterioration of facilities, infrastructure, property, or other physical assets of an institution for which there are insufficient funds from state appropriations or insurance proceeds to repair or replace;

7. Public comments about the material posted on MDHE's website pertaining to the institution's waiver request; and

8. Magnitude of tuition increase and the likely impact on the students the institution serves.

AUTHORITY: section 173.1000, RSMo 2016, and section 173.1003, RSMo Supp. 2018. Original rule filed April 30, 2019.

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

PRIVATE COST: This proposed rule 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 rule with the Department of Higher Education, General Counsel, PO Box 1469, Jefferson City, MO 65102-1157. 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 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.010 Definitions. This rule defined the special terms used in 9 CSR 30-4.020–9 CSR 30-4.190 regarding the certification standards for mental health agencies.

PURPOSE: The department is rescinding this rule in its entirety because definitions will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.140.

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Emergency amendment filed July 2, 1992, effective July 12, 1992, expired Nov. 8, 1992. Emergency amendment filed July 6, 1993, effective July 16, 1993, expired Nov. 12, 1993. Amended: Filed July 6, 1993, effective March 10, 1994. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed July 31, 2002, effective March 30, 2003. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.020 Procedures to Obtain Certification. This rule described the procedures to obtain certification from the Department

of Mental Health for mental health agencies as authorized by section 630.655, RSMo.

PURPOSE: The department is rescinding this rule in its entirety because procedures to obtain certification will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.130.

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.030 Certification Standards Definitions. This rule defined terms and explained usage rules for terms used in certification procedures and standards developed under section 630.655, RSMo, for community psychiatric rehabilitation programs and certain services serving persons with serious mental illnesses and disorders.

PURPOSE: This rule is being rescinded in its entirety because definitions will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.140.

AUTHORITY: sections 630.055 and 632.050, RSMo 2000, and section 630.050, RSMo Supp. 2011. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs

PROPOSED RESCISSION

9 CSR 30-4.031 Procedures to Obtain Certification for Centers.

This rule described procedures to obtain certification from the Department of Mental Health for community psychiatric rehabilitation programs.

PURPOSE: This rule is being rescinded in its entirety because procedures to obtain certification will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.130.

AUTHORITY: sections 630.050, 630.655 and 632.050, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.032 [Administration] Administrative Structure for Community Psychiatric Rehabilitation Programs. The department is amending the rule title, purpose, and sections (1) and (2), adding new section (3), and deleting old sections (3) and (4).

PURPOSE: This amendment updates terminology and removes requirements for the governing body and policy and procedure manual which have been moved to Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.090.

PURPOSE: This rule sets out responsibilities and authority of the [governing body and] director of a community psychiatric rehabilitation (CPR) program.

(1) Each [agency] organization that is certified or deemed certified by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance [Abuse] Use Disorder Treatment Programs, 9 CSR 10-7.090 Governing Authority and Program Administration.

(2) A CPR program director shall be appointed whose qualifications, authority, and duties are defined in writing. The director shall have responsibility and authority for all operating elements of the CPR

program, including all administrative and service delivery staff. If the CPR program director is not a qualified mental health professional (QMHP) as defined in [9 CSR 30-4.030, then the agency shall identify] 9 CSR 10-7.140, a clinical supervisor who is a [qualified mental health professional who has responsibility for monitoring and supervising] QMHP shall be designated by the agency to monitor and supervise all clinical aspects of the program. If the agency is certified to provide services to children and youth, [then] the CPR program director shall have at least two (2) years of supervisory experience with children and youth. If the CPR program director does not meet these requirements, the agency shall identify a clinical supervisor for children and youth services who is a [qualified mental health professional] QMHP who has responsibility for monitoring and supervising all clinical aspects of the program and meets the above requirements.

[(3) The CPR provider shall maintain a policy and procedure manual for all aspects of its operations. CPR program plans, policies and procedures shall include descriptions, details and relevant information about—

(A) The philosophy, types of services and organization of the CPR provider;

(B) Goals and objectives;

(C) Organization and methods of personnel utilization;

(D) Relationship among components within the organization and with agencies outside of the program;

(E) Location of service sites;

(F) Hours and days of operation of each site;

(G) The outreach plan for all services offered;

(H) Infection control procedures, addressing at least those infections that may be spread through contact with bodily fluids;

(I) The scope of volunteer activities;

(J) Safety precautions and procedures for clients, volunteers, employees and others;

(K) Staff communication with the governing body;

(L) The on-site use of tobacco, alcohol and other substances;

(M) Emergency policies and procedures by staff, volunteers, clients, visitors and others for—

1. Medical emergencies;

2. Natural emergencies, such as earthquakes, fires, severe storms, tornado or flood;

3. Behavioral crisis;

4. Abuse or neglect of clients;

5. Injury or death of a client; and

6. Arrest or detention of a client.

(N) Policies and procedures which address commonly occurring client problems such as missed appointments, appearing under the influence of alcohol or drugs, broken rules, suicide attempts, loitering, accidents, harassment and threats; and

(O) Relevant information about service provision for children and youth addressing any and all aspects of subsections (A) through (N) of this rule.

(4) The governing body shall establish a formal mechanism to solicit recommendations and feedback from clients, client family members and client advocates regarding the appropriateness and effectiveness of services, continuity of care and treatment. The CPR provider shall document issues raised, including recommendations made by clients, client family members and client advocates; actions taken by the governing body, director and CPR program staff; an implementation plan and schedule to resolve issues cited.]

(3) The CPR program shall maintain a policy and procedure manual for all aspects of its operations including, but not limited

to:

(A) Personnel and staff development in accordance with 9 CSR 30-4.034;

(B) Admission criteria, referral process, and transfer of records in accordance with 9 CSR 30-4.042;

(C) Provision of core and optional CPR services as specified in 9 CSR 30-4.043; and

(D) Specialized programs and/or services as specified in department contracts.

AUTHORITY: section 630.655, RSMo [2000] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.033 Fiscal Management of Community Psychiatric Rehabilitation Program. This rule prescribed the fiscal policies and procedures for community psychiatric rehabilitation programs.

PURPOSE: The department is rescinding this rule in its entirety because fiscal policies and procedures will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.100.

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication

in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED AMENDMENT

9 CSR 30-4.034 [Personnel and Staff Development] General Staffing Requirements for Community Psychiatric Rehabilitation Programs. The department is amending the rule title, purpose and sections (1) and (6), deleting old sections (2)-(5) and (7)-(12), adding new sections (2) and (4), and renumbering as needed. Staff qualifications and service descriptions are being moved to 9 CSR 30-4.043.

PURPOSE: This amendment updates terminology and requirements for caseload size, and adds competency requirements for staff working in community psychiatric rehabilitation (CPR) programs.

PURPOSE: This rule [prescribes personnel policies and procedures for community psychiatric rehabilitation] specifies requirements for caseload size, clinical privileging, and core competencies for staff working in CPR programs.

(1) Each agency that is certified or deemed certified by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance [Abuse] Use Disorder Treatment Programs, 9 CSR 10-7.110 Personnel.

[(2) Only qualified professionals shall provide community psychiatric rehabilitation (CPR) services. Qualified professionals for each service shall include:

(A) For intake/annual evaluations, an evaluation team consisting of, at least, a physician, one (1) other mental health professional, as defined in 9 CSR 30-4.030, and including, for the annual evaluation, the community support worker assigned to each client;

(B) For brief evaluation, an evaluation team consisting of at least, a physician and one (1) other mental health professional, as defined in 9 CSR 30-4.030;

(C) For treatment planning, a team consisting of at least a physician, one (1) other mental health professional as defined in 9 CSR 30-4.030 and the client's community support worker;

(D) For crisis intervention and resolution, any mental health professional as defined in 9 CSR 30-4.030;

(E) For medication services, a physician, psychiatric pharmacist, or advanced practice nurse as defined in 9 CSR 30-4.030;

(F) For medication administration, a physician, registered professional nurse (RN), licensed practical nurse (LPN), advanced practice nurse, or psychiatric pharmacist;

(G) For metabolic syndrome screening, a registered professional nurse (RN), or licensed practical nurse (LPN);

(H) For psychosocial rehabilitation illness management and recovery, an individual with department-approved training;

(I) For individual and group professional psychosocial rehabilitation, a professional counselor licensed or provisionally licensed under Missouri law and with specialized training in mental health services; or a clinical social worker licensed or master social worker licensed under Missouri law and with specialized training in mental health services; or a psychologist licensed or provisionally licensed or temporary licensed under Missouri law with specialized training in mental health services;

(J) For community support—

1. A mental health professional or an individual with a bachelor's degree in social work, psychology, nursing, or a human services field, which includes, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, and rehabilitation counseling; and supervised by a psychologist, professional counselor, clinical social worker, psychiatric nurse, or individual with an equivalent degree as defined in 9 CSR 30-4.030; or

2. At least two (2) years of higher education with (2) two years of experience in psychiatric, substance abuse treatment, or developmental disabilities, or any four- (4-) year degree with two (2) years of experience in psychiatric, substance abuse treatment, or developmental disabilities

3. Four (4) years of equivalent experience with consumers and their families receiving psychiatric, substance abuse treatment, or developmental disabilities services to move towards their personal, social, and vocational competency in order to live successfully in the community;

(K) For peer support services, a Certified Missouri Peer Specialist with at least a high school diploma or equivalent and applicable training and testing as required by the department, supervised by a qualified mental health professional as defined in 9 CSR 30-4.030;

(L) For family support, a family member of a child or youth who had or currently has a behavioral or emotional disorder; has a high school diploma or equivalent and has completed training approved by or provided by the department and supervised by qualified mental health professionals defined in 9 CSR 30-4.030;

(M) For child and adolescent family assistance, an individual with a high school diploma and two (2) years experience working with children who have a severe emotional disorder or have experienced abuse and neglect; has completed training approved by or provided by the department; and shall be supervised by a qualified mental health professional as defined in 9 CSR 30-4.030;

(N) For day treatment for youth, one (1) qualified mental health professional and one (1) appropriately certified, licensed, or credentialed ancillary staff for children ages three (3) to five (5) years of age; and one (1) qualified mental health professional and, at a minimum, two (2) appropriately certified, licensed, or credentialed ancillary staff for school-aged children. Ancillary staff shall meet at least one (1) of the following criteria:

1. Occupational therapist;
2. Physical therapist;
3. Assistant behavior analyst;
4. Individual with a bachelor's degree in child development, psychology, social work, or education;
5. Individual with an associate degree with two (2) years experience in related mental health or child-related fields; or
6. Individual with two (2) years of college and two (2) years experience in related mental health or child-related fields;

(O) For psychosocial rehabilitation (PSR) for youth, the director shall be a qualified mental health professional with two (2) years experience working with children and youth. One (1) full-time equivalent mental health professional shall be available onsite during the provision of services. The staffing ratios shall be based on the client's age. For those clients between the ages of three (3) and eleven (11), the staffing ratio shall be one (1) staff to four (4) clients. For those clients between the ages of twelve (12) and seventeen (17), the staffing ratio shall be one (1) staff to six (6) clients. Other staff of the PSR team shall be composed of the fol-

lowing providers as needed by the children:

1. A registered nurse;
2. An occupational therapist;
3. A recreational therapist;
4. A rehabilitation therapist;
5. A community support worker; or
6. A family assistance worker; and

(P) For consultation services, a physician, a psychiatric pharmacist, or advanced practice nurse, as defined in 9 CSR 30-4.030.

(3) The CPR provider shall ensure that an adequate number of appropriately qualified staff is available to support the functions of the program. The department shall prescribe caseload size and supervisory-to-staff ratios.

(A) Caseload size shall vary according to the acuity, symptom complexity, and the needs of the individuals served. However, caseload size should not exceed one (1) community support worker to thirty (30) adults in the rehabilitation level of care and one (1) community support worker to twenty (20) children and youth in the rehabilitation level of care. Should any individual receiving CPR services believe that a community support worker's caseload size is too large to attend to his or her service needs, that individual or his or her guardian has the right to request an independent review by the CPR program director sufficient to determine the adequacy of the caseload size and to implement an adjustment should one be deemed necessary.

(B) The supervisory-to-staff ratio in the rehabilitation level of care should not exceed one (1) qualified mental health professional to eight (8) total staff.

(4) The department may issue waivers and exceptions to the staffing patterns promulgated under this section as it deems necessary and appropriate.

(5) Personnel policies and procedures shall comply with all aspects of 9 CSR 10-7.110, shall apply to all staff and volunteers working in the CPR program, and shall include:

(A) Requirements for an annual written job performance evaluation for each employee and procedures which provide staff with the opportunity to review the evaluation; and

(B) Client abuse and neglect and procedures for investigating alleged violations.]

(2) **Qualified Staff.** The program director shall ensure an adequate number of qualified professionals are available to provide community psychiatric rehabilitation (CPR) services.

(A) Caseload size may vary according to the acuity, symptom complexity, and needs of individuals served. An individual being served or his or her parent/guardian has the right to request an independent review by the CPR director if they believe individual needs are not being met. If the CPR director deems it necessary, caseload size or other changes may be implemented.

(B) The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by persons served.

(C) The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

[(6)](3) The [provider] program shall have and implement a process for granting clinical privileges to practitioners to deliver CPR services.

(A) Each treatment discipline shall define clinical privileges based upon identified and accepted criteria approved by the governing body.

(B) The process shall include periodic review of each practitioner's credentials, performance, education, and the like, and the renewal or revision of clinical privileges at least every two (2) years.

(C) *[The provider shall base i]*Initial granting and renewal of clinical privileges shall be based on—

1. Well-defined written criteria for qualifications, clinical performance, and ethical practice related to the goals and objectives of the program;
2. Verified licensure, certification, or registration, if applicable;
3. Verified training and experience;
4. Recommendations from the agency's program, department service, or all of these, in which the practitioner will be or has been providing service;
5. Evidence of current competence;
6. Evidence of health status related to the practitioner's ability to discharge his/her responsibility, if indicated; and
7. A statement signed by the practitioner that *[s/he]* he/she has read and agrees to be bound by the policies and procedures established by the provider and governing body.

(D) Renewal or revision of clinical privileges *[also]* shall also be based on—

1. Relevant findings from the *[provider's]* CPR program's quality assurance activities; and
2. The practitioner's adherence to the policies and procedures established by the *[provider]* CPR program and its governing body.

(E) As part of the privileging process, the *[provider]* CPR program shall establish procedures to—

1. Afford a practitioner an opportunity to be heard, upon request, when denial, curtailment, or revocation of clinical privileges is planned;
2. Grant temporary privileges on a time-limited basis; and
3. Ensure that non-privileged staff receive close and documented supervision from privileged practitioners until training and experience are adequate to meet privilege requirements.

[(7) The CPR provider shall establish, maintain, and implement a written plan for professional growth and development of personnel.

(A) The CPR provider shall provide orientation within thirty (30) calendar days of employment, documented, for all personnel and affiliates, and shall include, but not be limited to:

1. Client rights and confidentiality policies and procedures, including prohibition and definition of abuse, neglect, and misuse of funds as defined in 9 CSR 10-5.200;
2. Client management, for example, techniques which address verbal and physical management of aggressive, intoxicated, or behaviorally-disturbed clients;
3. CPR program emergency policies and procedures;
4. Infection control;
5. Job responsibilities;
6. Philosophy, values, mission, and goals of the CPR provider; and
7. Principles of appropriate treatment, including for staff working with children and youth, principles related to children and youth populations.

(B) Staff who are transferred or promoted to a new job assignment shall receive orientation to their new job responsibilities within thirty (30) days of actual transfer.

(C) The CPR provider shall provide orientation for volunteers and trainees within thirty (30) calendar days of initial attendance or employment that includes, but is not limited to, the following:

1. Client rights and confidentiality policies and procedures, including abuse, neglect, and misuse of funds as defined in 9 CSR 10-5.200;
2. CPR program emergency policies and procedures;
3. Philosophy, values, mission, and goals of the CPR provider; and

4. Other topics relevant to their assignments.

(D) Staff working within the CPR program also shall receive additional training within six (6) months of employment. This training shall include, but is not limited to:

1. Signs and symptoms of disability-related illnesses;
2. Working with families and caretakers of clients receiving services;
3. Rights, roles, and responsibilities of clients and families;
4. Methods of teaching clients self-help, communication, and homemaking skills in a community context;
5. Writing and implementing an individual treatment plan specific to community psychiatric rehabilitation services, including goal setting, writing measurable objectives, and development of specific strategies or methodologies;
6. Basic principles of assessment;
7. Special needs and characteristics of individuals with serious mental illnesses;
8. Philosophy, values, and objectives of community psychiatric rehabilitation services for individuals with serious mental illnesses; and
9. Staff working with children and youth shall receive additional training in the above areas as it pertains to children and youth.

(8) The CPR provider shall develop and implement a written plan for comprehensive training and continuing education programs for community support workers, Certified Missouri Peer Specialists, and supervisors in addition to those set out in section (7).

(A) Orientation for community support workers, Certified Missouri Peer Specialists, and supervisors shall include, but is not limited to, the following items:

1. Philosophy, values, and objectives of community psychiatric rehabilitation services for individuals with serious and persistent mental illnesses;
2. Behavioral management, crisis intervention techniques, and identification of critical situations;
3. Communication techniques;
4. Health assessment and medication training;
5. Legal issues, including commitment procedures;
6. Recovery and wellness practices;
7. Resources including treatment alternatives, employment opportunities, health and wellness, and community resources; and
8. Staff working with children and youth shall receive additional training approved by the department in the above areas as it pertains to children and youth.

(B) The curricula for training shall include a minimum set of topics as required by the department.

(9) Each community support worker, Certified Missouri Peer Specialist, and supervisor shall complete ten (10) hours of initial training before receiving an assigned client caseload or supervisory caseload.

(10) Qualified staff providing individual and group professional psychosocial rehabilitation, shall complete training as required by the department in addition to training set out in section (7).

(11) 9 CSR 10-7.110 requires that all staff shall participate in at least thirty-six- (36-) clock hours of relevant training during a two- (2-) year period. All staff working within the CPR program and services shall receive a minimum of twelve- (12-) clock hours per year of continuing education and relevant training.

(12) All training activities shall be documented in employee personnel files, to include the training topic, name of instructor, date of activity, duration, skills targeted/objective of skill, certification/continuing education units (if any), and location.]

(4) Direct care staff and staff providing supervision to direct care staff shall complete training in the service competency areas listed below.

(A) Competent staff shall—

1. Operate from person-centered, person-driven, recovery-oriented, and stage-wise service delivery approaches that promote health and wellness;
2. Develop cultural competence that results in the ability to understand, communicate with, and effectively interact with people across cultures;
3. Deliver services according to key service functions that are evidence-based and best practices;
4. Practice in a manner that demonstrates respect and understanding of the unique needs of persons served;
5. Use effective strategies for engagement, re-engagement, relationship-building, and communication; and
6. Be knowledgeable of mandated reporting requirements for abuse and neglect of children and reporting requirements related to abuse, neglect, or financial exploitation of senior citizens and individuals who are disabled.

(B) Staff providing supervision to community support specialists must have additional training or experience in order to be knowledgeable in the supervision competency areas listed below. Competent supervisors—

1. Practice in a manner that demonstrates use of management strategies that focus on individual outcomes, care coordination, collaboration, and communication with other service providers both within and external to the organization;
2. Ensure new and existing staff are competent by providing training/supervision, guidance and feedback, field mentoring, and oversight of services to individuals served by the team;
3. Ensure processes exist for tracking and review of data such as missed appointments, hospitalization and follow-up care, crisis responsiveness and follow-up, timeliness and quality of documentation, and need for outreach and engagement; and
4. Monitor and review services, interventions, and contacts with individuals served to ensure services are implemented according to individualized treatment plans or crisis prevention plans, evaluate the effectiveness and appropriateness of services in achieving recovery/resiliency outcomes in areas such as housing, employment, education, leisure activities and family, peer and social relationships.

(C) New staff shall job shadow their supervisor and/or experienced staff in a position equivalent to their qualifications and skill level.

(D) Staff shall receive ongoing and regular clinical supervision.

(E) A written plan shall be developed indicating how competencies will be measured and ensured for all staff providing direct services and staff providing supervision including, but not limited to, some combination of the following:

1. Testing;
2. Observation/field supervision;
3. Clinical supervision/case discussion;
4. Quality review of case documentation;
5. Use of relevant findings from quality assurance activities;
6. Satisfaction with services as conveyed by individuals served and family members/natural supports;
7. Stakeholder/interagency satisfaction with services; and
8. Treatment outcomes for individuals and family members/natural supports.

(F) Demonstrated competency must be documented within the first six (6) months of employment with the CPR program.

(G) Staff shall participate in at least thirty-six (36) clock hours of relevant training during any two (2) year period. A minimum of twelve (12) clock hours of training must be completed annually.

(H) Documentation of all orientation, training, job shadowing, and supervision activities must be maintained and available for review by department staff or other authorized representatives.

(I) Documentation of training must include the topic, date(s) and length, skills targeted/objective of skill, certification/continuing education units (as applicable), location, and name, title, and credentials of instructor(s).

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo [2000, and section 630.050, RSMo Supp. 2011] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed April 29, 2019.

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.

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Title 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.035 [Client Records of a Community Psychiatric Rehabilitation Program] Eligibility Determination, Assessment, and Treatment Planning in Community Psychiatric Rehabilitation Programs. The department is amending the rule title, purpose, and section (1), deleting old sections (2)-(18), and adding new sections (2)-(15).

PURPOSE: This amendment updates terminology, adds requirements for eligibility determination, functional assessment, and crisis prevention planning, and revises the assessment, treatment planning, and documentation requirements for Community Psychiatric Rehabilitation (CPR) programs.

PURPOSE: This rule [prescribes the] specifies the eligibility determination, comprehensive assessment, functional assessment, treatment planning, [content requirements of a clinical record maintained] and documentation requirements for [by a] community psychiatric rehabilitation (CPR) programs.

(1) Each agency that is certified or deemed certified by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Abuse Use Disorder Treatment Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

[(2) The CPR provider shall implement policies and procedures

to assure routine monitoring of client records for compliance with applicable standards.

(3) At intake, each CPR provider shall compile in a format acceptable to the department, and file in the client record an evaluation which shall include:

(A) Presenting problem, request for assistance, symptoms, and functional deficits;

(B) Personal, family, educational, treatment, and community history;

(C) Reported physical and medical complaints and the need for screening for medical, psychiatric, or neurological assessment or other specialized evaluation;

(D) Findings of a brief mental status examination;

(E) Current functional strengths and weaknesses obtained through interview and behavioral observation;

(F) Specific problem indicators for individualized treatment;

(G) Existing personal support systems and current use of community resources;

(H) Diagnostic formulation;

(I) Specific recommendations for further evaluation and treatment;

(J) Consultation between a physician and the psychologist or other mental health professional(s) conducting the psychosocial/clinical evaluation addressing the client's need and the appropriateness of outpatient rehabilitation. Consultation may be performed by an advanced practice nurse if that individual is providing medication management services to the client; and

(K) The clinical record must support the level of care.

(4) The CPR provider shall develop and maintain for each client an individual treatment plan using a standardized format furnished by the department, at its discretion, which is filed in the master client record. The treatment plans shall record, at a minimum, the following as indicated:

(A) Service Data.

1. The reason(s) for admission into rehabilitation services.

2. Criteria or plans, or both for movement.

3. Criteria for discharge.

4. A list of agencies currently providing program/services; the type(s) of service; date(s) of initiation of program/services.

5. A summary statement of prioritized problems and assets; and

(B) Treatment Goals and Objectives for the Treatment Plan and Any Components.

1. Specific individualized medication, psychosocial rehabilitation, behavior management, critical intervention, community support goals and other services and interventions as prescribed by the team.

2. The treatment regimen, including specific medical and remedial services, therapies and activities that will be used to meet the treatment goals and objectives.

3. A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter.

4. The type of personnel who will furnish the services.

5. A projected schedule for completing reevaluations of the client's condition and for updating the treatment plan.

6. Resources required to implement recommended services.

7. A schedule for the periodic monitoring of the client that reflects factors which may adversely affect client functioning.

8. Level of care.

(5) A physician shall approve the treatment plan. A licensed psychologist may approve the treatment plan only in instances when the client is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications. An advanced practice nurse may approve the treatment plan if that individual is providing medication management services to the client.

(6) The CPR provider shall ensure that the client participates in the development of the treatment plan and signs the plan. Client signature is not required if signing would be detrimental to client's well-being. If the client does not sign the treatment plan, the CPR provider shall insert a progress note in the case record explaining the reason the client did not sign the treatment plan.

(7) The treatment plan, goals, and objectives shall be completed within thirty (30) days of the client's admission to services.

(8) Each client's record shall document services, activities, or sessions that involve the client.

(A) Client records shall be legible and made contemporaneously with the delivery of the service or within three (3) business days of the time the service was provided.

(B) Services shall be documented in the client record prior to submitting for payment.

(C) For psychosocial rehabilitation, the clinical record shall include:

1. A weekly note that summarizes specific services rendered, client response to the services, and pertinent information reported by family members or significant others regarding a change in the [client's condition, or an unusual/unexpected occurrence in the client's life, or both; and

2. Daily attendance records or logs that include actual attendance times, as well as activity or session attended. These program attendance records/logs must be available for audit and monitoring purposes, however integration into each clinical record is not required.

(D) For psychosocial rehabilitation illness management and recovery (PSR-IMR), the clinical record shall include:

1. A weekly note that summarizes services rendered, client response to the services, and pertinent information reported by family members or significant others regarding a change in the client's condition or an unusual/unexpected occurrence in the client's life, or both. If a provider is billing both PSR-IMR and PSR, there shall be either a single weekly summary progress note that clearly addresses both the PSR-IMR and PSR sessions and activities during the week, or two (2) separate weekly summary progress notes addressing each type of PSR provided during the week.

2. Daily attendance records or logs that include the actual attendance times, as well as description of the activity or session attended clearly identifying and distinguishing PSR-IMR as the specific type of psychosocial session and activity. These program attendance records/logs must be available for audit and monitoring purposes, however integration into each clinical record is not required.

(E) For all other community psychiatric rehabilitation program services, the client record shall include documentation of each session or episode that involves the client.

1. The specific services rendered.

2. The date and actual time the service was rendered.

3. Who rendered the service.

4. The setting in which the services were rendered.

5. The amount of time it took to deliver the services.

6. The relationship of the services to the treatment regimen described in the treatment plan.

7. Updates describing the client's response to prescribed care and treatment.

(9) In addition to documentation required under section (8) the CPR provider shall provide additional documentation for each service episode, unit, or as clinically indicated for each service provided to the client as follows:

(A) Medication Services.

1. Description of the client's presenting condition.
2. Pertinent medical and psychiatric findings.
3. Observations and conclusions.
4. Client's response to medication, including identifying and tracking over time, one (1) or more target symptoms for each medication prescribed.

5. Actions and recommendations regarding the client's ongoing medication regimen.

6. Pertinent/significant information reported by family members or significant others regarding a change in the client's condition, an unusual or unexpected occurrence in the client's life, or both;

(B) Metabolic Syndrome Screening. Completion of a form approved by the department; and a summary progress note verifying the completion of the screening and plans for ongoing monitoring of the individual based on the results of the screening. The form and progress note shall be filed in the client record and available for review and verification by the department and other authorized staff;

(C) Crisis Intervention and Resolution Services.

1. Description of the precipitating event(s)/situation, when known.
2. Description of the client's mental status.
3. Interventions initiated to resolve the client's crisis state.

4. Client response to intervention.

5. Disposition.

6. Planned follow-up by staff; and

(D) Community Support Services.

1. Phone contact reports.

2. Pertinent information reported by family members or significant others regarding a change in the client's condition, an unusual or unexpected occurrence in the client's life, or both.

(10) An evaluation team, consisting of at least, a qualified mental health professional and the client's community support worker, if appropriate, shall review the treatment plan, goals and objectives on a regular basis, as determined by department policy.

(A) The review will determine the client's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the client's continued participation in specific community psychiatric rehabilitation services.

(B) The team shall document the review in detail in the client record.

(C) The CPR provider shall make the review available as requested for state or federal review purposes.

(D) The CPR provider shall ensure the client participates in the treatment plan review.

(E) For clients in the rehabilitation level of care, treatment plans shall be reviewed at a minimum every ninety (90) calendar days and the review documented in the case record.

(11) The treatment plan shall be rewritten annually and shall comply with the guidelines set forth in 9 CSR 30-4.035(4), (5), and (6).

(12) The CPR program also shall include other information in the client record, if not otherwise addressed in the intake/annual evaluation or treatment plan, including:

(A) The client's medical history, including:

1. Medical screening or relevant results of physical examinations; and

2. Diagnosis, physical disorders, and therapeutic orders;

(B) Evidence of informed consent;

(C) Results of prior treatment; and

(D) Condition at discharge from prior treatment.

(13) Any authorized person making any entry in a client's record shall sign and date the entry, including corrections to information previously entered in the client record.

(14) CPR program staff shall conduct or arrange for periodic evaluations for each client. Clients in the rehabilitation and intensive levels of care shall have annual evaluations completed. The evaluation shall be in a format approved by the department and shall include:

(A) Presenting problem and request for assistance;

(B) Changes in personal, family, educational, treatment, and community history;

(C) Reported physical/medical complaints;

(D) Current functional weaknesses and strengths;

(E) Changes in existing personal support systems and use of community resources;

(F) Description of the client's apparent change in condition from one (1) year ago;

(G) Specific problem indicators required by the department;

(H) Update of the diagnostic formulation;

(I) Specific recommendations for further evaluation and/or treatment;

(J) Information obtained through interview and behavioral observations that will contribute to the formulation of a new treatment plan; and

(K) Consultation between a physician and/or psychologist and the mental health professional(s) conducting the psychosocial/ clinical evaluation addressing the client's need and appropriateness for continued outpatient rehabilitation.

(15) CPR program staff shall prepare and enter a discharge summary in the client's record when the client has been discharged from the CPR program. This discharge summary shall meet all requirements in 9 CSR 10-7.030(9).

(16) The CPR provider shall establish and implement a procedure that assures the inter-center transfer of referral and treatment information within five (5) working days.

(17) The CPR provider shall provide information, as requested, regarding client characteristics, services, and costs to the department in a format established by the department.

(18) Each agency that is certified shall be subject to recoupment of all or part of Department of Mental Health payments when:

(A) The client record fails to document the service paid for was actually provided;

(B) The client record fails to document the service paid for was provided by a qualified staff person, as defined in the Department of Mental Health Purchase of Service Catalog;

(C) The client record fails to document the service that was paid meets the service definition, as defined in the Department of Mental Health Purchase of Service Catalog;

(D) The client record fails to document the amount, duration, and length of service paid for by the department; and

(E) *The client record fails to document the service paid for was delivered under the direction of a current treatment plan that meets all the requirements for treatment plans set forth in 9 CSR 10-7.030 and 9 CSR 30-4.035.*

(2) **Eligibility Determination.** Eligibility determination requires confirmation of an eligible diagnosis as evidenced by a signature from a licensed diagnostician or a physician/physician extender. The licensed diagnostician or physician/physician extender is accountable for the stated diagnosis.

(A) The following mental health professionals are approved to render diagnoses:

1. Physician (includes psychiatrist, psychiatry resident, assistant physician, and physician assistant);
2. Psychologist (licensed or provisionally licensed);
3. Advanced Practice Nurse (APRN);
4. Professional Counselor (licensed or provisionally licensed);
5. Marital and Family Therapist (licensed or provisionally licensed);
6. Licensed Clinical Social Worker (LCSW); and
7. Licensed Master Social Worker (LMSW) under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker. LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis.

A. These professions are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. Individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

(B) The signature from a licensed diagnostician or physician/physician extender is required prior to delivery of CPR services. The signature can be obtained as follows:

1. A face-to-face meeting with the organization's licensed diagnostician (licensed psychologist, licensed professional counselor, LCSW) or a physician/physician extender; or
2. A face-to-face meeting with an unlicensed qualified mental health professional (QMHP) with sign-off by the organization's licensed diagnostician or a physician/physician extender; or
3. Written confirmation of an eligible diagnosis received from a physician for a psychiatric hospitalization within ninety (90) days of discharge.

(C) CPR services are billable to the department beginning on the date eligibility determination is completed.

(D) Documentation of eligibility determination must include, at a minimum:

1. Presenting problem and referral source;
2. Brief history of previous psychiatric/addiction treatment including type of admission;
3. Current medications;
4. Current mental health symptoms supporting the diagnosis;
5. Current substance use;
6. Current medical conditions;
7. Diagnoses, including mental disorders, medical conditions, and notation for psychosocial and contextual factors;
8. Identification of urgent needs including suicide risk, personal safety, and risk to others;
9. Initial treatment recommendations;
10. Initial treatment goals to meet immediate needs within the first forty-five (45) days of service; and
11. Signature and title of staff completing the eligibility determination, except when the diagnosis is established as specified in subsection (2)(B)3. of this rule.

(3) **Initial Comprehensive Assessment.** A comprehensive assess-

ment must be completed within thirty (30) days of eligibility determination.

(A) Documentation of the initial comprehensive assessment must include, at a minimum:

1. Basic information (demographics, age, language spoken);
2. Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause him/her to seek services;
3. Risk assessment (suicide, safety, risk to others);
4. Trauma history (experienced and/or witnessed abuse, neglect, violence, sexual assault);
5. Mental health treatment history;
6. Mental status;
7. Substance use treatment history and current use including alcohol, tobacco, and/or other drugs; for children/youth prenatal exposure to alcohol, tobacco, or other substances;
8. Medication information, including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications;
9. Physical health summary (health screen, current primary care, vision and dental, date of last examinations, current medical concerns, body mass index, tobacco use status, and exercise level; immunizations for children/youth and medical concerns expressed by family members that may impact the child/youth);
10. Functional assessment using an instrument approved by the department (challenges, problems in daily living, barriers);
11. Risk-taking behaviors including child/youth risk behavior(s);
12. Living situation, including where living and with whom, financial situation, guardianship, need for assistive technology, and parental/guardian custodial status for children/youth;
13. Family, including cultural identity, current and past family life experiences, family functioning/dynamics, relationships, current issues/concerns impacting children/youth;
14. Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech problems, hearing and language problems, emotional, behavioral, intellectual functioning, self-care abilities;
15. Spiritual beliefs/religious orientation;
16. Sexuality, including current sexual activity, safe sex practices, and sexual orientation;
17. Need for and availability of social, community, and natural supports/resources such as friends, pets, meaningful activities, leisure/recreational interests, self-help groups, resources from other agencies, interactions with peers including child/youth and family;
18. Legal involvement history;
19. Legal status such as guardianship, representative payee, conservatorship, probation/parole;
20. Education, including intellectual functioning, literacy level, learning impairments, attendance, achievement;
21. Employment, including current work status, work history, interest in working, and work skills;
22. Military service history;
23. Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders, psychological/social adjustment to disabilities and/or disorders;
24. Diagnosis;
25. Individual's expression of service preferences;
26. Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities, barriers; and
27. Signature of the staff person completing the assessment.

(4) **Annual Assessment.** An annual assessment must be completed for individuals engaged in CPR services.

(A) Documentation of the annual assessment must include, at a minimum:

1. Identification of sections of the clinical assessment being

updated, such as check boxes;

2. Updated narrative for each section of the previous assessment that has changed;
3. Clinical formulation (interpretive summary);
4. Diagnosis change/update;
5. Individual's expression of service preferences;
6. Assessed needs/treatment recommendations; and
7. Signature of the staff person completing the assessment, Community Support Supervisor (unless they are completing the assessment), and a licensed diagnostician or physician/physician extender.

(5) **Initial Treatment Plan.** An individual treatment plan must be developed within forty-five (45) days of completion of eligibility determination for CPR services.

(A) The treatment plan is developed collaboratively with the individual or parent/guardian and a QMHP, the individual's community support supervisor, if different from the QMHP, and a physician/physician extender.

(B) Documentation for completion of the initial treatment plan must include, at a minimum:

1. Identifying information;
2. Goals as expressed by the person served and family members/natural supports, as appropriate, that are measurable, achievable, time-specific with start date, strength/skill based and include supports/resources needed to meet goals and potential barriers to achieving goals;
3. Specific treatment objectives, including a start date, that are understandable to the individual served, sufficiently specific to assess progress, responsive to the disability or concern, and reflective of age, development, culture, and ethnicity;
4. Specific interventions including action steps, modalities, and services to be used, duration and frequency of interventions, who is responsible for the intervention, and action steps of the individual served and his/her family/natural supports;
5. Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CPR program to be addressed through referral/services with another organization;
6. Anticipated discharge and continuing recovery planning which includes, but is not limited to, criteria for service conclusion, how will the individual served and/or parent/guardian and clinician know treatment goals have been accomplished; and
7. Signature of the individual or parent/guardian, QMHP/community support supervisor.

A. Physician/physician extender signature must be obtained within ninety (90) days of completion of the eligibility determination after a face-to-face meeting, consultation, or case review. The physician/physician extender signature certifies treatment is needed and services are appropriate, as described in the treatment plan, and does not recertify the diagnosis.

B. A licensed psychologist may approve the treatment plan when the person served is not currently receiving prescribed medications and the clinical recommendations do not include a need for prescribed medications.

(C) If signing the treatment plan is determined to be detrimental to the individual's well-being and they do not sign the plan, a progress note must justify the lack of signature.

1. For persons eighteen (18) years of age and younger, the parent/guardian must sign the treatment plan. Lack of parent/guardian signature must be justified in a progress note.

2. For adults with a legal guardian, the guardian's signature must be obtained. Lack of the guardian's signature must be justified in a progress note and include two (2) reasonable attempts to obtain the signature. Reasonable attempts include home visits, phone calls, mailed letters, and faxes to the guardian.

(6) **Crisis Prevention Plan.** If a potential risk for suicide, violence, or other at-risk behavior is identified during the assessment process, or any time during the individual's engagement in services, a crisis prevention plan shall be developed with the individual as soon as possible.

(A) Documentation for completion of the crisis prevention plan shall include, at a minimum, factors that may precipitate a crisis, a hierarchical list of skills/strengths identified by the individual to regain a sense of control to return to his or her level of functioning before the crisis or emergency, and a hierarchical list of staff interventions that may be used when a critical situation occurs.

(7) **Annual Treatment Plan.** Treatment plans must be updated annually for individuals engaged in CPR services to reflect current goals, needs, and progress in treatment.

(A) The plan is updated collaboratively with the individual or parent/guardian, community support supervisor, community support specialist, and physician/physician extender.

1. A licensed psychologist may take the place of the physician/physician extender if medications are not currently prescribed and the clinical recommendations do not include a need for prescribed medications.

(B) Documentation for completion of the annual treatment plan must include, at a minimum:

1. Updates related to the annual assessment and periodic updates to the functional assessment;
2. Signature of community support supervisor;
3. Signature of community support specialist;
4. Signature of individual or parent/guardian; and
5. Signature of physician/physician extender or licensed psychologist.

(C) If obtaining the individual's signature on the annual treatment plan is determined to be detrimental to his or her well-being and he/she does not sign the plan, a progress note must justify the lack of signature.

(8) **Functional Assessment.** A department-approved functional assessment must be completed with each individual as part of the initial comprehensive assessment. The functional assessment shall be updated in accordance with department policy to assess current level of functioning, progress toward treatment objectives, and appropriateness of continued services. The treatment plan shall be revised to incorporate the results of the initial functional assessment and subsequent updates.

(A) Documentation of the initial functional assessment and regular updates shall include, at a minimum:

1. Barriers, issues, or problems conveyed by the individual, parent/guardian, family/natural supports, and/or staff indicating the need for focused services;
2. A brief explanation of any changes or progress in the daily living functional abilities in the prior ninety (90) days; and
3. A description of the changes for the treatment plan based on information obtained from the functional assessment.

(B) Documentation of the findings from the functional assessment includes any of the following:

1. A narrative section with the treatment plan that includes the functional update content requirements;
2. A narrative section on the functional assessment with the content requirements; or
3. A progress note in the individual record documenting the content requirements.

(C) Completed functional assessments must be available to department staff and other authorized representatives for review/audit purposes upon request.

(D) For individuals receiving services in a community residential program, the functional assessment must be completed a minimum of every ninety (90) days and documented in the individual

record.

(9) Discharge. When individuals are discharged from CPR services, a discharge summary must be prepared and entered in the individual record in accordance with 9 CSR 10-7.030.

(10) Data. The CPR program shall provide data to the department, upon request, regarding characteristics of individuals served, services, costs, or other information in a format specified by the department.

(11) Availability of Records. All documentation must be made available to department staff and other authorized representatives for review/audit purposes at the site where the service(s) was rendered. Documentation must be legible and made contemporaneously with the delivery of the service (at the time the service was provided or within five (5) business days of the time it was provided), and address individual specifics including, at a minimum, individualized statements that support the assessment or treatment encounter.

AUTHORITY: section 630.655, RSMo [2000] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.038 Client Rights of Individuals Served for Community Psychiatric Rehabilitation Programs. This rule described client rights and confidentiality requirements for community psychiatric rehabilitation programs.

PURPOSE: The department is rescinding this rule in its entirety because individual rights will be included in *Core Rules for Psychiatric and Substance Use Disorder Treatment Programs*, 9 CSR 10-7.020.

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.039 Service Provision. This rule described the requirements for the provision of community psychiatric rehabilitation services.

PURPOSE: This department is rescinding this rule in its entirety because the requirements of the rule are being moved to 9 CSR 30-4.005 and 9 CSR 30-4.043.

AUTHORITY: sections 630.655 and 632.050, RSMo 2000, and section 630.050, RSMo Supp. 2011. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the *Code of State Regulations*. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.040 Quality Assurance. This rule included the requirements for performance improvement activities and functions for community psychiatric rehabilitation programs.

PURPOSE: The department is rescinding this rule in its entirety because performance improvement requirements will be included in *Core Rules for Psychiatric and Substance Use Disorder Treatment Programs*, 9 CSR 10-7.040.

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994,

effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED AMENDMENT

9 CSR 30-4.[042]005 [Admission Criteria] Eligibility Criteria and Admission Criteria for Community Psychiatric Rehabilitation Programs. The department is renumbering the rule, amending the rule title and purpose, adding new sections (1)-(15), and deleting old sections (1)-(5).

PURPOSE: This amendment updates terminology, revises criteria for priority populations for admission to a community psychiatric rehabilitation (CPR) program, and incorporates eligibility requirements from 9 CSR 30-4.039 Service Provision, which is being rescinded.

PURPOSE: This rule establishes criteria and procedures for admission of eligible individuals to a community psychiatric rehabilitation (CPR) program.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

[(1) Prior to admitting any individual, community psychiatric rehabilitation (CPR) providers that have been awarded provisional certification may be required to submit documentation for clinical review.

(A) The clinical review unit, within seven (7) working days, either shall—

1. Determine that the individual is eligible for admission and authorize the appropriate services;
2. Suspend eligibility determination and prior authorization of services pending the receipt of requested additional information; or
3. Determine that the individual is not eligible for admission.

(B) No provisionally-certified CPR provider shall admit any individual before approval is given by the clinical review unit.

(2) Prior to admitting or reauthorizing any individual for CPR

services, all certified CPR providers and affiliates shall submit to the appropriate administrative agent or designee, the name of the person seeking services with basic demographic information, background, and historical information, if available and shall provide support to the person by arranging an appointment for an evaluation. The administrative agent or designee shall conduct an evaluation to determine that the individual is eligible for admission to the CPR provider and to determine whether the individual is among the priority populations of the division as specified in 9 CSR 30-4.039(1)(A) and further defined in the Administrative Agent's Service Area Agreements and Plans available from the Division of Comprehensive Psychiatric Services.

(A) The administrative agent or designee within thirty (30) working days, shall—

1. Conduct a complete intake or annual evaluation as set out in 9 CSR 30-4.035(7) and (18);

2. For persons seeking admission to the CPR services, provide or authorize emergency services and crisis intervention during the period prior to completion of the intake evaluation; and

3. Forward to the referring agency and the client—

A. Confirmation that the individual is eligible to be admitted to the CPR program, and determine that the individual is among the priority populations of the division;

B. A determination that the individual is not eligible for admission to the CPR program and a statement of the client's rights of appeal; or

C. Confirmation that the individual is eligible to be admitted to the CPR program, but has been determined not to be among the priority populations of the division and, therefore, is eligible for admission only after eligible priority clients have been admitted to the CPR program. A statement of the client's right of appeal with regard to any finding that the individual is not in the priority population shall also be provided.

(B) If the administrative agent or designee confirms that the individual is eligible to be admitted to the CPR program and determines that the individual is among the priority populations of the division, then the individual shall be given an opportunity to select a CPR provider from among the CPR programs available in the service area. All eligible priority clients shall be provided the list of providers as set out in Appendix A.

1. The CPR provider selected by the individual shall work with the individual to develop the individual treatment/rehabilitation plan.

2. If an individual does not express a CPR provider preference, then the individual will be admitted to the administrative agent's, or the designee's, program.

(C) If the administrative agent or designee determines that the individual is not eligible to be admitted to the CPR program, then the individual shall be referred to other programs and services for which s/he may be eligible. The referral to other programs and services shall accompany the notice of appeal rights furnished the client as set out in 9 CSR 30-4.042(2)(A)3.C.

(D) If the administrative agent or designee confirms that the individual is eligible to be admitted to the CPR program, but determines that the individual is not among the priority populations of the division, the administrative agent or designee may provide services as appropriate.

(E) An individual denied services because of the intake process shall have the right to appeal the decision to deny services to the division director or his/her designee. This appeal shall be sent in written form to the division director within sixty (60) days following notice of denial by the administrative agent.

(3) The CPR provider shall not admit any person who would not benefit from the services of a CPR provider.

(4) The criteria for admission to community psychiatric rehabilitation program services shall include:

(A) Disability. There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally-appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning, as indicated by intake evaluation and assessment:

1. Social role functioning/family life—the ability to sustain functionally the role of worker, student, homemaker, family member, or a combination of these; and

2. Daily living skills/self-care skills—the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling individual finances, using community resources, performing household chores), learning ability/self-direction, and activities appropriate to the individual's age, developmental level, and social role functioning;

(B) Diagnosis. A physician or licensed psychologist shall certify a primary Diagnostic and Statistical Manual (DSM) diagnosis as defined in 9 CSR 10-7.140(2)(OO) or International Classification of Diseases, Ninth Revision with Clinical Modification (ICD-9-CM), using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses in Axis I or other areas.

1. Schizophrenia.

A. Disorganized.

(I) DSM IV code: 295.1X

(II) ICD-9-CM code: 295.1X

B. Catatonic.

(I) DSM IV code: 295.2X

(II) ICD-9-CM code: 295.2X

C. Paranoid.

(I) DSM IV code: 295.3X

(II) ICD-9-CM code: 295.3X

D. Schizophreniform.

(I) DSM IV code: 295.4X

(II) ICD-9-CM code: 295.4X

E. Residual.

(I) DSM IV code: 295.6X

(II) ICD-9-CM code: 295.6X

F. Schizoaffective.

(I) DSM IV code: 295.7X

(II) ICD-9-CM code: 295.7X

G. Undifferentiated.

(I) DSM IV code: 295.9X

(II) ICD-9-CM code: 295.9X

2. Delusional disorder.

A. DSM IV code: 297.1X

B. ICD-9-CM code: 297.1X

3. Bipolar I disorders.

A. Single manic episode.

(I) DSM IV code: 296.0X

(II) ICD-9-CM code: 296.0X

B. Most recent episode manic.

(I) DSM IV code: 296.4X

(II) ICD-9-CM code: 296.4X

C. Most recent episode depressed.

(I) DSM IV code: 296.5X

(II) ICD-9-CM code: 296.5X

D. Most recent episode mixed.

(I) DSM IV code: 296.6X

(II) ICD-9-CM code: 296.6X

4. Bipolar II disorders.

A. DSM IV code: 296.89

B. ICD-9-CM code: 296.89

5. Psychotic disorders NOS.

A. DSM IV code: 298.9

B. ICD-9-CM code: 298.9

6. Major depressive disorder-recurr.

A. DSM IV code: 296.3X

B. ICD-9-CM code: 296.3X

7. Obsessive-Compulsive Disorder.

A. DSM IV code: 300.30

B. ICD-9-CM code: 300.3

8. Post Traumatic Stress Disorder.

A. DSM IV code: 309.81

B. ICD-9-CM code: 309.81

9. Borderline Personality Disorder.

A. DSM IV code: 301.83

B. ICD-9-CM code: 301.83

10. Anxiety Disorders.

A. Generalized Anxiety Disorder.

(I) DSM IV code: 300.02

(II) ICD-9-CM code: 300.02

B. Panic Disorder with Agoraphobia.

(I) DSM IV code: 300.21

(II) ICD-9-CM code: 300.21

C. Panic Disorder without Agoraphobia.

(I) DSM IV code: 300.01

(II) ICD-9-CM code: 300.01

D. Agoraphobia without Panic Disorder.

(I) DSM IV code: 300.22

(II) ICD-9-CM code: 300.22

E. Social Phobia.

(I) DSM IV code: 300.23

(II) ICD-9-CM code: 300.23

11. For children and youth only.

A. Major depressive disorder, single episode.

(I) DSM IV code: 296.2X

(II) ICD-9-CM code: 296.2

B. Bipolar disorder, not otherwise specified.

(I) DSM IV code: 296.80

(II) ICD-9-CM code: 296.7

C. Reactive attachment disorder of infancy or early childhood.

(I) DSM IV code: 313.89

(II) ICD-9-CM code: 313.89

12. For adults aged sixty (60) years and over.

A. Major depressive disorder, single episode.

(I) DSM IV code: 296.2X

(II) ICD-9-CM code: 296.2

(C) Duration. Rehabilitation services shall be provided to those individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following occurrences:

1. Persons who have undergone psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);

2. Persons who have experienced an episode of continuous residential care other than hospitalization, for a period long enough to disrupt the normal living situation;

3. Persons who have exhibited the psychiatric disability for one (1) year or more; or

4. Persons whose treatment of psychiatric disorders has been or will be required for longer than six (6) months;

(D) A functional assessment may be used to establish eligibility and the need for and amount of services, including results from a standardized assessment prescribed by the department; and

(E) Whenever discrepancies occur regarding the appropriateness of an ICD-9-CM versus a DSM diagnosis, the DSM

diagnosis shall prevail.

(5) Under the following circumstances, children and adolescents under the age of eighteen (18) years of age may be provisionally admitted to community psychiatric rehabilitation program services:

(A) *Disability:* There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by intake evaluation and assessment:

1. *Social role functioning/family life*—the individual is at risk of out-of-home or out-of-school placement; and

2. *Daily living skills/self-care skills*—the individual is unable to engage in personal care (such as grooming, personal hygiene) and community living (performing school work or household chores), learning, self-direction, or activities appropriate to the individual's age, developmental level, and social role functioning;

(B) *Diagnosis:* If a person is exhibiting behaviors or symptoms that are consistent with an unestablished CPRP eligible diagnosis, they may be provisionally admitted to CPRP for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR eligible diagnosis is appropriate without an opportunity to observe and evaluate the person's behavior, mood, and functional status. In such cases, there must be documentation that clearly supports the individual's level of functioning as defined in subsection (5)(A);

(C) *Duration:* There must be documented evidence of an individual's functional disability as defined in subsection (5)(A) for a period of ninety (90) days prior to provisional admission;

(D) *Provisional admissions shall not exceed ninety (90) days.* Immediately upon completion of the ninety (90) days or sooner, if the individual has been determined to have an eligible diagnosis as listed in 9 CSR 30-4.042(4)(B) of the rule, the diagnosis must be documented and the individual may continue in the CPR program;

(E) *If an individual who has been provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging appropriate follow-up services. Follow-up services shall be documented in the discharge summary of the clinical record; and*

(F) *All admission documentation is required for those provisionally admitted, with the exception of the comprehensive evaluation, which may be deferred for ninety (90) days.]*

(1) The department designates the minimum geographic boundaries for CPR service areas throughout the state. Exceptions to the designated service areas may be granted by the department.

(A) The CPR program shall operate within its designated service area and provide services to eligible individuals to the extent adequate program capacity allows.

(B) Policies and procedures shall ensure eligible individuals have access to CPR services throughout the twelve (12) months of the year and to other services/resources beyond the scope of the program.

(C) Community support services shall be available to meet individual needs, which may include evenings and weekends.

(D) Community support and crisis intervention services shall be available to eligible individuals in their home and other locations apart from the CPR offices/facilities.

(E) Policies and procedures shall ensure eligible individuals are not required to visit a pre-selected site to receive needed services, other than medication, physician consultation, and psychosocial rehabilitation (PSR). Individuals shall have a choice in the loca-

tion where they receive CPR services, to the extent program capacity and the treatment plan allows.

(2) The CPR program shall have written policies and procedures defining its service delivery process, including screening, eligibility determination, admission, assessment, treatment and recovery planning, and discharge for individuals served.

(A) Policies and procedures shall ensure admission to services within ten (10) business days of the date of eligibility determination for individuals with serious mental illness or serious emotional disturbance.

(B) Individuals shall not be denied admission to a CPR program based on eligibility for Medicaid benefits or other sources of reimbursement for services.

(3) Policies and procedures shall ensure all CPR services are provided under the direction of a physician/physician extender and are medically necessary and reasonable for the treatment of the individual's mental illness or disorder.

(A) Emergency and crisis intervention services shall be provided prior to completion of the initial comprehensive assessment for individuals determined to need immediate assistance.

(B) A physician/physician extender must be available for emergency and crisis intervention services twenty-four (24) hours per day, seven (7) days per week.

(4) The CPR program shall implement written policies and procedures to ensure eligible individuals are admitted to treatment within ten (10) days of the date of eligibility determination.

(A) CPR services shall be prioritized for individuals who—

1. Have been discharged from inpatient psychiatric hospitalization programs within the last ninety (90) days;

2. Are residents of supervised or semi-independent apartments, psychiatric group homes, or community residential programs;

3. Have been committed by court order under provisions of section 632.385, RSMo;

4. Have been conditionally released under section 552.040, RSMo;

5. Are homeless or considered homeless in accordance with the following criteria:

A. Persons who are sleeping in places not meant for human habitation such as cars, parks, sidewalks, and abandoned buildings;

B. Persons who are sleeping in emergency shelters or doubled up (unable to maintain their housing situation and forced to stay with a series of friends and/or extended family members, paying no rent, and uncertain as to how long they will be able to stay);

C. Persons who are from transitional or supportive housing for homeless persons who originally came from streets or emergency shelters;

D. Persons who are being evicted within the week from a private dwelling unit, no subsequent residence has been identified, and they lack the resources and support networks needed to obtain access to housing;

E. Persons who are being discharged within the week from facilities in which they have been a resident for more than ninety (90) consecutive days, no subsequent residence has been identified, and they lack the resources and support networks needed to obtain access to housing; and

F. Persons who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.

6. Are having a current episode of acute crisis or being referred from the crisis system;

7. Have used a hospital emergency room related to a psychiatric illness two (2) or more times during the prior year;

8. Have attempted suicide;
9. Are high utilizers of Medicaid services with co-occurring behavioral health and other chronic health conditions; and
10. Children and adolescents at risk of disruption from a preferred living environment due to symptoms of a serious emotional disturbance.

(5) The CPR program may refuse admission when an individual poses an imminent threat of harm to self or others, or the program is operating at full capacity (a level previously determined by organizational leadership). The program shall implement policies and procedures to monitor capacity.

(6) Eligibility criteria for admission to a CPR program shall include:

(A) Disability—there is clear evidence of serious and/or substantial impairment in the individual's ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by the intake evaluation and assessment:

1. Social role functioning/family life—the ability to sustain functionally the role of a worker, student, homemaker, family member, or a combination of these; and

2. Daily living skills/self-care skills—the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling individual finances, using community resources, performing household chores), learning ability/self-direction and activities appropriate to the individual's age, developmental level, and social role functioning.

(B) Diagnosis—a licensed diagnostician certifies a primary diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)* published by and available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901 or the *International Classification of Diseases Tenth Revision (ICD-10)* published by and available from the World Health Organization, 525 23rd Street N.W., Washington, DC 20037. The diagnosis may coexist with other psychiatric diagnoses. Specific diagnoses for eligibility can be found in the *MO HealthNet CPR Provider Manual* published by and available from the Missouri Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500. The documents incorporated by reference do not include any later revisions or updates.

(C) Duration—rehabilitation services shall be provided for individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following:

1. Received psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);

2. Experienced an occurrence of continuous residential care, other than hospitalization, for a period long enough to disrupt the normal living situation;

3. Exhibited the psychiatric disability for one (1) year or more; or

4. Treatment of the psychiatric disorder has been or will be required for longer than six (6) months.

(D) For adults and children age six (6) and above a functional assessment may be used to establish eligibility for CPR services, including results from a standardized assessment prescribed by the department.

(E) Individuals currently enrolled in a CPR program for youth are automatically eligible for admission to an adult CPR program when the transfer is determined to be clinically appropriate and documented in the record.

(7) Children and youth under the age of eighteen (18) may be provisionally admitted to a CPR program based on the following:

(A) Disability—there is clear evidence of serious and/or substantial impairment in the child's ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by intake evaluation and assessment:

1. Social role functioning/family life—the child is at risk of out-of-home or out-of-school placement; and

2. Daily living skills/self-care skills—the child is unable to engage in personal care, such as grooming and personal hygiene, and in community living such as performing school work or household chores, learning, self-direction or activities appropriate to the individual's age, developmental level, and social role functioning.

(B) Diagnosis—if a child is exhibiting behaviors or symptoms consistent with a non-established CPR eligible diagnosis, he/she may be provisionally admitted for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR diagnosis is appropriate without an opportunity to observe and evaluate the child's behavior, mood, and functional status. In such cases documentation must clearly support the individual's level of functioning based on disability as defined in subsection (A) of this section.

(C) Duration—there must be documented evidence of the child's functional disability as defined in subsection (A) of this section for a period of ninety (90) days prior to provisional admission.

(D) Provisional admission shall not exceed ninety (90) days. Immediately upon completion of the ninety (90) days, or sooner if the individual has been determined to have an eligible diagnosis as indicated in subsection (A) of this section, the diagnosis must be documented and he/she may continue to receive services in the program.

(E) If a child who was provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging follow-up services needed. Arrangements for follow-up services must be documented in the discharge summary.

(F) All admission documentation is required for those provisionally admitted with the exception of the comprehensive assessment which may be deferred for ninety (90) days.

(8) The CPR program shall ensure individuals receive the most appropriate care and treatment available. Transferring an individual to another service, from a community program to a hospital, hospital to a community program, or to another CPR program consistent with individual needs, may be considered to obtain necessary care and treatment.

(A) Written procedures shall ensure exchange of information within five (5) days when an individual is referred or transferred to another service component within the organization or to an outside provider for services. Policies and procedures must ensure—

1. Applicable records, portions of records, and other information are readily transferable and handled in compliance with state and federal confidentiality regulations; and

2. Timely follow-up is made with the alternate CPR program or service provider.

(B) Policies and procedures stipulate the conditions under which referrals are made, such as the need for special services not provided by the current CPR program or the need for ancillary services which will contribute to the well-being of the individual.

(C) Policies and procedures shall assure continuity of care among referring providers including prior inpatient hospitalization, residential support, and outpatient psychiatric and/or substance use disorder treatment.

(D) A current resource directory of area community service agencies must be readily available to individuals and family members/natural supports for referral purposes and upon request by

the public.

(9) The CPR program shall coordinate with providers of inpatient psychiatric care to assure continuity of services for eligible individuals returning to the community. This includes active participation of community support staff in discharge planning for the individual.

(A) Policies and procedures shall ensure individuals engaged in CPR have a documented face-to-face visit with a community support specialist within five (5) days of discharge from inpatient psychiatric care, including active follow-up within five (5) days for individuals who fail to keep their appointment.

(10) The CPR program shall implement written policies and procedures to ensure individuals who miss a scheduled appointment for services or whose absence is unanticipated are contacted by a community support specialist or other staff person providing their services/supports. The procedures shall establish time frames for contacting individuals, consistent with clinical needs and the seriousness of their disability, not to exceed forty-eight (48) hours.

(11) The CPR program shall provide equal opportunity to individuals with disabilities in accordance with the Americans with Disabilities Act.

(12) The program shall have policies and procedures to ensure individuals determined ineligible for CPR services are referred to other programs and services in the community for which they may be eligible.

(13) The CPR program shall only admit individuals who will benefit from services available. Individuals who have not received services for a six- (6-) month period should be discharged from the program.

(14) The CPR program shall participate in coordination and liaison activities with the adult and juvenile justice systems to—

(A) Promote effective relationships with local law enforcement systems (including courts) through training, education, and consultation;

(B) Educate law enforcement and court officials, juvenile officers, and probation/parole personnel about services offered by the CPR program; and

(C) Provide CPR services, as capacity allows, to persons with serious mental illness who are on probation/parole or in forensic aftercare by working with probation/parole and juvenile officers and department forensic case monitors within the limits of confidentiality.

(15) The CPR program shall participate in coordination and liaison activities with federal, state, and local public assistance agencies, housing agencies, and employment/vocational support agencies to—

(A) Promote effective relationships through training, education, and consultation;

(B) Educate staff about services offered by the CPR provider; and

(C) Assist individuals in seeking public benefits to expedite the application process and maintain/regain their eligibility for assistance within the limits of confidentiality.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo [2000, and section 630.050, RSMo Supp. 2011] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.043 [Treatment Provided by Community Psychiatric Rehabilitation Programs] Service Provision, Staff Qualifications, and Documentation Requirements for Community Psychiatric Rehabilitation Programs. The department is amending the rule title and purpose, adding new sections (1)-(3), and deleting old sections (1)-(2).

PURPOSE: This amendment incorporates all community psychiatric rehabilitation (CPR) service descriptions, documentation requirements, and staff qualifications into one chapter. These requirements were previously included in two separate chapters, 9 CSR 30-4.034 which is being amended to include general staffing requirements, and 9 CSR 30-4.039 which is being rescinded.

PURPOSE: [This rule sets policies and procedure requirements relating to psychiatric treatment services provided by community psychiatric rehabilitation programs.] This rule specifies the core and optional psychiatric treatment services, staffing requirements, and documentation requirements for community psychiatric rehabilitation (CPR) programs.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

[(1) The community psychiatric rehabilitation (CPR) provider shall establish and implement written policies and procedures regarding the evaluation of the medical need of clients in consultation with a physician.

(A) The evaluation team shall determine a person's need for a physical examination.

1. The procedure shall include health questions, date of last physical examination, awareness of any medical problems, and current medications prescribed and taken.

2. The CPR provider shall file results of the physical examination in the person's clinical record.

(2) The CPR provider shall provide the following community psychiatric rehabilitation services to eligible clients, as

prescribed by individualized treatment plans:

(A) Crisis intervention and resolution, face-to-face emergency or telephone intervention services, available twenty-four (24) hours a day on an unscheduled basis to the client, designed to resolve crisis, provide support and assistance, and to promote a return to routine adaptive functioning. Key service functions shall include, at a minimum, but are not limited to:

1. Interacting with an identified client, family members, legal guardian, significant others, or a combination of these;
2. Specifying factors that led to the client's crisis state, when known;
3. Identifying the maladaptive reactions exhibited by the client;
4. Evaluating the potential for rapid regression;
5. Attempting to resolve the crisis; and
6. When indicated, referring the client for treatment in an alternative setting. Nonmedical staff providing crisis intervention and resolution shall have immediate twenty-four (24-) hour telephone access to physician consultation;

(B) Medication services, goal-oriented interaction regarding the need for psychoactive medications and the management of a medication regimen. Advanced practice nurses and psychiatric pharmacists may provide this service, subject to the guidelines and limitations promulgated for each specialty in statutes and administrative rules. Psychiatric pharmacists are allowed to provide all key service functions with the exception of prescribing medications under paragraph (2)(B)7. Key service functions shall include, but are not limited to:

1. An assessment of the client's presenting condition;
2. A mental status exam;
3. A review of symptoms and medication side effects;
4. A review of client functioning;
5. An assessment of the client's ability to self-administer medication;
6. Client education regarding the effects of medication and its relationship to the client's mental illness; and
7. When indicated, the prescription of medications;

(C) Consultation services, a service provided by a physician, an advanced practice nurse, or a psychiatric pharmacist and consisting of a review of a client's current medical situation either through consultation with one (1) staff person or in team discussions related to the specific client. The intent is to provide direction to treatment. This is an optional service which may not substitute for supervision nor for face-to-face intervention with clients;

(D) Medication Administration. Key service functions include: any therapeutic injection of medication (subcutaneous or intramuscular); monitoring lab levels including consultation with physicians, consumers, and caseworkers; coordination of medication needs with pharmacies, clients, and families, including the use of indigent drug programs (excluding the routine placing of prescription orders and refills with pharmacies); setting up medication boxes; medication drops to consumer residences; patient education regarding medications; recording initial patient histories and vital signs; monitoring medication compliance; monitoring medication side-effects including the use of standardized evaluations; and monitoring physician orders for treatment modifications requiring patient education;

(E) Metabolic Syndrome Screening. Clients who are receiving antipsychotic medications shall be screened annually for the following risk factors: obesity, hypertension, hyperlipidemia, and diabetes.

1. Services shall be provided by a registered nurse or a licensed practical nurse. Key service functions include:

- A. Taking and recording of vital signs;

B. Conducting lab tests to assess lipid levels and blood glucose levels and/or HgbA1c;

C. Arranging for and coordinating lab tests to assess lipid levels and blood glucose levels and or HgbA1c;

D. Obtaining results of lab tests to assess lipid levels and blood glucose levels and/or HgbA1c; and

E. Recording the results of all required vital signs and lab tests on a form approved by the department.

2. If the lab tests are conducted by a registered nurse or a licensed practical nurse onsite, the provider shall use the Cholestech LDX analyzer or other machine approved by the department. Recently completed lipid panel and blood glucose levels and/or HgbA1c from other health care providers may be obtained. When a client is being regularly followed by a health care provider, the results of the most recently completed lipid panel and blood glucose levels and/or HgbA1c may be obtained and used to complete the metabolic syndrome screening process. Metabolic syndrome screening shall be limited to no more than one (1) time every ninety (90) days per individual;

(F) Community support, activities designed to ease an individual's immediate and continued adjustment to community living by coordinating delivery of mental health services with services provided by other practitioners and agencies, monitoring client progress in organized treatment programs, among other strategies. Key service functions include, but are not limited to:

1. Assessing and monitoring a client's adjustment to community living;
2. Monitoring client participation and progress in organized treatment programs to assure the planned provision of service according to the client's individual treatment plan;
3. Participating in the development or revision of a specific individualized treatment plan;
4. Providing individual assistance to clients in accessing needed mental health services including accompanying clients to appointments to address medical or other health needs;
5. Providing individual assistance to clients in accessing a variety of public services including financial and medical assistance and housing, including assistance on an emergency basis, and directly helping to meet needs for food, shelter, and clothing;
6. Assisting the client to access and utilize a variety of community agencies and resources to provide ongoing social, educational, vocational and recreational supports and activities;
7. Interceding on behalf of individual clients within the community-at-large to assist the client in achieving and maintaining their community adjustment;
8. Maintaining contact with clients who are hospitalized and participating in and facilitating discharge planning;
9. Training, coaching, and supporting in daily living skills, including housekeeping, cooking, personal grooming, accessing transportation, keeping a budget, paying bills, and maintaining an independent residence;
10. Assisting in creating personal support systems that include work with family members, legal guardians, or significant others regarding the needs and abilities of an identified client;
11. Encouraging and promoting recovery efforts, consumer independence/self-care, and responsibility; and
12. Providing support to families in areas such as treatment planning, dissemination of information, linking to services, and parent guidance;

(G) Certified Missouri Peer Specialists, as defined in 9 CSR

30-4.030 and 9 CSR 30-4.034, may provide the following peer support services:

1. Assisting an individual to recover by—
 - A. Helping an individual recognize what he or she thinks would improve the quality of his or her life such as setting a recovery goal; and
 - B. Helping an individual identify and remove the barriers to achieving that life;
2. Certified Missouri Peer Specialists use the power of peers to support, encourage, and model recovery and resilience from mental illness in ways that are specific to the needs of each individual including the following:
 - A. Peer support services are individual or group services with a rehabilitation and recovery focus;
 - B. Peer support services promote skills for coping with and managing psychiatric symptoms while encouraging the use of natural supports and enhancing community living;
 - C. Peer support activities assist in achieving goals and objectives set forth by the individual in their individualized treatment or recovery plan; and
 - D. Peer support activities emphasize the opportunity for individuals to support each other as they move forward in their recovery;
3. Certified Missouri Peer Specialists interventions may include, but are not limited to, the following:
 - A. Sharing lived experiences of recovery and sharing and supporting the use of recovery tools and modeling successful recovery behaviors;
 - B. Helping individuals recognize their capacity for resilience;
 - C. Helping individuals connect with other consumers and their communities at large;
 - D. Helping individuals who have mental illness develop a network for information and support;
 - E. Assisting individuals who have mental illness to make independent choices and to take a proactive role in their treatment;
 - F. Assisting individuals with identifying strengths and personal resources to aid in their recovery; and
 - G. Helping individuals set and achieve recovery goals;
4. The job description for a Certified Missouri Peer Specialist shall include supportive activities including, but not limited to, the following:
 - A. Starting and sustaining mutual support groups;
 - B. Promoting dialogues on recovery and resilience;
 - C. Teaching and modeling symptom management skills;
 - D. Teaching and modeling problem-solving skills;
 - E. Supporting efforts to find and maintain paid employment;
 - F. Using the stages in recovery concept to promote self-determination; and
 - G. Assisting peers in setting goals and following through on wellness and health activities;
5. Certified Missouri Peer Specialists shall follow a code of ethics determined by the department;
 - (H) Family Support. Services designed to provide a support system for parents of children up to age twenty-one (21) with serious emotional disorders. Activities are directed and authorized by the child's individualized treatment plan. Key service functions include, but are not limited to the following:
 1. Determining level of understanding of the child's diagnosis and special needs;
 2. Engaging the parents or guardians to actively participate in the child and family team meetings by helping them predetermine their roles and the roles of natural supports;
 3. Assisting the parents or guardians in identifying their

natural supports or surrogate supports;

4. Helping the parents or guardians identify the child's strengths and strengths of the family;
5. Supporting the parents or guardians at child and family team meetings and modeling good advocacy skills;
6. Assisting in trouble shooting and problem solving with strategies that are not working;
7. Connecting families to community resources; and
8. Helping the parents or guardians find and empower their own voice to become part of the system of care for their child;
 - (I) Child and Adolescent Family Assistance. Services designed to focus on the child or adolescent and the development of home and community living skills, communication, socialization, and identifying and arranging for appropriate community services. Key service functions include, but are not limited to, the following:
 1. Modeling appropriate behaviors and coping skills for the child;
 2. Exposing the child to activities that encourage positive choices, promote self-esteem, support academic achievement, and develop problem solving skills regarding home and school;
 3. Teaching appropriate social skills through hands on experiences; and
 4. Mentoring appropriate social interactions with the child or adolescent or resolving conflict with peers;
 - (J) Day Treatment for Youth. An intensive array of services provided in a structured, supervised environment designed to reduce symptoms of a psychiatric disorder and maximize functioning. Services are individualized based on the child's needs and include a multidisciplinary approach of care under the direction of a physician. The provision of educational services shall be in compliance with Individuals with Disabilities Education Act 2004 and section 167.126, RSMo. Services shall be provided in the following manner:
 1. Hours of operation shall be determined by the individual providers based on capacity, staffing availability, and space requirements. The child shall be in attendance for a minimum of three (3) hours per day, four (4) days per week, and no more than seven (7) hours per day;
 2. Eligibility criteria shall include the following:
 - A. For children six (6) years of age and older, the client must be at risk of inpatient or residential placement as a result of their serious emotional disturbance; and
 - B. For children five (5) years of age or younger, the child must have one (1) or more of the following:
 - (I) Has been expelled from multiple day care/early learning programs due to emotional or behavioral dysregulation in relation to serious emotional disturbance or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Zero to Three, Revised (DC03R) diagnosis and previous services provided in an early childhood program were unsuccessful;
 - (II) At risk for an acute psychiatric hospital or residential treatment center placement as a result of their serious emotional disturbance; and/or
 - (III) Score in the seriously impaired functioning level on the standardized functional tools approved by DMH for this age range; and
 3. Key service functions include, but are not limited to the following:
 - A. Providing integrated treatment combining education, counseling, and family interventions;
 - B. Promoting active involvement of parents or guardians in the program;

C. Providing consultation and coordination to establish and maintain continuity of care with the child's/family's private service providers;

D. Coordinating and information sharing, consistent with Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act, and discharge planning with the school;

E. Requesting screening and assessment reports for special education from the school;

F. Planning with the school how the individualized education needs of each child will be addressed; and

G. Additional core services as prescribed by the department;

(K) *Psychosocial Rehabilitation for Youth.* A combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the youth's ability to function as independently as possible within the family or community. Services shall be provided according to the individual treatment plan with an emphasis on community integration, independence, and resiliency;

(L) *Intensive Community Psychiatric Rehabilitation (CPR)* as defined in 9 CSR 30-4.045;

(M) *Psychosocial Rehabilitation.* Key service functions include, but are not limited to, the following services which must be available within the community psychiatric rehabilitation program as indicated by individual client need:

1. Initial screening to evaluate the appropriateness of the client's participation in the program;

2. Development of individualized program goals and objectives;

3. The provision of rehabilitative services which may occur during the day, evenings, weekends, or a combination of these. Services should be structured, but are not limited to a program site;

4. Services that enhance independent living skills;

5. Services that address basic self-care needs;

6. Services that enhance the use of personal support systems;

7. Transportation to and from community facilities and resources as a part of program strategies;

8. Services shall be provided according to individual need toward goals of community inclusion, integration, and independence; and

9. Services should be available to adults as well as children and youth who need age-appropriate developmental focused rehabilitation;

(N) *Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR).* A Psychosocial Rehabilitation program may offer department-approved psychosocial services provided individually or in a small group setting with a focus on recovery and the management of mental illness. Key service functions include, but are not limited to, the following services:

1. Psychoeducation;

2. Relapse prevention; and

3. Coping skills training;

(O) *Individualized Professional Psychosocial Rehabilitation.* Individualized mental health interventions may be offered using a skills based approach to address identified behavioral problems and functional deficits relating to a mental disorder that interferes with an individual's personal, family, or community adjustment. Services must be documented according to the requirements set forth in 9 CSR 30-4.035(8)(E); and

(P) *Group Professional Psychosocial Rehabilitation.* Group mental health interventions may be offered using a skills-based approach to address identified behavioral problems and functional deficits relating to a mental disorder that interferes with an individual's personal, family, or communi-

ty adjustment. Maximum group size is one (1) professional to eight (8) individuals. Services must be documented according to the requirements set forth in 9 CSR 30-4.035(8)(E).]

(1) CPR programs shall comply with requirements set forth in department Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

(A) Service delivery and documentation requirements specific to the CPR program are included in this rule.

(2) Core Services. At a minimum, CPR programs shall directly provide the following core services, or ensure the services are available through a subcontract as specified in 9 CSR 10-7.090(6):

(A) Eligibility determination, in accordance with 9 CSR 30-4.005;

(B) Initial comprehensive assessment, in accordance with 9 CSR 30-4.035;

(C) Annual assessment, in accordance with 9 CSR 30-4.035;

(D) Treatment planning, in accordance with 9 CSR 30-4.035;

(E) Community support, in accordance with 9 CSR 30-4.047;

(F) Crisis Intervention and Resolution—face-to-face emergency or telephone intervention available twenty-four (24) hours a day, on an unscheduled basis, to assist individuals in resolving a crisis and providing support and assistance to promote a return to routine, adaptive functioning. Services must be provided by a qualified mental health professional (QMHP). Nonmedical staff providing crisis intervention and resolution must have immediate, twenty-four (24) hour telephone access to consultation with a physician/physician extender.

1. Minimum service functions shall include, but are not limited to—

A. Interacting with the identified individual and his or her family members/natural supports, legal guardian, or a combination of these;

B. Specifying factors that led to the individual's crisis state, when known;

C. Identifying maladaptive reactions exhibited by the individual;

D. Evaluating potential for rapid regression;

E. Attempting to resolve the crisis; and

F. Referring the individual for treatment in an alternative setting when indicated.

2. Documentation must include—

A. A description of the precipitating event(s)/situation when known;

B. A description of the individual's mental status;

C. The intervention(s) initiated to resolve the individual's crisis state;

D. The individual's response to the intervention(s);

E. The individual's disposition; and

F. Planned follow-up by staff.

(G) Medication Administration—assures the appropriate administration and continuing effectiveness of medication(s) being prescribed for the individual served. Services must be provided by a physician, assistant physician, physician assistant, registered professional nurse (RN), licensed practical nurse (LPN), advanced practice nurse (APRN), psychiatric resident, or psychiatric pharmacist. Key service functions shall include—

1. Administering therapeutic injections of medication (subcutaneous or intramuscular);

2. Monitoring lab tests/levels including consultation with the physician(s), individual served, and community support specialist;

3. Coordinating medication needs with the individual served and his or her family members/natural supports, as appropriate,

and pharmacy staff, including the use of indigent drug programs (does not include routine placing of prescription orders and refills with pharmacies);

4. Setting up medication boxes;
5. Delivering medication to the individual's home;
6. Educating the individual about medications;
7. Recording the individual's initial histories and vital signs;
8. Ensuring medication is taken as prescribed;
9. Monitoring side effects of medication including the use of standardized evaluations; and

10. Monitoring prescriber's orders for treatment modifications and educating the individual served.

(H) Medication Services—goal-oriented interaction with the individual served regarding the need for medication and management of a medication regimen. A physician assistant, assistant physician, psychiatric resident, APN, or psychiatric pharmacist may provide this service, subject to the guidelines and limitations promulgated for each specialty in statutes and administrative rules.

1. Individuals requiring or requesting medication shall be seen by a qualified staff person within fifteen (15) days, or sooner, if clinically indicated. All efforts shall be made to ensure established psychotropic medications are continued without interruption. Medication services must occur at least every six (6) months for individuals taking psychiatric medications. Key service functions shall include, but are not limited to—

- A. Review of the individual's presenting condition;
- B. Mental status exam;
- C. Review of symptoms and medication side effects;
- D. Review of the individual's functioning;
- E. Review of the individual's ability to self-administer medication;

F. Education on the effects of medication and its relationship to the individual's mental illness and his/her choice of medication; and

- G. Prescription of medications when indicated.

2. Documentation for medication services must include, at a minimum:

- A. A description of the individual's presenting condition;
- B. Pertinent medical and psychiatric findings;
- C. Observations and conclusions;
- D. Any side effects of medication as reported by the individual;

E. Actions and recommendations regarding the individual's ongoing medication regimen; and

F. Pertinent information reported by family members/natural supports regarding a change in the individual's condition or an unusual or unexpected occurrence in his or her life, or both.

(I) Metabolic Syndrome Screening—identifies risk factors for obesity, hypertension, hyperlipidemia, and diabetes. The screening is required annually for adults and children/youth who are receiving antipsychotic medication.

1. Services must be provided by an RN or LPN. Key service functions shall include, but are not limited to—

- A. Taking and recording vital signs;
- B. Conducting lab tests to assess lipid levels and blood glucose levels and/or HgbA1c;
- C. Arranging and coordinating lab tests to assess lipid levels and blood glucose levels and/or HgbA1c;
- D. Obtaining results of recently completed lab tests from other health care providers to assess lipid levels and blood glucose levels and/or HgbA1c; and
- E. Recording the results of the metabolic screening on a form/tool approved by the department.

2. Metabolic syndrome screening is limited to no more than one (1) screening every ninety (90) days, per individual. If the lab tests are conducted by a nurse, an analyzer approved by the department must be used.

3. Documentation must reflect completion of the Metabolic Syndrome Screening and Monitoring Tool and a summary progress note.

(J) Physician Consultation/Professional Consultation—medical services provided by a physician, assistant physician, physician assistant, APN, psychiatric resident, or a psychiatric pharmacist. The service is intended to provide direction to treatment and consists of a review of an individual's current medical situation either through consultation with one (1) staff person, or a team discussion(s) related to a specific individual. This service cannot be substituted for supervision or face-to-face intervention with the individual. Key service functions shall include, but are not limited to:

1. An assessment of the individual's presenting condition as reported by staff;
2. Review of the treatment plan through consultation;
3. Participant-specific consultation with staff especially in situations which pose a high risk of psychiatric decompensation, hospitalization, or safety issues; and
4. Participant-specific recommendations regarding high risk issues and, when needed, to promote early intervention.

(K) Psychosocial Rehabilitation for Adults, in accordance with 9 CSR 30-4.046.

(3) Optional Services. In addition to the core services defined in section (2) of this rule, the following optional services may be provided directly by the CPR program, or through a subcontract as specified in 9 CSR 10-7.090(6):

(A) Adult Inpatient Diversion, in accordance with 9 CSR 30-4.045;

(B) Assertive Community Treatment (ACT), in accordance with 9 CSR 30-4.032;

(C) Children's Inpatient Diversion, in accordance with 9 CSR 30-4.045;

(D) Day Treatment for Children/Youth—an intensive array of services provided to children/youth in a highly structured and supervised environment designed to reduce symptoms of a psychiatric disorder and maximize the child's functioning so he or she can attend school and interact in his/her community and family setting. Services are individualized based on the child's needs and include a multidisciplinary approach to care under the direction of a physician. The provision of educational services must comply with the Individuals with Disabilities Education Act 2004 and section 167.126, RSMo.

1. Hours of operation are based on program capacity, staffing availability, space requirements, and as specified by the department.

2. Eligibility criteria includes—

A. For children six (6) years of age and older, he or she must be at risk of inpatient or residential placement as a result of a serious emotional disturbance (SED);

B. For children five (5) years of age or younger, he or she must exhibit one (1) or more of the following:

(I) Has been expelled from multiple day care/early learning programs due to emotional or behavioral dysregulation in relation to SED or diagnosis based on the 2016 edition of the *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC:0-5™)*, published by and available from ZERO TO THREE, 1255 23rd St. NW, Suite 350, Washington, DC 20037, telephone (202) 638-1144 or (800) 899-4301. The document incorporated by reference does not include any later amendments or additions;

(II) Is at risk for placement in an acute psychiatric hospital or residential treatment center as a result of a SED; or

(III) Has a score in the seriously impaired functioning level on the standardized functional tools approved by the department for this age range.

3. Key service functions shall include, but are not limited to:

A. Providing integrated treatment combining education, counseling, and family interventions;

B. Promoting active involvement of the parent/guardian in the program;

C. Consulting and coordinating with the child's/family's private service providers, as applicable, to establish and maintain continuity of care;

D. Coordinating and sharing information with the child's school, including discharge planning, consistent with the Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act (HIPAA);

E. Requesting screening and assessment reports from the child's school to determine any special education needs;

F. Planning the individualized educational needs of the child with his or her school; and

G. Providing other core services as prescribed by the department.

4. For programs serving children three (3) to five (5) years of age, services must be provided by a team of at least one (1) QMHP and one (1) appropriately certified, licensed, or credentialed ancillary staff. For programs serving school-age children, services must be provided by a team consisting of at least one (1) QMHP and two (2) appropriately certified, licensed, or credentialed ancillary staff. Ancillary staff include—

A. Occupational therapists;

B. Physical therapists;

C. Assistant behavior analysts;

D. Individuals with a bachelor's degree in child development, psychology, social work, or education; and

E. Individuals with an associate's degree, or two (2) years of college, and two (2) years of experience in a mental health or child-related field.

5. Documentation must include relevant information reported by family members/natural supports regarding a change in the child's condition or an unusual or unexpected occurrence in his/her life.

(E) Evidence-Based Practices for Children and Youth, in accordance with 9 CSR 30-4.045;

(F) Family Assistance—services focus on development of home and community living skills and communication and socialization skills for children and youth, including coordination of community-based services. Staff must have a high school diploma or equivalent and two (2) years of experience working with children who have a SED or have experienced abuse and neglect. Staff must also complete training approved by/provided by the department and be supervised by a QMHP. Key service functions shall include, but are not limited to:

1. Modeling appropriate behaviors and coping skills for the child;

2. Exposing the child to activities that encourage positive choices, promote self-esteem, support academic achievement, and develop problem-solving skills for home and school;

3. Teaching appropriate social skills through hands-on experiences; and

4. Mentoring appropriate social interactions with the child or resolving conflict with peers.

(G) Family Support—provides a support system for parents/caregivers of a child or youth seventeen (17) years of age and younger who has a SED. Activities are directed and authorized by the individualized treatment plan. Services must be provided by a family member of a child who has or had a behavioral or emotional disorder. The family member must have a high school diploma or equivalent certificate, complete training required by the department, and be supervised by a QMHP. Key service functions shall include, but are not limited to:

1. Providing information and support to the parents/caregivers so they have a better understanding of the child's needs and options to be considered as part of treatment;

2. Assisting the parents/caregivers in understanding the planning process and importance of their voice in the development and implementation of the individualized treatment plan;

3. Providing support to empower the parents/caregivers to be a voice for the child and family in the planning meeting;

4. Working with the family to highlight the importance of individualized planning and the strengths-based approach;

5. Assisting the family in understanding the roles of various providers and the importance of the team approach;

6. Discussing the benefits of natural supports within the family and community;

7. Introducing methods for problem-solving and developing strategies to address issues needing attention;

8. Providing support and information to parents and caregivers to shift from being the decision maker to the support person as the child/youth becomes more independent;

9. Connecting families to community resources;

10. Empowering parents and caregivers and children/youth to become involved in activities related to planning, developing, implementing, and evaluating programs and services; and

11. Connecting parents, caregivers, children/youth to others with similar lived experiences to increase their support system.

(H) Individual Professional PSR and Group Professional PSR—mental health interventions provided on an individual or group basis. A skills-based approach is utilized to address identified behavioral problems and functional deficits related to a mental disorder that interfere with an individual's personal, family, or community adjustment. Maximum group size is one (1) professional to eight (8) individuals. This service cannot be provided to individuals under the age of five (5). Services must be provided by the following staff who complete training required by the department:

1. A professional counselor licensed or provisionally licensed under Missouri law with specialized training in mental health services;

2. A licensed clinical social worker or master social worker licensed under Missouri law with specialized training in mental health services;

3. A licensed, provisionally licensed, or temporarily licensed psychologist under Missouri law with specialized training in mental health services; or

4. A marital and family therapist licensed or provisionally licensed under Missouri law with specialized training in mental health services.

(I) Integrated Treatment for Co-Occurring Disorders (ITCD), in accordance with 9 CSR 30-4.0431;

(J) Intensive CPR, in accordance with 9 CSR 30-4.045;

(K) Metabolic Syndrome Screening—optional service for individuals not receiving antipsychotic medications and, if provided, must be in accordance with subsection (2)(I) of this rule;

(L) Peer Support—assists individuals in their recovery from a behavioral health disorder in a person-centered, recovery-focused manner. Individuals direct their own recovery and advocacy processes to develop skills for coping with and managing their symptoms, and identify and utilize natural support systems to maintain and enhance community living skills. Services are directed toward achievement of specific goals defined by the person served and specified in the individual treatment plan.

1. Services are provided by Certified Peer Specialists who have at least a high school diploma or equivalent certificate, complete applicable training and testing required by the department, and are supervised by a QMHP. Certified Peer Specialists are part of the individual's treatment team and participate in staff meetings/discussions related to services, but they cannot be assigned an independent caseload. The Certified Peer Specialist Code of Ethics must be followed. Job duties include, but are not limited to:

A. Starting and sustaining mutual support groups;

- B. Promoting dialogues on recovery and resilience;
- C. Teaching and modeling skills to manage symptoms;
- D. Teaching and modeling skills to assist in solving problems;
- E. Supporting efforts to find and maintain paid employment;
- F. Using the stages in recovery concept to promote self-determination; and
- G. Assisting peers in setting goals and following through on wellness and health activities.

2. Certified Peer Specialists use the power of peers to support, encourage, and model recovery and resilience from behavioral health disorders in ways that are specific to the needs of each individual. Services may be provided on an individual or group basis and are designed to assist individuals in achieving the goals and objectives on their individual treatment plan or recovery plan. Activities emphasize the opportunity for individuals to support each other as they move forward in their recovery. Interventions may include, but are not limited to—

- A. Sharing lived experiences of recovery, sharing and supporting the use of recovery tools, and modeling successful recovery behaviors;
- B. Helping individuals recognize their capacity for resilience;
- C. Helping individuals connect with other peers and their community at large;
- D. Helping individuals who have behavioral health disorders develop a network for information and support;
- E. Assisting individuals in making independent choices and taking a proactive role in their treatment;
- F. Assisting individuals in identifying strengths and personal resources to aid in their recovery; and
- G. Helping individuals set and achieve recovery goals.

(M) Professional Parent Home-Based Services, in accordance with 9 CSR 30-4.045;

(N) Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR), in accordance with 9 CSR 30-4.046;

(O) Psychosocial Rehabilitation for Youth, in accordance with 9 CSR 30-4.046; and

(P) Intensive Home-Based Services for Children and Youth, in accordance with 9 CSR 30-4.045.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo [2000, and section 630.050, RSMo Supp. 2011] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. For intervening history, please consult the Code of State Regulations. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED AMENDMENT

9 CSR 30-4.0431 Integrated [Dual Disorders Treatment Programs] Treatment for Co-Occurring Disorders (ITCD) in Community Psychiatric Rehabilitation Programs. The department is amending the rule title, purpose, and sections (1)-(8), and adding new section (9).

PURPOSE: This amendment updates terminology and other requirements related to ITCD.

PURPOSE: This rule sets forth standards and regulations for the provision of [integrated dual disorders treatment services] ITCD in community psychiatric rehabilitation programs (CPR) for adults.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) [Integrated Dual Disorders Treatment (IDDT) is integrating substance abuse] ITCD is integrating substance use disorder treatment with community psychiatric rehabilitation [treatment] for individuals with co-occurring psychiatric and substance use disorders. [IDDT] ITCD is a practice based on evidence and research for individuals with serious mental illness and substance use disorders.

(2) Agencies certified or deemed certified by the department as Community Psychiatric Rehabilitation (CPR) [providers] programs may offer further specialized treatment for co-occurring psychiatric and substance use disorders and shall use the [Co-occurring Disorders: Integrated Dual Disorders Treatment (IDDT) Implementation Resource Kit published by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services at PO Box 42557, Washington, DC 20015 Evaluation Edition 2003, to implement integrated treatment for individuals with co-occurring psychiatric and substance use disorders. A copy of the IDDT Implementation Resource Kit is available at the Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health and a copy may be obtained by contacting the Division of Comprehensive Psychiatric Services.] Integrated Treatment for Co-Occurring Disorders: The Evidence resource KIT published in 2010 by the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Publication No. SMA-08-4366, Rockville, MD 20009. This publication may be downloaded or ordered at www.samhsa.gov/shin, or by calling SAMHSA's Health Information Network at 1-877-726-4727 (English and Español). The [IDDT Implementation Resource Kit that is] resource KIT incorporated by reference with this rulemaking does not include any later amendments or additions.

(3) The agency shall have policies approved by the governing body as defined in 9 CSR 10-7.090 that are consistent with the provision of effective evidence-based interventions to guide the co-occurring services and be consistent with the [IDDT] ITCD model of treatment.

(4) Admission Criteria. Persons meeting criteria for [this level of

service/ **ITCD** must meet admission criteria as defined in 9 CSR 30-4.042/005 and must have a co-occurring substance use disorder.

(A) Individuals shall receive screening for **both** mental health and substance [use/abuse] use disorders [using the department-approved screening tools].

(B) If individuals present with both mental health and substance use identified service needs, the individuals shall receive an integrated assessment identifying service needs as well as stage of readiness for change.

(5) Personnel and Staff Development. [IDDT] **ITCD** shall be delivered by a multidisciplinary team responsible for coordinating a comprehensive array of services available to the individual through CPR with the amount [of] and frequency of service commensurate with the individual's assessed need.

(A) The multidisciplinary team shall include, but is not limited to, the following individuals:

1. A [physician or an advanced practice nurse] licensed prescriber;

2. A registered professional nurse;

3. A qualified mental health professional [as defined in 9 CSR 30-4.030(2)(HH)] (**QMHP**);

4. Additional staff sufficient to provide community support[,] and retain the responsibility for acquisition of appropriate housing and employment services;

5. A qualified [substance abuse] addiction professional (**QAP**) defined as a person who demonstrates substantial knowledge and skill regarding substance [abuse] use disorders by being one (1) of the following:

A. A physician or [qualified mental health professional] **QMHP** who is licensed or provisionally licensed in Missouri [with at least one (1) year of full-time experience in the treatment of persons with substance use disorders]; or

B. A person who is certified or registered as a [substance abuse professional] **QAP** by the Missouri [Substance Abuse Counselor's Certification] **Credentialing Board**, [Incorporated].

(B) The multidisciplinary treatment team shall meet regularly to discuss each individual's progress and goals and provide insights and advice to one another.

(C) Multidisciplinary team members shall receive ongoing training in [IDDT] **ITCD** and [shall] have a training plan that addresses specific [IDDT] **ITCD** criteria, including co-occurring disorders, motivational interviewing, stage-wise treatment, cognitive behavioral interventions, and substance use disorders treatment.

(D) The number of [IDDT] **integrated treatment** teams [shall be] is determined by the needs and number of individuals being supported.

(E) Only qualified staff shall provide [IDDT] **integrated treatment for co-occurring disorder** services. Qualified staff for each service [shall include] are:

[1. For individual counseling, group counseling, and assessment a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) or a qualified substance abuse professional defined as a person who demonstrates substantial knowledge and skill regarding substance abuse by being one (1) of the following:

A. A physician or qualified mental health professional who is licensed in Missouri with at least one (1) year of full-time experience in the treatment of persons with substance use disorders; or

B. A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselor's Certification Board, [Incorporated].]

1. Individual counseling, group counseling, and assessment, a licensed or provisionally licensed QMHP, an individual holding the Co-Occurring Disorders Professional or Co-Occurring Disorders Professional Diplomat credential, a non-licensed QMHP who meets the co-occurring counselor competency

requirements established by the department, or a QAP who meets the co-occurring counselor competency requirements established by the department.

2. [For g]Group education, eligible providers shall have documented education and experience related to the topic presented and either be, or be supervised by, a [qualified mental health professional or a qualified substance abuse professional] **QMHP** or **QAP** who meets co-occurring counselor competency requirements established by the department[; and].

[3. Qualified mental health professionals and qualified substance abuse professionals shall meet the co-occurring counselor competency requirements as approved by the department.]

(6) Treatment.

(A) [IDDT] **ITCD** shall be delivered according to the [IDDT] **ITCD model** and criteria [and will be] specified by the department. Services are time unlimited with the intensity modified according to level of need and degree of recovery; [shall] include **outreach efforts** and interventions to promote physical health, **especially related to substance use**; and [shall] target specific services to individuals who do not respond to treatment.

(B) In addition to eligible CPR services, [IDDT] **integrated treatment for co-occurring disorder** services include the following:

1. Co-occurring individual counseling. A structured goal-oriented therapeutic process in which an individual interacts on a face-to-face basis with a counselor in accordance with the individual's rehabilitation plan in order to resolve problems related to the individual's documented mental [disorders] and substance use disorders that interfere with functioning. Individual co-occurring counseling involves the use of practices such as motivational interviewing, cognitive behavioral therapy, harm reduction, and relapse prevention. Individual co-occurring counseling may include face-to-face interaction with one (1) or more members of the individual's family or **other natural supports** for the purpose of assessment or supporting the individual's recovery;

2. Co-occurring group counseling. Face-to-face goal oriented therapeutic interaction among a counselor and two (2) or more individuals as specified in individual rehabilitation plans designed to promote individual self-understanding, self-esteem, and resolution of personal problems related to the individual's documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. Group size shall not exceed ten (10) individuals;

3. Co-occurring group education. Informational and experiential services designed to assist individuals, family members, and others identified by the individual as a primary natural support, in the management of the substance use and mental health disorders. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and substance use disorders. This includes integrating affective and cognitive aspects in order to enable the [participants, consumers as well as] **individuals receiving services**, family members and **other natural supports**[,] to cope with the illness and understand the importance of their individual plan of care. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms, understanding of the precursors to crisis, crisis planning, community resources, recovery management, and medication action, [and] interaction, and **side effects**. Group size shall not exceed twenty (20) individuals;

4. Co-occurring assessment supplement. Individuals [suspected of having co-occurring] who present with **both** substance use [disorders] and mental health [disorders must] **identified service needs** must receive additional assessments to document the co-occurring disorders and assess the interaction of the co-occurring disorders over time[. The completion of the co-occurring assessment shall be documented by the submission to the department of

data required by the department and the development of a comprehensive integrated treatment plan to address problems related to the co-occurring disorders];

5. The agency shall arrange for referrals for **withdrawal management/detoxification** or hospitalization services when appropriate;

6. The agency shall provide housing and vocational services consistent with the *[IDDT] ITCD* model; and

7. Other services as appropriate.

(C) Staff shall help individuals in the engagement and persuasion stages recognize the consequences of their substance use, resolve ambivalence related to their addiction, and introduce them to self-help principles. Individuals in the active treatment or relapse prevention stage *[are assisted to]* **shall receive co-occurring individual and/or group counseling and be assisted in connecting** with self-help programs in the community.

(D) Families and *[significant others]* **other natural supports** shall receive education and, as appropriate, be involved in *[therapy] counseling*.

(7) Records.

(A) An integrated treatment plan shall be developed by the multi-disciplinary team, **including input from the integrated treatment specialist**, and shall include participation of the individual receiving services.

(B) The treatment plan shall address mental health and substance *[abuse] use disorder* treatment strategies that involve building both skills and supports for recovery.

(C) Interventions shall be consistent with, and determined by, the individual's identified stage of treatment.

(8) *[Quality] Performance [i]*Improvement. The agency's *[quality] performance* improvement plan shall include monitoring **its** compliance with the *[provider's IDDT] ITCD* program; **model** and identifying and measuring *[the individual's]* satisfaction and outcomes; *and self-assessing fidelity to the IDDT model]* **of individuals served. Fidelity improvement shall be included as part of the agency's overall performance improvement efforts.**

(9) **The team shall participate in fidelity reviews and fidelity improvement activities conducted by the department.**

AUTHORITY: sections 630.050, [RSMo Supp. 2008 and sections] 630.655, and 632.050, RSMo [2000] 2016. Original rule filed Sept. 2, 2008, effective April 30, 2009. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED AMENDMENT

9 CSR 30-4.0432 Assertive Community Treatment (ACT) in Community Psychiatric Rehabilitation Programs. The department is amending the rule title, purpose, and sections (1)-(3) and (5)-(13).

PURPOSE: This amendment updates terminology and requirements related to the delivery of ACT services.

PURPOSE: This rule sets forth standards and regulations for the provision of [assertive community treatment] ACT services in community psychiatric rehabilitation programs for adults.

PUBLISHER'S NOTE: The [Department of Mental Health] secretary of state has determined that the publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Assertive Community Treatment (ACT) is a *[team-based approach to delivering]* **transdisciplinary team model used to deliver** comprehensive and flexible treatment, support, and services to *[individuals]* **adults or transition-age youth** who have the most *[serious]* **severe symptoms of [severe] a serious mental illness or severe emotional disturbance** and who have the greatest difficulty with basic daily activities.

(2) Agencies certified or deemed certified as Community Psychiatric Rehabilitation (CPR) providers may offer ACT services and shall use the *[Assertive Community Treatment (ACT) Implementation Resource Kit published in 2003 by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services at PO Box 42557, Washington, DC 20015, Evaluation Edition 2003, to implement the ACT program.] Assertive Community Treatment: How to Use the Evidence-Based Practice KIT published in 2008 by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Publication No. SMA-08-4344, Rockville, MD 20008. This publication may be downloaded or ordered at www.samhsa.gov/shin or by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).* Agencies shall also use *A Manual for ACT Start-Up* by Deborah J. Allness, M.S.S.W. and William H. Knoedler, M.D., published in 2003 by National Alliance for the Mentally Ill (NAMI), *[Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042. A copy of the ACT Implementation Resource Kit and A Manual for ACT Start-Up is available at the Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health. and a copy may be obtained by contacting the Division of Comprehensive Psychiatric Services. The ACT Implementation Resource Kit and A Manual for ACT Start-Up that are incorporated by reference with this rulemaking do not include any later amendments or additions.]* **3803 N. Fairfax Drive, Suite 100, Arlington, VA 22203, (703) 524-7600. The documents incorporated by reference with this rule do not include any later amendments or additions.**

(3) Agencies providing ACT services shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance *[Abuse] Use Disorder Treatment Programs*, 9 CSR 10-7.010 through 9 CSR 10-7.140.

(5) Personnel and Staff Development. ACT shall be delivered by a *[multi]transdisciplinary team* (team) responsible for coordinating a

comprehensive array of services. The team shall include, but is not limited to, the following disciplines:

(A) The team shall have adequate prescribing capacity by meeting one (1) of the following:

1. A psychiatrist, **physician assistant, psychiatric resident**, or an advanced practice nurse who shall be available sixteen (16) hours per week to no more than fifty (50) individuals to assure adequate direct psychiatric treatment;

2. A combination of a psychiatrist, **physician assistant, psychiatric resident**, and an advanced practice nurse equaling sixteen (16) hours per week shall be available to no more than fifty (50) individuals; or

3. In a service area designated as a Mental Health Professional Shortage Area, the psychiatrist, **physician assistant, or psychiatric resident** shall be available ten (10) hours per week to no more than fifty (50) individuals; or an advanced practice nurse shall be available sixteen (16) hours per week to no more than fifty (50) individuals;

(B) The *[psychiatrist or advanced practice nurse]* **ACT team prescriber** shall attend at least two (2) team meetings per week either face-to-face or by teleconference;

(C) *[The team shall have adequate nursing capacity by meeting one (1) of the following:*

1.] A registered *[professional]* nurse with six (6) months of psychiatric nursing experience **who** shall work with no more than fifty (50) individuals on a full-time basis; *[during the first year of program operation; or*

2. *During the first year of program operation, a registered professional nurse shall work with no more than fifty (50) individuals as a seventy-five percent (75%) Full-Time Equivalent (FTE) for up to twelve (12) months;]*

(D) A team leader who is a **licensed or provisionally licensed** qualified mental health professional (**QMHP**) as defined in *[9 CSR 30-4.030(2)(HH)]* **9 CSR 10-7.140** that is full time with one (1) year of supervisory experience and a minimum of two (2) years experience working with adults **and/or transition-age youth** with a serious mental illness **or severe emotional disturbance** in community settings;

(E) The team shall have adequate substance *[abuse]* **use disorder** treatment capacity by meeting one (1) of the following:

1. A *[substance abuse]* **co-occurring disorder** specialist who is a qualified *[substance abuse]* **addiction professional** *[QAP]* (**QAP**) as defined in 9 CSR 10-7.140*[(2)(RR) 1. or 2.]* with one (1) year of training or supervised experience in substance *[abuse]* **use disorder** treatment shall be assigned to no more than fifty (50) individuals; or

2. *If the QAP is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the QAP shall attend at least two (2) team meetings per week; or]*

*[3.]*2. A *[QAP]* **QAP** who has less than one (1) year of experience in *[Integrated Dual Disorders Treatment (IDDT)]* **integrated treatment for co-occurring disorders** shall be actively acquiring twenty-four (24) hours of training in *[IDDT-specific content]* **that area and shall receive supervision from** *[experienced IDDT staff;]* **staff with experience in integrated treatment for co-occurring disorders;**

(F) The team shall have adequate *[vocational]* **employment and education** specialization capacity by meeting one (1) of the following:

1. An *[vocational]* **employment and education** specialist who qualifies as a community support *[worker]* **specialist** as defined in *[9 CSR 30-4.034(2)(H)1.]* **9 CSR 10-7.140** with one (1) year of experience and training in *[vocational rehabilitation and]* supported employment shall be available to no more than fifty (50) individuals; or

2. If the *[vocational]* **employment and education** specialist is not assigned to a team full-time or is assigned to a team with less than fifty (50) individuals, the *[vocational]* **employment and educa-**

tion specialist shall attend at least two (2) team meetings per week; *[or]*

[3. A vocational specialist with six (6) months of vocational experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation;]

(G) The team shall include a peer specialist *[which shall be]* **who is self-identified as** *[a present or former primary consumer of]* **currently or formerly receiving** mental health services; *[be]* **is assigned full-time to a team and** *[shall participate]* **participates** in the clinical responsibilities and functions of the team in providing direct services; and *[serve]* **serves** as a model, a support, and a resource for the team members and individuals being served *[by the first year of program operation]*. Peer specialists, at a minimum, shall meet the qualifications of a *[community support assistant]* **Certified Peer Specialist** as defined in *[9 CSR 30-4.030(2)(P) and 9 CSR 30-4.034(2)(H)2.;* **9 CSR 10-7.140;**

(H) The team shall include a program assistant. *[A team of one hundred (100) individuals requires one (1) Full Time Equivalent (FTE) prorated based on team size.]* The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including, but not limited to, the following:

1. Managing medical records;

2. Operating and coordinating the management information system; and

3. Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services;

(I) Other team members may be assigned to work exclusively with the team and must qualify as a community support *[worker]* **specialist** or a qualified mental health professional as defined in *[9 CSR 30-4.034 (2)(H)1. or 9 CSR 30-4.030(2)(HH); and]* **9 CSR 10-7.140; and**

(6) Team Operations.

(A) The team shall function as the primary provider of services for the purpose of recovery from serious mental illness **or severe emotional disturbance and/or substance use disorders** and shall have responsibility to help *[individuals]* **adults or transition-age youth** meet their needs in all aspects of living in the community.

(B) The team shall meet face-to-face at least *[four (4)]* **five (5)** times per week to review the status of each individual via the daily communication log, staff report, services, and contacts scheduled per treatment plans and triage.

(C) The team members shall be available to one another throughout the day to provide consultation or assistance.

(D) The ACT specialists shall cross-train their teammates to help each member develop knowledge and skills for each specialty area.

(7) Admission Criteria. *[Individuals]* **Adults or transition-age youth** who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive *[mental]* **behavioral** health services. Individuals shall have at least one (1) of the *[following]* **diagnoses as approved by the department**, one (1) or more of the *[following]* **identified** conditions, and meet all other admission criteria as defined in 9 CSR 30-4.042*[-]*.

[(A) Schizophrenia.

1. *Disorganized.*

A. *DSM IV code: 295.1X*

B. *ICD-9-CM code: 295.1X*

2. *Catatonic.*

A. *DSM IV code: 295.2X*

B. *ICD-9-CM code: 295.2X*

3. *Paranoid.*

A. *DSM IV code: 295.3X*

B. *ICD-9-CM code: 295.3X*

4. *Schizophreniform*.
A. DSM IV code: 295.4X
B. ICD-9-CM code: 295.4X
5. *Residual*.
A. DSM IV code: 295.6X
B. ICD-9-CM code: 295.6X
6. *Schizoaffective*.
A. DSM IV code: 295.7X
B. ICD-9-CM code: 295.7X
7. *Undifferentiated*.
A. DSM IV code: 295.9X
B. ICD-9-CM code: 295.9X;
- (B) *Delusional Disorder*.
1. DSM IV code: 297.1X
2. ICD-9-CM code: 297.1X;
- (C) *Bipolar I Disorders*.
1. *Single manic episode*.
A. DSM IV code: 296.0X
B. ICD-9-CM code: 296.0X
2. *Most recent episode manic*.
A. DSM IV code: 296.4X
B. ICD-9-CM code: 296.4X
3. *Most recent episode depressed*.
A. DSM IV code: 296.5X
B. ICD-9-CM code: 296.5X
4. *Most recent episode mixed*.
A. DSM IV code: 296.6X
B. ICD-9-CM code: 296.6X;
- (D) *Bipolar II Disorders*.
1. DSM IV code: 296.89
2. ICD-9-CM code: 296.89;
- (E) *Psychotic Disorders NOS*.
1. DSM IV code: 298.9
2. ICD-9-CM code: 298.9;
- (F) *Major Depressive Disorder-Recur*.
1. DSM IV code: 296.3X
2. ICD-9-CM code: 296.3X;]
- [(G)](A) The diagnosis may coexist with other psychiatric diagnoses [in Axis II or other areas];].
- [(H)](B) For [individuals] adults or transition-age youth exhibiting extraordinary clinical needs, the team may apply to the [clinical director of the division] department to approve admission to ACT services[; and].
- [(I)](C) The conditions shall include the following:
- Recent discharge from an extended stay of three (3) months or more in a state hospital for an adult or an extended stay in a residential facility for transition-age youth (ages 16-25);
 - High utilization of two (2) admissions or more per year in an acute psychiatric hospital and/or six (6) or more per year for psychiatric emergency services;
 - Have a co-occurring substance use disorder greater than six (6) months duration;
 - Exhibit socially disruptive behavior with high risk of [criminal justice] involvement in the justice system including arrest and incarceration;
 - Reside in substandard housing, is homeless, or at imminent risk of becoming homeless;
 - [Have been identified through department data indicating high use of services or who are functioning poorly and do not attend office-based mental health programs consistently;] Experience the symptoms of an initial episode of psychosis within the past two (2) years (hallucinations, delusions or false beliefs, confused thinking or other cognitive difficulties) leading to a significant decrease in overall functioning; or
 - Other indications demonstrating that the [individual] adult or transition-age youth has difficulty thriving in the community.

(8) Admission Process.

(A) The team shall develop a process for identifying [individuals] adults or transition-age youth who are appropriate for ACT services.

(B) When the team receives a referral for ACT services, the team leader shall confirm/s that the individual meets the ACT admission criteria.

(C) The team leader shall arrange an admission meeting that includes current providers of services, the team leader, and the individual. The meeting may also include, but is not limited to, the following:

- Family members, significant others, natural supports, or guardians, if the individual grants permission;

- Team members who will be working with the newly enrolled individual; and/or

- The team psychiatrist.

(D) At the admission meeting, team members shall introduce themselves and explain the ACT program.

(E) When the individual decides [that] he or she accepts ACT services, the team shall immediately open a record and schedule initial service contacts with the individual for the next few days.

[(F)] No more than six (6) new individuals shall be admitted to an ACT team per month unless approved by the department.]

[(G)](F) An initial assessment shall be completed on the day of admission. The initial assessment shall be based on information obtained from the individual, referring treatment provider, and family/natural supports, or other supporters who participate in the admission process and shall include, but not be limited to, the following:

- The individual's mental and functional status;

- The effectiveness of past treatment; and

- The current treatment, rehabilitation, and support service needs.

[(H)](G) The initial treatment plan shall be completed on the day of admission, include initial needs and interventions, be used to support recovery, [help the individual to achieve initial goals,] and be used by the team as a guide until the comprehensive assessment and treatment plans are completed[, and include initial problems and interventions].

[(I)](H) The team shall ensure [that] the individual receiving services participates in the development of the treatment plan and signs the plan. The individual's parent/legal guardian also participates and signs the plan. The individual's signature is not required if signing would be detrimental to the individual's well-being. If the individual does not sign the treatment plan, the team shall insert a progress note in the case record explaining the reason the individual did not sign the treatment plan.

[(J)](I) [A psychiatrist] The team's licensed prescriber shall approve the treatment plan. A licensed psychologist, as a team member, may approve the treatment plan only in instances when the individual is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications. [An advanced practice nurse may approve the treatment plan if he/she is providing medication management services to the individual.]

(9) Comprehensive Assessment and Treatment Planning.

(A) To be in compliance with this standard, the team shall follow a systematic process including admission, comprehensive and ongoing assessment, and continuous treatment planning utilizing the assessment and treatment planning protocol and components included in the publication, *A Manual for ACT Start-Up* and in the fidelity protocol identified by the department.

(B) The team shall conduct the comprehensive ACT assessment as they are working with the individual in the community delivering services outlined in the initial treatment plan.

(C) The comprehensive ACT assessment provides a guide for the team to collect information including the individual's history,

including trauma history, past treatment, and to become acquainted with the individual and *[their] his/her* family members. This assessment enables the team to individualize and tailor ACT services to ensure courteous, helpful, and respectful treatment. The comprehensive assessment includes *[seven (7) parts as follows]*, but is not limited to:

1. Psychiatric history, mental status, and diagnosis;
2. Physical health;
3. Use of drugs and/or alcohol;
4. Education and employment;
5. Social development and functioning;
6. Activities of daily living; *[and]*
7. Family structure and relationships*[/]*; and

8. Functional assessment approved by the department.

(D) *[The primary case manager and other members of the team, with supervision from the team leader, shall complete the comprehensive assessment within thirty (30) days of admission]* Team members, with supervision from the team leader, shall complete their respective sections of the comprehensive assessment within thirty (30) days of admission.

(E) The assessment is ongoing throughout the course of ACT treatment and consists of information and understanding obtained through day-to-day interactions with the individual, the team, and others, such as landlords, employers, family, friends, and others in the community.

(F) The comprehensive assessment is a daily and *[continuous]* ongoing process that is continuously updated *[every six (6) months]* and documented as information changes or is received.

[(G)] A psychiatric and social functioning history timeline shall be developed using the protocol included in the publication, *A Manual for ACT Start-Up*.

[(H)](G) Treatment plans shall be developed utilizing information obtained from the *[psychiatric and social functioning history timeline and the]* comprehensive assessment.

[(I)](H) Treatment plans shall contain objective goals based on the individual's preferences and shall be person-specific.

[(J)](I) Treatment plans shall contain specific interventions and services that will be provided, by whom, for what duration, and location of the service.

[(K)](J) The comprehensive treatment plan shall be developed within *[thirty (30)]* forty-five (45) days *[after]* of admission.

[(L)](K) The treatment plan shall be *[reviewed and]* revised or re-written every six (6) months.

(10) Service Provision.

(A) ACT services shall be delivered seven (7) days per week including evenings and holidays based upon individual needs.

(B) ACT services shall be available at least two (2) hours of direct services each weekend day or holiday.

(C) A team member shall be on call *[at all hours]* twenty-four (24) hours per day, seven (7) days per week.

(D) *[Crisis assessment is provided by the team or arranged for by an after-hours crisis intervention system, twenty-four (24) hours per day. When the team is contacted, the team shall determine the need for team intervention either by phone or face-to-face with backup by the team leader and psychiatrist.]* The team shall be available to individuals on an ACT team who are in crisis twenty-four (24) hours a day, seven (7) days a week. The team is the first-line crisis evaluator and responder. If another crisis responder screens calls, there is minimal triage. When the team is contacted, the team shall determine the need for team intervention and whether that be by telephone or face-to-face, with back-up by the team leader and ACT team prescriber.

(E) Individualized, practical crisis prevention plans shall be available to staff who are on call.

[(E)](F) Individuals *[are]* shall be offered services on a time unlimited basis, with less than ten percent (10%) dropping out annu-

ally, excluding those who graduate from services.

[(F)](G) The team shall provide goal driven *[case management functions]* services for all individuals enrolled in ACT including, but not limited to, the following:

[1. Locating and maintaining safe, affordable housing with an emphasis on individual choice and independent community housing;

2. Assistance with financial management support, including the use of legal mechanisms when appropriate;

3. Support and skills training and illness management strategies to support activities of daily living;

4. Facilitating peer support and self-help programs as desired by the individual; and

5. Providing psycho-education to individuals, and their family members, with the individual's permission, as appropriate.]

1. Psychopharmacologic treatment;

2. Nursing;

3. Integrated treatment for co-occurring disorders;

4. Supported employment and education;

5. Peer support;

6. Crisis intervention;

7. Psychiatric rehabilitation and skills training to improve functioning;

8. Wellness management and recovery;

9. Empirically supported psychotherapy; and

10. Supportive housing.

[(G)](H) The team shall have a process to manage emergency funds for *[individual's]* individuals served.

[(H)](I) *[Clinical staff to client ratio,]* The ratio for clinical staff to individuals served, excluding the psychiatrist, shall be no more than one to ten (1:10).

[(I)](J) *[Clinical staff to client ratio]* The ratio for clinical staff to individuals served shall be no more than one to thirteen (1:13) if the team continues to demonstrate outcomes in areas such as *[vocational,]* employment, housing, and hospitalizations comparable to teams with lower caseloads.

[(J)](K) The clinical team shall be *[no smaller than five (5) FTE and no larger than ten (10) FTE]* of sufficient, absolute size to consistently provide necessary staffing diversity and coverage based on team caseload size.

[(K)](L) At a minimum, individuals shall be contacted face-to-face by the team an average of two (2) hours per week.

[(L)](M) For individuals who refuse services, the team shall attempt to engage individuals with at least two (2) face-to-face contacts per month for a minimum of six (6) months.

[(M)](N) Individuals who are experiencing severe, emergent, or acute symptoms shall be contacted multiple times daily by the team.

[(N)](O) At a minimum, seventy-five percent (75%) of team contacts shall occur out of the office.

[(O)](P) Individuals shall have direct contact with more than two (2) team members per month.

[(P)](Q) Individuals with co-occurring *[substance abuse]* disorders shall be provided integrated mental health and substance *[abuse]* use disorder treatment.

[(Q)](R) The team shall monitor and, when needed, provide supervision, education, and support in the administration of psychiatric medications for all individuals.

[(R)](S) The team shall monitor symptom response and medication side-effects.

[(S)](T) The team shall educate individuals and families about symptom management and early identification of symptoms.

[(T)](U) The team shall have an average of *[four (4)]* one (1) or more contacts per month with family and support systems in the community, including landlords and employers, after obtaining the individual's permission.

[(U)](V) The team shall actively and assertively engage and reach out to family members, natural supports, and significant others to

include, but not be limited to, the following:

1. Establishing ongoing communication and collaboration between the team, family members/**natural supports**, and others;

2. Educating the family/**natural supports** about mental illness or severe **emotional disturbance** and/or **substance use disorder** and the family's role in treatment;

3. Educating the family/**natural supports** about symptoms management and early identification of symptoms indicating onset of *[disease]* illness; and

4. Providing interventions to promote positive interpersonal relationships.

[(V)](W) At a minimum, the team supports, facilitates, or ensures the individual's access to the following services:

1. Medical and dental services;

2. Social services;

3. Transportation; and

4. Legal advocacy.

[(W)](X) Inpatient admissions shall be jointly planned with the team and the team, at a minimum, shall make weekly contact with individuals while hospitalized.

[(X)](Y) The team shall *[participate in]* **coordinate** discharge planning **in cooperation with hospital staff**.

(11) *[Discharge Criteria.]* **Transition to Less Intensive Services.**

[(A)] Individuals shall have achieved community living goals for the previous six (6) months.

[(B)] Social supports shall have been in place for the previous six (6) months.

[(C)] Individuals shall have stable housing for the previous six (6) months.]

(A) The team shall conduct regular assessment of the need for ACT services.

(B) The team shall use explicit criteria or markers for the need to transfer to a less intensive service option.

(C) Transition shall be gradual and individualized, with assured continuity of care.

(D) The team shall monitor the individual's status following transition based on individual need.

(E) There shall be an option to return to the team, as needed.

[(D)](F) A transition plan shall be developed incorporating graduated step down in intensity and including overlapping team meetings as needed to facilitate the transition of the individual.

[(E)](G) The individual shall be engaged in the next step of treatment and rehabilitation.

[(F)](H) Documentation of *[discharge]* **transition to less intensive services** shall include a systematic plan to maintain continuity of treatment at appropriate levels of intensity to support the individual's continued recovery and have easy access to return to the ACT team if needed.

[(G)](I) A discharge summary shall include, but is not limited to, the following:

1. Dates of admission and *[discharge]* **transition to less intensive services**;

2. Reason for admission and referral source;

3. Diagnosis or diagnostic impression;

4. Description of services provided and outcomes achieved, including any prescribed medication, dosage, and response;

5. Reason for or type of **transition or discharge from the team**; and

6. Medical status and needs that may require ongoing monitoring and support.

[(H)](J) An aftercare plan shall be completed prior to *[discharge]* **transition to less intensive services or discharge from the team**. The plan shall identify services, designated provider(s), or other planned activities designed to promote further recovery.

(12) Records.

(A) The ACT provider shall implement policies and procedures to

assure routine monitoring of individual records for compliance with applicable standards.

(B) All staff contacts with individuals *[are logged]* **shall be documented** and easily accessible to team members.

(C) Each individual's record shall document services, activities, or sessions that involve the individual including—

1. The specific services rendered;

2. The date and actual time the service was rendered;

3. *[Who]* **The name of the team member who** rendered the service;

4. The setting in which the services were rendered;

5. The amount of time it took to deliver the services;

6. The relationship of the services to the treatment regimen described in the treatment plan; and

7. Updates describing the individual's response to prescribed care and treatment.

(D) In addition to documentation required under subsection (12)(C), for medication services, the ACT provider shall provide additional documentation for each service episode, unit, or as clinically indicated, for each service provided to the individual as follows:

1. Description of the individual's presenting condition;

2. Pertinent medical and psychiatric findings;

3. Observations and conclusions;

4. Individual's response to medication, including identifying and tracking over time one (1) or more target symptoms for each medication prescribed;

5. Actions and recommendations regarding the individual's ongoing medication regimen; and

6. Pertinent/significant information reported by family members, **natural supports**, or significant others regarding a change in the individual's condition, an unusual or unexpected occurrence in the individual's life, or both.

[(E)] *The team shall review the treatment plan, goals, and objectives on a regular basis, as determined by department policy.*

1. The review shall determine the individual's progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for the individual's continued participation in specific community psychiatric rehabilitation services.

2. The team shall document the review in detail in the individual's record.

3. The ACT provider shall make the review available as requested for state or federal review purposes.

4. The ACT provider shall ensure the individual participates in the treatment plan review.]

(E) The ACT team shall update the department-approved functional assessment every ninety (90) days to assess individual functioning, progress toward treatment objectives, and appropriateness of continued services. The treatment plan shall be revised and updated based on the findings from the functional assessment. Documentation in the individual record shall include, but is not limited to:

1. Barriers, issues, or problems identified by the individual, family, guardian, and/or team that identify the need for focused services;

2. A brief explanation of any change or progress in the daily living functional abilities in the prior ninety (90) days; and

3. A description of the changes for the plan of treatment based on information obtained from the functional assessment.

(F) The ACT program also shall include other information in the individual record, if not otherwise addressed in the intake/annual evaluation or treatment plan, including—

1. The individual's medical history, including—

A. Medical screening or relevant results of physical examinations; and

B. Diagnosis, physical disorders, and therapeutic orders;

2. Evidence of informed consent;
3. Results of prior treatment; and
4. Condition at discharge from prior treatment.

(G) Any authorized person making any entry in an individual's record shall sign and date the entry, including corrections to information previously entered in the individual's record.

(H) *[The ACT provider shall establish and implement a procedure that assures the intercenter transfer of referral and treatment information within five (5) working days.]* The ACT program shall implement written procedures to ensure exchange of information within five (5) working days when an individual is referred or transfers to another service component within the organization or to an outside entity for services.

(I) The ACT provider shall provide information, as requested, regarding individual characteristics, services, and costs to the department in a format established by the department.

[(J) Each agency that is certified shall be subject to recoupment of all or part of department payments when—

1. *The individual's record fails to document the service paid for was actually provided;*
2. *The individual's record fails to document the service paid for was provided by a qualified staff person, as defined in the Department of Mental Health Purchase of Service Catalog;*
3. *The individual's record fails to document the service that was paid meets the service definition, as defined in the Department of Mental Health Purchase of Service Catalog;*
4. *The individual's record fails to document the amount, duration, and length of service paid for by the department; or*
5. *The individual's record fails to document the service paid for was delivered under the direction of a current treatment plan that meets all the requirements for treatment plans set forth in 9 CSR 10-7.030.]*

(13) *[Quality] Performance Improvement[—].* The agency's *[quality] performance* improvement plan shall include monitoring compliance with the ACT standards.

(A) Records shall show evidence that the team monitors hospitalization, housing, employment/education, substance use, and *[criminal justice contacts] contact with the justice system* for all individual/s using a tracking form approved by the department and submitted to the *[division] department* on a quarterly basis.

(B) The agency shall *[conduct an annual fidelity self-assessment] include fidelity improvement as part of its overall performance improvement efforts.*

(C) The team shall participate in fidelity reviews and **fidelity improvement activities** conducted by the *[division] department*.

(D) Team members or a designee(s) *[are expected to] shall* meet with the department and stakeholder groups and collaborate as needed.

AUTHORITY: sections 630.050, *[RSMo Supp. 2009 and sections] 630.655, and 632.050, RSMo [2000] 2016. Original rule filed Aug. 14, 2009, effective March 30, 2010. Amended: Filed April 29, 2019.*

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments*

must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.045 Intensive Community Psychiatric Rehabilitation (ICPR). The department is amending the rule title, purpose, and sections (1)-(5), and adding new sections (6)-(12).

PURPOSE: *This amendment updates terminology and adds additional service components for ICPR.*

PURPOSE: *This rule sets forth standards and regulations for the provision of [intensive community psychiatric rehabilitation service] ICPR services.*

(1) Intensive Community Psychiatric Rehabilitation (ICPR). *[A level of support] Services* are designed to help *[consumers] individuals* who are experiencing a severe *[and significant]* psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient setting or a restrictive living setting. *[It is] ICPR* is a comprehensive, **time-limited** community-based service, according to the needs of service recipients, delivered to *[consumers] for individuals* who are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.

(A) *[The intensive community psychiatric rehabilitation] ICPR* is intended for *[the following consumers:]—*

1. Persons who would be hospitalized without the provision of intensive community-based intervention; *[or]*
2. Persons who have extended or repeated hospitalizations; *[or]*
3. Persons who have crisis episodes; *[or]*
4. Persons who are at risk of being removed from their home or school to a more restrictive environment; *[or] and*
5. Persons who require assistance in transitioning from a highly restrictive setting to a community-based alternative, including specifically persons being discharged from inpatient psychiatric settings who require assertive outreach and engagement.

(B) *[Intensive community psychiatric rehabilitation is provided by t/Treatment teams deliver/ing/ services that will maintain [the consumer] the individual within the family and significant support systems and assist [consumers] them in meeting basic living needs and age appropriate developmental needs.*

[(C) A treatment team comprised of individuals required to provide the specific services identified on the Individualized Treatment Plan (ITP), delivers this level of service to consumers who meet the Community Psychiatric Rehabilitation (CPR) eligibility criteria.]

(2) Admission Criteria. *[Persons meeting criteria for this level of service] To be eligible for ICPR, the individual* must meet admission criteria as defined in *[9 CSR 30-4.042, will be in need of intensive clinical intervention or support to alleviate or eliminate the need for admission into a psychiatric inpatient or a restrictive living setting,] 9 CSR 30-4.005* and *[must meet]* at least one (1) of the following *[descriptions] criteria:*

(A) *[A person who is] Is* being discharged from a *[Department of Mental Health] department* facility or *[Department of Mental Health purchased] bed funded by the department;*

(B) *[A person who has] Has* had extended or repeated psychiatric inpatient hospitalizations or crisis episodes within the past six (6) months;

(C) *[A person who has]* **Has** had multiple out-of-home placements due to *[their]* **his/her** mental disorder; or

(D) *[A person who is]* **Is** at risk of being removed from his/her home, school, or current **natural** living situation.

(3) *[Personnel and Staff Development. Intensive CPR shall be delivered by a]* **Staff Requirements.** A treatment team *[responsible for coordinating]* **coordinates** a comprehensive array of services available to the individual through the **CPR program.** *[with the amount of and frequency of service commensurate with the individual's assessed acuity and need.]*

(A) The treatment team *[shall be]* **is** supervised by a qualified mental health professional *[as defined in 9 CSR 30-4.030(2)(HH)]* **(QMHP)** and *[shall]* include the following:

1. *[Individuals]* **Staff** required to provide specific services identified on the *[individualized]* **T/treatment** *[P]* **plan;** and

2. The *[consumer,]* **individual receiving services** and family members or other **natural supports** if developmentally appropriate.

[(B) Treatment team models shall follow one (1) of two (2) options:

1. *The treatment team may serve exclusively individuals enrolled in the intensive CPR level;* or

2. *The treatment team may serve individuals enrolled in intensive CPR and individuals enrolled in the rehabilitation levels.]*

(4) **Treatment.**

(A) *[Intensive]* **ICPR** shall include—

1. Multiple face-to-face contacts **with the individual** on a weekly basis, and may require contact on a daily basis, **as required for each service type;**

2. Services that are available twenty-four (24) hours per day, *[and]* seven (7) days per week; **and**

3. Crisis response services that may be coordinated with an existing crisis system.

(B) A full array of CPR services, as defined in 9 CSR 30-4.043, shall be available to each individual based upon identified needs. *[In addition, the following services are also available, including but not limited to:*

1. *Outreach and engagement;*

2. *Behavioral aide/family assistance worker;*

3. *Targeted case management;*

4. *Clinical interventions for the purpose of stabilizing the individual offered twenty-four (24) hours per day and seven (7) days per week;*

5. *Increased services to assist the individual with medication stabilization;*

6. *Utilization of natural services and supports needed to maintain the individual in the community;*

7. *Day treatment.]*

(C) The **amount and** frequency of services *[delivery shall be]* **is** based upon the individual's assessed acuity and need.

[(D) Individuals can be moved out of the intensive level when—]

(D) A crisis prevention plan shall be developed for each individual, including clinical issues that may impact his/her transition to less intensive services.

(E) **Individuals no longer need ICPR when—**

1. There is a reduction of severe *[and significant]* symptoms; and

2. *[The individual is]* **They are** able to function *[in the rehabilitation level of CPR]* **without intensive services;** or

3. *[The individual]* **They choose[s]** to *[move from the intensive level]* **no longer receive intensive services.**

(5) *[Client Records]* **Documentation Requirements.** **ICPR services must be documented in accordance with 9 CSR 10-7.030(13), and as specified in this rule.**

[(A) For consumers currently enrolled in the CPR Program, documentation must be present in the client record indicating the individual's acuity level and supporting admission into the intensive level of care. Upon admission to the intensive level of care, the following is required—

1. *A progress note must be written that documents the individual's acuity level and compliance with admission criteria;*

2. *The treatment plan must be updated to reflect the higher level of service the individual will receive while participating in the intensive level of care;*

3. *The appropriate outcomes packet shall be completed and forwarded to the department; and*

4. *Service system reporting shall be updated to reflect participation with the appropriate program code.]*

(A) **For individuals currently enrolled in the CPR program, the following documentation is required upon admission to ICPR:**

1. **Verification they meet admission criteria;**

2. **Acuity level; and**

3. **Treatment plan update indicating the higher level of service he/she will be receiving.**

(B) For *[new consumers]* **individuals [who have been]** newly admitted directly from the community into *[the intensive level of care]* **ICPR,** a *[brief evaluation]* **comprehensive behavioral health assessment must be completed** to substantiate acuity and criteria for admission *[will initially be accepted which may be in the form of a separate report or progress note that includes the following elements: presenting problem, recent psychiatric history, current medications, current housing status, current legal status, family and/or guardian, and mental status examination].*

1. Each individual shall have a psychiatric evaluation at admission. For individuals *[who have been]* discharged from *[an]* inpatient *[bed]* **hospitalization** into *[the intensive level of care]* **ICPR,** a psychiatric evaluation completed at the facility/**hospital** will initially be accepted.

2. *[A comprehensive evaluation shall]* **The comprehensive assessment must** be completed within thirty (30) days of admission except for individuals admitted provisionally.

3. Treatment plans shall be developed upon admission *[to the intensive level of care]* **and updated as necessary.**

4. *The appropriate outcomes packet shall be completed and forwarded to the department.*

5. *Service system reporting shall be updated to reflect participation with the appropriate program code.]*

(C) Treatment plans shall be reviewed *[on a weekly basis]* **as required for each service type** and *[the review documented in the case record]* **documented in the individual record** with a summary progress note, including updates to the treatment plan as appropriate.

[(D) Each individual shall have a critical intervention plan.

(E) **All services provided must have accompanying progress notes that include:**

1. *Specific type of service rendered as defined in the CPR menu of services or the Purchase of Service Catalogue;*

2. *Date and actual time the service was rendered;*

3. *Who rendered the service;*

4. *The setting in which the service was rendered;*

5. *The amount of time it took to deliver the service;*

6. *The relationship of services to the treatment regimen described in the treatment plan;*

7. *Updates describing the client's response to prescribed care and treatment; and*

8. *Signature and position of staff member delivering the service.]*

[(F)](D) Upon change from [the intensive level of care] ICPR services, a transition [plan] summary [for follow-up services

must be documented in a level of care transition summary and reflected in an updated treatment plan.] must be completed by a QMHP and included in an updated treatment plan.

[(G) Upon change from the intensive level of care, the provider must complete the appropriate outcomes packet and forward to the department.]

[(6) Quality Assurance.

(A) The department will track the following indicators:

1. Hospitalizations that occur while the individual is participating in the intensive level of care; and

2. Consumer movement to a more restrictive level of care while the individual is participating in the intensive level of care.

(B) The department will monitor specific services provided to an individual while they are enrolled in intensive CPR. The providers shall maintain and have available for review, the detail regarding service delivery. This information must be in the same format as if the services had been billed separately. The review may consist of documents sent to the department for review or a face-to-face review on-site at an agency.]

(6) ICPR for Children and Youth. Services are medically necessary to maintain a child with a Serious Emotional Disturbance (SED) in their natural home, or maintain a child with a serious mental illness or SED in a community setting who has a history of failure in multiple community settings, and/or the presence of ongoing risk of harm to self or others, which would otherwise require long-term psychiatric hospitalization. Clinical interventions are provided by a multidisciplinary treatment team on a daily basis, and the interventions must be available twenty-four (24) hours per day, seven (7) days per week for stabilization purposes. The child's family and other natural supports may receive services when they are for the direct benefit of the child in accordance with their individual treatment plan.

(A) Services shall include, but are not limited to—

1. Medication administration/management of medication;
2. Ongoing behavioral health assessment and diagnosis;
3. Monitoring to assure individual safety;
4. Individual and group counseling; and
5. Community support.

(B) The ICPR multidisciplinary team shall include the following staff, based on the needs of the individual served:

1. Physician, psychiatrist, child psychiatrist, psychiatric resident, or Advanced Practice Nurse (APRN);
2. QMHP;
3. RN;
4. LPN;
5. Community Support Specialist; and
6. Individuals with a high school diploma, or equivalent certificate, under the direction and supervision of a QMHP.

(C) Services are limited to ninety (90) days. Exceptions may be granted by the department and must be documented in the individual record.

(7) Intensive Home-Based Services for Children and Youth. Intensive therapeutic interventions are provided to improve the child's functioning and prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting due to a SED.

(A) Services are for children whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting.

(B) Providers must complete extensive, specialized training required by the department and meet department licensure requirements as specified in 9 CSR 40.

(C) The provider shall participate in pre-placement and ongoing meetings with the child's CPR treatment team and assist in development of the treatment plan. The provider is responsible for implementing the treatment plan and maintaining contact with the child's natural parent/guardian and completing documentation as required by the department.

(D) Services and supports are individualized and strength-based to meet the needs of the child and family across life domains to promote success, safety, and permanence in the home, school, and community. Therapeutic interventions target the child's serious mental health issues and promote positive development and healthy family functioning.

(E) Children must meet CPR admission criteria and their behavior must be sufficiently under control to live safely in a community setting with appropriate support.

(F) Staff of the CPR program who supervise the child's services must be available twenty-four (24) hours per day, seven (7) days per week to assist the provider if a crisis situation occurs.

(G) Placement, duration, and intensity of services is based on the specific needs of each child as specified in the MO HealthNet CPR Provider Manual, available from the Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, and as specified in the department contract. The referenced document does not include any later revisions or updates.

(8) Evidence-Based Practices (EBP) for Youth. Services involve proven treatment supports for children and youth to address specific behavioral health needs. The selected EBP is based on individual needs and desired outcomes as identified in the treatment plan.

(A) The EBP must be approved by the department.

(B) Activities associated with the service must include, but are not limited to:

1. Extensive monitoring and data collection;
2. Specific skills-training in a prescribed or natural environment; and
3. Prescriptive responses to a psychiatric crisis and/or frequent contact with the individual and/or family, in addition to the arranged therapy sessions.

(9) ICPR for Adults and Transition-Age Youth. Services are delivered by teams using one (1) of the following methods:

(A) Linking and transitioning individuals from acute or long-term services to less intensive treatment. The time frame for services is approximately ninety (90) days or less, but varies according to individual needs;

(B) Modified Assertive Community Treatment (ACT), as approved by the department. The time frame varies based on individual needs; or

(C) Intensive wrap-around stabilization services for individuals with substantial mental health needs who may otherwise require inpatient hospitalization. The expected period of engagement is approximately ninety (90) days or less, but varies according to individual needs.

(D) Teams may be designated exclusively for individuals in ICPR or be mixed teams serving individuals in ICPR and rehabilitation services.

(E) A department-approved functional assessment must be completed monthly and documented in the individual record.

(10) Intensive Home-Based Services for Adults. Medically necessary services/supports are provided to adults who have a serious mental illness and are transitioning from an inpatient psychiatric hospital to the community, or who are at risk of returning to inpatient care due to their clinical status or need for increased support. Services and supports are provided in the individual's natural home, under the supervision of a QMHP. The home/program is

structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services.

(A) Staff providing services/supports must be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalent certificate. Two (2) years of direct health care experience, or a bachelor's degree in behavioral sciences, is preferred.

(B) Staff must be systematically trained to provide intensive interventions and supports to reduce the symptoms of mental illness, and intervene and redirect individuals in a psychiatric crisis who are exhibiting behaviors potentially dangerous to themselves or others. A training plan must be in place for each staff person identifying specific topics and frequency of refresher training on each topic, including documentation of course completion.

(C) Support and rehabilitation services related to activities of daily living and crisis prevention and intervention must be provided.

(D) CPR programs that provide services for adults must be approved by the department to provide intensive home-based services.

(E) Documentation must reflect delivery of direct (face-to-face) services and supports such as, daily summary progress notes, group notes, individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, and prompting or reminders.

(11) **Children's Inpatient Diversion.** A full array of intensive clinical services are provided to children/youth in a highly structured therapeutic setting. Services are designed to restore the child to a prior level of functioning, decrease risk of harm, and prevent transition to a more restrictive setting.

(A) Emergency medical services must be available on site or in close proximity.

(B) A psychiatrist must supervise services which are delivered by a multi-disciplinary treatment team.

(C) Licensed nursing staff must be available on a daily basis.

(D) Licensed occupational and recreational therapists must be available based on individual needs.

(E) The provision of services is limited to certified or deemed-certified CPR programs for children and youth. The service must be accredited by a national accrediting body approved by the department.

(12) **Adult Inpatient Diversion.** A full array of intensive clinical services are provided to adults in a highly supervised and structured therapeutic setting. Services are designed to restore the individual to a prior level of functioning, decrease risk of harm, and prevent transition to a more restrictive setting.

(A) Emergency medical services must be available on site or in close proximity.

(B) Services must be provided in a coordinated effort under the direction of a psychiatrist. Other staff on the treatment team includes licensed nurses, licensed psychologists, social workers, counselors, psychosocial rehabilitation specialists, and other trained supportive staff.

(C) Services shall include, but are not limited to—

1. Nursing;
2. Community support;
3. Psychosocial rehabilitation; and
4. Co-occurring disorder counseling and other evidence-based services.

(D) The provision of services is limited to CPR programs for adults. The service must be accredited by a national accrediting body approved by the department.

AUTHORITY: sections 630.050, [RSMo Supp. 2010 and sections] 630.655, and 632.050, RSMo [2000] 2016. Emergency rule filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002.

Original rule filed Dec. 28, 2001, effective July 12, 2002. Emergency amendment filed June 14, 2010, effective July 1, 2010, expired Feb. 24, 2011. Amended: Filed June 14, 2010, effective Feb. 24, 2011. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH Division 30—Certification Standards Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.046 Psychosocial Rehabilitation (PSR) in Community Psychiatric Rehabilitation Programs. The department is amending the rule title and purpose, adding new sections (1)-(8), and deleting old sections (1)-(13).

PURPOSE: This amendment updates requirements for the PSR program, including service array and documentation of services.

PURPOSE: This rule provides standards for [psychosocial rehabilitation] PSR programs operated as part of a community psychiatric rehabilitation (CPR) program.

[(1) The activities of the psychosocial rehabilitation program (PSR) shall focus on—

(A) Development of behaviors and abilities that will allow the client to return to activities appropriate to his/her age and based on the client's assessed needs;

(B) Development of behaviors and abilities that will allow the client to fully participate in community living;

(C) Prevention of extended psychiatric hospitalization(s);

(D) Establishment and improvement of an individual's desire or motivation to maximize independence;

(E) Development of a personal support system; and

(F) Provision of meaningful activity which is appropriate to the age and level of functioning and interest of the client.

(2) The psychosocial rehabilitation program shall be accredited by the Council on Accreditation of Rehabilitation Facilities or licensed as a day program by the department under 9 CSR 40-1.015–9 CSR 40-10.155 inclusive.

(A) In those instances in which certification standards are more restrictive than licensure standards, the certification standards shall prevail.

(B) The director of the psychosocial rehabilitation program shall be a mental health professional and shall have two (2) years of relevant work experience.

(3) The psychosocial rehabilitation program shall implement policies and procedures for intake screening, referral, and

client assignment.

(A) Intake policies and procedures shall define procedures for referral of persons ineligible for psychosocial rehabilitation services.

(B) Maximum client waiting time from initial face-to-face contact to intake screening is ten (10) working days or sooner if clinically indicated.

(C) The intake screening shall determine the client's need of psychosocial rehabilitation, functional strengths and weaknesses, and transportation needs.

(D) Full assessment and development of a psychosocial rehabilitation program plan shall occur within thirty (30) days of admission to the program.

(4) The psychosocial rehabilitation program shall establish policies and procedures to implement and maintain documentation of measurable progress in the following key services:

(A) Training/rehabilitation in community living skills;

(B) Prevocational training/rehabilitation either directly or through subcontracts, according to individual client need, including, at a minimum, but not limited to, the following:

1. Interview and job application skills;
2. Therapeutic work opportunities; and
3. Temporary employment opportunities; and

(C) Development of personal support systems through a group modality.

(5) The psychosocial rehabilitation program may provide illness management and recovery services that promote physical and mental wellness, well-being, self-direction, personal empowerment, respect, and responsibility in individual and group settings. The maximum group size for Psychosocial Rehabilitation Illness Management and Recovery shall not exceed eight (8) participants; however, if there are other curriculum-based approaches that suggest different group size guidelines, larger group sizes may be approved by the department. Services shall be person-centered and strength-based and include, but are not limited to, the following:

(A) Psychoeducation;

(B) Relapse prevention; and

(C) Coping skills training.

(6) Individual professional psychosocial rehabilitation may be provided utilizing a skills-based approach to address identified behavioral problems and functional deficits relating to a mental disorder that interferes with an individual's personal, family, or community adjustment.

(7) Group professional psychosocial rehabilitation may be provided utilizing a skills-based approach to address identified behavioral problems and functional deficits relating to a mental disorder that interferes with an individual's personal, family, or community adjustment with maximum group size of one (1) professional to eight (8) individuals.

(8) Psychosocial rehabilitation for youth may be provided as a combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the youth's ability to function as independently as possible within the family or community. Services shall be provided according to the individual treatment plan with an emphasis on community integration, independence, and resiliency. Hours of operation shall be determined by the individual providers based on capacity, staffing availability, geography, and space requirements but shall be no more than six (6) hours per day.

(9) The community psychiatric rehabilitation (CPR) provider shall provide or arrange transportation to and from the psychosocial rehabilitation program, as well as to various sites in the community, to provide off-site training/rehabilitation in realistic settings.

(10) The psychosocial rehabilitation program shall provide regular client access to facilities and equipment necessary to provide opportunities for training and rehabilitation in daily living skills, including at a minimum, those activities associated with meal preparation and laundry.

(11) The psychosocial rehabilitation program shall provide off-site services on a regular basis as part of the structured plan of activities for training/rehabilitation of community living skills.

(12) The psychosocial rehabilitation program shall provide or arrange for services on evenings and weekends, as required, to effectively address the rehabilitation needs of the program clients.

(13) The psychosocial rehabilitation program shall implement policies and procedures to provide for the participation of clients, client family members, and client advocates (with client agreement) in the planning, development, and evaluation of the psychosocial rehabilitation program's activities.]

(1) The PSR program must be accredited by CARF International, The Joint Commission, Council on Accreditation, or other accrediting body recognized by the department. If the Psychosocial Rehabilitation (PSR) program is not accredited, department licensure rules as specified in 9 CSR 40 shall apply.

(2) The community psychiatric rehabilitation (CPR) program shall provide or arrange transportation to and from the PSR site, and to/from various locations in the community, to provide individuals with opportunities for off-site training and rehabilitation in realistic settings.

(3) Policies and procedures shall be implemented for intake screening, referral, and assignment of individuals eligible for services.

(A) Intake policies and procedures shall define referral procedures to be followed for persons determined ineligible for PSR services.

(B) The maximum wait time from an individual's initial face-to-face contact with the PSR program to intake screening shall be ten (10) working days, or sooner, if clinically indicated.

(C) The intake screening shall determine the individual's need for PSR, functional strengths and weaknesses, and transportation needs.

(D) PSR services shall be incorporated into the individual's treatment plan within forty-five (45) days of admission to the program.

(4) Policies and procedures shall ensure program staff document measurable progress for individuals engaged in key services.

(A) Key services shall include, but are not limited to—

1. Training/rehabilitation in community living skills;
2. Development of personal support systems through a group modality; and

3. Prevocational training/rehabilitation provided directly by the program or through subcontract, including at a minimum—

- A. Interview and job application skills;
- B. Therapeutic work opportunities; and
- C. Temporary employment opportunities.

(B) Documentation of key services must include—

1. A weekly note summarizing specific services rendered, the individual's involvement in and response to the services, and relationship of the services to the treatment plan;

2. Pertinent information reported by family members or other natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in his or her life; and

3. Daily attendance records, including each individual's actual attendance time and the activity or session attended (this information does not need to be integrated into the individual record). Attendance records must be available to department staff and other authorized representatives for audit and monitoring purposes, upon request.

(5) PSR services shall be structured and may occur during the day, evening, weekend, or a combination of these, to effectively address the rehabilitation needs of individuals served. Services and activities are not limited to the program location/site.

(A) The program shall directly provide or ensure the following services available for individuals served:

1. Opportunities for training and rehabilitation in daily living skills, including activities associated with meal preparation and laundry, at a minimum;

2. Off-site training/rehabilitation in community living skills; and

3. Opportunities for family members/natural supports and advocates to participate in the planning, development, and evaluation of the PSR program.

(6) PSR for Adults. Services are for adults who need age-appropriate, developmentally focused rehabilitation. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to assist individuals in developing personal support systems, social skills, community living skills, and pre-vocational skills that promote community inclusion, integration, and independence.

(A) Key service functions shall include, but are not limited to—

1. Screening to evaluate the appropriateness of the individual's participation in PSR;

2. Addressing individualized program goals and objectives;

3. Enhancing independent living skills;

4. Addressing basic self-care skills; and

5. Enhancing use of personal support systems.

(B) The director of the program must be a Qualified Mental Health Professional (QMHP) with two (2) years of relevant work experience.

(C) All direct care staff must have a high school diploma or equivalent certificate.

(D) Each day program shall have, as a minimum, a daily direct care staff ratio of one (1) staff person for each sixteen (16) individuals served (1:16) unless program needs or the needs of individuals being served require otherwise.

(E) At least one (1) staff person must be on duty at all times when individuals enrolled in PSR are present at the program.

(7) PSR for Children and Youth. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to improve or maintain the child's ability to function as independently as possible within their family and/or in the community. Services are provided according to the individual treatment plan, with an emphasis on community integration, independence, and resiliency. Hours of operation are determined by the program based on capacity, staffing availability, geography, and space requirements, but shall be no more than six (6) hours daily, per child.

(A) The director must be a QMHP with two (2) years of experience working with children and youth. One (1) full-time mental health professional must be available during the provision of

services.

(B) Staffing ratios shall be based on the ages and needs of the children being served. For individuals between the ages of three (3) and eleven (11), the staffing ratio shall be one (1) staff to four (4) participants (1:4). For individuals between the ages of twelve (12) and seventeen (17), the staffing ratio shall be one (1) staff to six (6) participants (1:6).

(C) Other staff of the PSR team shall include the following, based on the needs of individuals served:

1. Registered nurse;

2. Occupational therapist;

3. Recreational therapist;

4. Rehabilitation therapist;

5. Community support specialist; and

6. Family assistance worker.

(D) Key service functions shall include, but are not limited to:

1. Assisting the child in gaining or regaining skills for community/family living such as personal hygiene, completing age-appropriate household chores, and family, peer, and school activities;

2. Developing interpersonal skills which provide a sense of participation and personal satisfaction (opportunities should be age and culturally appropriate daytime and evening activities which offer the chance for companionship, socialization, and skill building); and

3. Assisting the child and family in developing normative behaviors and expectations of relationships, and providing the opportunity to practice affiliated skills which can be valuable to an individual reestablishing family and personal support relationships.

(E) Group sessions may be provided for parents/guardians to develop and enhance parenting skills. In these situations, the PSR services and expected goals and outcomes must be documented in the child/youth's treatment plan and clearly relate to the treatment and rehabilitation goals of the child or youth.

(8) Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR). Services promote physical and mental wellness, well-being, self-direction, personal empowerment, respect, and responsibility. Services shall be provided in individual and group settings using curriculum approved by the department. Services must be delivered by staff who have completed required training.

(A) The maximum group size shall not exceed eight (8) individuals; however, if there are other curriculum-based approaches that suggest different group size guidelines, larger groups may be approved by the department.

(B) Services shall be person-centered and strength-based including, but not limited to—

1. Psychoeducation;

2. Relapse prevention; and

3. Coping skills training.

(C) CPR programs must be approved by the department to provide this service.

(D) If a program is accredited by Clubhouse International and submits its accreditation report to the department, it may be deemed as a PSR-IMR program by the department.

(E) Required documentation includes a weekly note summarizing the services rendered and the individual's response to the services, and pertinent information reported by family members or other natural supports regarding a change in the individual's condition, or an unusual/unexpected occurrence in their life, or both.

1. If an individual is participating in PSR-IMR and PSR, a single, weekly summary progress note must clearly address the PSR-IMR and PSR sessions and activities during the week, or two (2) separate summary progress notes must address each type of PSR service provided during the week.

2. Daily attendance records or logs clearly identifying and

distinguishing PSR-IMR as the specific type of session/activity, with actual attendance times and description of service, must also be maintained. The attendance records/logs must be available for audit and monitoring purposes, but do not need to be integrated into each clinical record.

AUTHORITY: section 630.655, RSMo [2000] 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED RESCISSION

9 CSR 30-4.160 Client Records. This rule prescribed the contents to be found in client records for community psychiatric rehabilitation programs.

PURPOSE: The department is rescinding this rule in its entirety because requirements for individual records will be included in Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.030.

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, 1706 E. Elm Street, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

**Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs**

PROPOSED AMENDMENT

9 CSR 30-4.190 Outpatient Mental Health Treatment Programs. The department is amending the rule title, purpose, sections (1)-(5), and deleting old section (6).

PURPOSE: This amendment updates terminology and the screening, assessment, and treatment planning requirements for outpatient mental health treatment programs.

PURPOSE: This rule prescribes policies and procedures for outpatient mental health treatment programs.

(1) Each agency that is certified by the department as an outpatient mental health treatment program shall comply with all requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance [Abuse] Use Disorder Treatment Programs, [9 CSR 10-7.030 Service Delivery Process and Documentation] 9 CSR 10-7.010 through 9 CSR 10-7.140.

(A) The agency shall have written policies and procedures defining eligibility for services, screening, admission, and clinical assessment to assist in the support of each individual.

(B) The program shall maintain reasonable hours to assure accessibility.

[(2) The program shall have written policies and procedures defining client eligibility requirements, intake procedures and client assessment.

(3) Services shall be provided under the direction of a treatment plan.

(A) An initial treatment plan shall be developed at intake during admission to the outpatient program.

(B) A master treatment plan shall be developed after ten (10) visits.

(4) The program shall provide treatment which will assist in the support and rehabilitation of client.

(A) Clients who have not received services for a six (6)-month period shall be placed on an inactive list.

(B) Clients who have not received services for a twelve (12)-month period shall be discharged from the program.

(5) All services shall be delivered by qualified professionals as defined in the Department of Mental Health Purchase of Service Catalog.

(6) The program shall maintain reasonable hours to assure accessibility.]

(2) The program shall ensure an intake screening and admission assessment is conducted in accordance with 9 CSR 10-7.030 (1) and (2).

(A) The following services shall be provided on an outpatient basis, in accordance with individual needs:

1. Crisis prevention and intervention;
2. Treatment planning;
3. Individual and group counseling;
4. Continuing recovery planning; and
5. Information and education.

(3) Services shall be provided under the direction of an individual treatment plan as specified in 9 CSR 10-7.030(4).

(A) An initial treatment plan shall be developed at intake to

address immediate needs during the admission process to the outpatient treatment program.

(B) The admission assessment and master treatment plan shall be completed within the first three (3) outpatient visits.

1. Each individual shall participate in the development of his/her treatment plan and sign the plan unless signing would be detrimental to his or her well-being. Lack of the individual's signature must be explained in a progress note and included in the individual record.

2. For children and youth, the parent or guardian must participate in the development of the treatment plan and sign the plan. Lack of parent/guardian signature must be explained in a progress note and included in the individual record.

A. The child/youth is not required to sign the plan, however, the child/youth must participate in the development of the plan, as appropriate.

(C) Treatment plans shall be reviewed and updated every ninety (90) days to reflect the individual's progress and changes in treatment goals and services.

(D) Treatment plans must be revised and rewritten at least annually.

(E) Treatment plans shall be developed and approved by a licensed mental health professional.

(4) Individual and group counseling must be delivered by a licensed mental health professional.

(5) Each agency shall maintain an organized clinical record system in accordance with 9 CSR 10-7.030(13) which ensures easily retrievable, complete, and usable records stored in a secure and confidential manner.

(A) Each agency shall implement written procedures to assure quality of individual records, including a routine review to ensure documentation requirements are being met.

AUTHORITY: sections 630.050 and 630.655, RSMo [2000] 2016. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 9—DEPARTMENT OF MENTAL HEALTH

Division 30—Certification Standards

Chapter 4—Mental Health Programs

PROPOSED AMENDMENT

9 CSR 30-4.195 Access Crisis Intervention (ACI) Programs. The department is amending the rule title, purpose, and sections (1)-(5), and deleting sections (2), (3), and (8).

PURPOSE: This amendment updates terminology and requirements for the ACI Program.

PURPOSE: This rule sets forth standards and regulations for [Access Crisis Intervention] ACI Programs.

(1) The [Access Crisis Intervention (ACI)] program is [designed to be] provided or arranged by administrative agents [with certified outpatient programs].

(3) Unless the context clearly requires otherwise, the following terms as used in this rule shall mean—

(A) Access Crisis Intervention (ACI)—crisis intervention/referral services provided **twenty-four (24) hours per day, seven (7) days per week** by telephone **hotline** or face-to-face **mobile response** at the location of the crisis or at another location in the community;

(B) Administrative agent—an agency and its approved designee(s) authorized by the Division of [Comprehensive Psychiatric Services (CPS)] **Behavioral Health (DBH)** as an entry and exit point into the state mental health service delivery system for a geographic service area defined by the [division] department;

[C] *Alcohol and drug detoxifications services—services providing detoxification which is the process of withdrawing a person from alcohol, other drugs or both in a safe, humane, and effective manner;*

(C) Advocate—individual who assists those receiving department-funded services with treatment planning, care issues, and the complaint/grievance and resolution process;

(D) Community outreach/education plan—a plan outlining how [families, consumers, consumer] individuals receiving services and their family members/natural supports, advocates, state agencies, law enforcement and others in the community will become familiar with the local Access Crisis Intervention System;

(E) Community Psychiatric Rehabilitation Program—a specialized program that provides or arranges for, at a minimum, the following core services: [intake and annual evaluations,] **eligibility determination, initial comprehensive assessment, annual assessment, treatment planning**, crisis intervention and resolution, medication services, physician/professional consultation services, medication administration, community support, **metabolic syndrome screening (for individuals receiving antipsychotic medication)**, and psychosocial rehabilitation in a nonresidential setting for individuals with serious mental illness or serious emotional disturbances; [in conjunction with standards set forth in 9 CSR 30-4.031–9 CSR 30-4.047;]

(F) Community support—as defined in 9 CSR [30-4.043(2)(F)–(G)]**30-4.047**;

[G] *Consumer—a person who receives mental health services or ACI services, regardless of source of payment. Parents and/or legal custodians/guardians of children and youth are primary consumers if they are actively engaged in the treatment planning and/or delivering services and supports for the child or youth. A secondary consumer is an individual who is concerned and involved in supporting and treating primary consumers. This category includes family members and significant others involved in the treatment and support processes; sponsors for persons who engage in substance abuse; children of parents who have mental illness or substance abuse issues; and persons who advocate for vulnerable populations;*

(H) *Consumer advocate—individuals who will assist consumers with treatment planning, care issues and the complaint/grievance and resolution process;*

(I) *Consumer satisfaction—a measure of the degree to which an individual, who is receiving or has received ACI services from the department, perceives the services to be successfully addressing, or to have successfully addressed, their individual needs for professional services;*

(J) Division—the Division of Comprehensive Psychiatric Services;

(G) Crisis Intervention Team (CIT)—law enforcement officers with specialized training for response to behavioral health crises;

(H) Individual served—anyone receiving department-funded services directly from an organization/agency;

[(K)/(I) Internal agency protocol—a specific method indicating how the agency plans to respond to guidelines set forth by the department;

[(L) Mental health coordinator—as defined in 632.005(10), RSMo;

(M) Mental health professionals—as defined in 9 CSR 30-4.030(2)(HH);]

[(N)/(J) Mobile crisis response—specialized staff available twenty-four (24) hours per day, seven (7) days per week to assess and intervene face-to-face with [consumers] individuals where the crisis is occurring or another secure location in the community;

(K) Qualified Mental Health Professional (QMHP)—as defined in 9 CSR 10-7.140;

[(O)/(L) Risk assessment—the process of assessing dangerousness to self or others;

[(P)/(M) Residential crisis services—a service used for persons who are at high risk for hospitalization or who are being diverted from hospitalization and can include specific crisis stabilization units, group homes, residential, apartments, motels/hotels, and foster home type settings;

[(Q)/(N) Specialized program—programs operated by an agency that provide specific services to designated eligible [consumers] individuals enrolled in that program;

[(R)/(O) Telephone hotline services [twenty-four (24)-hour]—a published, centralized, twenty-four (24)[-] hours per day, seven (7) days per week staffed toll-free telephone number to provide direct means of crisis assessment and triage for [consumers] individuals in crisis, their families/natural supports, and agencies needing assistance[.]; and

(P) Withdrawal management/detoxification—support provided to persons served during withdrawal from alcohol and/or other drugs.

(4) [Consumer] Records and Documentation Requirements.

(A) [Consumers] A treatment plan is not required for individuals receiving only telephone hotline or mobile outreach through the ACI program. [do not require a treatment plan, however, for current clients] Evidence of coordination between the ACI staff and the treating staff for individuals currently receiving department-funded services, [of the department] or those who are in the process of being admitted to a [mental health] CPR program, [there shall be evidence of coordination between the ACI staff and the treating staff] must be documented in the individual record.

(B) At a minimum, [those] programs funded for ACI must keep the following records for telephone hotline services when possible to obtain from caller:

1. Date and time of telephone call;
2. Identity of caller, including but not limited to, parent, [client] individual receiving services, law enforcement, judge, hospital, emergency room, mental health professional;
3. Name, address, telephone number, and date of birth;
4. Presenting problem; **and**
5. Disposition and follow-up.

(C) ACI programs must have a method for retaining hotline data in compliance with 9 CSR 10-7.030.

(D) When a call is received regarding another person, the identified [consumer] service recipient for the purpose of intervention must be the person calling, as well as, the person being called about. For data collection, the identified [consumer] service recipient is the person being called about.

(E) At a minimum, [those] agencies providing ACI services must keep the following records for mobile outreach services when the individual agrees to provide identifying information:

1. Date and time of referral;
2. Date, time, and place of face-to-face contact;
3. Person accompanying mobile worker;
4. Person in attendance at face-to-face contact;
5. Name, address, telephone number, date of birth;
6. Presenting problem; **and**
7. Disposition and follow-up.

(F) The agency must document when the [consumer] individual does not provide identifying information.

(G) Agencies providing ACI services must submit **data reports and documentation** to the department, [reports and documentation as prescribed by the department according to] **in accordance with the department's standardized form and protocol.**

(H) Agencies providing ACI services must meet the **documentation and confidentiality requirements** as defined in 9 CSR 10-7.030.

(5) Treatment.

(A) Each administrative agent must provide or arrange for the delivery of ACI services.

[(B) Consumers receiving only telephone hotline or mobile outreach through the ACI program do not require a treatment plan, however, for current clients of the department or those who are in the process of being admitted to a mental health program, there should be evidence of coordination between the ACI staff and the treating staff.]

[(C)/(B) ACI programs must operate or arrange for [a] twenty-four (24)[-] hours per day, seven (7) days per week telephone hotline. Each program shall have a written description of the telephone hotline system including the following:

1. Name of the agency or contractor that operates the hotline;
2. Numbers and qualifications of hotline staff;
3. Written documentation that clinical supervision is provided including, but not limited to: meeting minutes, supervision logs, or peer review processes;
4. Written description of how the telephone hotline is staffed;
5. Written documentation of case reviews and quality assurance activities relating to hotline services;
6. Written documentation of how telephone hotline services are provided to [hard-of-hearing, deaf and persons who have a limited understanding of the English language] **individuals who are deaf or from cultural minority groups;**
7. Written description of ongoing hotline outreach activities; **and**
8. Written description of a process for identifying and utilizing community resources in the delivery of telephone hotline services.

[(D)/(C) Each administrative agent must have a designated agency staff person or persons on call to the ACI system twenty-four (24) hours per day [and], seven (7) days per week.

[(E)/(D) If the [consumer, consumer] individual served, advocate, [or] family member/natural support requests to speak with [an individual] a staff member from a specialized program[,] including, but not limited to, the [Community Psychiatric Rehabilitation Program (CPRC)] CPR program's community support [worker] specialist and[,] the ACI clinical staff have determined [that] this action is clinically necessary, the ACI hotline staff shall contact the appropriate designated agency staff person.

[(F)/(E) The ACI hotline staff shall remain in contact with the caller until a successful hand-off contact between caller and designated agency staff person has occurred.

[(G)/(F) Once [this] contact between the caller and agency staff has occurred, the designated agency staff person shall respond to the caller and/or secure the appropriate requested specialized program personnel involved.

[(H)/(G) The designated agency staff person shall remain in contact with the caller until a successful hand-off or contact between

specialized program personnel and caller has occurred.

[(I)](H) Each administrative agent must have a written internal agency protocol in place for how the designated agency staff person will be able to contact staff from specialized programs that require twenty-four (24) hours **per day**, seven (7) days per week crisis intervention as a component of their service menu.

[(J)](I) If ACI staff does not follow the procedure listed in *[(I)] and (J) of this section,* subsection (H) of this section, there must be a written protocol for contacting the ACI supervisor and the specialized program supervisor within twenty-four (24) hours to review the immediate action taken and then reviewed for a *[quality assurance] performance improvement* process within forty-eight (48) hours.

[(K)](J) ACI programs must have a written description for resource and referral to the following services:

1. Acute hospitalization;
2. Medical services;
3. *[Alcohol and drug detoxification] Withdrawal management/detoxification* services;
4. Priority outpatient scheduling within twenty-four (24) hours or the next working day;
5. Children and youth services; **and**
6. Psychiatric availability;
7. *Civil involuntary detentions when initiated by the mental health coordinators.*

[(L)](K) ACI programs must operate *[a] twenty-four (24)[-] hours per day, seven (7) days per week* mobile response system. Each program shall have a written description of the mobile response system including the following:

1. Name of the agency or contractor that operates the *[hotline] mobile response system*;
2. Written description of how mobile crisis response teams are staffed twenty-four (24) hours per day, seven (7) days per week;
3. Numbers and qualifications of staff;
4. Written documentation that clinical supervision is provided including, but not limited to: meeting minutes, supervision logs, or peer review processes;
5. Written documentation of case reviews and quality assurance activities relating to mobile response services; **and**
6. Written documentation of how mobile response services respond to *[hard-of-hearing, deaf and persons who have a limited understanding of the English language] individuals who are deaf or from cultural minority groups.*

[(M)](L) ACI programs shall provide mobile response to known and unknown *[consumers] individuals* twenty-four (24) hours per day *[and]*, seven (7) days per week at the location of the crisis or *[to]* another secure community location.

[(N)](M) Mobile response shall not be provided exclusively in emergency rooms, jails or mental health facilities.

[(O)](N) When a call is referred to mobile response, a phone-only response is appropriate if the clinical needs of the person who is in crisis can be addressed over the phone and/or the crisis has been deescalated.

[(P)](O) Each agency providing ACI services must have safety mechanisms in place for mobile response. These may include, but are not limited to:

1. Mobile phones;
2. Risk assessments *[both]* for phone and continually during contact;
3. Availability of multiple staff to respond for face-to-face contact;
4. Backup *[available by pager] availability*; **and**
5. Written protocols for mobile response to be delivered in safe locations when necessary.

[(Q)](P) In crisis situations in which law enforcement need to be contacted by the ACI staff, the ACI staff must make the initial contact and remain involved until the crisis is resolved, *[either]* by phone or with the mobile response team. **Law enforcement officers trained in crisis intervention shall be contacted first, if they are**

available in the city/county where the crisis situation is taking place, and ACI staff have established arrangements to make direct contact with them.

[(R)](Q) If the caller is not satisfied, the grievance procedure must be followed as defined in 9 CSR 10-7.020(7)*[(A)-(C)]*.

(6) *[Quality Assurance.] Performance Improvement.*

(A) Each *[agency] administrative agent [providing ACI services]* must develop a community outreach/education plan that includes details of how the following groups will become familiar with the ACI system:

1. Families/**natural supports**;
2. *[Consumers] Individuals receiving services*;
3. *[Consumer advocates] Advocates of individuals receiving services*;
4. State agencies including, **but not limited to**, the *[Division of Family Services, Division] Family Support Division, Children's Division, Division of Youth Services, Department of Health and Senior Services, Senior and Disability Services, and [Division of Youth Services] Department of Corrections, Division of Probation and Parole*;
5. *[Law enforcement agencies;] Emergency responders (law enforcement agencies, 911, paramedics)*;
6. *911 personnel*;
7. **6. Primary and secondary [S]schools**;
8. *Juvenile courts*;
7. **Court system including, but not limited to, juvenile, family, mental health, and drug courts**;
9. *Emergency medical services personnel*;
10. **8. Residential care [facilities;] programs, homeless shelters, public housing**;
11. *Homeless shelters and/or providers*;
12. *Public housing*;
9. **Public health agencies**;
10. **Community health centers**;
11. **Primary care medical offices**; **and**
13. **12. General public.**

(D) Agencies providing ACI services must, *[at least annually, [demonstrate community awareness] be able to demonstrate their community awareness and education activities, at least annually, in a report or other format specified by the department which may include, but is not limited to, number of hotline calls, walk-ins, media outreach, and outreach/educational efforts with schools, law enforcement, or other entities in the community.*

(E) The telephone number for ACI must be published in *[a] local telephone books distributed in each service area and be prominently displayed on agency websites and social media pages.*

(F) If the level of crisis services provided by an agency is significantly below the state average~~,~~ or other established benchmarks, this circumstance must be addressed in the *[Quality Assurance] performance improvement [P]plan.*

[(G)] Programs providing ACI services must conduct the Consumer Satisfaction ACI Interview Survey as prescribed by the department.

(G) Agencies providing ACI services must promptly respond to requests from local institutions of higher education to assist in developing appropriate crisis response systems on college campuses.

(7) Personnel and Staff Development.

(A) Staff providing telephone hotline services must have a bachelor's degree with three (3) years of behavioral health and crisis intervention experience or a master's degree with one (1) year of behavioral health and crisis intervention experience.

1. Staff providing telephone hotline services must be supervised by a *[qualified mental health professional as defined in 9 CSR 30-4.030] QMHP.*

2. Staff providing telephone hotline services must have immediate access to a [qualified mental health professional] QMHP.

(B) For mobile response, the mobile crisis team shall have at least one (1) [qualified mental health professional] QMHP to provide face-to-face crisis intervention for each mobile response.

(C) Each administrative agent shall designate a coordinator for ACI services who must be a [qualified mental health professional as defined in 9 CSR 30-4.030] QMHP.

(D) The agency shall have written documentation that clinical supervision is provided on a scheduled basis including, but not limited to: meeting minutes, supervision logs, or peer review processes.

(E) For administrative agents that subcontract for hotline services this standard applies. Administrative agents shall have designated staff on call to the ACI system twenty-four (24) hours per day, seven (7) days per week for specialized programs. This designated staff person or persons shall have received crisis intervention training and have experience in responding to crisis situations with individuals and families.

(F) Each [region and/or provider must] agency shall have an ACI Training Plan. The training plan shall include [consumers] individuals served, families/natural supports, and [consumer] advocates in the development and implementation of the plan.

(G) Staff providing ACI services shall complete the designated ACI training required by the department[,] at least annually[,] that includes, but is not limited to, the following core competencies as defined by the department:

1. Crisis intervention strategies and techniques;
2. ACI and legal issues;
3. Safety;
4. ACI responsiveness to [consumers] individuals and families served; and

5. [Other competencies as required by the department.] Available resources and services in the community.

(K) Each agency shall provide a written plan of how it will measure the competencies of the ACI staff. The plan must include at least two (2) measurable outcomes including, but not limited to:

1. Review of case documentation;
2. Review of assessment forms for appropriate interventions;

and

3. Question, answer, [and] observation, and feedback by supervisory staff and peers[;].

[4. Consumer satisfaction and clinical outcomes.]

(L) New ACI staff must receive clinical supervision and [must] job-shadow the supervisor or experienced crisis workers for a minimum of [two (2) weeks] forty (40) hours prior to providing crisis services.

[(M) 9 CSR 10-7.110 requires that all staff participate in at least thirty-six (36) clock hours of relevant training during a two (2)-year period. All staff working within the ACI program and services shall receive a minimum of twelve (12) clock hours per year of continuing education and relevant training.

(N) All training activities shall be documented in employee personnel files, to include the training topic, name of instructor, date of activity, duration, skills targeted/objective of skill, certification/continuing education units (if any) and location.

(8) Fiscal Management. The agency will provide financial information to the department or any of its divisions upon request, relating but not limited to, program administration and services provided through any programs, services or activity using funds provided by the department.]

AUTHORITY: sections 630.050 and 630.655, RSMo [2000] 2016. Original rule filed Aug. 28, 2002, effective April 30, 2003. Amended: Filed Dec. 29, 2003, effective July 30, 2004. Amended: Filed April 29, 2019.

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 by writing to Gail Vasterling, General Counsel, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be delivered by regular mail, express or overnight mail, or by courier within thirty (30) days after publication in the *Missouri Register*. If to be hand-delivered, comments must be brought to the Department of Mental Health at 1706 E. Elm Street, Jefferson City, Missouri. No public hearing is scheduled.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

PROPOSED AMENDMENT

10 CSR 10-6.050 Start-Up, Shutdown, and Malfunction Conditions. The commission proposes to amend section (2) and subsections (3)(A) and (3)(B). If the commission adopts this rule action, the department intends to submit this rule amendment to the U.S. Environmental Protection Agency to replace the current rule that is in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Proposed Rules website www.dnr.mo.gov/proposed-rules.

PURPOSE: This rule, applicable to all installations in Missouri, provides the owner or operator of an installation the opportunity to submit data regarding conditions which result in excess emissions. This amendment is to comply with Executive Order 17-03 criteria and update the notification process per U.S. Environmental Protection Agency (EPA) comments received during the 2010 rulemaking, add definitions specific to this rule, and remove any unnecessary restrictive words. The evidence supporting the need for this proposed rulemaking, per 536.016, RSMo, is Executive Order 17-03 and an EPA email dated January 19, 2010.

(2) Definitions. [Definitions of certain terms in this rule, other than those specified in this rule section, may be found in 10 CSR 10-6.020.]

(A) Excess emissions—The emissions which exceed the requirements of any applicable emission control regulation.

(B) Malfunction—A sudden and unavoidable failure of air pollution control equipment or process equipment or of a process to operate in a normal and usual manner. Excess emissions caused by improper design is not a malfunction.

(C) Shutdown—The cessation of operation of any air pollution control equipment or process equipment, except the routine phasing out of process equipment.

(D) Start-up—The setting into operation of any air pollution control equipment or process equipment, except the routine phasing in of process equipment.

(E) Definitions of certain terms in this rule, other than those specified in this rule section, may be found in 10 CSR 10-6.020.

(3) General Provisions.

(A) In the event of a malfunction[,] which results in excess emissions that exceeds one (1) hour, the owner or operator of such facility shall notify the Missouri Department of Natural Resources' Air Pollution Control Program in the form of a written report [which shall be] submitted [within] **as-soon-as-possible, but no more than** two (2) business days. The written report shall include, at a minimum, the following:

1. Name and location of installation;
2. Name and telephone number of person responsible for the installation;
3. Name of the person who first discovered the malfunction and precise time and date that the malfunction was discovered;
4. Identity of the equipment causing the excess emissions;
5. Time and duration of the period of excess emissions;
6. Cause of the excess emissions;
7. Air pollutants involved;
8. Estimate of the magnitude of the excess emissions expressed in the units of the applicable requirement and the operating data and calculations used in estimating the magnitude;
9. Measures taken to mitigate the extent and duration of the excess emissions; and
10. Measures taken to remedy the situation which caused the excess emissions and the measures taken or planned to prevent the recurrence of these situations.

(B) The owner or operator shall notify the Missouri Department of Natural Resources' Air Pollution Control Program at least ten (10) days prior to any maintenance, start-up, or shutdown activity, which is expected to cause an excess release of emissions that exceeds one (1) hour. If notification cannot be given ten (10) days prior to any maintenance, start-up, or shutdown activity, which is expected to cause an excess release of emissions that exceeds one (1) hour, notification shall be given as soon as practicable prior to the maintenance, start-up, or shutdown activity. If prior notification is not given for any maintenance, start-up, or shutdown activity which resulted in an excess release of emissions that exceeded one (1) hour, notification shall be given [within] **as-soon-as-possible, but no more than** two (2) business days of the release. In all cases, the notification shall be a written report and [shall] include, at a minimum, the following:

1. Name and location of installation;
2. Name and telephone number of person responsible for the installation;
3. Identity of the equipment involved in the maintenance, start-up, or shutdown activity;
4. Time and duration of the period of excess emissions;
5. Type of activity and the reason for the maintenance, start-up, or shutdown;
6. Type of air contaminant involved;
7. Estimate of the magnitude of the excess emissions expressed in the units of the applicable emission control regulation and the operating data and calculations used in estimating the magnitude;
8. Measures taken to mitigate the extent and duration of the excess emissions; and
9. Measures taken to remedy the situation which caused the excess emissions and the measures taken or planned to prevent the recurrence of these situations.

AUTHORITY: section 643.050, RSMo [2000] 2016. Original rule filed March 15, 1979, effective Nov. 11, 1979. Amended: Filed April 2, 1987, effective Aug. 27, 1987. Amended: Filed June 15, 2001, effective Feb. 28, 2002. Amended: Filed Nov. 13, 2009, effective July 30, 2010. Amended: Filed May 1, 2019.

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 enti-

ties more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m. July 25, 2019. The public hearing will be held at the St. Louis Regional Office, 7545 South Lindbergh, Suite 220, DESE Conference Room, St. Louis, Missouri. Opportunity to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a statement of their views until 5:00 p.m., August 1, 2019. Send online comments via the proposed rules web page www.dnr.mo.gov/proposed-rules, email comments to apcprulespn@dnr.mo.gov, or written comments to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling
and Reference Methods and Air Pollution Control
Regulations for the Entire State of Missouri

PROPOSED AMENDMENT

10 CSR 10-6.140 Restriction of Emissions Credit for Reduced Pollutant Concentrations From the Use of Dispersion Techniques.

The commission proposes to amend sections (1) thru (3) and add sections (4) and (5). If the commission adopts this rule action, the department intends to submit this rule amendment to the U.S. Environmental Protection Agency to replace the current rule that is in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Proposed Rules website www.dnr.mo.gov/proposed-rules.

PURPOSE: This rule implements provisions of federal regulations which restrict credit in the calculation of emission limitations for reduced pollutant concentrations due to the use of dispersion techniques. This amendment is to comply with Executive Order 17-03 criteria by adding a reference in the applicability section, adding definitions specific to this rule, making changes as a result of rule comment forms, and removing any unnecessary restrictive words. The evidence supporting the need for this proposed rulemaking, per 536.016, RSMo, is Executive Order 17-03 Red Tape Reduction Review and rule comment forms dated May 29, 2013 and February 25, 2016.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Applicability.

(A) This rule [shall apply] **applies** to the procedures to account for emission dispersion techniques used in the calculation of any emission limitation or any revision of any limitation to be established by the director or to be considered for establishment by the Missouri Air Conservation Commission (MACC). This rule also requires that all emission limitations established by the director or by the MACC after December 31, 1970, be reviewed for compliance with this rule.

(B) 40 CFR 51, Appendix W, promulgated as of July 1, 2017 shall apply and is hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington DC 20401. This rule does not incorporate any subsequent amendments or additions.

(C) Exemptions. The provisions of section (3) of this rule do not apply to emission limitation credits from—

1. Stack heights on which construction commenced on or before December 31, 1970, except where pollutants are being emitted from the stacks by source operations which were constructed, reconstructed, or on which major modifications were carried out after December 31, 1970; or

2. Dispersion techniques implemented before December 31, 1970, except where these dispersion techniques are being applied to source operations which were constructed, reconstructed, or on which major modifications were carried out after December 31, 1970.

[(2) General.

(A) The degree of emission limitation required of any installation for control of any air pollutant must not be affected by that portion of any installation's stack height that exceeds good engineering practice (GEP) or by any other dispersion technique, except as provided in section (3).

(B) Before the director or the MACC establishes an emission limitation that is based on a GEP stack height that exceeds the formula GEP height allowed by 10 CSR 10-6.020 (2)(G)2.B., the director must notify the public of the availability of the demonstration study and must provide opportunity for public hearing on it.

(C) This rule does not restrict the actual stack height of any installation or the use of any dispersion technique by any installation.

(3) Exemptions. The provisions of section (2) shall not apply to emission limitation credits from—

(A) Stack heights on which construction commenced on or before December 31, 1970, except where pollutants are being emitted from the stacks by source operations which were constructed, or reconstructed or on which major modifications were carried out after December 31, 1970; or

(B) Dispersion techniques implemented before December 31, 1970, except where these dispersion techniques are being applied to source operations which were constructed, or reconstructed or on which major modifications were carried out after December 31, 1970.]

(2) Definitions.

(A) Commence—For the purposes of major stationary source construction or major modification, the owner or operator has all necessary preconstruction approvals or permits and—

1. Began, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

2. Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the source to be completed within a reasonable time.

(B) Dispersion technique—

1. Any technique designed to affect the concentration of a pollutant in the ambient air by—

A. Using that portion of a stack which exceeds good engineering practice stack height;

B. Varying the rate of emission of a pollutant according to atmospheric conditions or ambient concentrations of that pollutant; or

C. Increasing final exhaust gas plume rise by manipulating source process parameters, exhaust gas parameters, stack parameters, or combining exhaust gases from several existing stacks into one (1) stack; or other selective handling of exhaust gas streams so as to increase the exhaust gas plume rise; and

2. This definition does not include:

A. The reheating of a gas stream, following use of a pollution control system, for the purpose of returning the gas to the temperature at which it was originally discharged from the installation generating the gas stream;

B. The merging of exhaust gas streams where—

(I) The installation owner or operator demonstrates that the installation was originally designed and constructed with the merged gas streams;

(II) After July 8, 1985, the merging is part of a change in operation at the installation that includes the installation of emissions control equipment and is accompanied by a net reduction in the allowable emissions of a pollutant. This exclusion from the definition of dispersion technique shall apply only to the emission limitation for the pollutant affected by a change in operation; or

(III) Before July 8, 1985, the merging was part of a change in operation at the installation that included the installation of emissions control equipment or was carried out for sound economic or engineering reasons. Where there was an increase in the emission limitation or in the event that no emission limitation was in existence prior to the merging, the director shall presume that merging was significantly motivated by an intent to gain emissions credit for greater dispersion. Without a demonstration by the source owner or operator that merging was not significantly motivated by that intent, the director shall deny credit for the effects of merging in calculating the allowable emissions for the source;

C. Smoke management in agricultural or silvicultural prescribed burning programs;

D. Episodic restrictions on residential woodburning and open burning; or

E. Techniques under subparagraph (2)(B)1.C. of this rule which increase final exhaust gas plume rise where the resulting allowable emissions of sulfur dioxide from the installation do not exceed five thousand (5,000) tons per year.

(C) Emission limitation—A regulatory requirement, permit condition, or consent agreement which limits the quantity, rate, or concentration of emissions on a continuous basis, including any requirement which limits the level of opacity, prescribes equipment, sets fuel specifications, or prescribes operation or maintenance procedures for an installation to assure continuous emission reduction.

(D) Excessive concentration—

1. For installations seeking credit for reduced ambient pollutant concentrations from stack height exceeding that defined in paragraph (2)(E)2. of this rule, an excessive concentration is a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, or eddy effects produced by nearby structures or nearby terrain features which are at least forty percent (40%) in excess of the maximum concentration experienced in the absence of the downwash, wakes, or eddy effects, and that contributes to a total concentration due to emissions from all installations that is greater than an ambient air quality standard. For installations subject to the prevention of significant deterioration program as set forth in 10 CSR 10-6.060(8), an excessive concentration means a maximum ground-level concentration due to emissions from a stack due to the same conditions as mentioned previously and is greater than a prevention of significant deterioration increment. The allowable emission rate to be used in making demonstrations under this definition shall be prescribed by the new source performance regulation as referenced by 10 CSR 10-6.070 for the source category

unless the owner or operator demonstrates that this emission rate is infeasible. Where demonstrations are approved by the director, an alternative emission rate shall be established in consultation with the source owner or operator;

2. For installations seeking credit after October 11, 1983, for increases in stack heights up to the heights established under paragraph (2)(E)2. of this rule, an excessive concentration is either—

A. A maximum ground-level concentration due in whole or part to downwash, wakes, or eddy effects as provided in paragraph (2)(D)1. of this rule, except that the emission rate used shall be the applicable emission limitation (or, in the absence of this limit, the actual emission rate); or

B. The actual presence of a local nuisance caused by the stack, as determined by the director; and

3. For installations seeking credit after January 12, 1979, for a stack height determined under paragraph (2)(E)2. of this rule where the director requires the use of a field study of fluid model to verify good engineering practice stack height, for installations seeking stack height credit after November 9, 1984, based on the aerodynamic influence of cooling towers, and for installations seeking stack height credit after December 31, 1970, based on the aerodynamic influence of structures not represented adequately by the equations in paragraph (2)(E)2. of this rule, a maximum groundlevel concentration due in whole or part to downwash, wakes, or eddy effects that is at least forty percent (40%) in excess of the maximum concentration experienced in the absence of downwash, wakes, or eddy effects.

(E) Good engineering practice (GEP) stack height—The greater of—

1. Sixty-five meters (65 m) measured from the ground-level elevation at the base of the stack;

2. For stacks on which construction commenced on or before January 12, 1979, and for which the owner or operator had obtained all applicable permits or approvals required under 40 CFR 51 and 52, $H_g = 2.5H$ provided the owner or operator produces evidence that this equation was actually relied on in establishing an emission limitation; and for all other stacks, $H_g = H + 1.5L$ Where: H_g = GEP stack height, measured from the ground-level elevation at the base of the stack; H = height of nearby structure(s) measured from the ground-level elevation at the base of the stack; and L = lesser dimension, height, or projected width of the nearby structure(s). Provided that the director may require the use of a field study or fluid model to verify GEP stack height for the installation; or

3. The height demonstrated by a fluid model or field study approved by the director, which ensures that the emissions from a stack do not result in excessive concentrations of any air pollutant as a result of atmospheric downwash, wakes, or eddy effects created by the source itself, nearby structures, or nearby terrain features.

(F) Major modification—Any physical change or change in the method of operation at an installation or in the attendant air pollution control equipment that would result in a significant net emissions increase of any pollutant. A physical change or a change in the method of operation, unless previously limited by enforceable permit conditions, shall not include:

1. Routine maintenance, repair, and replacement of parts;

2. Use of an alternative fuel or raw material by reason of an order under sections 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974, a prohibition under the Power Plant and Industrial Fuel Use Act of 1978, or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;

3. Use of an alternative fuel or raw material, if prior to January 6, 1975, the source was capable of accommodating the fuel or material, unless the change would be prohibited under any enforceable permit condition which was established after

January 6, 1975;

4. An increase in the hours of operation or in the production rate unless the change would be prohibited under any enforceable permit condition which was established after January 6, 1975; or

5. Use of an alternative fuel by reason of an order or rule under section 125 of the Clean Air Act.

(G) Nearby—Nearby, as used in the definition good engineering practice (GEP) stack height in paragraph (2)(E)2. of this rule, is defined for a specific structure or terrain feature—

1. For purposes of applying the formula provided in paragraph (2)(E)2. of this rule, nearby means that distance up to five (5) times the lesser of the height or the width dimension of a structure, but not greater than one-half (1/2) mile; and

2. For conducting fluid modeling or field study demonstrations under paragraph (2)(E)3. of this rule, nearby means not greater than one-half (1/2) mile, except that the portion of a terrain feature may be considered to be nearby which falls within a distance of up to ten (10) times the maximum height of the feature, not to exceed two (2) miles if feature achieves a height one-half (1/2) mile from the stack that is at least forty percent (40%) of the GEP stack height determined by the formula provided in paragraph (2)(E)2. of this rule, or twenty-six meters (26 m), whichever is greater, as measured from the ground-level elevation at the base of the stack. The height of the structure or terrain feature is measured from the ground-level elevation at the base of the stack.

(H) Stack—Any spatial point in an installation designed to emit air contaminants into ambient air. An accidental opening such as a crack, fissure, or hole is a source of fugitive emissions, not a stack.

(I) Definitions of certain terms in this rule, other than those specified in this rule section, may be found in 10 CSR 10-6.020.

(3) General Provisions.

(A) The degree of emission limitation required of any installation for control of any air pollutant must not be affected by that portion of any installation's stack height that exceeds good engineering practice (GEP) or by any other dispersion technique, except as provided in section (1).

(B) Before the director or the MACC establishes an emission limitation that is based on a GEP stack height that exceeds the formula GEP height allowed by this rule, the director must notify the public of the availability of the demonstration study and must provide opportunity for public hearing on it.

(C) This rule does not restrict the actual stack height of any installation or the use of any dispersion technique by any installation.

(4) Reporting and Recordkeeping. (*Not applicable*)

(5) Test Methods. (*Not applicable*)

AUTHORITY: section 643.050, RSMo Supp. [1992] 2016. Original rule filed Jan. 6, 1986, effective May 11, 1986. Amended: Filed May 1, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., July 25, 2019. The public hearing will be held at the St. Louis Regional Office, 7545 South Lindbergh, Suite 220, DESE Conference Room, St. Louis, Missouri. Opportunity to be heard at

the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a statement of their views until 5:00 p.m., August 1, 2019. Send online comments via the proposed rules web page www.dnr.mo.gov/proposed-rules, email comments to apcprulespn@dnr.mo.gov, or written comments to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming**

PROPOSED AMENDMENT

11 CSR 45-5.190 Minimum Standards for Electronic Gaming Devices. The commission is amending section (4).

PURPOSE: This amendment permits additional games to be authorized in Missouri.

(4) Electronic gaming devices shall—

(H) Have a random selection process that must not produce detectable patterns of game elements or detectable dependency upon any previous game outcome, the amount wagered, or upon the style or method of play; **however, the commission may allow a game with a game feature or play mechanic with a detectable dependency if a white paper for the game feature or play mechanic is submitted to and approved by the commission prior to testing by an independent testing laboratory (ITL). The commission reserves the right to require the removal of the program if it determines, in its sole discretion, that removal is in the best interest of the state of Missouri;**

(L) Have available for random selection at the initiation of each play **based upon the selected wager**, each possible permutation or combination of game elements which produce winning or losing game outcomes **for that wager; however, the commission may allow a game with a game feature or play mechanic that does not offer each possible winning or losing game outcome if a white paper for the game feature or play mechanic is submitted to and approved by the commission prior to testing by an ITL. The commission reserves the right to require the removal of the program if it determines, in its sole discretion, that removal is in the best interest of the state of Missouri;** and

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, [and] 313.805, and 313.807, RSMo [Supp. 2013] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming

Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming**

PROPOSED AMENDMENT

11 CSR 45-5.200 Progressive Slot Machines. The commission is amending sections (2) and (8), adding a new section (3), and renumbering sections after that.

PURPOSE: This amendment changes regulations for progressive slot machines.

(2) A meter that shows the accurate amount of the progressive jackpot must be conspicuously displayed at or near the machines to which the jackpot applies. At a minimum, on the same day each week while the casino is closed, each licensee shall record the amount displayed on each progressive's top award jackpot meter at the licensee's establishment, except for wide-area progressive systems and stand-alone progressives where the software for the progressive is embedded within the [EGD's] **electronic gaming device's** Critical Program Storage Media (CPSM). The top award jackpot amount shall be reconciled to the [system] meters [by multiplying the progression rate by the amount-in for the period between which the meter amounts were recorded, less any jackpots that have occurred plus any reset amounts] **using the reconciliation formula provided by the supplier.** In order to perform this reconciliation, the top award jackpot on these local progressive games shall require the **electronic gaming device (EGD)** to lock-up requiring a hand-paid jackpot. The licensee authorized to provide a wide-area progressive system shall perform the required reconciliation for each system provided by such licensee. At the conclusion of the reconciliation, if a variance exists between the amount shown on each progressive jackpot meter and the expected amount, the licensee shall document the variance amount. The licensee shall make the necessary adjustment(s) to ensure the correct amount is displayed by the end of the gaming day following the day on which the reconciliation occurred. Explanations for meter reading differences or adjustments thereto shall be maintained with the progressive meter reading sheets. In addition to the weekly reconciliation, each licensee shall record the top award jackpot progressive meter display amount once each banking day for each non-exempt progressive EGD to ensure jackpot resets occurred properly, to determine whether the meters incremented since the last reading, and to identify any obvious atypical results which could indicate there is a problem with the progressive meter. If known variances are discovered during the daily review, which require a change to the meter display of one dollar (\$1) or more, the meter display shall be adjusted by the end of the gaming day. Each licensee shall record the base amount of each progressive jackpot the licensee offers.

(3) Suppliers shall have progressive reconciliation instructions and a method to adjust the current progressive award value(s) displayed, including hidden meters, for each progressive EGD, provide them to the Class B licensee, and make the instructions immediately available to the commission upon request.

[(3)](4) A licensee may impose a limit on the jackpot of a progressive slot machine if the limit imposed is greater than the possible maximum jackpot payout on the slot machine at the time the limit is imposed. The licensee must inform the public with a prominently posted notice of progressive slot machines that have limits. Such notice shall clearly state the amount of the limits and must be approved by the commission.

[(4)](5) A licensee shall not reduce the amount displayed on a progressive jackpot meter or otherwise reduce or eliminate a progressive jackpot unless—

(A) A player wins the jackpot; or

(B) The licensee adjusts the progressive jackpot meter to correct a malfunction or to prevent the display of an amount greater than a limit imposed pursuant to section (3) of this rule and the licensee documents the adjustment and the reasons for it; or

(C) The licensee's gaming operations at the establishment cease for any reason other than a temporary closure where the same licensee resumes gaming operations at the same establishment within a month; or

(D) The licensee distributes the incremental amount to another progressive jackpot as approved in writing by the commission and—

1. The licensee documents the distribution;

2. Any machine offering the jackpot to which the licensee distributes the incremental amount does not require that more money be played on a single play to win the jackpot than the machine from which the incremental amount is distributed;

3. Any machine offering the jackpot to which the incremental amount is distributed complies with the minimum theoretical payout requirement of 11 CSR 45-5.190(1); and

4. The distribution is completed within thirty (30) days after the progressive jackpot is removed from play or within a longer period as the commission for good cause may approve; or

(E) The commission for good cause approves a reduction, elimination, distribution, or procedure not otherwise described in this section, which approval is confirmed in writing.

[(5)](6) The operation of wide-area progressive slot machines is allowed subject to compliance with all other requirements of this rule, in addition to the following conditions:

(A) The wide-area system must have the ability to monitor entry into the main door of each networked slot machine as well as the logic area of each networked slot machine and report it to the central system immediately;

(B) A licensee utilizing a wide-area progressive system must suspend play on the system if a communication failure in the system cannot be corrected within a period of time approved by the commission prior to the commencement of play on the wide-area progressive system. If a communication failure occurs in a wide-area progressive system, the licensee authorized to provide the system must take a reading during the time the system is down to make sure that the jackpot amount is the same at all excursion gambling boats connected to the system before bringing the system that failed back online;

(C) The licensee authorized to provide a wide-area system must keep a hard or electronic copy log of all events for a period of at least sixty (60) days;

(D) Jackpot verification procedures must include the following:

1. When a jackpot is won, the licensee authorized to provide the wide-area system may inspect the machine when accompanied by a gaming agent. The inspection shall include examining the critical program storage media, the error events received by the central system, and any other data which could reasonably be used to ascertain the validity of the jackpot;

2. The central system shall produce reports that will clearly demonstrate the method of arriving at the payoff amount. This shall include the amount contributed beginning at the polling cycle or data transfer immediately following the previous jackpot and will include all amounts contributed up to, and including, the polling cycle or data transfer, which includes the jackpot signal. Amounts contributed to the system before the jackpot message is received will be deemed to have been contributed to the progressive amount prior to the current jackpot. Amounts contributed to the system subsequent to the jackpot message being received will be deemed to have been contributed to the progressive amount of the next jackpot;

3. The jackpot may be paid in installments as long as each machine clearly displays the fact that the jackpot will be paid in

installments. In addition, the number of installments and time between installments must be clearly displayed on the face of the machine in a non-misleading manner that is approved by the commission; and

4. Two (2) jackpots that occur in the same polling cycle or data transfer will be deemed to have occurred simultaneously and therefore, each "winner" shall receive the full amount shown on the meter unless another method of operation has been approved in advance by the commission;

(E) Approval by the commission of any wide-area progressive system shall occur in two (2) phases—

1. The "initial approval" stage, wherein the underlying gaming devices and any associated device or system, including all hardware and software, shall be subject to testing by the commission or an independent testing laboratory designated by the commission; and review and approval by the commission. Testing shall include examination for adherence to the regulatory and technical standards adopted by the commission; and

2. The "on-site testing" phase, wherein a field inspection is conducted at the central computer site as well as multiple field sites to ensure compliance with these rules. Operation of the system will be authorized only after the commission is satisfied that the system meets both the Phase I and Phase II testing requirements, as well as any other requirements that the commission may impose to assure the integrity, security and legal operation of the wide-area progressive system;

(F) Any licensee authorized to provide a wide-area progressive system, must supply reports to the commission which support and verify the economic activity on the system;

(G) Any licensee authorized to provide a wide-area progressive system, must supply, as requested, reports and information to the commission indicating the amount of, and basis for, the current jackpot amount (the amount currently in play). Such reports shall include an "aggregate report" and a "detail report." The "aggregate report" shall show only the balancing of the system with regard to system-wide totals. The "detail report" shall be in such form as to indicate for each machine, summarized by location, the amount-in and amount-out totals as such terms are commonly understood in the industry. In addition, upon the invoicing of any licensee participating in a wide-area progressive system, each such licensee must be given a printout of each machine at that licensee's establishment linked to the system, the amount contributed by each machine to the jackpot for the period for which an invoice is remitted, and any other information required by the commission to confirm the validity of the licensee's contributions to the jackpot amount;

(H) The licensee authorized to provide a wide-area progressive system, must obtain approval from the commission as to the methods of funding the progressive prize pool and calculating and receiving payments from participating licensees for the provision of equipment and services associated with the wide-area progressive system;

(I) In calculating Adjusted Gross Receipts, a licensee may deduct its pro rata share of the present value of any progressive jackpots awarded during the month. The deducted amount shall be listed on the detailed accounting records provided by the licensee authorized to provide the wide-area progressive system. A licensee's contribution is based on the amount-in from machines at that licensee's gaming establishment which are on the wide-area progressive system, compared to the total amount-in on the whole system for the time period(s) between jackpot(s) awarded;

(J) The right to receive the jackpot payments may not be encumbered, assigned, or otherwise transferred in any way by any winner, estate, or heir(s) of a deceased winner, except to the estate or heir(s) of such person upon his/her death and that any attempt to make a prohibited transfer may result in such person forfeiting the right to receive future payments;

(K) In the event a licensee ceases operations and a progressive jackpot is awarded subsequent to the last day of the final month of operation, the licensee may not file an amended tax return or make

claim for a gaming tax refund based on its contributions to that particular progressive prize pool;

(L) The central monitoring system for the wide-area progressive system must be in a location approved by the commission. The office containing the central monitoring system shall be secure and shall have surveillance coverage that has been approved by the commission. The central monitoring system shall employ on-line data redundancy that permits a complete and prompt recovery of all information in the event of any malfunction and utilize environmental controls such as uninterruptible power supplies and fireproof and waterproof materials to protect critical hardware and software from natural disasters. The licensee authorized to provide a wide-area progressive system shall be required to keep and maintain an entry and exit log for the office in a manner approved by the commission. The commission shall at all times have the right to immediate access to the office containing the central monitoring system and the system itself. If the licensee operating the central monitoring system proposes to locate the system outside the state of Missouri, the licensee shall reimburse the commission for all reasonable and necessary expenses incurred by its agents—

1. To travel to the site to inspect the system's configuration and operation prior to authorizing use of the system;
2. To otherwise inspect the system location in connection with investigations concerning failures of the system or its operation; or
3. For such other reasons as the commission deems appropriate;

(M) The provider of the wide-area progressive system may not allow any agent or employee to work on any component of the system until that person has obtained a level II occupational license from the commission; however, the commission may require any agent or employee of the licensee to obtain a level I occupation license;

(N) The licensee authorized to provide a wide-area progressive system, must maintain a copy of all lease and contractual agreements relating to the wide-area progressive system and supply a copy to the commission upon request;

(O) The licensee authorized to provide a wide-area progressive system shall ensure the wide-area progressive system prize fund (the amount of money contributed by the participating licensees) is audited, in accordance with generally accepted auditing standards, on the fiscal year-end of the licensee, by an independent certified public accountant licensed by the Missouri State Board of Accountancy pursuant to Chapter 326, RSMo. Two (2) copies of this report must be submitted to the commission upon issuance of the audit report or ninety (90) days after the conclusion of the licensee's fiscal year, whichever occurs first. The cost of the audit shall be paid by the licensee providing the wide-area progressive system; and

(P) Gaming devices connected to a common wide-area progressive system shall:

1. All require the same maximum wager; or
2. If requiring different maximum wagers, utilize the expected value of winning the top award by setting the odds of winning the top award in proportion to the amount wagered. The method of equalizing the expected value of winning the top award shall be conspicuously displayed on each device connected to the system.

[[6]](7) Licensees shall preserve the records required by this rule for at least five (5) years after they are made unless the commission approves otherwise in writing. The records should be stored in a location acceptable to the commission.

[[7]](8) During the normal mode of progressive slot machines, the progressive controller, or other approved device must continuously monitor each machine on the link for amounts inserted and must multiply the accepted amounts by the rate of progression and denomination in order to determine the correct amounts to apply to the progressive jackpot. The progressive display must be constantly updated, in a manner approved by the commission, as play on the link is continued.

[[8]](9) Progressive slot machines shall not be multi-game or multi-denomination devices unless:

(A) The computerized slot monitoring system required by 11 CSR 45-5.220 separately and accurately accounts for the amount-in for each denomination and game, or all games offered for play by the devices contribute to the progressive jackpot; and

(B) The odds of attaining the *[winning combination]* progressive award are the same for each game, within 0.005%; and

(C) Each game requires the same maximum wager to win the progressive jackpot, or if requiring different maximum wagers, utilizes the expected value of winning the top award by setting the odds of winning the top award in proportion to the amount wagered. The method of equalizing the expected value of winning the top award shall be conspicuously displayed on each device connected to the system.

[[9]](10) The odds of winning a progressive jackpot shall not be greater than one in fifty million (1:50,000,000) unless specifically approved in writing by the commission.

[[10]](11) Each progressive controller must be housed in a secure, locked location which allows only authorized accessibility and which contains a progressive entry authorization log that is completed by any person gaining entrance to the secured location. Both the location housing progressive controllers and the form on which entry is logged shall be approved by the commission prior to use. The storage medium that contains the progressive controller program shall have a unique signature that allows program verification by an agent of the commission through use of a commission-approved verification device. After verification the storage medium shall be secured in the controller with a commission security seal. The security seal must be affixed by and may only be broken and removed by an authorized commission agent. Additionally, each progressive controller linking one (1) or more wide-area progressive slot machines must be housed in a double-keyed compartment. A gaming agent must be in possession of one (1) of the keys and no person may have access to the controller without the presence of a gaming agent. Normal operation of progressive gaming devices notwithstanding, communication to a progressive controller shall be permitted only by authorized personnel through entrance to the controller's secured location and who document such access and the purpose therefore on the progressive entry authorization log.

[[11]](12) If this rule prescribes multiple items of information to be displayed on a slot machine, it is sufficient to have the information displayed in an alternating fashion.

[[12]](13) In addition to the metering requirements provided for in the Minimum Internal Control Standards (MICS), each slot machine attached to one (1) or more wide-area progressive slot machine meters must have a separate software meter that counts the number of times each primary progressive meter is activated.

[[13]](14) Each machine must have a separate key and key switch to reset the progressive meter or meters or another reset mechanism approved in writing by the commission.

[[14]](15) Unless the commission has approved the payment of prizes by installments, a licensee who has a progressive slot machine must maintain minimum cash reserves in accordance with 11 CSR 45-8.150. The commission must approve all such cash reserves. Notwithstanding the provisions of 11 CSR 45-5.240 Periodic Payments, to the contrary, the commission shall require that the licensee authorized to provide a wide-area progressive system—

(A) Maintain in a restricted account a reserve consisting of cash, United States Government Treasury Securities, United States Government Agency Securities and/or Missouri state debt instruments of not less than the sum of the following amounts:

1. The present value of the aggregate remaining balances owed on all jackpots previously won by patrons through the wide-area progressive system; and

2. An amount sufficient to fully fund the present value of all amounts currently reflected on the progressive meters of the wide-area progressive systems; and

(B) In addition, the licensee authorized to provide the wide-area system shall at all times satisfy and be in compliance with the following ratios and tests:

1. An interest coverage ratio of not less than three to one (3:1); and

2. Debt to EBITDA (earnings before interest, taxes, depreciation, and amortization) of not more than four to one (4:1); and

3. Satisfaction of one (1) of the following ratios and tests:

A. A current ratio of not less than two to one (2:1); or

B. Working capital that is greater than twenty percent (20%) of the licensee's total jackpot liability; or

C. Working capital in excess of one hundred (100) million dollars and a credit rating from at least two (2) of the following credit rating organizations equal to or higher than the following:

(I) Standard & Poor's Corporate BBB-;

(II) Moody's Long-Term Baa3; or

(III) Fitch Corporate BBB-.

[(15)](16) The requirements of this rule shall apply equally to one (1) progressive gaming device linked to a progressive controller or which is internally controlled, as well as several progressive gaming devices linked to one (1) progressive controller within one (1) casino or multiple casinos.

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, [and] 313.805, and 313.807, RSMo [Supp. 2011] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 5—Conduct of Gaming

PROPOSED AMENDMENT

11 CSR 45-5.210 Integrity of Electronic Gaming Devices. The commission is amending section (1).

PURPOSE: This amendment allows the likelihood of certain game outcomes to be adjusted based on prior games if specifically reviewed and approved by the commission.

(1) Electronic gaming devices shall—

(N) Contain the rules of play for each electronic gaming device displayed on the face or screen. Rules shall be complete, clear, and easily understood. Each electronic gaming device must also display the credits wagered and the credits awarded for the occurrence of each possible winning combination based on the number of credits wagered. All information required by this subsection must be kept under glass or another transparent substance and at no time may stickers or other removable items be placed over this information. Additionally:

1. If the game contains a bonus feature including a game within a game, the following rules shall be met:

A. The game shall display clearly to the player which game rules apply to the current game state;

B. If the game requires obtaining several events or symbols toward a bonus feature, the number of events or symbols needed to trigger the bonus feature shall be indicated along with the number of events or symbols collected at any point;

C. The game shall not adjust the likelihood of a bonus feature occurring based on the history of prizes obtained in previous games; **however, the commission may allow the likelihood to be adjusted if a white paper is submitted to and approved by the commission prior to testing by an independent testing laboratory;**

D. If a bonus game is triggered after accruing a certain number of events or symbols or combination of events or symbols of a different kind, the probability of obtaining like events or symbols shall not decrease as the game progresses; and

E. The game display shall make it clear to the player that the game is in a bonus mode;

2. If a bonus feature requires extra credits to be wagered and the game accumulates all winnings to a temporary win meter, the game shall:

A. Provide a means where winnings on the temporary meter can be bet to allow for instances where the player has an insufficient credit meter balance to complete the feature;

B. Transfer all credits on the temporary meter to the credit meter upon completion of the feature; and

C. Provide the player an opportunity not to participate;

3. If the game offers a menu of games to a player:

A. The methodology employed by a player to select and discard a particular game for play shall be clearly displayed on the gaming device and easily followed;

B. The gaming device shall be able to clearly display to the player, at the player's request, all games, game rules and pay-tables before the player must commit to playing any game;

C. The player shall at all times be made aware of which game has been selected for play and is being played, as applicable;

D. The player shall not be forced to play a game just by selecting that game. The player shall be able to return to the main menu;

E. It shall not be possible to start a new game before the current play is completed and all game meters have been updated;

F. The set of games offered to the player for selection or the pay-table can be changed only by a secure method approved by the commission, which includes turning on and off games available for play through a video screen interface; and

G. No changes to the set of games offered to the player for selection or to the pay-table are permitted while there are credits on the player's credit meter or while a game is in progress;

AUTHORITY: sections 313.004, 313.800 and 313.805, RSMo [2000] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed May 13, 1998, effective Oct. 30, 1998. Amended: Filed March 31, 2005, effective Oct. 30, 2005. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming**

PROPOSED AMENDMENT

11 CSR 45-5.237 Shipping of Electronic Gaming Devices, Gaming Equipment, or Supplies. The commission is amending sections (1) and (2).

PURPOSE: The commission is amending and renumbering section (1), and renumbering and removing language from section (2) to ensure that procedures required by the rule are consistent with advances in technology.

(1) Licensees shipping electronic gaming devices or gaming equipment/supplies as defined in 11 CSR 45-1.090, with the exception of critical program storage media and progressive controllers as defined in 11 CSR 45-1.090, into, out of, or within Missouri, must file a request [in a format specified by the Missouri Gaming Commission (MGC)] at least five (5) calendar days prior to such shipment. The request shall include the following information, if applicable:

- (A) Shipper's Name;
- (B) Shipper's Address;
- (C) Shipper's License Number;
- (D) Submission Date;
- (E) Shipping Date;
- (F) Shipper's Contact Information;
- (G) Recipient's Name;
- (H) Recipient's License Number;
- (I) Item Type and Description (i.e. color, artwork number, size, finish, card type, cabinet/hardware, part number, model number, serial number, manufacturer);
- (J) Invoice/Sales Order Number;
- (K) Destination Name;
- (L) Destination Address;
- (M) Destination Contact Information;
- (N) Quantity of Each Item; and
- (O) Estimated Arrival Date.

(2) The licensee shall receive MGC approval of the request prior to shipping the listed items.

[(2)](3) Critical program storage media shall be approved for use in the state prior to shipment [and shall be shipped separately from electronic gaming devices unless otherwise approved in writing by the commission].

AUTHORITY: sections 313.004, [RSMo 2000, and sections]

313.805, and 313.807]. 4], RSMo [Supp. 2013] 2016. Original rule filed Sept. 2, 1997, effective March 30, 1998. Amended: Filed April 3, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 31, 2005, effective May 30, 2006. Amended: Filed June 19, 2006, effective Feb. 28, 2007. Amended: Filed Oct. 31, 2013, effective June 30, 2014. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 8—Accounting Records and Procedures; Audits**

PROPOSED AMENDMENT

11 CSR 45-8.140 Application and Verification Procedures for Granting Credit. The commission is amending section (3).

PURPOSE: This amendment corrects the reference to the statute.

(3) Upon receipt of an application for credit, a confidential credit file for that person containing the information required under section (1) shall be prepared by a cage or credit employee of the Class B licensee either manually or electronically prior to the Class B licensee's approval of a person's credit limit. The information used to determine that an applicant is a "qualified person" pursuant to section [313.317.8] 313.817.8, RSMo, must be contained in the person's credit file. A cage or credit employee who is responsible for receiving, processing, or verifying the information in credit applications shall not have authority to approve any credit limits or credit limit increases.

AUTHORITY: sections 313.004, 313.800, 313.805, 313.812, 313.817, 313.830, and 313.930, RSMo 2016. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Emergency amendment filed July 28, 2016, effective Aug. 28, 2016, expired Feb. 23, 2017. Amended: Filed July 28, 2016, effective Feb. 28, 2017. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of

this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System**

PROPOSED AMENDMENT

11 CSR 45-9.105 Minimum Internal Control Standards (MICS)—Chapter E. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter E of the *Minimum Internal Control Standards* to ensure procedures are consistent with advances in technology.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards (MICS) Chapter E—Electronic Gaming Devices (EGDs)*, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter E does not incorporate any subsequent amendments or additions as adopted by the commission on [January 30, 2013] **April 24, 2019**.

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, [and] 313.805, and 313.807, RSMo [Supp. 2012] 2016. Original rule filed Oct. 22, 2010, effective June 30, 2011. Amended: Filed Sept. 27, 2012, effective May 30, 2013. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 12—Liquor Control**

PROPOSED AMENDMENT

11 CSR 45-12.020 Excursion Liquor License and Definitions. The commission is amending subsections (1)(B) and (1)(D).

PURPOSE: This amendment allows for the sale of individual containers of beer and makes the rule consistent with state liquor law, 311.200, RSMo 2016.

(1) As used in this chapter, the following terms mean:
(B) "Licensed premises," any **excursion gambling boat and any**

and all property owned and operated by the Class B applicant or licensee immediately neighboring its riverboat gaming operation as defined in 11 CSR 45-1.090. 11 CSR 45-12.091 to the contrary notwithstanding, hotel guest rooms are not considered to be on the licensed premises;

(D) "Original package," any package containing [three (3)] **one (1) or more standard bottles [or], cans, or pouches of beer or malt liquor, fifty (50) milliliters (1.7 ounces) or more of spirituous liquors and one hundred (100) milliliters (3.4 ounces) or more of vinous liquors in the manufacturer's original container. A standard bottle is any bottle or can containing sixteen (16) ounces or less of beer or malt liquor; and**

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.805, and 313.840, RSMo [Supp. 2013] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 12—Liquor Control**

PROPOSED AMENDMENT

11 CSR 45-12.080 Hours of Operation. The commission is amending sections (1) and (2).

PURPOSE: This amendment modifies the hours for liquor sales to mirror the state liquor control rules.

(1) Any excursion liquor licensee may serve, offer for sale, sell, or supply intoxicating liquor only during the times authorized by the Missouri Gaming Commission (commission). Intoxicating liquor may be served on an excursion gambling boat from 8/6:00 a.m. to 3:00 a.m. the following day. Intoxicating liquor may be served, offered for sale, sold, or supplied in nongaming areas from 8/6:00 a.m. to 1:30 a.m. the following day, unless the commission specifically approves other hours of operation. A licensee shall submit, with its application, the proposed hours for approval by the commission.

(2) An excursion liquor licensee is prohibited from serving, offering for sale, selling, giving away, or otherwise allowing the consumption of intoxicating liquor in any quantity after the hours the commission has approved for that licensee to serve, sell, offer for sale, or supply intoxicating liquor. **An excursion liquor licensee shall not allow intoxicating liquor to be taken off the excursion gambling boat**

between the hours of 1:30 a.m. and 6:00 a.m., unless the commission specifically approves other hours.

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.805, and 313.840, RSMo [Supp. 2013] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

PROPOSED AMENDMENT

11 CSR 45-40.100 Audits. The commission is deleting section (1) and subsection (2)(C), and amending and renumbering section (2).

PURPOSE: This amendment modifies the requirements for the annual audit to be consistent with the statutory change.

[(1) Independent certified public accountants (C.P.A.s), shall conduct annual financial and authorized internet website audit of each licensed operator.]

[(2)](1) The annual financial [and authorized internet website] audit shall be conducted by an independent certified public accountant (CPA) in accordance with generally accepted auditing standards as follows:

(A) Audit the licensed operator's annual financial statements in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports; **and**

(B) Audit the annual total entry fees, entry fees from Missouri residents, resident percentage calculation, winnings paid, net revenue, and the annual operation fee from the most recently filed Annual Operation Fee report, in order to report on the fair representation of such amounts. The C.P.A. shall reconcile these audited amounts to similar amounts on the annual financial reports and system reports; **and**.

[(C) Audit the licensed operator and its authorized internet website for compliance with each requirement set forth in sections 313.900 to 313.955, RSMo, and Chapter 11 CSR 45-40.]

AUTHORITY: sections 313.910, 313.915, [313.940,] 313.950, and 313.955, RSMo 2016, **and section 313.940, RSMo Supp. 2018.** Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired

March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed March 1, 2018, effective Oct. 30, 2018. Amended: Filed April 25, 2019.

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 OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, July 2, 2019, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 2—Income Tax**

PROPOSED AMENDMENT

12 CSR 10-2.015 Employers' Withholding of Tax. The department is amending sections (1)–(8), (10)–(27), (29), and (30).

PURPOSE: The amendment modifies the calculation for determining the amount of withholding and clarifies the instructions to employers.

(1) General Information. The Missouri general assembly in 1972 enacted Senate Bill 549, a new Missouri income tax law. This law adopts many provisions and terms of the *Internal Revenue Code*. Its withholding provisions are applicable to wages paid after December 31, 1972. The "Missouri Employer's Tax Guide" and this rule are designed to assist employers in withholding Missouri income tax from wages paid from sources in Missouri. An employer may generally follow the provisions of the Internal Revenue Service (IRS) [publication titled "Employer's Tax Guide"] **Publication 15 (Circular E), Employer's Tax Guide** relating to withholding income tax. An employer already assigned a Missouri [withholding] tax identification number will not need to obtain a new one. If a business is discontinued, transferred, or sold, the employer must file [an Employer's Withholding] a Final Report, Form [MO-941F] **5633**, to close the employer's withholding account. If the business of another employer is acquired, do not use the number assigned to that business; a new number must be obtained.

(2) Employers. An employer is any person, firm, corporation, association, fiduciary of any kind, or other type of organization for whom an individual performs service as an employee, unless the person or organization for whom the individual performs service does not have control of the payment of compensation for the service[,] (section 143.191, RSMo). The term employer means the person, including all government agencies, who controls the payment of the compensation. An employer required to withhold Missouri income tax is personally liable for the tax. Any amount of tax actually deducted and withheld by an employer is a special fund in trust for the director of revenue (section 143.241, RSMo). An employee does not have a right of action against the employer in respect to any money deducted and withheld from his [//] or her wages if it is paid over to the director of revenue in good faith compliance with the Missouri Income Tax Law.

(3) Registration of Employers. Every employer must register with the Missouri Department of Revenue by completing the Missouri Tax Registration Application, Form DOR-2643. A permanent registration number will be assigned. A new application is required, and a new Missouri tax identification number will be assigned, when any change in ownership or ownership type occurs. An employer who receives a new identification number as a result of a change in ownership type[,] must file *[an Employer's Withholding]* a Final Report, Form *[MO-941F]* 5633, to close the old account. These numbers are not transferable and should be referred to in all reports and correspondence concerning withholding.

(4) Employer With More Than One (1) Payroll Unit—Complex Employer. If a consolidated report and remittance of the tax withheld cannot be made by the employer because of the complexity of the organization, branch offices, or divisions may be designated as withholding agents. These agents can perform the actual withholding and remitting. However, regardless of any internal arrangements which may be established by the complex employer, the legal responsibility and liability under the law still rests with the home office. If the complex employer has designated withholding agents, and the agents wish to claim the compensation deduction, only one (1) agent will be entitled to the full deduction and the remaining agents will be entitled to one-half of one percent (1/2%) deduction of income taxes withheld if the returns are filed timely.

(5) Seasonal. If *[your business]* an employer is only open for several months out of the year, *[you]* the employer may register as a seasonal employer.

(6) Employees. The term employee for Missouri withholding purposes has the same meaning as it has for federal withholding *[see "Employer's Tax Guide," Circular E, published by the IRS]* as set forth in Publication 15, (Circular E), Employer's Tax Guide. This definition is the same for Missouri residents and nonresidents.

(7) Wages. The term wages for Missouri withholding purposes has the same meaning as it has for federal withholding *[see "Employer's Tax Guide," Circular E, published by the IRS]* as set forth in Publication 15, (Circular E), Employer's Tax Guide. Wages include all pay given to an employee for services performed. The pay may be in cash or in other forms. It includes salaries, vacation allowances, bonuses, and commissions, regardless of how measured or paid.

(8) Interstate Transportation Employees.

(A) Rail, Motor and **Motor** Private *[Motor]* Carriers. 49 U.S.C. section 11504, limits state taxation on wages of employees of rail, motor, and **motor** private *[motor]* carriers. Missouri withholding is required on rail, motor, and **motor** private *[motor]* carrier employees whose state of residence is Missouri. Employees of rail carriers and motor carriers who perform regularly assigned duties in more than one (1) state are subject to state income tax only in their state of residency.

(10) Resident of Missouri Employed in Another State. A Missouri resident paying income tax to another state because of employment in that state may file a Withholding Affidavit For Missouri Residents, Form MO W-4C. If the employee does not complete Form MO W-4C, the employer may withhold Missouri taxes on all services performed, regardless of where performed. All income received for services performed in another state not having a state income tax is subject to Missouri withholding. If services are performed partly within and partly without the state, only wages paid for that portion of the services performed within Missouri are subject to Missouri withholding tax, provided that the services performed in the other state are subject to the other state's withholding provisions. If a service is partly within and partly without Missouri and only a portion of an

employee's wages is subject to Missouri withholding tax, then the amount of Missouri tax required to be withheld is calculated using a percentage of the amount listed in the withholding tables. The calculation begins by determining the amount that would be withheld if all the wages were subject to Missouri withholding. This amount is then multiplied by a percent, which is determined by dividing the wages subject to Missouri withholding tax by the total federal wages.

(A) Example: A resident employee earns \$1,500 per month[,] and is single *[and claims one allowance]*. The employee performs 40% of his *[/]* or her services in Kansas. The remaining 60% of the employee's services are performed in Missouri. If the total withholding on all earnings is \$40 per month, the actual withholding for Missouri would be \$24 ($\$40 \times 60\% = \24).

(11) Missouri Employer with Nonresident Employees. If a nonresident employee performs all services outside Missouri, his *[/]* or her wages are not subject to Missouri withholding. A nonresident employee performing services in more than one (1) state is subject to withholding as outlined in section (9).

(12) Supplemental Wage Payments. If supplemental wages are paid, such as bonuses, commissions, overtime pay, back pay, including retroactive wage increases or reimbursements for nondeductible moving expenses in the same payment with regular wages, *[withhold]* Missouri income tax **shall be withheld** as if the total of the supplemental and regular wages were a single wage payment for the regular payroll period. If supplemental wages are paid in a different payment from regular wages, the method of withholding income tax depends in part on whether income tax is withheld from the employee's regular wages.

(A) If income tax has been withheld from the employee's regular wages, choose either one (1) of the following methods for withholding income tax on the supplemental wages:

1. Method One. Withhold at a flat percentage rate **that is the lower of *[six percent (6%)]* a) five and four tenths percent (5.4%) or b) the highest individual income tax rate determined under section 143.011, RSMo, for the current tax year** of the supplemental wages, *using zero withholding allowances*; or

2. Method Two. Add the supplemental wages to the employee's regular wages paid to the employee within the same calendar year for the payroll period and determine the income tax to be withheld as if the aggregate amount were one (1) payment. Subtract the tax already withheld from the regular wage payment and withhold the remaining tax from the supplemental wage payment.

(B) If income tax has not been withheld from the regular wages (for example, where an employee's withholding exemption exceeds his *[/]* or her wages), use Method Two described in paragraph (12)(A)2. of this rule. Add the supplemental wages to the regular wages paid within the same calendar year for the payroll period and withhold income tax on the total amount as though the supplemental wages and regular wages were one (1) payment for a regular payroll period.

(13) Tips Treated as Supplemental Wages. Employers must withhold Missouri income tax based upon total tips reported by the employee, **unless the amount of tips received by the employer and remitted to the employee is greater in which case the greater amount shall be withheld. If an employee shares tips, the employer shall withhold only from the employee who actually receives the shared tips. Employers shall *[W/]*withhold income tax on tips using the same options indicated for withholding on supplemental wage payments.**

(14) Vacation Pay. Vacation pay received by an employee is subject to withholding as though it were a regular wage payment made for the payroll periods during the vacation. If vacation pay is paid in addition to regular wages for the vacation period, the vacation pay is treated as a supplemental wage payment. An employee who is not a

resident of Missouri but works in Missouri is subject to withholding on his *[/]* or her vacation pay.

(15) Lump-Sum and Periodic Distribution. Missouri follows the federal guidelines for lump-sum and periodic distributions. *[If a/A lump-sum distribution [, withhold at the rate of six percent (6%)] is withheld at a flat rate that is the lower of a) five and four tenths percent (5.4%) or b) the highest individual income tax rate determined under section 143.011, RSMo, for the current tax year.* If a periodic distribution, follow the computer formula or tax tables.

(16) Determining Proper Amount to Withhold. To determine income tax withholding, take *[the following factors]* into account:

(A) Wages paid during the payroll period, including tips and vacation pay; **and**

(B) *[Marital]* Filing status, *[- T]* as there are separate withholding calculations for single, *[and]* married *[employees]*, **and head of household employees. *;* **and****

(C) Withholding allowances as indicated on the MO W-4.]

(17) Exemption for Nontaxable Individuals. Exemption from withholding for an individual is valid only if the employee submits to the employer a completed Form MO W-4 (Employee's Withholding Allowance Certificate), certifying that the employee has no income tax liability from the previous year and expects none for the current year. The employee must file a Form MO W-4 annually if *[s/he]* the employee wishes to continue to be exempt.

(18) Employee Withholding *[Allowance]* Certificate. Each employee is required to file a completed Form MO W-4 *[to determine the number of exemptions to which the employee is entitled] that reflects the filing status on his or her income tax return.* The Form MO W-4 must be used by the employer to determine the amount of Missouri income tax which must be withheld from each paycheck. If an employee has more than one (1) employer, *[s/] he or she* may want *[reduce the number of allowances on any MO W-4 that does not pertain to his/her principal employer] withhold an additional amount on Line 2 of Form MO W-4 for his or her principal employer to ensure that the total amount withheld approximates the actual income tax liability.* Failure to *[reduce the MO W-4 allowances] withhold enough from each payroll period* could cause an employee *[to have too little tax withheld and make the employee] to be* subject to underpayment penalties. If an employee expects to have income other than his *[/]* or her wages, *[s/he may request to have additional amounts withheld in addition to the amounts indicated by the allowances claimed on the employee's MO W-4. The additional amount should be included on line 6 of the MO W-4.] or income from multiple jobs, he or she may request additional amounts be withheld in addition to the standard withholding calculations that are based on the standard deduction for the filing status indicated on the Form MO W-4. The additional amount should be included on Form MO W-4, Line 2. Employees who expect to receive a refund (as a result of itemized deductions, modifications, or tax credits) on their tax returns may direct the employer to only withhold the amount indicated on Form MO W-4, Line 3, in which case the employer will not use the standard calculations for withholding. If the employee does not indicate an amount to be withheld or if the amount indicated is more than is available for the payroll period, the employer will use the standard calculations.* Employers are required to submit a copy of each completed Form MO W-4 or an equivalent form for each new employee to the Missouri Department of Revenue within twenty (20) calendar days *[of completion of each form] of hire. "Date of hire" is defined as the date the employee reports to work or the date the employee signs the federal W-4 form, whichever is earlier.* The department will in turn forward the Form MO W-4 to the Division of Child

Support Enforcement.

(19) Withholding Tables. Withholding tables prepared by the Missouri Department of Revenue take into account allowable deductions; therefore withholding is based on gross wages before any deductions, such as Federal Insurance Contribution Act (FICA), state unemployment insurance, pension funds, or insurance, etc. In determining the amount of tax to be withheld, the employer should use the table for the correct payroll period—daily, weekly, bi-weekly, semi-monthly, and monthly periods. Any other period would be a miscellaneous pay period. Tables show wage brackets in the two (2) left-hand columns. *[The withholding allowances are shown at the top of each of the remaining columns and correspond to the number of allowances claimed by an employee on the Form MO W-4.] The filing status is shown at the top of each of the remaining columns.*

(20) Percentage *[Formula]* Withholding **Formula.** A percentage withholding formula has been published by the director of revenue and it may be used on electronic data processing equipment for withholding Missouri income tax. Any other method must be submitted to and approved by the director of revenue. *[The formula is mathematically stated as gross income minus standard deduction, minus personal and dependent exemptions, minus federal income tax withheld equals taxable income. Taxable income multiplied by the rate equals Missouri withholding.] Missouri withholding is calculated by subtracting the annual standard deduction from the employee's annual gross income and multiplying the result by the applicable tax rate.* The formula is illustrated in the "*[Missouri]* Employer's Tax Guide (Form 4282)."

(21) Filing Frequency Requirements. Missouri withholding returns must be filed by the due date as long as an account is maintained with the Missouri Department of Revenue, even if there was no payroll for the reporting period. Returns must be filed each reporting period, even though there may not have been any tax withheld. There are four (4) filing frequencies: quarter-monthly, monthly, quarterly, and annually (section 143.221 and 143.225, RSMo). A newly registered employer is initially assigned a filing frequency on the basis of *[his/her]* the employer's estimation of future withholdings. If the assigned filing frequency differs from the filing requirements established by statute, it is the employer's responsibility to immediately notify the Department of Revenue. The time for filing shall be as follows:

(22) Reporting Requirement. Every employer withholding Missouri income tax from employee's wages is required by statute to report and remit the tax to the state of Missouri on the *[Missouri Form MO-941] Employer's Return of Income Taxes Withheld (Form MO-941).* See regulation 12 CSR 10-2.016 for information on *[filing a Form MO-941P] the requirements for employers* to remit *[required] payments on Quarter-Monthly accounts.*

(A) A separate reporting form must be filed for each reporting period. A personalized booklet of reporting forms detailing the employer's name, address, employer identification number, filing frequency, and due date is provided to each active account. *[The voucher booklet supplied to an employer required to pay on a quarter-monthly basis also includes payment vouchers Form MO-941P, for the four (4) quarter-monthly periods.]* If an employer misplaces, damages, or does not receive the necessary reporting forms, replacement forms should be requested, allowing sufficient time to file a timely return. If a blank form is used, the employer's name, address, and identification number must appear as filed on previous returns and the period for which the remittance is made must be indicated. Failure to receive reporting forms does not relieve the employer of responsibility to report and remit tax withheld. If an employer temporarily ceases to pay wages, a return must be filed for each period indicating that no tax was withheld. Failure

to do so will result in the issuance of non-filer notices.

(B) *[On or before February 28, or with the final return filed at an earlier date, each employer must file a Form MO W-3 (Transmittal of Wage and Tax Statements) and copies of all withholding tax statements, Form W-2/1099R, copy 1, for the year.]* Do not include the fourth quarter or twelfth month return with the Form W-2(s)/1099R(s) and Form MO W-3. The last annual remittance must be sent separately with Form MO-941. **Employers with two hundred fifty (250) or more employees are required to submit these items electronically by the last day of January. Paper filers are required to submit copies of all withholding statements by the last day of February. Paper filings must also be accompanied by a list, preferably an adding machine tape or a computer printout, of the total amount of the income tax withheld as shown on all "Copy 1s" of Form W-2 and Form 1099-R.** Large numbers of forms may be forwarded to the Department of Revenue in packages of convenient size. Each package must be identified with the name and account number of the employer and the packages must be consecutively numbered. Any employee's copies of the Withholding Statement (Form W-2/*/* or Form 1099-R) which cannot be delivered to the employee after reasonable effort is exerted, must be kept by the employer for at least four (4) years. The Department of Revenue will accept computer produced magnetic tape records instead of the paper Form W-2/*/* or Form 1099-R. The employer must meet tape data specifications which are established by the Department of Revenue. The department follows specifications outlined in Social Security Administration Publication 42-007. Employers must also include the Supplemental record (Code S or Code 1 S).

(C) If an employer *[goes out-of-business]* closes or ceases to pay wages, a Final Report, *[MO-941F]* **Form 5633** must be filed. This form, which is included in the voucher booklet, is provided to all active accounts.

(23) Time and Place for Filing Returns and Remitting Tax.

(A) All returns and remittances must be filed with the Department of Revenue at the specific address indicated on the form. The dates on which the returns and payments are due are as follows:

1. Quarter-Monthly (see 12 CSR 10-2.016). The quarter-monthly periods are: the first seven (7) days of a calendar month; the eighth to the fifteenth day of a calendar month; the sixteenth to the twenty-second day of a calendar month; and the twenty-third day through the last day of a calendar month. Payments must be *[mailed]* made within three (3) banking days after the end of the quarter-monthly period or received by the Department of Revenue or its designated depository within four (4) banking days after the end of the quarter-monthly period. *[A monthly return (MO-941)]* **Quarter-monthly filers are required to pay by use of an electronic funds payment system established by the department. If quarter-monthly filers are unable to use the electronic funds payment system, alternative electronic payment methods are outlined in the "Employer Tax Guide" Form 4282. An Employer's Return of Income Taxes Withheld (Form MO-941)** reconciling the quarter-monthly payments and detailing any underpayment of tax is due by the fifteenth day of the following month except for the third month of a quarter in which case the *[MO-941]* **Employer's Return of Income Taxes Withheld (Form MO-941)** is due the last day of the succeeding month;

2. Monthly. Return and payment must be made by the fifteenth day of the following month except for the third month of a quarter in which case the return is due the last day of the succeeding month;

3. Quarterly. Return and payment must be made on or before the last day of the month following the close of the calendar quarter; and

4. Annually. Return and payment must be made on or before January 31 of the succeeding year.

(B) When the due date falls on a Saturday, Sunday, or legal holiday, the return and payment will be considered timely if made on the

next business day (section 143.851, RSMo).

(24) Correcting Mistakes in Reporting or Withholding.

(A) Overpayment. If withholding tax has been over-reported, the employer must file an **Amended Employer's [Withholding Tax Overpayment Amended Report,] Return of Income Taxes Withheld**, Form *[MO-941X along with]* **Form MO-941, along with** supporting documentation $;/;$, such as a copy of *[your]* the payroll ledger, records, or W-2s. A claim for credit or refund of an overpayment of withheld tax must be filed by the taxpayer within three (3) years from the time the return was filed or two (2) years from the time the tax was paid, whichever period expires later. If no return was filed by the taxpayer, a claim for credit or refund must be filed within two (2) years from the time the tax was paid. No claim for credit or refund will be allowed after the expiration of the period of limitation prescribed in section 143.801, RSMo.

(B) Underpayment. If withholding tax has been under-reported, the employer must file an **Amended Employer's [Withholding Tax Underpayment Amended Return,] Return of Income Taxes Withheld** (Form MO-941/*U*) to report the additional withholding.

(25) Erroneous Withholding. If Missouri tax has been withheld from an employee's paycheck and the employee is not subject to Missouri tax, it is the employer's responsibility to complete an **Amended Employer's [Withholding Tax Overpayment Amended Report,] Return of Income Taxes Withheld** (Form MO-941/*X*), along with supporting documentation $;/;$, such as a copy of *[your]* the payroll ledger, records, or W-2s.

(26) Employer Compensation. For every remittance made to the director of revenue, on or before the respective due date for the payment involved, each employer (except the United States, the state of Missouri, and all agencies and political subdivisions of the state of Missouri or the United States government) may deduct and retain as compensation the following percentages of the total amount of the tax withheld and paid annually: two percent (2%) of the first five thousand dollars (\$5,000) or less; one percent (1%) of the amount in excess of five thousand dollars up to ten thousand dollars (\$5,000–\$10,000); one-half of one percent (1/2%) of the amount collected in excess of ten thousand dollars (\$10,000). The employer is not entitled to any compensation if any payment is not made on or before the due date. Compensation for complex employers is covered in section (4).

(27) Failure to Pay Taxes Withheld—Special Deposits. Any employer who fails to remit income tax withheld, or to file tax returns as required, may be required to deposit the taxes in a special trust account for Missouri (see section 32.052, RSMo). Penalties are provided for failure to make payment. If the director of revenue finds that the collection of taxes required to be deducted and withheld by an employer may be jeopardized by delay, */s/he or she* may require the employer to remit the tax or make a return at any time. A lien outstanding with regard to any tax administered by the director shall be a sufficient basis for this action (see section 143.221.4, RSMo). In addition, any officer, director, statutory trustee, or employee of any corporation who has direct control, supervision, or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to section 143.241.2, RSMo.

(29) Records to Be Kept by Employers.

(A) The following records must be retained for all employees:

1. Name, address, Social Security number, and period of employment;

2. Amounts and dates of all wage payments subject to the Missouri withholding tax;

3. Employees' state income tax withholding *[allowance]* certificate;
4. Employer's state income tax withholding registration number;
5. Record of quarter-monthly, monthly, quarterly, and annual returns filed including dates and amounts of payments; **and**
6. Records that would assist the Missouri Department of Revenue in auditing the employer's records; *and*.

[7.](B) All records should be kept for at least three (3) years after the date the taxes to which they relate become due, or the date the taxes are paid, whichever is later.

[(B)](C) In addition to the records listed in paragraphs (29)(A)1.–*[7.].6.*, all records of the allocation of working days in the state of Missouri must be retained for all nonresident employees.

(30) Penalties, Interest, and Additions to Tax.

(F) A person who willfully fails to collect, account for, or pay withholding taxes is subject to a penalty equal to the amount not paid to the state, pursuant to section 143.751.4, RSMo. In addition, any officer, director, statutory trustee, or employee of any corporation who has direct control, supervision, or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to section 143.241.1, RSMo.

(G) Penalties for criminal offenses are also provided *[throughout]* in sections 143.911–*[]* to 143.951, RSMo.

AUTHORITY: section 143.961, RSMo [2000] 2016. This rule was previously filed as “Missouri Employer’s Tax Guide” Feb. 20, 1973, effective March 2, 1973. Original rule filed Jan. 29, 1974, effective Feb. 8, 1974. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed April 16, 2019, effective April 26, 2019, expires Feb. 5, 2020. Amended: Filed April 16, 2019.

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 Department of Revenue, General Counsel’s Office, PO Box 475, Jefferson City, MO 65105-0475. 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 40-2.180 Confidentiality of Case Records. The division is updating terminology and adding subsections to section (1). Section (1) is the only section in the rule.

PURPOSE: This amendment updates terminology and identifies instances in which the disclosure of confidential information is authorized.

(1) *It shall be the duty of all officers and employees of the Division of Family Services to* Pursuant to sections 208.120 and 208.155, RSMo, the Family Support Division shall protect

from public disclosure any information concerning an applicant or recipient of public assistance *[or child welfare services]*, and the file and record of an applicant or recipient shall be open to inspection only to those persons directly connected with the administration of *[this act in the performance of their official duties]* the relevant assistance program. The division may disclose information that is protected by this rule if the specific type of disclosure is not otherwise prohibited by state or federal law and if—

(A) The disclosure is of a specific kind that is authorized by state or federal law;

(B) The federal laws and regulations, if any, governing the program that is relevant to the information being disclosed allow for such a disclosure; or

(C) The division has the written consent of the applicant or recipient, or the applicant or recipient’s legal guardian or conservator, to disclose the information.

AUTHORITY: sections [207.020, RSMo 1986] 207.022 and 660.017, RSMo 2016. Original rule filed May 4, 1959, effective May 14, 1959. Amended: Filed April 24, 2019.

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 Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to *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.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 20—Pharmacy Program

PROPOSED AMENDMENT

13 CSR 70-20.320 Pharmacy Reimbursement Allowance. The division is amending subsection (2)(E).

PURPOSE: This amendment increases the quarterly aggregate allowable adjustment for the Pharmacy Federal Reimbursement Allowance from .5% to 1.5%.

(2) Payment of the PRA.

(E) PRA Rates.

1. The PRA tax rate will be a uniform effective rate of one and twenty hundredths percent (1.20%) with an aggregate annual adjustment, by the MO HealthNet Division, not to exceed five hundredths percent (.05%) based on the pharmacy’s total prescription volume.

2. Beginning January 1, [2010] 2019, the PRA tax rate will be a uniform effective rate of one and [eighty-two (1.82%)] **forty-three hundredths percent (1.43%)** with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed [five-tenths (0.5%)] **one and five-tenths percent (1.5%)** based on the pharmacy’s total prescription volume.

3. The maximum rate shall be five percent (5%).

AUTHORITY: sections 208.201 and 338.505, RSMo [Supp. 2009] 2016. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed July 15, 2002, effective

Feb. 28, 2003. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 26, 2019.

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 Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to 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.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 2030—Missouri Board for Architects,
Professional Engineers, Professional Land Surveyors, and
Professional Landscape Architects
Chapter 4—Applications**

PROPOSED AMENDMENT

20 CSR 2030-4.090 Evaluation—Comity Applications—Professional Landscape Architects. The board is amending the purpose and section (1).

PURPOSE: This amendment clarifies the requirements for application.

PURPOSE: This rule ensures that an applicant for licensure by comity meets the [minimum] equivalent requirement for licensure in Missouri.

(1) Any person applying for licensure as a professional landscape architect under section 327.381, RSMo, who was licensed in another state, territory, or possession of the United States or in another country and has [the qualifications which are at least equivalent to the requirements for licensure as a professional landscape architect in this state] a degree in landscape architecture from an accredited school of landscape architecture, or who possesses an education which in the opinion of the board equals or exceeds the education received by a graduate of an accredited school, and who has acquired at least three (3) years of satisfactory landscape architectural experience and has taken and passed all sections of the landscape architectural registration examination administered by the Council of Landscape Architectural Registration Boards (CLARB) may apply for licensure by comity.

AUTHORITY: sections 327.041 and 327.381, RSMo 2016. This rule originally filed as 4 CSR 30-4.090. Original rule filed Oct. 30, 2002, effective April 30, 2003. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 18, 2019.

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 Board of Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects, PO Box 184, Jefferson City, MO 65102, via facsimile at (573) 751-8046, or via email at moapeplspla@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 2030—Missouri Board for Architects,
Professional Engineers, Professional Land Surveyors, and
Professional Landscape Architects
Chapter 5—Examinations**

PROPOSED AMENDMENT

20 CSR 2030-5.105 Reexaminations—Professional Engineers. The board is amending section (2).

PURPOSE: The professional engineering exam is being transitioned to computer based testing; therefore, this rule is being amended to accommodate the policy for that transition.

(2) An applicant for examination and licensure as a professional engineer failing to make a passing grade on the NCEES Principles and Practice of Engineering Examination may have unlimited opportunities to retake the examination so long as the applicant remains qualified to be examined on the date of the reexamination and providing the [following criteria are met:] applicant applies for reexamination in accordance with NCEES policy.

[(A) The applicant applies for reexamination on forms furnished by the board; and

(B) The applicant pays the reexamination fee; and

(C) The applicant files his/her application for reexamination on or before the filing deadline established by the board; and

(D) The applicant provides any additional information deemed pertinent to the board.]

AUTHORITY: sections 327.041, 327.241, and 327.251, RSMo 2016. This rule originally filed as 4 CSR 30-5.105. Original rule filed Dec. 8, 1981, effective March 11, 1982. Amended: Filed Nov. 1, 2001, effective June 30, 2002. Moved to 20 CSR 2030-5.105, effective Aug. 28, 2006. Non-substantive change filed Oct. 21, 2015, published Dec. 31, 2015. Amended: Filed May 30, 2018, effective Dec. 30, 2018. Amended: Filed April 18, 2019.

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 Board of Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects, PO Box 184, Jefferson City, MO 65102, via facsimile at (573) 751-8046, or via email at moapeplspla@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 2030—Missouri Board for Architects,
Professional Engineers, Professional Land Surveyors, and
Professional Landscape Architects
Chapter 5—Examinations**

PROPOSED AMENDMENT

20 CSR 2030-5.150 Standards for Admission to Examination—Professional Landscape Architects. The board is amending the rule title and section (1).

PURPOSE: This rule is being amended to add the word *Professional* in front of *Landscape Architects* in the title. It is also being amended to allow applicants to take the examination while obtaining their experience and also to provide applicants admission to the examination if they have either a degree in landscape architecture from an accredited school of landscape architecture or a degree deemed equivalent.

(1) A Missouri applicant for licensure shall have a degree in landscape architecture from an accredited school of landscape architecture [and have acquired] or a degree deemed equivalent in the opinion of the board. The minimum length of experience required of the applicant, based on education, is at least three (3) years of satisfactory landscape architectural experience after acquiring that degree [to qualify]. Any applicant who meets the educational requirements of section 327.612, RSMo, qualifies for admission to the Council of Landscape Architectural Registration Boards' (CLARB) Landscape Architect Registration Examination (LARE), or its successor.

AUTHORITY: sections 327.041 and 327.612, RSMo [Supp. 2003] 2016. This rule originally filed as 4 CSR 30-5.150. Original rule filed Oct. 30, 2002, effective April 30, 2003. Amended: Filed Sept. 8, 2003, effective March 30, 2004. Moved to 20 CSR 2030-5.150, effective Aug. 28, 2006. Non-substantive change filed Oct. 21, 2015, published Dec. 31, 2015. Amended: Filed April 18, 2019.

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 Board of Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects, PO Box 184, Jefferson City, MO 65102, via facsimile at (573)751-8046, or via email at moapeplspla@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 2030—Missouri Board for Architects,
Professional Engineers, Professional Land Surveyors, and
Professional Landscape Architects
Chapter 10—Corporations**

PROPOSED AMENDMENT

20 CSR 2030-10.010 Application for Certificate of Authority. The board is amending section (1).

PURPOSE: The rule is being amended to clarify that the managing agent to whom responsibility for the conduct of the corporation's licensed activities is assigned must be licensed in the same profession for which the Certificate of Authority is issued. This is compelled both by the requirements of section 327.401, RSMo, and by the prohibitions on unlicensed practice in Chapter 327, RSMo, which prohibit a person licensed in one profession from supervising or engaging in activities of another profession, except to the extent such activities are incidental to the practice of the licensee's own profession.

(1) [A] Pursuant to section 327.401, RSMo, a corporation desiring a certificate of authority authorizing it to render architectural, professional engineering, professional land surveying, or professional landscape architectural services in this state shall submit an application to the executive director of the board, listing the names and addresses of all officers and directors for a corporation or all members and managers for a limited liability company, and listing the managing agent for each profession who is licensed in this state to practice architecture, engineering, land surveying, or landscape architecture.

(A) The directors of the corporation shall assign responsibility for the proper conduct of its architectural activities in this state to an architect licensed and authorized to practice architecture in this state.

(B) The directors of the corporation shall assign responsibility for the proper conduct of its professional engineering activities in this state to a professional engineer licensed and authorized to practice professional engineering in this state.

(C) The directors of the corporation shall assign responsibility for the proper conduct of its professional land surveying activities in this state to a professional land surveyor licensed and authorized to practice professional land surveying in this state.

(D) The directors of the corporation shall assign responsibility for the proper conduct of its professional landscape architectural activities in this state to a professional landscape architect licensed and authorized to practice professional landscape architecture in this state.

1. A corporation which is currently authorized by this board to provide professional landscape architectural services may continue to renew its certificate of authority under the rules that were in effect prior to December 31, 2019 so long as the managing agent listed in the corporation's application does not change.

2. If there is any change in the managing agent listed in the corporation's application, the provisions in this rule apply. The change shall be reported on a new form and submitted to the executive director of the board within thirty (30) days after the effective day of the change.

AUTHORITY: section 327.041, RSMo 2016. This rule originally filed as 4 CSR 30-10.010. Original rule filed Dec. 8, 1981, effective March 11, 1982. For intervening history, please consult the *Code of State Regulations*. Amended: Filed April 18, 2019.

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 Board of Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects, PO Box 184, Jefferson City, MO 65102, via facsimile at (573)751-8046, or via email at moapeplspla@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 2220—State Board of Pharmacy
Chapter 2—General Rules**

PROPOSED AMENDMENT

20 CSR 2220-2.500 Nuclear Pharmacy—Minimum Standards for Operation. The board is amending the purpose and amending and updating all sections.

PURPOSE: The board is amending all sections of the current rule to update, modernize, and clarify requirements.

PURPOSE: This rule defines minimum standards for the operation of nuclear pharmacies[, a specialty of pharmacy practice] and the preparation, labeling, dispensing, delivering, compounding, and repackaging of radiopharmaceuticals pursuant to a prescription drug or medication order. This regulation is intended to supplement other regulations of the Board of Pharmacy, as well as those of other state and/or federal agencies.

(1) Definitions.

[(A) The “practice of nuclear pharmacy” means a patient-oriented service that embodies the scientific knowledge and professional judgment required to improve and promote health through the assurance of the safe and efficacious use of radiopharmaceuticals and other drugs.]

(A) “Agreement state” means any state that has entered into an agreement under subsection 274b of the Atomic Energy Act of 1954, as amended, in which the United States Nuclear Regulatory Commission has relinquished to such states the majority of its regulatory authority over source material, by-product, and special nuclear material in quantities not sufficient to form a critical mass.

(B) “Authentication of product history” means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

(C) “Authorized address or location” means the building or buildings that are identified on the license and where by-product material may be received, prepared, used, or stored as defined by 10 CFR 35.2 or a temporary job site for providing mobile nuclear medicine services in accordance with 10 CFR 35.80.

(D) “Authorized nuclear pharmacist” (ANP) means a pharmacist who holds a current license issued by the board and who is either certified as a nuclear pharmacist by the Board of Pharmacy Specialties, has attained status as an authorized nuclear pharmacist, or an authorized user of radioactive material, as specified by the Nuclear Regulatory Commission or Agreement State regulations, including, but not limited to, 10 CFR 35.55, 35.57 and 35.59.

(E) “Contingency prescription drug order” means a radioactive prescription drug order issued for contingency material for a diagnostic purpose.

(F) “Controlled access area” means an area outside of the restricted area but inside the pharmacy, access to which will be limited to the public.

(G) “NRC” means the United States Nuclear Regulatory Commission.

[(B)](H) [The term] “[n]uclear pharmacy” means the location that provides radiopharmaceutical services and where [radioactive drugs,] radiopharmaceuticals and chemicals within the classification of legend drugs, are prepared, compounded, repackaged,

dispensed, stored, [or] sold, or used for nuclear medicine procedures. The term “nuclear pharmacy” does not include the nuclear medicine facilities of hospitals or clinics where radiopharmaceuticals are compounded or dispensed to patients under the supervision of a licensed physician, authorized by the Nuclear Regulatory Commission *[and/or the Missouri Department of Health]* or Agreement State regulations. Nothing in this rule shall be construed as requiring a licensed clinical laboratory, which is also licensed by the Nuclear Regulatory Commission or Agreement State to handle radioactive materials, to obtain the services of a nuclear pharmacist, or to have a pharmacy permit, unless the laboratory is engaged in the commercial sale or resale of radiopharmaceuticals.

[(C) A “qualified nuclear pharmacist” means a pharmacist who holds a current license issued by the board and who is either certified as a nuclear pharmacist by the Board of Pharmaceutical Specialties, a pharmacist who meets minimal standards of training for status as an authorized nuclear pharmacist or an authorized user of radioactive material, as specified by the Nuclear Regulatory Commission or by agencies of states that maintain certification agreements with the Nuclear Regulatory Commission.

(D) “Radiopharmaceutical services” means the procurement, storage, handling, compounding, preparation, labeling, quality control testing, dispensing, distribution, transfer, record keeping and disposal of radiochemicals, radiopharmaceuticals and ancillary drugs, and also includes quality assurance procedures, radiological health activities, any consulting activities associated with the use of radiopharmaceuticals, health physics, and any other activities required for provision of pharmaceutical care.]

(I) “Nuclear pharmacy technician” means a person who has successfully completed a nuclear pharmacy technician training program provided by an accredited college program or meets the American Pharmacist’s Association’s (APhA) Guidelines for Nuclear Pharmacy Technician Training Program or an equivalent company sponsored program that meets APhA guidelines for nuclear pharmacy technician training.

(J) “Practice of nuclear pharmacy” means a patient-oriented service that embodies the scientific knowledge and professional judgment required to improve and promote health through the assurance of the safe and efficacious use of radiopharmaceuticals and other drugs.

(K) “Preparing of radiopharmaceuticals” means the addition of a radioactive substance, or the use of a radioactive substance in preparation of a single-dose or multiple-dose medication, pursuant to the prescription drug order/contingency prescription drug order. Such preparing of radiopharmaceuticals includes, but is not limited to, loading and eluting of radionuclide generators, using manufactured reagent kits to prepare radiopharmaceuticals, preparing reagent kits, aliquoting reagents, and conducting quality control tests of radiopharmaceuticals.

(L) “Prescription drug order” means a prescription drug order issued for a specific patient for a diagnostic or therapeutic purpose.

[(E)](M) “Quality control testing” means, but is not limited to, the performance of appropriate chemical, biological, [and physical tests on compounded] physical, radiochemical, and radionuclidic purity tests on radiopharmaceuticals and the interpretation of the resulting data to determine their suitability for use in humans and animals.

[(F)](N) “Quality assurance procedures” means all activities necessary to assure the quality of the process used to provide radiopharmaceutical services, including authentication of product history and maintenance of all records as required by pertinent regulatory agencies.

[(G) “Authentication of product history” means identifying the purchasing source, the ultimate fate, and any intermediate

handling of any component of a radiopharmaceutical or other drug.]

[(H)] (O) "Radiopharmaceutical" means any drug which exhibits spontaneous disintegration of unstable nuclei with the emission of nuclear particles or photons and includes any nonradioactive reagent kit or nuclide generator which is intended to be used in the preparation of any such substance but does not include drugs such as carbon-containing compounds or potassium-containing salts which contain trace quantities of naturally occurring radionuclides. The term "radiopharmaceutical" also includes any biological product which is labeled with a radionuclide or intended solely to be labeled with a radionuclide.

(P) "Radiopharmaceutical services" means, but not limited to, the procurement, storage, handling, compounding, preparation, repackaging, labeling, quality control testing, dispensing, delivery, transfer, record-keeping, and disposal of radiochemicals, radiopharmaceuticals, and ancillary drugs; the participation in radiopharmaceutical selection and radiopharmaceutical utilization review, and also includes quality assurance procedures, radiological healthcare activities, any consulting activities associated with the use of radiopharmaceuticals, and any other activities required for provision of radiopharmaceutical care; the responsibility for advising, where necessary or where regulated, of therapeutic values, hazards and use of radiopharmaceuticals; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation management, and control of a nuclear pharmacy.

(Q) "Restricted area" means an area within the pharmacy that is secured from the Controlled Access Area and to which access is limited for the purpose of protecting individuals against exposure to radiation and radioactive materials.

(R) "Therapeutic prescription drug order" means a radioactive prescription drug issued for a specific patient for a therapeutic purpose.

(S) "Unit dose container" (e.g., shield or "pig") means a container designed to hold doses of radiopharmaceutical agents and to prevent or minimize/reduce the emission of radiation or radioactive materials by using appropriate shielding materials.

(2) General Requirements for Pharmacies Providing Radiopharmaceutical Services.

(A) No person may receive, acquire, possess, prepare, compound, [or] dispense, repackage, transfer, dispose of, or manufacture for sale or resale any radiopharmaceutical except in accordance with the provisions of this rule and the conditions of rules and regulations promulgated by the Nuclear Regulatory Commission [and/or the Missouri Department of Health] or applicable Agreement State. [The requirements of this rule are in addition to and not in substitution of, other applicable statutes and regulations administered by the State Board of Pharmacy or the Missouri Department of Health.

(B) Nothing in this rule shall be construed as requiring a licensed physician to obtain a separate license as a nuclear pharmacist, when the use of radiopharmaceuticals is limited to the diagnosis and treatment of patients under the supervision of the physician.

(C) Nothing in this rule shall be construed as requiring a licensed clinical laboratory, which is also licensed by the Nuclear Regulatory Commission and/or the Missouri Department of Health to handle radioactive materials, to obtain the services of a nuclear pharmacist, or to have a pharmacy permit, unless the laboratory is engaged in the commercial sale or resale of radiopharmaceuticals.

(D) Nothing in this rule shall be construed to require a department of nuclear medicine which is located in a hospital, which has a physician board certified in his/her specialty and which is licensed by the Nuclear Regulatory Commission and/or the Missouri Department of Health to handle radioac-

tive materials, to obtain the services of a pharmacist or to have a nuclear pharmacy license for radiopharmaceutical preparation and distribution to patients within that institution.]

(B) Nuclear pharmacies shall post, in a conspicuous area of the pharmacy, a copy of the current registration with the Board of Pharmacy and a copy of the most current U.S. NRC or applicable Agreement State license which details a listing of its authorized nuclear pharmacists. A reference to its specific location within the pharmacy is acceptable.

(C) A nuclear pharmacy must have on file a copy of the current radioactive materials license for the licensed facility requesting any radiopharmaceutical before the radioactive drug is permitted to be dispensed to that facility. The radiopharmaceutical may only be delivered to the authorized addresses or locations listed in, or temporary job sites as authorized by, the NRC/Agreement State license. The authorized physician ordering radiopharmaceuticals is hereby recognized as the patient's authorized designee for delivery purposes. This section is an exemption for Class E pharmacies to 20 CSR 2220-2.013(2) Prescription Delivery Requirements, which details authorized delivery sites.

(D) Nuclear pharmacies shall comply with any applicable requirements of other governing agencies regarding its daily operations and the disposal of any biohazardous medical waste. Appropriately labeled and, when required shielded, disposal containers shall be used for radioactive and biohazardous waste from the preparation or the return of radiopharmaceuticals. Disposal of biohazardous waste shall comply with all applicable local, state, and federal requirements.

(E) Any reusable unit dose container that is returned shall be considered to be contaminated. No pharmacy shall utilize a reusable unit dose container for radioactive doses without either an effective process to decontaminate the container of biohazardous substances or an effective mechanism to avoid contamination of the container. No pharmacy may reuse a unit dose container that remains contaminated with blood or other biohazardous substances.

(F) A Class E pharmacy may accept returns and waste as authorized by the NRC/Agreement State-regulations.

(3) Permits. Any pharmacy providing radiopharmaceutical services must obtain a Class E radiopharmaceutical permit from the board. Nuclear pharmacies preparing, compounding or repackaging sterile preparations must have Class H Sterile Product Compounding on their permit.

(A) A permit to operate a nuclear pharmacy shall only be issued to a person who is, or who employs, [a qualified] an authorized nuclear pharmacist. All personnel performing tasks in the preparation and distribution of radiopharmaceuticals and ancillary drugs shall be under the direct supervision of [a qualified] an authorized nuclear pharmacist, who shall be in personal attendance]. The pharmacist-in-charge shall be an authorized nuclear pharmacist and be responsible for all operations of the pharmacy.

(B) The permit to operate a nuclear pharmacy is effective only [so long as] if the pharmacy also holds a current Nuclear Regulatory Commission and/or [Missouri Department of Health license] Agreement State radioactive materials license. Copies of the most recent regulatory inspection reports [shall] must be made available upon request to the board for inspection.

[(C) Any nuclear pharmacy which provides (transfers) product outside of a patient specific prescription service must be licensed as a drug distributor in order to provide a product for a prescriber's use.]

(C) The nuclear pharmacist-in-charge shall notify the Board of Pharmacy by letter of the outcome of any hearings under state or federal laws or regulations governing radioactive materials involving or against the pharmacy location licensed by the board. Notification must be within thirty (30) days of the date of

the outcome.

(4) Space, Security, Record-Keeping and Equipment.

(A) Nuclear pharmacies shall have adequate space and equipment, commensurate with the scope of services *[required and]* provided, and as required by the Nuclear Regulatory Commission or Agreement State radioactive materials license or as required by 20 CSR 2220-2.200 Sterile Compounding, 20 CSR 2220-2.400 Compounding Standards of Practice or other applicable rules of the board. Radionuclide generators shall be stored and operated in an ISO 8 or better classified area. All pharmacies handling radiopharmaceuticals shall include, but not be limited to, the following areas:

1. Radiopharmaceutical nonsterile and sterile preparation/dispensing area;
2. Radioactive material shipping/receiving area;
3. Radioactive material storage area; and
4. Radioactive waste decay area.

(B) The nuclear pharmacy *[professional service]* restricted area shall be secured against unauthorized personnel and must be totally enclosed and lockable.

(C) Nuclear pharmacies shall maintain records of acquisition, inventory, preparing, compounding, repackaging, dispensing, distribution, and disposition of all radioactive drugs and other radioactive materials in accordance with State Board of Pharmacy[,] and Nuclear Regulatory Commission *[and/or Missouri Department of Health statutes and regulations]* or Agreement State rules/requirements.

[(D) Nuclear pharmacies shall compound and dispense radiopharmaceuticals in accordance with accepted standards of radiopharmaceutical quality assurance. The State Board of Pharmacy recognizes that the preparation of radiopharmaceuticals involves the compounding skills of the nuclear pharmacist to assure that the final drug product meets accepted professional standards of purity and quality.]

(E) A nuclear pharmacy shall have available the following resources:

1. A vertical laminar airflow hood that is annually certified to assure aseptic conditions within the working areas;
2. A sanitary work area that is designed to avoid outside traffic and outside airflow and that is ventilated so that it does not interfere with sanitary conditions. The sanitary work area shall not be used for bulk storage of supplies or other materials;
3. A sink located nearby that is suitable for cleaning purposes;
4. A current policy and procedure manual that includes the following subjects:
 - A. Sanitation;
 - B. Storage;
 - C. Dispensing;
 - D. Labeling;
 - E. Record keeping;
 - F. Recall procedures;
 - G. Responsibilities and duties of supportive personnel;
 - H. Training and education in aseptic technique; and
 - I. Compounding procedures.]

(D) Nuclear pharmacies shall prepare, compound, repackage, and dispense radiopharmaceuticals in accordance with accepted standards of nuclear pharmacy practice and in compliance with 20 CSR 2220-2.200 Sterile Compounding and 20 CSR 2220-2.400 Compounding Standards of Practice. Appropriate safety and containment techniques for preparing, repackaging, and compounding radiopharmaceuticals shall be used in conjunction with the aseptic techniques required for sterile preparations. Only authorized nuclear pharmacists, intern pharmacists, and nuclear pharmacy technicians may prepare, compound, repackage, or

dispense radiopharmaceuticals.

(E) Unless required by other rule or applicable law, all records required by this rule must be maintained for two (2) years and must be made available to the board or its representative upon request.

(5) Dispensing, Packaging, Labeling.

(A) A radiopharmaceutical shall be dispensed only to a *[licensed physician]* a practitioner or facility authorized by the Nuclear Regulatory Commission *[and/or the Missouri Department of Health]* or an Agreement State to possess, use and administer such drug. *A radiopharmaceutical shall be dispensed only upon receipt of a prescription or medication order from such licensed physician. Except that a radiopharmaceutical may be transferred to a person who is authorized to possess and use the drug for nonclinical applications.], provided that a radiopharmaceutical may be transferred to a person who is authorized to possess the drug in accordance with the regulations of the NRC/Agreement State. A radiopharmaceutical shall not be dispensed directly to a patient. A nuclear pharmacy may distribute radionuclide elutions to other authorized users to meet a drug shortage.*

[(B) Radioactive drugs are to be dispensed only upon a non-refillable prescription order from a licensed physician or the physician's designated agent. Upon receiving an oral prescription order for a radiopharmaceutical, the nuclear pharmacy shall immediately have the prescription order reduced to writing or recorded in a data processing system. The order must be taken by a pharmacist, intern pharmacist, nuclear medicine technologist or designated agents. Nuclear medicine technologists may only receive prescription orders for diagnostic radiopharmaceuticals, and all such prescriptions must be reviewed and initialed by the pharmacist.]

(B) The amount of radioactivity shall be determined by dose calibrator, appropriate radiometric methods, or decay calculation methods for each individual dose immediately prior to dispensing.

(C) Radiopharmaceuticals are to be dispensed only upon a non-refillable prescription drug order or a contingency prescription drug order from a practitioner or facility authorized by the Nuclear Regulatory Commission or Agreement State to possess, use, and administer radiopharmaceuticals or the practitioner's/facility's designated agent. The prescription drug order/contingency prescription drug order must be taken by an authorized nuclear pharmacist, intern pharmacist, or nuclear pharmacy technician under the supervision of an authorized nuclear pharmacist. Only authorized nuclear pharmacists may receive verbal therapeutic prescription drug orders. The prescription record shall contain all information as required in [4 CSR 220-2.018] 20 CSR 2220-2.018 Prescription Requirements and shall also include:

1. The date of dispensing and the calibration time of the radiopharmaceutical; and

2. The *[name of the procedure]* patient's name for therapeutic prescription drug orders and blood-containing products.

[(C)](D) The [immediate outer container shield] unit dose container of a radiopharmaceutical to be dispensed shall be labeled with—

1. The name and address of the pharmacy;

2. The name and address of the authorized prescriber/facility where the prescription drug order/contingency prescription drug order is to be administered;

3. The date of dispensing and a unique readily retrievable identifier;

[4. The serial number assigned to the order for the radiopharmaceutical;]

[5.]4. The standard radiation symbol;

[6.]5. The words "Caution Radioactive Material";

[7.]6. The name of the procedure, if known;

[8.]7. The name or generally recognized and accepted abbreviation of the radiopharmaceutical, radionuclide, and chemical form;

[9.]8. The requested amount of radioactivity [and] at the calibration date and time;

[10. If a liquid, the volume;

11. If a solid, the number of items or weight;

12. If a gas, the number of ampules or vials;]

9. The radiopharmaceutical beyond-use date;

10. The quantity dispensed;

[13.]11. If applicable, Molybdenum-99 content to *United States Pharmacopoeia* (USP) limits of <0.15uCi Mo-99 per 1mCi Tc-99m at time of administration or product expiration; and

[14. The patient name or the words "Physician's Use Only" in the absence of a patient name. When the prescription is for a therapeutic or blood-product pharmaceutical, the patient name shall appear on the label. The requirements of this paragraph shall be met when the name of the patient is readily retrievable from the physician upon demand.]

12. The patient name or the words "Physician's Use Only," "Contingency Prescription Drug Order," "Per Physician's Order," or similar wording in the absence of a patient name. If no patient name is used, the pharmacy must be able to retrieve the name of the patient from the authorized prescriber/facility within three (3) days if requested. When the prescription is for a therapeutic or blood-containing radiopharmaceutical, the patient name shall appear on the label.

[(D)](E) The immediate inner container label of a radiopharmaceutical to be dispensed shall be labeled with—

1. The standard radiation symbol;

2. The words "Caution Radioactive Material";

3. The identity of the [radionuclide] radiopharmaceutical; [and]

4. The [serial number] unique, readily retrievable identifier of the radiopharmaceutical[.]; and

5. The patient's name, if known or the words "Physician's Use Only," "Contingency Prescription Drug Order," "Per Physician's Order," or similar wording in the absence of a patient name.

[(E) When a radiopharmaceutical is dispensed under the authority of an Investigational New Drug Application (IND), the nuclear pharmacy records shall include an investigator's protocol for the preparation of the radiopharmaceutical, a copy of the Institutional Review Board approval form (or letter) and a letter from the manufacturer (sponsor) indicating that the physician requesting the radiopharmaceutical is a qualified investigator.]

(F) Radiopharmaceuticals approved by the United States Food and Drug Administration are not subject to the unit dose container labeling requirements in subsection (D) or the radiometric measurement requirements of this rule if the nuclear pharmacy does not process the radioactive drugs in any manner nor violate the original manufacturer product packaging/labeling.

(6) Reference Manuals. Each nuclear pharmacy shall have a current copy of, or electronic access to—

[(A) Each nuclear pharmacy shall have a copy of the Missouri Pharmacy Practice Act and current regulations under the act; one recognized text in nuclear pharmacy, and a current copy of state and federal regulations governing the safe storage, handling use, dispensing, transport and disposal of radioactive material.]

(A) Applicable reference materials commensurate with the scope of services provided;

(B) A current print or electronic edition of statutes and rules governing the pharmacy's practice, including, but not limited to,

Chapters 338 and 195, RSMo, 20 CSR 2220 and, if applicable, 19 CSR 30 governing controlled substances; and

(C) Agreement State and/or NRC regulations governing the safe storage, handling, use, dispensing, transport, and disposal of radioactive material, including but not limited to Title 10 and Title 49 of the United States Code of Federal Regulations.

[(7) Any preparation of Positron Emission Tomographic (PET) radio pharmaceuticals shall comply with 4 CSR 220-2.200 Sterile Pharmaceuticals and with applicable USP standards.]

(7) Special Conditions.

(A) To comply with NRC exposure guidelines of keeping radiation exposure as low as reasonably achievable (ALARA), the required pharmacist verification of the preparation shall be deemed satisfied if a pharmacist has previously verified the correct ingredients and calculations. Additionally, a pharmacist must verify the accuracy of the prescription/drug order information used and the label information prior to dispensing.

(B) At its discretion, for a pharmacy preparing, compounding, repackaging, or dispensing radiopharmaceuticals the board may grant an exemption to regulation requirements that do not pertain to the practice of nuclear pharmacy for a time period designated by the board if such exemption is not contrary to other law and the exemption will provide equal or greater protection of the public safety, health, or welfare. Exemption requests must be submitted in writing and identify the specific exemption requested, the grounds for exemption, the requested exemption length, and any proposed procedures or safeguards for protecting the public safety, health, or welfare if the exemption is approved. If deemed appropriate, the board may grant an exemption to all nuclear pharmacies based on one (1) pharmacy's request.

AUTHORITY: sections 338.210, 338.220, 338.240, 338.250, 338.280, [338.330(3)] and 338.350, RSMo [1994 and 338.220 and 338.350, RSMo Supp. 1997] 2016, and section 338.330(3), RSMo Supp. 2018. This rule originally filed as 4 CSR 220-2.500. Original rule filed Sept. 2, 1997, effective April 30, 1998. Moved to 20 CSR 2220-2.500, effective Aug. 28, 2006. Amended: Filed: April 23, 2019.

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 cost private entities approximately two hundred twenty-five thousand dollars (\$225,000) annually 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 the Missouri Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this amendment in the Missouri Register. No public hearing is scheduled.

**FISCAL NOTE
PRIVATE COST**

- I. Department Title: Department of Insurance, Financial Institutions and Professional Registration**
Division Title: State Board of Pharmacy
Chapter Title: General Rules

Rule Number and Title:	20 CSR 2220-2.500 (Nuclear Pharmacy- Minimum Standards of Operation)
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 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:
3	New Missouri nuclear pharmacy applicants	\$ 225,000 <i>recurring annually over the life of the rule</i>

III. ASSUMPTIONS/WORKSHEETS

The following general estimations were used to calculate private fiscal costs:

1. The amended rule primarily updates and modernizes current rule requirements without additional compliance costs. However, proposed section (4)(A) requires radionuclide generators to be stored and operated in an ISO-8 or better classified area. After consultation with multiple nuclear pharmacies and the Board’s inspection staff, the Board is unaware of any Missouri nuclear pharmacy that does not currently meet the requirements of section (4)(A). Accordingly, no compliance costs have been estimated for currently licensed nuclear pharmacies in relation to this section.
2. Based on Board licensing data, the Board estimates approximately three (3) new nuclear pharmacies will be licensed by the Board each year that will need to comply with section (4)(A). Based on industry data/cost estimates, the Board estimates the average size of the required ISO-8 area would be approximately 100 square feet with installation/construction costs of approximately \$ 750 per square foot. Accordingly, total annual compliance costs are estimated to be \$75,000 per new pharmacy applicant and \$ 225,000 in the aggregate (3 nuclear pharmacy applicants per year x 100 sq. feet per ISO-8 area x \$ 750 per sq. foot).
3. Estimated costs may vary with inflation and increase at the rate projected by the Legislative Oversight Committee. Costs will recur annually over the life of the rule, however, the number of affected licensees may fluctuate in a manner that is currently unknown.

**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 department is amending subsection (1)(C).

PURPOSE: This amendment reduces 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	\$/250.00/175.00
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 [2016] Supp. 2018. 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. Amended: Filed April 29, 2019.

PUBLIC COST: This proposed amendment will cost state agencies approximately seventeen thousand two hundred fifty dollars (\$17,250) 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 save private entities approximately seventeen thousand two hundred fifty dollars (\$17,250) 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 to 20 CSR 2233-1.040 Fees**

II. SUMMARY OF FISCAL IMPACT**Estimated Fiscal Impact**

Affected Agency or Political Subdivision	Estimated Cost of Compliance	
State Committee of Marital and Family Therapists	\$17,250	
	Total Decrease in Revenue Biennially for the Life of the Rule \$17,250	

III. WORKSHEET

See Private Entity Fiscal Note

IV. ASSUMPTION

1. 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 board's recent five year analysis, the committee voted on a \$75 reduction in renewal fees.
2. It is anticipated that the total decrease in revenue will occur for the life of the rule, may vary with inflation, and is expected to increase 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 337.712, RSMo, the committee shall by rule 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.

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 I - General Rules
Proposed Amendment to 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:
230	Renewal Fee (Renewal Fee Decrease @ \$75)	\$17,250
	Estimated Biennial Savings for the Life of the Rule	\$17,250

IV. ASSUMPTION

1. The above figures are based on FY18-FY19 actuals.
2. It is anticipated that the total fiscal savings will occur for the life of the rule, may vary with inflation, and is expected to increase at the rate projected by the Legislative Oversight Committee.